Northern Ireland Audit of Dementia Care

Northern Ireland Audit of Dementia Care in Acute Hospitals 2015

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Northern Ireland Audit of Dementia Care in Acute Hospitals 2015

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The Northern Ireland Audit of Dementia Steering Committee & Advisory Group

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Foreword

Admission to hospital can be an extremely distressing and overwhelming experience for people with dementia and their families/carers, and outcomes for people with dementia in the aftermath of admission can be very poor. This has led researchers, clinicians, hospital management and other staff, as well as Government, to consider the following question: Does the care of the person with dementia in an acute hospital contribute to the poor outcome?

There are approximately 19,000 people living with dementia in Northern Ireland, and with this figure set to increase to 60,000 by the year 2051, it is crucial that services providing dementia care are of a high standard. Up to 29% of older adults admitted to hospital have dementia (Cork Dementia Study, 2015; Travers et al., 2013), making service change and development in this area an urgent issue.

The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPS), have acknowledged this issue, and have published a strategy for dementia services, 'Improving Dementia Services in Northern Ireland - A Regional Strategy', with a section dedicated to acute hospital dementia care. This has led to hospitals focusing more on dementia care.

The present report holds the results of the first Northern Ireland Audit of Dementia Care in Acute Hospitals (NIAD), which was undertaken to gain a baseline picture of care in the 12 acute hospitals in Northern Ireland. This project will provide information that will enable further implementation of the principles of the regional dementia strategy relating to hospital care, and has made an array of recommendations for improvement across a number of critical domains relating to dementia care.

This report highlights a number of key areas that require change, and makes specific recommendations for improvement that would markedly benefit the person with dementia admitted to acute hospitals. It must be noted that there were also significant areas of good practice in dementia care, which are also underlined.

It is encouraging that the findings of this audit of dementia care in Northern Ireland compare favourably with the Republic of Ireland (2014) and England and Wales in their second round of audit (2013).

Given that this audit, when carried out in England and Wales, had a substantial impact on the quality of dementia care in hospitals, as evidenced by the improvements in the second round of audit, it is our hope that the results of this baseline audit will stimulate similar advances in quality of care.

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Co-Chairs of the Steering Committee of the Northern Ireland Audit of Dementia

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Executive Summary

Background

Dementia is an increasingly common diagnosis and the prevalence is growing each year as the population ages. In Northern Ireland, the number of people with dementia is set to triple to 60,000 by 2051. This will place great demands on health and social care services, which already struggle to provide best care for dementia.

Approximately 21-29% of adults over 70 admitted to acute hospitals have dementia (Cork Dementia Study, 2015; Travers et al., 2013), and we know that hospital admission currently places patients at an increased risk of a range of adverse health outcomes post-discharge, including cognitive and functional decline (Andrews, 2013), new admission to residential care/nursing home (Cork Dementia Study, 2015; de Siun et al., 2014), and increased mortality (Cork Dementia Study, 2015; Sampson et al., 2009).

Dementia care in hospitals can be suboptimal for a number of reasons; poor recognition of the condition (Laurila et al., 2004), lack of staff training and education in dementia care (Coffey et al., 2014; Leung & Todd, 2010), poor assessment (Royal College of Psychiatrists, 2011; 2013), over-use of antipsychotic medication (Banerjee, 2009), an unsuitable physical ward environment (Andrews, 2013), and poor discharge planning (Bauer et al., 2009).

Dementia care is costly; in the Regional Dementia Strategy it is estimated that health and social care costs and informal costs related to dementia care are approximately £284m in Northern Ireland, based on 2011/12 prices. It is projected that this could double over the next 20 years as the prevalence of dementia increases, if service reform is not implemented urgently. Better care can lead to reductions in length of hospital stay; a report by the Alzheimer's Society (2009) estimated that improving care and reducing length of stay for

people with dementia could result in savings of up to £80m for the NHS in Northern Ireland, England and Wales.

The Northern Ireland Regional Dementia Strategy 'Improving Dementia Services in Northern Ireland' gives direction on how to advance dementia care across health and social care services, including the acute hospital setting. The Northern Ireland Audit of Dementia Care in Acute Hospitals (NIAD) was undertaken to obtain a rich picture of the baseline quality of care, and to make tailored recommendations for improvement, which will facilitate further implementation of Northern Ireland's Regional Dementia Strategy.

Methodology

This audit was carried out between November 2014 and January 2015 in all 12 acute hospitals in Northern Ireland that admit adults (see Appendix A), to measure the quality of dementia care in this setting.

The tools used were adapted from the first National Audit of Dementia Care in General Hospitals in England and Wales (2011), for use in Northern Ireland's healthcare setting, with permission from the Healthcare Quality Improvement Partnership.

In total, the audit involved four modules;

Hospital Organisation Audit (Appendix D): This tool collected information through interview with senior hospital management and clinicians about governance, and the policies and procedures in place relating to the planning and delivery of dementia care at hospital level (n=12).

Case Note Review Audit (Appendix E): In this module, the case notes of patients (n=240) with dementia attending each hospital were reviewed. The tool collected information on multidisciplinary assessment, prescription of antipsychotic medication, discharge co-ordination and planning, and referral to specialist services. One-quarter of case notes were independently re-reviewed to assess inter-rater reliability.

Ward Organisation Audit (Appendix F): At ward level, information was collected through interview with ward managers (n=36) on staffing levels, systems for supporting staff development, access to specialist services, information available on the ward, nutrition, and systems for enabling communication.

Ward Environment Audit (Appendix G): This checklist involved observing the physical ward environment (n=36) for aspects of the built structure and design that may impact upon patients with dementia.

The data from all four modules of the audit has been collated in this report and the findings are arranged under the following distinct headings:

1) Governance
2) Multidisciplinary Assessment
3) Mental Health, Liaison Psychiatry and Antipsychotic Medication
4) Nutrition
5) Information and Communication
6) Staff Training
7) Staffing and Staff Support
8) Physical Ward Environment
9) Discharge and Discharge Planning
10) Palliative Care

Key Findings

Governance

Hospitals can often struggle with the issue of governance as it relates to care quality and improvement (Tabish, 2012). Effective governance is central to excellence in care provision, and should currently be a priority in dementia care.

Hospitals are quickly experiencing an increase in the number of admissions of people with dementia, and need policies, procedures, and systems in place to regulate the planning and delivery of dementia care. This audit investigated the policies and procedures in place governing the current care of people with dementia:

- No hospital reported having a dementia care pathway in place, or in development.
- 25% of hospitals could identify people with dementia when reviewing their data on delayed discharges/transfers.
- 33% of hospitals reported that they could identify people with dementia when reviewing in-patient falls.
- The management team receives feedback on a regular basis from clinical leads for older people, including people with dementia, in 33% of hospitals.
- 83% of hospitals have a named officer with designated responsibility for the protection of vulnerable adults, including people with dementia.
- Wards reported good access to specialist services including Social Work, Pharmacy, Physiotherapy, Dietetics, Speech and Language Therapy, Palliative Care, Geriatric Medicine, Liaison Psychiatry, Psychiatry of Old Age, and Occupational Therapy.
- No wards had access to Speech and Language Therapy, Dietetics or Continence services at the weekends.
- Most wards reported no access to Psychology (64%) and Specialist Continence Services (53%).
- One in five people with dementia admitted from home are discharged to a nursing home/long term care.
- The median length of stay for those admitted from and discharged to a nursing home (9 days), was shorter than those awaiting new nursing home placement (20.5 days), and those admitted from and discharged home (10 days).

- Those admitted from a nursing home were less likely to receive a cognitive assessment (10%) or an assessment of functioning (17%), than those admitted from and discharged to their own home (41%, 37% respectively).

The above findings indicate that there is significant room for improvement in policies/procedures governing care at hospital-level. The introduction of integrated care pathways and leads for dementia care would outline best practice for all healthcare professionals involved. Better visibility, reporting and reviewing of factors relating to the care of people with dementia would highlight hospital performance, promote accountability, and drive change. The findings also indicate a need for increased supports, resources and integrated care planning with community services. These results underline areas for future research in the governance of dementia care as it relates to discharge destination, length of stay and multidisciplinary assessment.

Multidisciplinary Assessment

People with dementia admitted to hospital have an increased risk of poor outcomes including cognitive and functional decline, institutionalisation, and increased mortality. A comprehensive assessment of physical and mental health, as well as health and social care needs may minimise the risk of adverse outcomes.

While most hospitals reported having guidelines/systems in place to ensure that comprehensive multidisciplinary assessment is carried out, the results of the case note review indicate that in practice, a number of assessments vital to the planning of care and prognostication in dementia are under-performed:

- Acceptable levels of physical assessments such as pressure sore risk (95%), nutritional status (91%), and continence needs (95%) were carried out.
- Lower levels of assessment were found for functional ability (29%), mobility (71%), and pain (82%).
- 33% of people with dementia received a cognitive assessment during the admission.

- Delirium screening was sub-optimal; less than one in three people with dementia received any screening for changes/fluctuations in behaviour that might indicate delirium.
- Mood and behavioural and psychological symptoms of dementia were rarely assessed (6%, 7% respectively).
- Only 28% of patients had collateral history recorded indicating the nature of the progression of the dementia.
- The need for a health and social care assessment was identified for 41% of patients, and the majority of these patients (90%) received an assessment during the admission.

Generally, there were good levels of physical assessment. However, the assessment of functioning, mobility and pain must be improved. Mental assessment was carried out less frequently than physical assessment; cognitive assessment and screening for delirium were under-performed, and this is concerning in a cohort with a recognised and recorded diagnosis of dementia. Health and social care assessment was acceptable, however up to 1 in 10 people with dementia that need an assessment, do not receive one prior to discharge. There was good access to Geriatric Medicine and Neurology services in hospitals, which are vital to the diagnosis and management of dementia.

Mental Health, Liaison Psychiatry and Antipsychotic Medication

Specialist mental health services can play an essential role in the assessment, monitoring and management of mental health needs in people with dementia. Undiagnosed and untreated comorbid mental health problems are costly and place the patient at an increased risk of adverse outcomes (Sharpe, 2014). As dementia becomes more prevalent in the acute setting, the specialised skills of services including Liaison Psychiatry and Psychiatry of Old Age will be in higher demand.

Behaviours that challenge are common in dementia, and can be burdensome for carers, thus increasing the risk of institutionalisation. Many reports have shown that antipsychotics are

often the first-line response to behaviours that challenge in acute hospitals, despite being associated with adverse side effects (Banerjee, 2009).

This audit investigated specialist mental health service provision, policies relating to mental health and behaviours that challenge, and the prescription and use of antipsychotic medication in people with dementia:

- All 12 acute hospitals reported providing access to a Liaison Psychiatry service which can provide assessment and treatment to adults throughout the hospital.
    - 75% of these services can provide emergency/urgent assessment.
    - 25% of hospitals can provide evening access to this service.
    - 25% of hospitals can provide weekend access to this service.
- All 12 acute hospitals reported providing access to a Liaison Psychiatry of Old Age service which can provide assessment and treatment to adults throughout the hospital.
    - 58% of these services can provide emergency/urgent assessment.
    - No hospital reported having evening or weekend access to this service.
- 92% of hospitals reported having a protocol in place governing the use of interventions for patients displaying violent or challenging behaviour, which is suitable for use in patients who present with behavioural and psychological symptoms of dementia.
- 21% of people with dementia had antipsychotic medication during their admission.
- 9% of people with dementia received a new prescription for antipsychotics during their admission.
- A reason was recorded for the new prescription of antipsychotics in hospital in 95% of case notes.
- The primary reason recorded for the prescription of antipsychotic medication was agitation (55%).

The access to specialist mental health services in acute hospitals is good, but could be improved upon by providing access in the evenings and at weekends. All but one hospital reported having protocols in place governing the use of interventions for behaviours that challenge. These protocols could be improved upon by including evidence-based guidelines for the prescription and administration of antipsychotic medication.

There were lower levels of antipsychotic medication prescribed here than in the audits in England and Wales (2013) and the Republic of Ireland (2014). However, efforts must continue to ensure that non-pharmacological approaches are used as the first line response to behaviours that challenge in people with dementia.

Nutrition

Malnutrition is prevalent in hospital settings and approximately 19-63% of adults present with this. Among older adults, malnutrition is particularly common, and is more common in hospitals than in other settings (Omar, 2015). Good nutrition and hydration is central to recovery and can be even more important in people with dementia than other populations, given that the incidence of eating disability can be as high as **41%** in those with moderate dementia, and increases as the condition progresses (Slaughter et al., 2011). According to NICE guidelines, every adult admitted to hospital should have a nutritional status assessment on admission, and have their weight/body mass index recorded. This audit investigated the assessment of nutrition and aspects of care relating to nutrition in people with dementia:

- **91% of patients with dementia had a nutritional status assessment performed during** their admission.
- **79%** of patients had their **body** mass index/weight recorded in their case notes.
- All 12 hospitals reported having protected mealtimes in place in all wards that admit adults, while **92%** of wards reported operating a successful protected mealtime system.
- **All wards with protected mealtimes reported that the system allows for family/carers** to visit and assist with feeding **during** mealtimes.
- **94%** of wards have systems in place to signal to staff on the ward that a patient might need help with eating e.g. red tray system.
- **92%** of wards can provide adapted utensils and cutlery to encourage patients to eat as independently as possible.
- Wards have good access to Speech and Language Therapy, Dietetics, and Occupational Therapy with the vast majority of wards reporting access at least 5 days

per week, however no wards have access to Speech and Language Therapy or Dietetics at the weekends.

This audit found generally good assessment of nutritional status in acute hospitals in Northern Ireland, and good practice in relation to minimising the risk of malnutrition e.g. protected mealtimes, red trays, adapted utensils. The recording of body mass index could be improved upon however, and all patients who can have this assessed should have it performed as early as possible during the admission. Finally, wards reported good week day access to specialist services equipped with the skills to manage complex cases including Speech and Language Therapy, Dietetics, and Occupational Therapy, however access to specialist services should be improved at weekends.

Information and Communication

The families and carers of people with dementia have reported feeling ignored, excluded and unsupported during hospital admission (Jamieson et al., 2014; Lowson et al., 2013). The communication of healthcare information to the person with dementia and their families and carers is central to the provision of person-centred care. Families and carers should be seen as useful assets to healthcare professionals because their input in vital to best care.

This audit investigated hospital and ward level systems for sharing and communicating information about the person with dementia, their diagnosis, and supports on discharge for both patients and carers;

- 58% of hospitals have clear guidelines around asking the carer about the extent to which they prefer to be involved in the care and support of the person with dementia.
- 62% of carers who should have had an assessment of their current needs prior to discharge had one performed.
- 58% of case notes have evidence indicating that the appropriate place of discharge was discussed with the family/carer prior to discharge.
- One-third (63/189) of families/carers received a copy of the discharge summary before leaving the hospital.
- 47% of families/carers received 24 hours or less notice of discharge.

- 97% of wards reported that a healthcare professional responsible for coordinating the care of the person with dementia is identified to the patient and their family/carer as their point of contact during the admission.
- 10% of case notes contained a section dedicated to collecting information about the patient, pertinent to providing person-centred care for the person with dementia.
- 42% (5/12) of hospitals have a system in place across the hospital to ensure that all staff from other areas outside of the ward are aware of the person's dementia whenever they access other treatment areas.
- Most wards (34/36) identified 'handover' as the system used for communicating information about the patient to other staff involved in their care.

General information relating to hospital admission is readily available at ward-level, however the communication of information relating to people with dementia and their care is poor across a number of areas, particularly discharge planning, and support on discharge for the person with dementia and their carers. Also of concern, is the lack of psychosocial and personal information recorded in case notes that would allow for the provision of person-centred care. Better guidance on, and more efficient systems for, collecting and sharing information about the person with dementia should be implemented at hospital level.

Staff Training

There is a growing body of literature indicating the need for improved dementia education and training for nurses and healthcare staff in acute hospital services. Lack of staff training can impact significantly on the quality of dementia care provided. Hospital staff themselves have described training in dementia as under-provided, particularly in areas such as challenging behaviour, recognising pain, understanding the risks associated with restraint/sedation, assessing cognitive ability, and communicating with people with dementia (Gandesha et al., 2012). This audit investigated the provision of training in dementia care for staff working in acute hospitals in Northern Ireland;

- Less than half of hospitals have a knowledge and training framework/strategy that allows for the identification of necessary skill development among staff caring for people with dementia.

- No hospital has mandatory dementia awareness training for staff.
- Dementia awareness training has been provided by the majority of hospitals in the 12 months prior to the audit for doctors (58%), registered nurses (59%), healthcare staff (67%), and allied health professionals (75%).
- 42% of hospitals provided their doctors, nurses and healthcare staff with training in communication skills specific to people with dementia in the previous 12 months.
- 83% of doctors received training in the assessment of capacity in the previous 12 months.
- 67% of hospitals provided training in the management of behaviours that challenge for both doctors and nurses in the previous 12 months.
- The majority of hospitals provided training on the assessment of risk when considering the use of restraint/sedation for doctors (67%), nurses (75%) and healthcare staff (75%) in the previous 12 months.
- 81% of wards could provide cover to allow staff to attend training relating to the care of people with dementia.

People with dementia can have complex psychosocial care needs that require staff to draw on a more specialised skillset. It is vital going forward that staff training in aspects of dementia care is made a priority at hospital-level. All hospitals should commit to creating a framework/strategy that allows them to identify gaps in training relating to dementia care. Furthermore, all hospital staff that work with or encounter people with dementia should have basic dementia awareness training.

Staffing and Staff Support

Research studies have reported an association between low staffing levels in hospitals and patient mortality and other poor outcomes (Needleman et al., 2002, 2011; Lang et al., 2004). Nurses working in hospitals with optimal staffing levels have reported less job dissatisfaction, burnout, and/or fewer problems relating to the quality of patient care. Staff skill mix can also impact upon patient outcomes (Twigg et al., 2012) and should be an important consideration for management.

This audit investigated staffing levels of nurses and healthcare staff, vacancies, and the type of supports in place to promote staff development on the wards.

- The mean number of registered nursing vacancies per ward is 2.12 and the mean number of healthcare staff vacancies per ward is 0.93.
- 78% of wards have at least one vacancy in their permanent nursing and healthcare staff.
- Vacancies are most often filled by hospital pool/bank (nurses, 94%, healthcare staff, 92%) and slightly less often by agency staff (nurses, 72% healthcare staff, 69%).
- 97% of wards have an agreed minimum staffing level across shifts.
    - 87% of these wards report that minimum staffing levels are generally met.
- Nursing staff have good access to appraisal/mentorship (97%), clinical supervision (94%) and the guidance of a dementia champion at ward level (64%).
- Healthcare staff have similar access to appraisal/mentorship (94%) and access to guidance from a dementia champion (64%), but poorer access to clinical supervision.
- 83% of wards do not offer peer support groups to staff, and 86% do not offer reflective practice groups.

The quality of dementia care provided in the acute hospitals in Northern Ireland may be negatively impacted upon by under-staffing on wards that admit people with dementia. On average, wards have just over two whole-time equivalent vacancies among their nursing staff, however as many as 8.31 vacancies were observed on wards between both the nursing and healthcare staff. This has resulted in the common use of hospital bank and agency staff, which can lead to less consistency in care, and an increased cost of care provision.

It is important that staff feel supported in their roles, and while appraisal/mentorship is readily available to nurses and healthcare staff, better access to the guidance and support of trained dementia champions could lead to exponential increases in the quality of dementia care in hospitals.

Physical Ward Environment

People with dementia can experience admission to an acute hospital as distressing, and their risk of poor outcomes such as cognitive/functional decline, institutionalisation and mortality are increased after admission to hospital (Andrews, 2013; Sampson et al., 2009). Among the many factors accountable for these outcomes is the built structure and features of the physical ward environment.

People with dementia can find it difficult to adapt to new environments due to reduced spatial orientation, and can become easily disorientated. The optimal physical ward environment should help to offset the impairments of dementia (Marshall 2001).

A module of this audit was dedicated to investigating the suitability of the physical ward environment for people with dementia:

- 58% of wards had no day room/lounge that patients could use, while 69% had no space for active patients to walk around safely.
- Keys areas such as the nursing station were not clearly marked on 53% of wards and signs to locate toilets were only visible to patients from their bed areas on 11% of wards.
- One ward had a colour scheme to aid navigation.
- 94% of toilet doors carried signs.
- Clocks and calendars/orientation boards were not visible to patients on 28% and 92% of wards respectively.
- On 25% of wards, messages from relatives and personal objects/items were visible to patients.
- Most floors (69%) were plain/subtly patterned.
- No ward had flooring level changes such as steps or slopes.

- 92% of wards were adapted to assist mobility difficulties, with all 36 having handrails in the toilets and being able to provide equipment to assist mobility.

While some aspects of the ward environment such as the flooring and features that promote mobility are generally suitable for people with dementia, it is clear that overall the ward environment is not optimally tailored to the needs of people with dementia.

Necessary and cost-effective changes that could be made largely at ward level include; dementia-appropriate signage, visual access cues for facilities e.g. the toilet, and colour schemes to aid navigation. Clocks and calendars/orientation boards would aid temporal orientation, and providing space for and encouraging a display of personal items/objects would help orientate people with dementia to their personal identity.

Discharge and Discharge Planning

Discharge planning and coordination can be a complicated process for hospital staff working with people with dementia in hospitals because the condition can give rise to complex physical and psychosocial needs. Good planning is essential for the welfare of the person with dementia, to ensure that their needs continue to be met post-discharge; inadequate practices are associated with poorer patient outcomes and an increased risk of readmission to hospital (Bauer et al., 2009).

This audit investigated the hospital discharge process and aspects of governance and care, as they relate to discharge planning and coordination:

- All 12 hospitals reported having a discharge policy which states that discharge should be an actively managed process which begins within 24 hours of admission.
    - However, the case note review revealed that discharge planning was only initiated within 24 hours of admission in 16% of case notes.
- All 12 hospitals reported that the discharge policy states that relatives and carers should be informed and updated about the prospective discharge date.
    - However, the case note review revealed that almost half (47%) of families/carers received 24 hours or less notice of discharge.

- 83% of hospitals reported having a named person who takes overall responsibility for complex needs discharge, and this includes people with dementia.
- 26% of case notes had no evidence of a discharge plan.
- A named person coordinated the discharge plan for only 55% of people with dementia.
- 16% of case notes showed evidence that the patients' level of cognitive impairment using a standardised instrument was summarised and recorded at the point of discharge.
- 55% of case notes had the cause of cognitive impairment recorded at discharge.
- Of those with delirium and BPSD during the admission, 43% and 25% respectively had the symptoms summarised and recorded for discharge.

While hospital policies regarding discharge are strong, it is important that reviews are carried out regularly to ensure that practice is in line with policy. In particular, policies relating to the transfer of patients with dementia should be strengthened. All people with dementia should have a discharge plan, and planning should begin within 24 hours of admission to ensure that the necessary supports and resources are in place upon discharge. Overall, significant improvements could be made in the recording of information relevant to discharge, to ensure continuity of care.

Palliative Care

The basic goal of palliative care is to help people with serious illnesses feel better throughout the entire course of the disease, while end of life care refers to care as it relates to dying, death and bereavement, and is provided in the final stages of the disease. Up to 41% of people with dementia die in hospitals (Houttekier et al., 2010), indicating that acute hospitals need to be able to provide high quality end of life and palliative dementia care. This can be a challenge in people with dementia as the disease trajectory can be uncertain, and varies from person to person.

This audit investigated the number of in-hospital deaths, referrals to specialist palliative care, and the management of care according to end of life care pathways for people with dementia:

- 9% (22/240) of people with dementia died in hospital during the admission.
- 10% (24/240) of patients were noted to be receiving end of life care, or were being managed according to an end of life care pathway.
    - Of those who died, 82% (18/22) were receiving end of life care, or being managed according to an end of life care pathway.
- 8% (18/237) of patients were referred to specialist palliative care during the admission.
    - 39% (7/18) of these people with dementia died in hospital.
- 41% (96/237) of patients with dementia had a decision for/against resuscitation documented in their case notes.
- 10% (24/240) of case notes had a record that the families/carers were offered bereavement support.

Almost 1 in 10 people with dementia died in hospital during the admission, highlighting the need for good palliative and end of life care for people with dementia in hospitals in Northern Ireland. Most of those who died were noted to be receiving end of life care. Only 41% had a decision for/against resuscitation recorded. These findings together highlight the importance of advance care planning in the early stages of dementia, that will serve to govern decisions relating to care later in the disease, including places of treatment/death, and interventions received or not.

Report of the Northern Ireland Audit of Dementia Care in Acute Hospitals

Introduction

Dementia is a chronic and progressive disease of aging that interferes with independent functioning, and is characterised by decline in cognitive domains including memory, language, recognition/familiarity, visuospatial function and self-control/management (DSM V, 2013). It is an increasingly common diagnosis and the prevalence is rapidly growing each year as the population lives longer. In the United Kingdom, there are approximately 700,000 people currently living with dementia, however over the next three decades it is projected that up to 1.4 million people will receive a diagnosis (Department of Health, 2009). In Northern Ireland, there are at least 19,000 people with dementia currently, and by 2051, this could triple to 60,000 people (Hofman et al., 1991).

These estimates indicate that dementia will shortly become a significant public health issue in Northern Ireland. We know that between half and two-thirds of hospital beds are occupied by older adults at any one time (Department of Health, Social Services and Public Safety, 2011; Smith, 2007). Approximately 21-29% of adults over 70 admitted to acute hospitals have a dementia, with up to 42% of medical admissions having dementia (Cork Dementia Study, 2015; Travers et al., 2013; Sampson et al., 2009), making service improvement for dementia care in the acute sector a matter of urgency.

Admission to an acute hospital for a person with dementia can be a distressing experience, and one which places patients at an increased risk of a range of adverse health outcomes post-discharge, including cognitive and functional decline (Andrews, 2013), new admission to residential care/nursing home (Cork Dementia Study, 2015; de Siun et al., 2014), and increased mortality (Cork Dementia Study, 2015; Sampson et al., 2009). Dementia is also a risk factor for delirium, and delirium superimposed on dementia places people at an even

greater risk of adverse outcomes (Morandi et al., 2014). However, dementia is generally not the reason for admission to hospital (Natalwala et al., 2008). The most common reasons for admission to hospital in people with dementia include syncope and collapse, fractured femurs, respiratory conditions, urinary tract infections and dehydration (Natalwala et al., 2008; Draper et al., 2011).

While the understanding of dementia has deepened across health disciplines, and new perspectives have emerged in the literature advocating for a more person-centred approach to care, the research-practice gap has not yet been bridged. In the current culture of care, the aim is to treat the acute illness for which the person has been admitted, and dementia can often go unrecognised by healthcare staff in acute hospitals (Gandesha et al., 2012). In 2007/2008, less than 5% of inpatients on any day in Northern Ireland had a diagnosis of dementia recorded, indicating poor recognition of the condition in the acute setting (Department of Health, Social Services and Public Safety, 2011). This is not acceptable as people with dementia have greater care needs than those without dementia, relating to agitation, confusion, eating/drinking, intravenous cannulation, and ADLs (showering, dressing and incontinence) (O' Connell et al., 2011), and poor recognition inevitably means poor care planning and execution.

A number of other factors have been implicated in poor quality dementia care and health outcomes. In particular, a concern which has gathered substantial attention in the literature is poor staff knowledge and lack of training in dementia care (Borbasi et al., 2006; Coffey et al., 2014). Previous audits of dementia care in hospitals in England and Wales (Royal College of Psychiatrists, 2011), and in the Republic of Ireland (de Siun et al., 2014), have found hospital provision of staff training around dementia awareness to be poor. Almost all people with dementia experience behavioural and psychological symptoms (BPSD) throughout the course

of the condition (Tariot et al., 1995) which healthcare staff find particularly difficult to manage (Alzheimer's Society, 2009). Some staff even feel that non-pharmacological intervention for such symptoms falls outside of their role (Ervin et al., 2014), leading to the over-use of medications such as antipsychotics to manage behaviours. This has been noted as a grave concern considering the associated side effects (Alzheimer's Society UK, 2011; Mittal et al., 2011). Other factors affecting quality of care include sub-optimal multidisciplinary assessment (de Siun et al., 2014, Royal College of Psychiatrists, 2011; 2013), particularly of pain (Corbett et al., 2012), the physical ward environment (Andrews, 2012; Ziesel et al., 2003; Marshall, 2009), and poor care co-ordination and discharge planning (de Siun et al., 2014; Royal College of Psychiatrists, 2011; Bauer et al., 2009).

Dementia is an expensive condition to manage; the formal and informal health and social care cost of dementia care in Northern Ireland was estimated at £284 million at 2011/2012 prices in the Regional Dementia Strategy (Department of Health, Social Services and Public Safety, 2011). Critically, it is projected that the cost of care will *double* over the next 20 years as the prevalence grows, in the absence of service reform.

A report by the Alzheimer's Society UK (2009), focused on costing dementia care in England, Wales and Northern Ireland, found that the length of hospital stay for people with dementia is significantly longer than for those without dementia, a common finding in the literature (Guijarro et al., 2010). This not only increases the risk of negative health outcomes for people with dementia, but also places greater financial strain on the shoulders of healthcare providers. In this report, the Alzheimer's Society concluded that with better care and adequate support, people with dementia could leave hospital one week earlier and savings of approximately £80 million per year could be made in the acute hospitals.

In 2011, the Northern Ireland Regional Dementia Strategy 'Improving Dementia Services in Northern Ireland' was launched and the document emphasized the importance of reducing the incidence of dementia in the population, increasing awareness of the condition in the public and within healthcare services, earlier diagnosis, providing staff training and development, maximising independence for people living with dementia, and supporting people with dementia and their carers to live with dignity.

It is clear from the international literature that acute hospitals are generally not equipped to provide best care for people with dementia, and in recognition of this, the strategy focused a section on supporting people with dementia in hospitals. The action plan relating to this section commits to enhancing knowledge and skills training for staff within the Health and Social Care Trusts, and ensuring that individual care plans are drawn up for all people with dementia admitted to hospital, focusing on the dementia-specific supports that are necessary for timely discharge. Other key issues cited that require action include using a person–centred and multidisciplinary approach to care, providing information to the person with dementia and their family/carers, maintaining functional ability and actively seeking to prevent decline, using medications and other interventions appropriately, and considering the impact of the hospital environment on people with dementia.

The present audit has been performed with a view to investigating the quality of dementia care as it currently stands in acute hospitals in Northern Ireland. While the Regional Dementia Strategy provides valuable direction on actions that must be taken to improve dementia care, the findings of this audit will allow for tailored recommendations to be made for the acute hospital setting, which are specific to the context of Northern Ireland. Obtaining this rich picture of baseline acute hospital dementia care in Northern Ireland is an important

step towards reforming the acute health and social care services and equipping them for the demand that the future will bring.

Methodology

This audit was carried out in all 12 acute hospitals in Northern Ireland that admit adults (Appendix A), in order to obtain a baseline measure of the quality of dementia care being provided in this setting.

Materials

The tools used were adapted from the first National Audit of Dementia Care in General Hospitals in England and Wales (2011), for use in Northern Ireland's healthcare setting, with permission from the Healthcare Quality Improvement Partnership. Amendments to the tools were minor and related to variances in healthcare terminology between settings. Questions relating to the assessment of communication, the standardised assessment of pain suitable for people with dementia, and referral to neurology services were added to the hospital organisation and case note review tools, as expert consensus by the Steering Committee and Advisory Group considered these criteria essential to dementia care in Northern Ireland.

In total, the audit involved four distinct modules, with tools measuring domains relating to dementia care at various levels within the hospital structure.

Hospital Organisation Audit (Appendix D): This tool collected information about governance, and the policies and procedures in place relating to the planning and delivery of dementia care at hospital level. Specifically, the form looks at multidisciplinary assessment, mental health needs, discharge and transfer policies, recognition of dementia, staff training in dementia care, resources available for supporting people with dementia, systems for collating

information about the person with dementia, and information about specialist services available within the hospital (Liaison Psychiatry, Psychiatry of Old Age, Geriatric Medicine, Neurology) and the organisation of those services.

Case Note Review Audit (Appendix E): In this module, the case notes of 20 patients per hospital with dementia were reviewed. The tool collected information relating to admission, including multidisciplinary assessment (physical, mental, and health and social care), prescription and use of antipsychotic medication, discharge co-ordination and planning (including supports for families/carers), and referral to specialist services (Liaison Psychiatry, Psychiatry of Old Age, Geriatric Medicine, Neurology and Palliative care).

Ward Organisation Audit (Appendix F): At ward level, information was collected on staffing levels and vacancies, systems for supporting staff development, access to specialist services on the ward, information available on the ward for patients and their families/carers, nutrition, and systems for communicating with, and about, patients with dementia.

Ward Environment Audit (Appendix G): This checklist involved surveying the physical ward environment for aspects of the built structure and design that may impact upon patients with dementia. Factors observed include ward size/layout, orientation (signage, visual access cues, temporal cues, and personal objects), flooring, colours, and the potential of the ward for promoting independence.

Procedure

Audit Liaisons were nominated by the Steering Committee and Advisory Group for each individual Health and Social Care Trust, and were contacted to assist in arranging site visits to each of the 12 hospitals within the five Health and Social Care Trusts.

The **hospital organisation audit tool** was completed through structured interviews with Senior Consultants and Senior Hospital Management Staff.

The **case note review** was carried out by the NIAD project team, Career Grade Doctors and Specialist Registrars in Geriatric Medicine, between November 2014 and January 2015. Each hospital identified 30 charts that met the inclusion criteria for this aspect of the audit, of which 20 were reviewed. Requesting surplus charts allowed for occasional miscoded charts, or charts required for emergency care that were not available on the day of review. Training was provided by the audit co-ordinator on the use of the case note review audit tool and the specific meaning of the questions, along with a guidance document (Appendix H) outlining the key issues pertinent to completing the review in line with the standardised approach set out. A total of 240 case notes were audited from the 12 hospitals, with all trusts self-auditing the case notes due to geographical constraints and restrictions in resources. A coding system was devised to anonymise all data yielded from the case note review.

The audit liaison arranged for the identification of the case notes through the coding department of the hospital. The inclusion criteria guiding the review included a formal diagnosis of dementia (ICD10 codes, F00, F01, F02, F03, F05.1), a length of stay greater than five days, and date of discharge falling between January 1st 2014 and April 30th 2014. If 30 charts could not be sourced from this time period, the difference was made up by charts with discharge dates between October 1st 2013 and December 31st 2013. In instances where patients had more than one admission within the designated audit timeline, the most recent admission for each patient was chosen for review.

A quality assurance process was in place for the case note review, such that five case notes out of the 20 reviewed by the doctors were re-reviewed by the NIAD audit team in order to assess the inter-rater reliability of the tool. Cohen's Kappa was used to evaluate each item on

the case note review audit tool. However, due to the limitations of this statistical technique concerning data that is not equally likely to be answered, for instance, 'yes' or 'no', the percentage agreement between raters was also calculated and taken into account.

Both the **ward organisation** tool and **environment checklist**, were completed on 36 wards (an average of 3 per hospital) that admit adults, by the NIAD audit team. At least one medical and one surgical ward were selected per hospital by the hospital-appointed audit liaison. Structured interviews were carried out with the ward managers to complete the ward organisation tool, while the NIAD audit team observed the built structure, design and facilities of the ward to complete the environment checklist.

Data entry, cleaning and analysis was completed by the NIAD audit team, and all data was analysed by SPSS version 20. Where there is missing data, or questions that are not applicable, valid percentages are reported. For example, where patients died during admission, the questions relating to discharge were not completed, and so it is necessary to report on the percentage of patients that the section is applicable to.

Case notes of patients identified (either from responses or auditor comments) as having self-discharged, transferred to another hospital, or patients being managed according to an end-of-life care pathway were also excluded from the reporting of these questions.

The data from all four modules of the audit has been collated in this report and the findings are arranged under the following distinct headings:

1) Governance
2) Multidisciplinary Assessment
3) Mental Health, Liaison Psychiatry and Antipsychotic Medication
4) Nutrition

5) **Information and Communication**

6) **Staff Training**

7) **Staffing and Staff Support**

8) **Physical Ward Environment**

9) **Discharge and Discharge Planning**

10) **Palliative Care**

Governance

Summary

- No hospital reported having a dementia care pathway in place, or in development.
- The management team receives feedback on a regular basis from clinical leads for older people, including people with dementia, in 33% (4/12) of hospitals.
- 83% (10/12) of hospitals have a named officer with designated responsibility for the protection of vulnerable adults, including people with dementia.
- 67% (8/12) of hospitals have access to an advocacy service with experience and training in working with people with dementia.
- Wards reported good access to Social Work, Pharmacy, Physiotherapy, Dietetics, Speech and Language Therapy, Palliative Care, Geriatric Medicine, Liaison Psychiatry, Psychiatry of Old Age, Occupational Therapy, Specialist Infection Control, and Tissue Viability Services at least 5 days per week.
- No wards had access to Speech and Language Therapy, Dietetics or Continence Services at the weekends.
- Most wards reported having no access to Psychology (64%) and Specialist Continence Services (53%).
- One in five people with dementia admitted from home are discharged to a nursing home/residential care.
- The median LOS for those admitted from and discharged to a nursing home (9 days) was shorter than those awaiting a new admission to a nursing home (20.5 days), and those admitted from and discharged home (10 days).
- Those admitted from and discharged to a nursing home were less likely to receive a cognitive assessment (10%) or an assessment of functioning (17%), than those admitted from and discharged home (41%, 37% respectively).

Hospitals play a central role in the provision of care for people with dementia. However, hospitals often struggle with the issue of governance, as it relates to care quality and improvement (Tabish, 2012). Effective and successful governance is fundamental to good quality care provision, and should currently be a priority in the case of dementia care. Hospitals are seeing an increase in the number of admissions of people with dementia, and need policies and procedures in place to ensure that best care is provided and that improvements continue to be made over time.

First-rate governance is central to raising performance in health care delivery, and so this audit evaluated the policies, procedures, guidelines and systems in place at hospital-level, regulating the planning and delivery of acute dementia care in Northern Ireland.

Dementia Care Pathways in Acute Hospitals

An integrated care pathway (ICP) is 'a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes' (Davis et al., 2005). In this way, an ICP is a guideline regarding best practice in relation to care when a patient presents at a healthcare service, allowing healthcare professionals to systematically and prescriptively plan care and organize follow-up where necessary.

With the number of people with dementia growing across the globe, there is a call for development of ICPs for dementia (Samsi & Manthrope, 2014). A number of ICP examples exist, such as the NICE dementia pathway, the Dementia Services Pathway (Australia), and the Social Care Institute of Excellence (England).

ICPs for dementia are urgently needed in hospitals, given that the quality of care currently provided is known to be suboptimal, and patients are often discharged with high support

needs requiring referral to other services. Better clinical governance and organisation of the care journey is needed to facilitate evidence-based dementia care.

This audit investigated the presence of ICPs for dementia in all acute hospitals in Northern Ireland.

- None of the 12 hospitals reported having a dementia care pathway in place, or in development.

Adapting a systematic approach to care provision by developing ICPs for dementia should become a priority going forward. This would serve to ensure better service planning and delivery, and would result in the best use of resources, as well as helping to achieve a reduction in the risk of adverse health outcomes for people with dementia (Irving et al., 2012).

Informing Hospital Policies and Procedures

Poor care and discharge planning for people with dementia in hospital can result in greater lengths of stay, greater financial burden on the healthcare service, increased risk of poor outcomes and of readmission (Bauer et al., 2009; Abad-Corpa et al., 2012; Cummings, 1999). This audit investigated the visibility of people with dementia in the information collected by hospitals on discharges/transfers and readmissions, as well as the reviewing of hospital discharge policies and procedures as they relate to people with dementia.

- 25% (3/12) of hospitals could identify people with dementia when reviewing their data on patient readmissions.

- 25% (3/12) of hospitals reported that they could identify people with dementia when reviewing their data on delayed discharges/transfers.
- One hospital reported having a process in place to regularly review hospital discharge policies and procedures, as they relate to people with dementia.

Falls can be common among older people admitted to hospital, with some estimates indicating that between 3 and 20% of older patients fall at least once during their hospital admission. Falls in hospital often result in injuries, leading to an increased length of stay and a greater cost of care (Cumming et al., 2008). People with dementia are two to three times more likely to fall compared to people without dementia (Härlein et al., 2011), indicating that this cohort are high risk, and should be identifiable and monitored closely at hospital-level. In this audit:

- 33% (4/12) of hospitals reported that they could identify people with dementia when reviewing their data on the number of in-patient falls.

Feedback from clinical leads to hospital management is important to inform improvements in patient care on the ground. This audit investigated if there were systems/processes in place which give clinical leads the opportunity to advise senior management based on their experience of providing care;

- The management team receives feedback on a regular basis from clinical leads for older people, including people with dementia, in 33% (4/12) of hospitals.

Complaints can be an important indicator of where the quality of patient care might be lacking in an organisation, by providing staff with an insight into the care experiences of the patient and/or their family/carers. This audit examined if complaints by older adults,

including those with dementia, or their family/carers could be easily compiled and made visible;

- 25% (3/12) hospitals reported that complaints could be analysed by age.

Improvements in care at hospital level can only be possible if there are systems and processes in place whereby information relating to people with dementia and deficits or risks relating to their care are made visible to hospital management and senior clinicians.

It is evident from the above findings that hospitals in Northern Ireland must make people with dementia and information relating to their admission more observable and amenable to review so that areas for improvement and risk reduction can be identified.

Supporting the Person with Dementia through the Admission

Key Workers

Hospital admission can be a distressing experience for people with dementia and their families; they can require extensive support throughout the admission in order to understand information relating to their care, to secure appropriate and necessary resources to manage the condition, and to obtain the best outcomes post-discharge.

This audit looked at the presence of key workers within the hospital that could provide information and advice to people with dementia and their family/carers;

- 83% (10/12) of hospitals have a named officer with designated responsibility for the protection of vulnerable adults, including people with dementia.

- 75% (9/12) of hospitals have a social worker or other designated member of staff who is responsible for working with people with dementia and their carers, providing advice and support, and directing to organisations and agencies where necessary.

Interpreting Services

Language barriers can hinder the communication of pertinent healthcare information between the patient/their carer and the healthcare professionals. Research has shown that patients who do not have English as their first language in an English-speaking country are less satisfied with the care that they receive and may be at an increased risk of experiencing medical errors (Jacobs et al., 2004).

As part of the case note review, the first language of the person with dementia was investigated; 82% had English documented in their case notes as their first language, while the remaining 17.5% did not have their first language documented, and one person had Irish documented. It is likely that some of the people that did not have this information documented may have had a first language other than English.

This audit investigated the availability of an interpreting service within acute hospitals:

- 17% (2/12) of hospitals have access to an interpreting service that could meet the communication needs of a person with dementia.

According to the 2011 census, 11% of the population of Northern Ireland is comprised of foreign nationals. As the immigrant population ages, there will be an increased need for interpreting services for people with dementia in hospitals, and this should be a consideration

for hospital management going forward. Research has shown that providing interpreting services is a financially viable method for enhancing delivery of health care to patients with limited English proficiency (Jacobs et al., 2004).

Patient Advocacy

Also investigated was the availability of patient advocacy services for use by patients during the admission. Advocacy services can play an important role in helping people with dementia to better understand issues, make decisions and give their input. Advocacy services for people with dementia seek to ensure that they are informed as best as possible, in order to reduce vulnerability and increase feelings of empowerment.

In this audit we found that:

- 67% (8/12) of hospitals have access to an advocacy service with experience and training in working with people with dementia.
- 67% (24/36) of wards can provide either written or verbal information on patient advocacy services to patients or their families/carers.

Faith Specific Support

Ward managers were also asked about access to faith-specific support for people with dementia, and if the people providing this support would have experience of interacting with vulnerable adults.

- 81% (29/36) of wards were able to provide access to relevant faith-specific support from someone with experience of supporting vulnerable adults such as people with dementia.

Most ward managers reported that they could access support from a wide range of religious groups, but noted that many families seeking support other than from the hospital chaplain, often want to source their own support from the community.

Ward Access to Specialist Services

Each ward manager was asked to indicate the availability of a pre-determined list of specialist services, which can all be necessary to dementia care under different circumstances.

As can be seen in table 1, *all* wards have access to Social Work, Pharmacy, Physiotherapy, Dietetics, Speech and Language Therapy, and Palliative Care at least five days per week. The majority of wards have at least five days access to Geriatric Medicine, Liaison Psychiatry, Psychiatry of Old Age, Occupational Therapy, Specialist Infection Control, and Tissue Viability Services, indicating good overall access to these services.

While services including Occupational Therapy, Dietetics, Speech and Language Therapy and Tissue Viability are accessible to the majority of wards Monday to Friday, there is limited or no access to these services at the weekends. Furthermore, regarding Speech and Language Therapy, the Royal College of Speech and Language Therapists have clarified that access to speech and language therapy provision is mainly for Dysphagia, and not for communication assessment or intervention.

Access to Psychology is poor, with 64% of wards reporting having no access to this service. This is in line with the findings in the Republic of Ireland (2014), and the baseline England and Wales audit (2011), both of which reported poor access to Psychology at ward level. Psychologists in hospital settings play a key role in the assessment, diagnosis and treatment of behavioural and psychosocial issues, which are prevalent in people with dementia. Psychologists are also equipped with specialised skills to improve well-being, alleviate distress, resolve crises, and foster the ability of the patient and their family/carer to solve problems and to make decisions (Wahass, 2005).

Table 1 – Availability of Specialist Services on Wards admitting Adults (n=36)

Service	4 days or less	Mon-Fri	7 days	No Access
Liaison Psychiatry	6%	47%	36%	11%
Psychiatry of Old Age	5.5%	64%	25%	5.5%
Geriatric Medicine	0%	36%	58%	6%
Occupational Therapy	0%	75%	22%	3%
Social Work	0%	39%	61%	0%
Pharmacy	0%	22%	78%	0%
Physiotherapy	0%	33%	67%	0%
Dietetics	0%	100%	0%	0%
Speech & Language	0%	100%	0%	0%
Psychology	0%	33%	3%	64%
Infection Control	0%	25%	72%	3%
Tissue Viability	0%	86%	11%	3%
Continence	0%	47%	0%	53%
Palliative Care	0%	28%	72%	0%

Furthermore, over half (53%) of wards have no access to Continence Services, a finding which again echoes the Republic of Ireland (2014) and England and Wales (2011), perhaps because continence services tend to largely be community-based. As deskilling and hospital-

associated disability is a problem in people with dementia, it is perhaps important that services with specialised skills in the assessment and management of complex cases relating to Continence issues are more readily available.

Continuity of Care and Patient Outcomes

Poor governance and service fragmentation at hospital level will have an impact on quality of care and thus outcomes for people with dementia. Almost all of the literature focusing on dementia care in the acute setting will investigate or comment upon the associated increased risk of adverse patient outcomes post-discharge, including functional and cognitive decline, and new admissions to residential care (Andrews, 2013; Manning et al., 2014).

Places of abode pre- and post-discharge were examined, and similar to the findings of the dementia audit in the Republic of Ireland (INAD, de Siun et al., 2014) and research carried out by Alzheimer Scotland (2009), a significant amount of people with dementia admitted from home were discharged to residential care/nursing homes:

- 56% (68/121) of people admitted from home were discharged home.
- 20% (24/121) of people admitted from home were discharged to residential care/ nursing homes.
- 7% (9/121) of people admitted from home were discharged to a rehabilitation unit, 6% (7/121) to intermediate care, and the remaining 11% were discharged to other facilities including transfer to another hospital, and convalescent/respite care.

The above findings show that one in five people with dementia admitted to hospitals in Northern Ireland from home are currently being discharged to residential care/nursing homes. This finding is line with the current literature on hospital-associated disability and indicates

that hospitalisation for this cohort can contribute to functional decline and deskilling (Pedone et al., 2005).

A greater length of stay (LOS) can also contribute to poorer outcomes. The case note review aspect of this audit found that the overall median LOS for people with dementia in acute hospitals was 10 days (interquartile range 7-18), ranging from a minimum of 5 days to a maximum of 74 days. The mean LOS of was 14.2 days (SD = 11.1).

LOS was investigated further, given the large standard deviation around the mean. Interestingly, those who were newly discharged to residential care had a significantly greater LOS than those not newly discharged to residential care ($p < .001$), possibly indicating poor availability of suitable residential placement, and/or inefficient discharge planning for people with dementia.

- The median LOS for those with dementia admitted from and discharged to a home environment was 10 days (interquartile range 7-20.5).
- The median LOS for those admitted from and discharged to a nursing home was 9 days (interquartile range 6-12.5).
- The median LOS for those admitted from home and discharged to residential care was 20.5 days (interquartile range 14.5-32.75).

Further investigation into discharge destination also revealed differences in the performance of multidisciplinary assessments including cognition and functional ability:

- Those admitted from and discharged to their own home were more likely to receive an assessment of their cognition (41%, 29/70), than those admitted from and discharged to a nursing home/residential care (10%, 9/89).

- Those admitted from and discharged to their own home were more likely to receive a standardised assessment of functioning (37%, 26/70), than those admitted from and discharged to a nursing home/residential care (17%, 15/88).

The above findings highlight a trend in quality of care, such that people with dementia who are residents in long-term care have shorter hospital admissions, but are less likely to receive vital assessments of cognition and functional ability that are necessary for tracking the nature of the progression of the disease, than people who live at home in the community. These findings are not unique to Northern Ireland; in the Republic of Ireland baseline audit (de Siun et al., 2014), those admitted from and discharged home were also more likely to receive an assessment of cognition than those admitted from and discharged to a nursing home.

This trend should be investigated further to determine why people with dementia admitted to acute hospitals are receiving fewer key assessments if they are nursing home residents, than if they live in the community.

Conclusion

Overall, these findings indicate that improvements could be made at hospital-level to better guide the planning and delivery of care for people with dementia admitted to acute hospitals in Northern Ireland. Creating dementia care pathways would outline best practice in terms of dementia care for all healthcare professionals involved, and would ensure a reduction in adverse outcomes relating to poor care delivery. It is also important that people with dementia are visible and identifiable to management when they are reviewing information relating to care, to inform risk reduction and improvements in care quality. While access to most specialist services is good for the majority of wards, access to Psychology and

Continence services at ward level must be improved. Future research should be carried out investigating differences in length of stay and multidisciplinary assessment by discharge destination.

Recommendations

1. Each hospital should appoint a senior clinician who specialises in dementia care to:
    - Take a lead in developing, implementing and monitoring an integrated dementia care pathway, adaptable for use within other existing care pathways (e.g. acute, end of life etc.).
    - Nominate other staff with an interest in dementia care in each department within the hospital and at ward level, to undergo specialised training and become Dementia Champions.
2. The hospital management team should ensure that people with dementia are identifiable in the data on readmissions, delayed discharge, falls, treatments and discharge, to further inform policies and procedures relating to people with dementia.
3. The hospital management team should regularly review existing policies and procedures as they relate to people with dementia.
4. The availability of specialist services vital to the care of people with dementia, including Psychology and Specialist Continence Services, should be reviewed at trust level.

Multidisciplinary Assessment

Summary

- High levels of physical assessments such as pressure sore risk (95%), nutritional status (91%) and continence needs (95%) were carried out.
- Lower levels of assessment were found for functional ability (29%), mobility (71%), and pain (82%).
- Mental assessment was performed less than physical assessment and only 33% of people with dementia received a cognitive assessment during their admission.
- Delirium screening was sub-optimal, with less than one in three people with dementia receiving any screening for changes/fluctuations in behaviour that might indicate the presence of delirium.
- Mood and behavioural and psychological symptoms of dementia were rarely assessed, with only 6% and 7% of patients receiving these assessments respectively.
- 28% of patients had collateral history recorded indicating the nature of the progression of the dementia.
- The need for a health and social care assessment was identified for 41% of patients; the majority of these patients (90%) received an assessment during the admission.

People with dementia admitted to an acute hospital have an increased risk of adverse outcomes, including cognitive and functional decline (Andrews, 2013), greater institutionalisation post-discharge (Manning et al., 2014; AIHW, 2004), and higher mortality rates (Manning et al., 2014; Sampson et al., 2009). One of the most important aspects of dementia care is good multidisciplinary assessment, which is not always provided for people with dementia in this setting (Borbasi et al., 2005).

Comprehensive geriatric assessment (CGA) is defined as a "multidimensional interdisciplinary diagnostic process focused on determining a frail elderly person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long term follow up" (Rubenstein 1991). The key components of CGA include:

- Identification of medical, physical, social and psychological problems;
- Co-ordinated multidisciplinary assessment;
- Formation of a plan of care including appropriate rehabilitation;
- Geriatric medicine expertise.

A review of 22 trials evaluating 10,315 older adults acutely admitted to hospitals across six countries found that those in receipt of CGA were more likely to be alive and in their own homes at six and twelve months when compared to those who received general medical care. In addition, patients were less likely to be institutionalised, and suffer death/deterioration (Ellis et al., 2011). This indicates the importance of good multidisciplinary assessment which covers all of the most important aspects of care: physical/functional, mental/psychological, and social and environmental. This audit looked at the performance of multidisciplinary assessments for people with dementia during an acute hospital admission across these three domains.

Physical Assessment

The results of this audit show that generally, physical assessment was adequate and that most case notes had the following information recorded:

- 89% (210/236) had a problem list recorded which comprehensively listed the patients' problems in a designated section of the patients' case notes.
- 98% (235/240) had a list of co-morbid conditions and diagnoses recorded.
- 95% (228/239) of case notes had a list of the patients' current medication recorded, *or* there was a record that the patient was not currently on medication.

High levels of a number of physical assessments were carried out on people with dementia at some point during the admission, and compare favourably to those found in the Republic of Ireland (2014) and England and Wales (2013) (see figure 1).

Risk assessment is the first step in planning pressure ulcer prevention strategies (Moore and Cowman, 2014) and is important for identifying those at risk of pressure ulcer development. Pressure sores are painful and the interventions employed to combat pressure ulcers are often expensive. It is a basic but vital assessment that every person with dementia admitted to an acute hospital should receive.

- Pressure Sore Risk was assessed in 95% (227/240) of people with dementia.

As nutrition is a significant predictor of poor outcomes for older patients (Bradshaw et al., 2013) and up to 39% of adults over 65 years admitted to hospital are at risk of malnutrition (Russell & Elia, 2011), assessment of nutritional status is a particularly important part of CGA. People with dementia can have poor eating behaviours and experience weight-loss

(Ikeda & Hodges, 2013). For this population, nutritional status assessment is a key assessment. This audit found that:

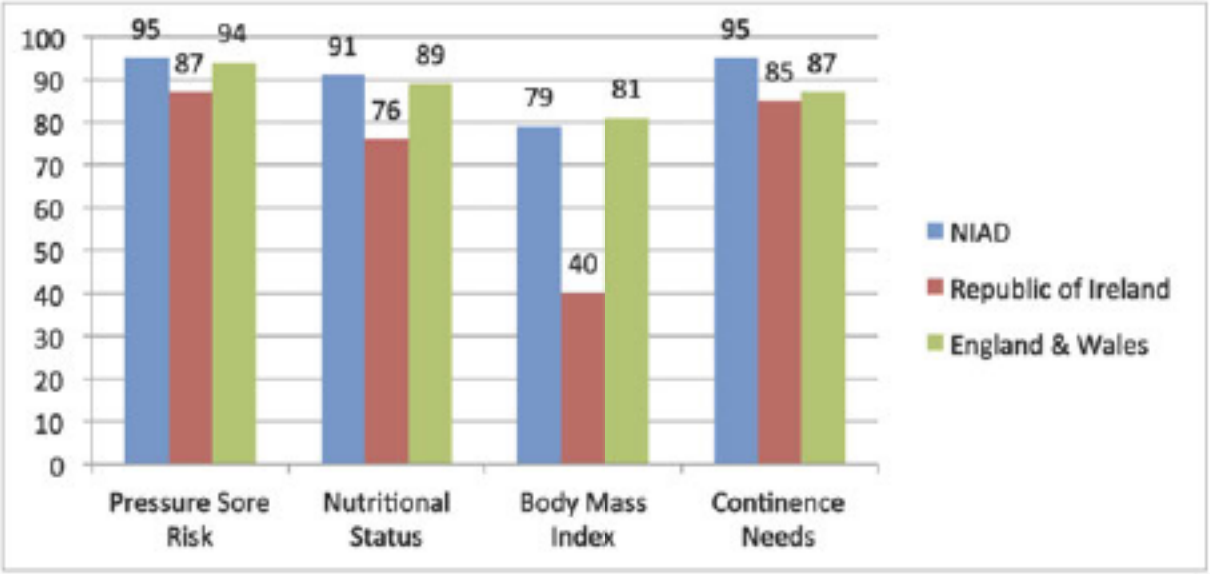
- The majority of people received a nutritional status assessment (91%, 216/238).
- Body mass index (BMI)/weight was recorded for 79% (169/214) of people with dementia.

People with dementia can experience a loss of continence. This can be a distressing experience, can exacerbate carer burden, and subsequently is likely to increase the risk of institutionalisation (Grant et al., 2013). Those with a dementia diagnosis in the community are nearly three times more likely to suffer urinary incontinence, and experience approximately four times the rate of faecal incontinence than those without dementia (Grant et al., 2013). Furthermore, admission to hospital can cause or worsen incontinence in people with dementia (Anderson et al., 2005). It is thus especially important that continence needs are assessed in hospital and that an emphasis is placed on halting decline for as long as possible. In this audit:

- An assessment of continence needs was recorded for 95% (227/240) of people with dementia.

As part of the current audit, we investigated if there was evidence that an assessment of communication was carried out by a healthcare professional and recorded in the case notes. This was not assessed in the audits carried out in England and Wales (2011; 2013), or in the Republic of Ireland (2014).

Figure 1: Percentage of physical assessments recorded in case notes in the current audit (NIAD), compared to the baseline INAD (2014) findings, and the second round England and Wales (2013) findings.



As dementia advances, problems in the comprehension and expression of language become more evident. When the ability to communicate becomes diminished in dementia, functional ability can be compromised, and behavioural and psychological symptoms may be aggravated (de Vries et al., 2013; Kovach et al 2005, Cohen-Mansfield et al 2007). The case note review revealed that:

- **84%** (201/240) of patients had an assessment of communication performed by a healthcare professional.

While this finding is positive, and indicates that communicative functioning is recognised as an important factor in the overall assessment of the person with dementia, this audit did not collect data to confirm whether this was a formal standardised assessment of receptive and

expressive language by a Speech and Language Therapist, or an informal assessment by another healthcare professional.

While physical assessment was generally good, and comparable to recent audits of dementia care in the Republic of Ireland (2014) and England and Wales (2013), the performance of assessments of functional ability, mobility and pain was poorer and requires improvement.

- A standardised assessment of functioning was recorded in only 29% (69/238) of case notes, which is marginally poorer than the Republic of Ireland (2014, 36%) and England & Wales (2013, 44%).
- An assessment of mobility was carried out by a healthcare professional for 71% of people with dementia, which is poorer than was found in England & Wales (2013, 94%) and in the Republic of Ireland (2014, 89%).

Loss of mobility and the ability to perform basic ADLs, including bathing, continence, dressing, feeding, toileting, and transfer may reduce quality of life for people with dementia (Beerens et al., 2013) and is likely to increase carer burden. Assessing for changes in functional ability is extremely important for making an informed prognosis, tracking ability, minimizing decline, and predicting mortality (Covinsky et al., 2011). Although good access to Occupational Therapy was reported at ward level, i.e. the service was almost universally available Monday to Friday, the low level of performance of functional assessments of a person with dementia may suggest that insufficient therapy time is available to perform a holistic assessment, or that Occupational Therapy resources are being under-utilised for the person with dementia.

- **82% (194/238) of patients had a record of being asked about the presence of pain during their admission, compared to 87% in England & Wales (2013) and 74% in the Republic of Ireland (2014).**

In conjunction with being asked about the presence of pain, this audit investigated if a formal standardised assessment of pain suitable for a person with dementia (e.g. PAINAD, Abbey Pain Scale) was carried out, a question which was not asked in the Republic of Ireland (2014) or in England & Wales (2011; 2013).

- **10% (18/177) of the people with dementia had a standardized assessment of pain suitable for someone with dementia recorded in their case notes.**

This audit did not collect data on dementia severity, and so the number of people who needed a dementia-suitable pain scale is not known. However, the prevalence of pain in this population can be as high as 45% (Ortega et al., 2015), or up to 57% upon movement (Sampson et al., 2015), and often goes untreated due to communication difficulties e.g. lower levels of analgesia are administered to patients with cognitive impairment who have undergone orthopaedic surgery, compared to patients without impairment (Sampson et al., 2005). This highlights the importance of assessing for indicators of pain where necessary, using for example, the Pain Assessment in Advanced Dementia (PAINAD) scale (Warden et al., 2003) and/or the Abbey Pain Scale (Abbey et al., 2004).

Mental Assessment

The performance of mental assessment is poorer than physical assessment for people with dementia in acute hospitals in Northern Ireland. Figure 2 depicts the performance of a number of mental assessments, and compares them to the findings in the Republic of Ireland (2014) and England & Wales (2011; 2013).

The findings in relation to cognitive assessment and screening for delirium are particularly of concern. In the present audit:

- 33% (72/219) of people with dementia have a cognitive assessment recorded in their case notes, which is lower than was found in the Republic of Ireland (2014) and England and Wales (2013).

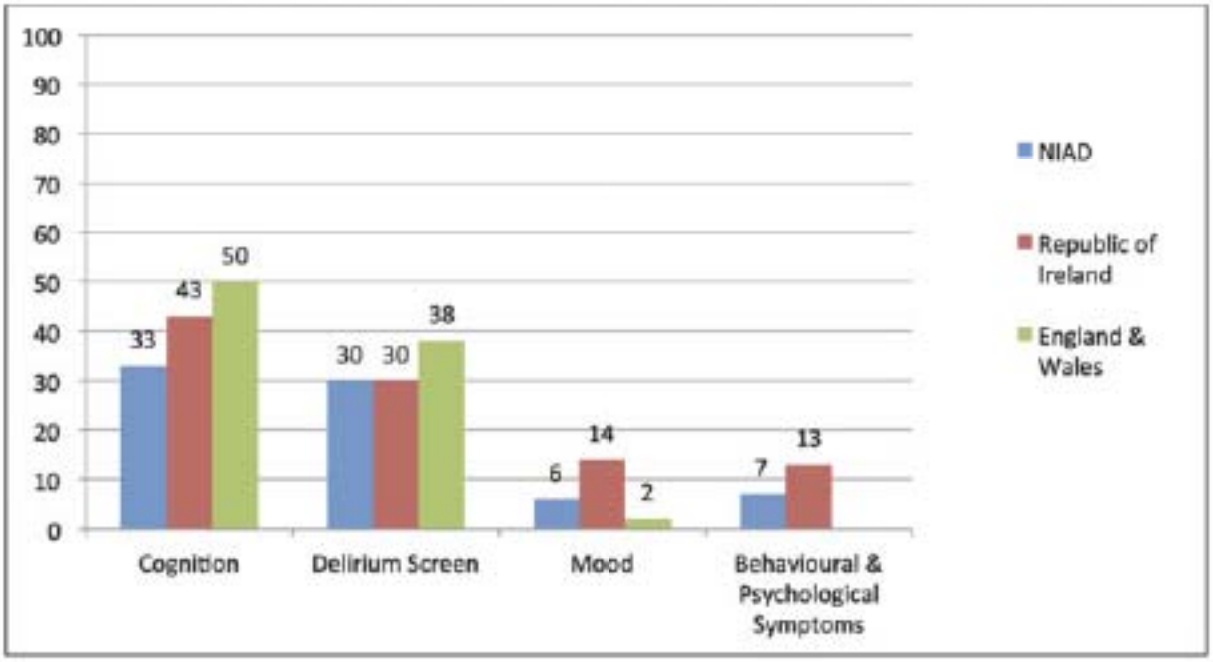
Dementia does not follow a straightforward trajectory, and cognitive assessment is vital for prognostication and can be a good indicator of the level of support that the person is likely to need going forward.

- Less than one in three (70/236) people had any form of screening for delirium during their admission.

This is unsurprising given that detection of delirium is known to be suboptimal in acute hospitals (Ryan et al., 2013). Delirium is very common in people with dementia and is linked with adverse health outcomes, including prolonged hospitalization, high readmission rate, cognitive decline, increased dependence and mortality at follow-up (Fong et al., 2012). Screening procedures should be in place to ensure that delirium does not go unrecognised, particularly in this high-risk population.

There was poor mood assessment (6%, 13/236) and assessment of behavioural and psychological symptoms of dementia (7%, 16/235). Depression and other behavioural and psychological symptoms are extremely common, and estimates suggest that almost all people with dementia experience symptoms at some point during the course of the illness (Savva et al., 2009). Such symptoms, if ignored and untreated, can become burdensome for caregivers and can result in earlier institutionalisation (Gitlin et al., 2012).

Figure 2: Percentage of mental assessments recorded in case notes in the current audit (NIAD), compared to the baseline INAD (2014) findings, and the second round England and Wales (2013) findings.



The recording of collateral information is a particularly important part of CGA, particularly for people with dementia who may not be able to accurately communicate information about the progression of their condition.

- 32% (76/240) had collateral information recorded regarding cognitive decline.

- 21% (50/239) had collateral information recorded indicating the time since the onset of the persons' memory problems.
- 28% (67/240) had collateral history recorded indicating the nature of the progression of the dementia.
- 41% (99/240) had collateral history recorded regarding loss of function.

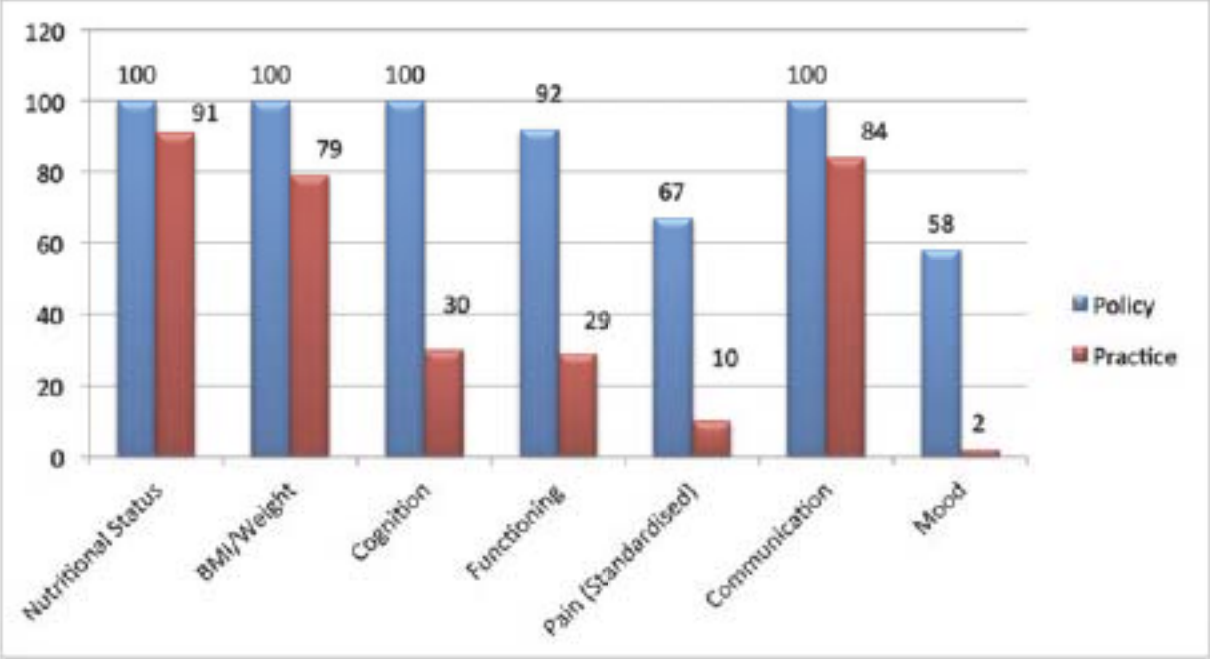
The above findings regarding collateral information are comparable to the Republic of Ireland (2014) findings, in which 44% of case notes had information on cognitive decline, 25% on the time since onset, 27% on the nature of the progression and 35% on functional decline. An improvement must be made in the collection and recording of collateral information to ensure good multidisciplinary communication of issues pertinent to providing best care for the person with dementia.

Assessment: Policy versus practice

Of note, the findings regarding multidisciplinary assessment from the case note review did not corroborate the findings from the hospital organisation module of this audit, and there were large gaps between hospital policies for assessment, and actual assessment in practice (see figure 3). For example, all 12 of the acute hospitals reported that there was a policy or system in place that would ensure that all patients with dementia would have an assessment of cognition completed and recorded in their case notes during their admission, however, in reality only 30% of patients had such an assessment recorded. The same pattern of disparity between policy and practice was found for assessments of nutritional status, BMI/weight, functioning, pain, communication and mood.

This finding is not unique to Northern Ireland; the audits in the Republic of Ireland (2014) and England and Wales (2011; 2013) reported incongruence between policy and practice indicating a lack of adherence to hospital assessment protocols in dementia care.

Figure 3: Percentage of acute hospitals in Northern Ireland including physical and mental assessment items in their policies, compared with the percentage of case notes containing evidence of the assessment being performed.



Health & Social Care Assessment

People with dementia and their families/carers often have complex unmet social and environmental needs upon admission to acute hospital, and require a thorough health and social care assessment to identify and secure the adequate supports and resources.

Admission to hospital can be a disempowering and distressing experience and healthcare professionals, particularly social workers, can play a crucial role in preventing the patient from becoming overwhelmed by the situation and the environment (Gibbons & Plath, 2009). The current audit found that:

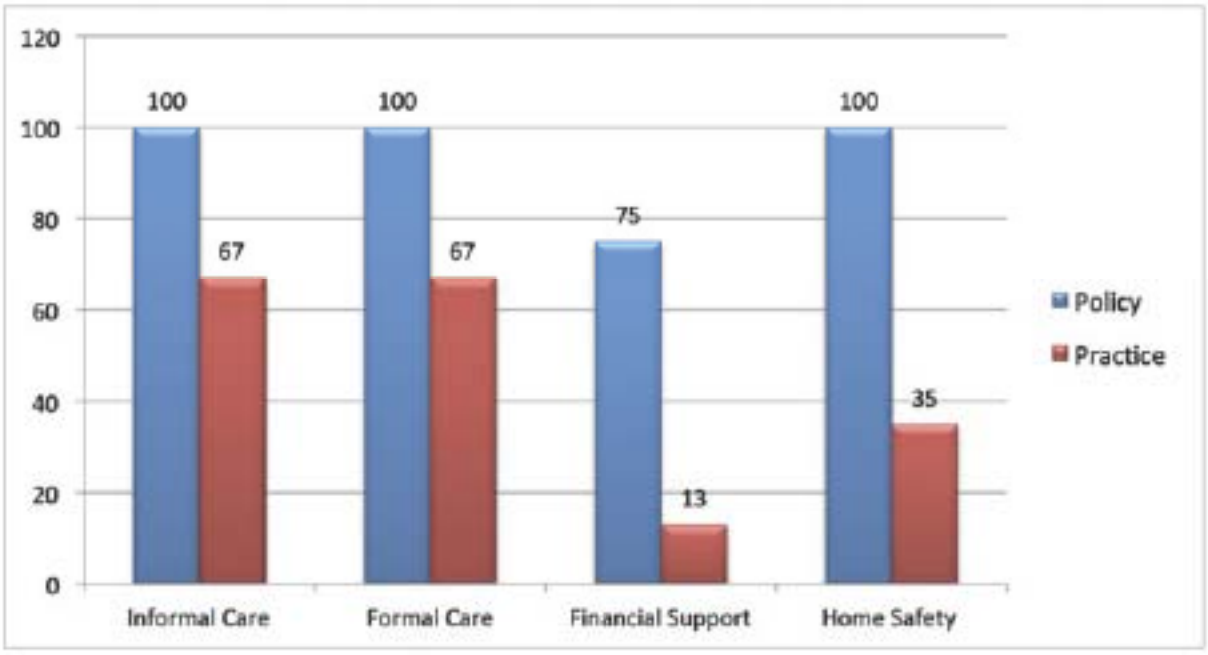
- The need for a health and social care assessment was identified for 41% of people with dementia (98/240), and a request for such an assessment was made for all 98 of these people.
- The majority of the 98 people with dementia, who were identified as needing a health and social care assessment, had one carried out during their admission (90%, 88/98).

Health and social care assessment, and its individual components, were investigated in the hospital organisation module of the audit, as well as through the case note review. As can be seen in figure 4, there was again a discrepancy between hospital policy regarding health and social care assessment, and health and social care assessment in practice. For example, all 12 hospitals reported that all people with dementia who receive a health and social care assessment will receive an assessment of their informal and formal care provision, and a home safety assessment (where applicable). However, only 67% of people who received a health and social care assessment had any record of informal and formal care provision, and 35% of those that could have had a home safety assessment actually received one. This pattern was also evident for financial support assessments; 75% (9/12) of hospitals reported that all patients receive a financial support assessment as part of the health and social care assessment; however, only 13% of patients who had an assessment carried out received a financial support assessment.

It is possible that more health and social care assessments were performed than were recorded in the case notes, as social work notes were in some cases stored separately to the main

medical case notes. In this way, it was generally known if an assessment was requested/ carried out, however the individual components of the assessment were not always known. This should be considered in the interpretation of the results presented in figure 4.

Figure 4 – Percentage of acute hospitals in Northern Ireland including health and social care assessment items in their policies, compared with the percentage of applicable case notes (n=88) containing evidence of the assessments being performed.



Geriatric Medicine

Geriatric medicine expertise is one of the key components of CGA, and the availability of a geriatric medicine service is central to good dementia care in acute hospitals for older people with dementia. This audit found that:

- All 12 acute hospitals in Northern Ireland reported having access to a geriatric medicine service which can provide assessment and treatment to adults throughout the hospital.
- 92% (11/12) have a geriatric medicine service that can provide emergency or urgent assessment to adults throughout the hospital.
- 92% (11/12) have a named consultant providing this liaison service.
- In 10/12 hospitals (83%), the consultant had dedicated time in his/her job plan for the provision of the liaison service, or the service is integral to their job.
- 75% of hospitals (9/12) reported that the geriatric medicine service is provided by a specialist team.
- All 12 hospitals reported that their geriatric medicine team is based on-site.
- All 12 hospitals reported that geriatric medicine is available during day time hours, while 2/12 hospitals reported there is availability in the evenings, and 2/12 reported availability at weekends.

Neurology

Neurology services are integral to dementia care for those people admitted to hospital under the age of 65 years. This service is vital for the assessment, diagnosis, treatment and management of the dementia condition for those with an early onset of the disease.

- 11/12 hospitals reported having access to a neurology service which can provide assessment and treatment to adults throughout the hospital.
- 64% (7/11) reported that this service provides emergency/urgent assessment to older adults throughout the hospital.

- 64% (7/11) have a named consultant neurologist providing this liaison service.
- 71% (5/7) of hospitals reported that the consultant neurologist has dedicated time in his/her job plan for the provision of this service, or the service is integral to their job.
- 55% of hospitals (6/11) reported that neurology is provided by a specialist team.
- 7/11 hospitals reported that the neurology team is based on-site, while 4/11 are based off-site.
- 100% (11/11) of hospitals with a neurology service reported that the service is available during day time hours, 3/11 hospitals reported that neurology is available in the evenings, and 3/11 reported availability at weekends.

Conclusion

There are generally high levels of physical assessments being carried out for people with dementia including continence needs, nutritional status, and pressure sore risk assessments; however there is significant room for improvement in areas of assessment such as functioning, mobility and pain. Mental assessment is less frequently performed on people with dementia. In particular, cognitive assessment and delirium screening are under-performed in the acute setting for people with dementia and this must be addressed. There was good access to Geriatric Medicine reported across the board and adequate access to Neurology Services.

Recommendations

1. The adherence to multidisciplinary assessment policies and procedures should be reviewed by hospital management, and systems should be put in place to reinforce adherence to such policies and procedures.

2. The performance of mental assessments, particularly for people with a recognised diagnosis of dementia, must be improved;
    - All people with an established diagnosis of dementia should receive a cognitive assessment on admission to hospital, and prior to discharge, if the admission is longer than 5 days.
    - Routine cognitive screening should be also carried out on all people over 65 on admission to acute hospitals in order to detect previously undiagnosed cognitive impairment.
    - All people with dementia should be screened for delirium during acute hospital admission.
3. The performance of a number of other assessments must be improved upon;
    - A standardised assessment of functioning should be carried out on all people with dementia to identify potential for rehabilitation, track functional ability, and allow for prognostication.
    - An assessment of mobility should be carried out on people with dementia, unless there is a recorded reason why this is not possible.
    - All people with dementia should be asked about the presence of pain, and where necessary, should receive a standardised assessment of pain suitable for people with dementia who may not be able to verbally communicate pain.
    - A standardised assessment of communication should be carried out to establish receptive and expressive language functioning to enable effective communication.

Mental Health, Liaison Psychiatry and Antipsychotic Medication

Summary

- All 12 acute hospitals reported providing access to a Liaison Psychiatry service which can provide assessment and treatment to adults throughout the hospital.
    - 75% of these services can provide emergency/urgent assessment.
- All 12 acute hospitals reported providing access to a Liaison Psychiatry of Old Age service which can provide assessment and treatment to adults throughout the hospital.
    - 58% of these services can provide emergency/urgent assessment.
- 92% (11/12) of hospitals reported having a protocol in place governing the use of interventions for patients displaying violent or challenging behaviour, which is suitable for use in patients who present with behavioural and psychological symptoms of dementia.
- 21% (51/238) of people with dementia had antipsychotic medication during their admission.
- 9% (21/238) of people with dementia received a new prescription for antipsychotics during their admission.
- A reason was recorded for the new prescription of antipsychotics in hospital in 95% (20/21) of case notes.
- The primary reason recorded for the prescription of antipsychotic medication was agitation (55%, n=11).

This chapter focuses on the reported availability of liaison psychiatry services, governance regarding mental health, and the prescription and use of antipsychotic medication.

Liaison Psychiatry

Liaison psychiatry (LP) is the subspecialty of general psychiatry that is concerned with the management of psychiatric illness in general medical settings, including acute hospitals. Mental health problems can interact with physical health, exacerbating other conditions and influencing overall health outcomes (Osborn et al., 2007; Lesperance et al., 2002). According to the *Liaison Psychiatry in the Modern NHS* report (2012), co-morbid mental health problems often go undiagnosed and untreated in general and acute hospitals, and are estimated to cost the NHS £6 billion per year; however having a liaison psychiatry service within a hospital setting has the potential to improve mental health assessment, patient experience, safety and outcomes, as well as reducing the cost of care (Sharpe, 2014). As the population ages, and conditions such as dementia, delirium, and other age-related mental health issues become more prevalent in the acute setting, the specialised skills of a LP service will become even more essential.

In relation to LP services in acute hospitals in Northern Ireland, this audit found that:

- All 12 hospitals reported providing access to a LP service which can provide assessment and treatment to adults throughout the hospital.
- All 12 hospitals also reported that the Psychiatrists within the service have dedicated time in their job plan to provide this liaison service.
- 75% of hospitals (9/12) reported having a named consultant psychiatrist delivering the LP service.
- 75% of hospitals (9/12) reported that the LP service can provide emergency/urgent assessment.

- 92% of hospitals (11/12) reported that the LP service regularly provides mental health care to both working age adults and older adults. One hospital reported that the LP service does not provide care to older adults.
- All 12 hospitals reported that the LP service is available during day time working hours, while 25% (3/12) reported that there is also evening access to LP, and 25% (3/12) also reported weekend access to the LP service.
- 42% (5/12) of hospitals reported that the LP service was based on-site, 50% (6/12) reported the LP service was based off-site, and one hospital reported the LP service to have bases both on and off-site.

These findings are generally on par with the England and Wales second round of audit (2013) and the baseline audit in the Republic of Ireland (2014), where nearly all hospitals (94%, 100% respectively for England & Wales, Ireland) reported having access to a LP service, and the majority of these (85%, 83% respectively) were able to provide emergency or urgent assessment. These findings indicate that there is good access to LP in acute hospitals in Northern Ireland; however access could be improved in the evenings and at weekends.

Psychiatry of Old Age

Mental health services that are even further specialised in the care of older people are becoming more and more necessary; According to the *Liaison Psychiatry in the Modern NHS* report (2012), in the ten years to 2010/11, the number of inpatient admissions among those over 75 years increased by 75%, and will continue to soar in the coming years. The above report also estimated that older people account for 80% of all hospital bed-days occupied by adult patients with co-morbid physical and mental health conditions. The authors conclude that older adults now comprise the greatest area of need in terms of psychiatric support in

hospitals. The provision of a rapid-response, multidisciplinary liaison psychiatry team specialising in the care of older adults could serve to reduce length of hospital stay, and reduce the risk of poor health outcomes, hospital readmission and new admission to long-term care (Parsonage et al., 2012).

This audit looked specifically at the availability of Liaison Psychiatry of Old Age (LPOA) Services within acute hospitals in Northern Ireland:

- All 12 hospitals reported having access to a LPOA service which can provide assessment and treatment to adults throughout the hospital.
    - All 12 hospitals reported that there is a named Consultant Psychiatrist of Old Age delivering the LPOA service.
    - All 12 hospitals also reported that the Psychiatrists of Old Age within the service all have dedicated time in their job plan to provide this liaison service.
    - Furthermore, all 12 hospitals reported that all healthcare professionals who are part of the LPOA service have dedicated time for the provision of the service.
- 58% (7/12) of hospitals reported that the LPOA service can provide emergency/urgent assessment.
- All 12 hospitals reported that the LPOA services are available during day time hours; however none of the hospitals reported having access to this service in the evenings, or at weekends.
- 58% (7/12) of hospitals reported that the LPOA team is based on-site, while 42% reported the team to be based off-site.

While the access to LPOA services was not investigated in the England and Wales audit, these figures compare favourably to findings of the Republic of Ireland audit (2014), in which 71% of hospitals reported having access to a LPOA service and only 31% have a

service that can provide emergency or urgent assessment. The above findings indicate good access to LPOA in acute hospitals in Northern Ireland; however the availability of the service could be improved to include evenings and weekends. Furthermore, the provision of emergency and urgent assessment could significantly improve these services.

Governance and Mental Health

Behaviours that challenge, such as agitation, have been defined as an expression of unmet needs (Camp et al., 2002), which could be physical, psychological or social in nature. Among people with dementia, behaviours that challenge are often called behavioural and psychological symptoms of dementia (BPSD). Almost all people with dementia are likely to experience BPSD over the course of their condition (Savva et al., 2009), and acute illness can exacerbate such behaviours in people with dementia admitted to hospital (O' Shea et al., 2014). Behaviours that challenge can cause caregiver burden, diminish the quality of life of service users and staff, and increase the likelihood of institutionalisation, referral to psychiatric services and hospital admission (Mace, 1990). It is thus highly important that people with dementia presenting with behaviours that challenge are carefully assessed and managed.

The audit looked at whether the acute hospitals in Northern Ireland have clear protocols on the management of challenging behaviour to guide the practices of healthcare staff;

- 92% (11/12) of hospitals reported having a protocol in place governing the use of intervention for patients displaying violent or challenging behaviour, aggression or extreme agitation, which is suitable for use in patients who present with BPSD.

Figure 5 – Key criteria included in the protocol guiding response to behaviours that challenge (n=11)

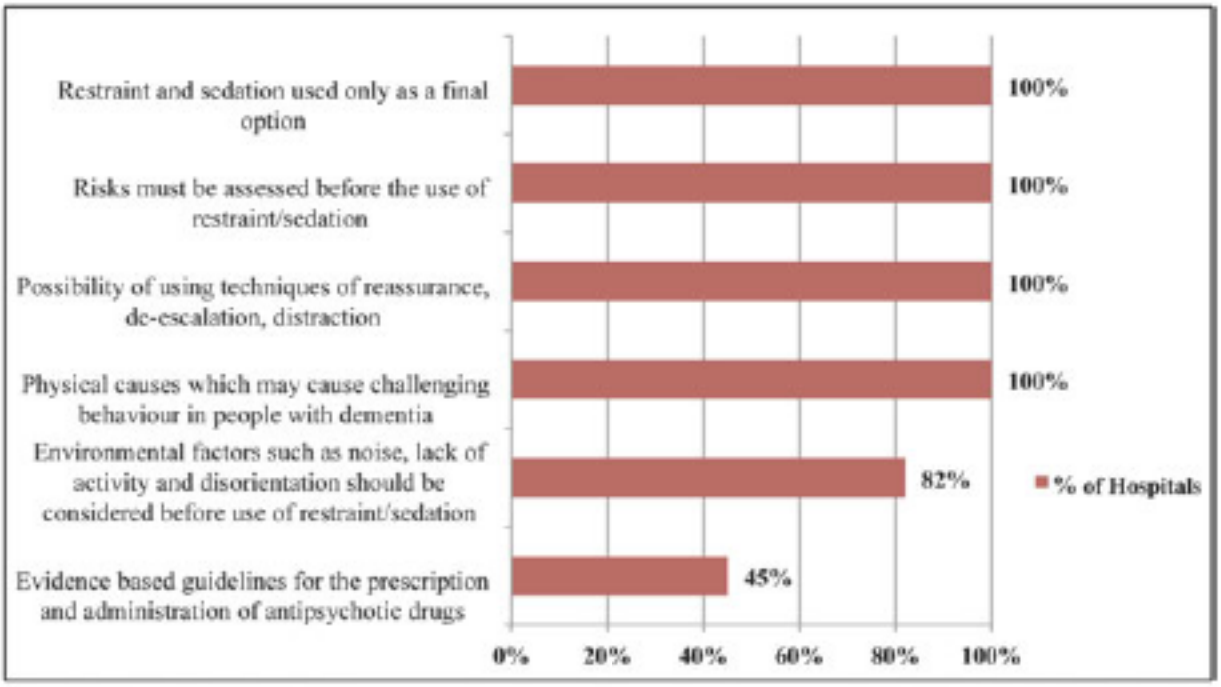


Figure 5 shows the components of the protocols guiding interventions for challenging behaviour in acute hospitals. While these results are generally positive, they show that where there is a protocol in place guiding interventions for challenging behaviour in a hospital, it often does not provide staff with guidance on the prescription and administration of antipsychotic medication. This should be remedied at hospital-level; protocols should be updated to include guidance on the prescription and use of antipsychotic medication.

Prescription of Antipsychotic Medication

The use of antipsychotic medication for the treatment of behavioural symptoms in people with dementia has become a contentious issue in recent times. The *Time for Action* report by

Banerjee in 2009, highlighted how antipsychotic medication is currently overprescribed, despite the fact that such medication has a limited positive effect in treating behaviours and is associated with significant adverse side effects. This report clarifies that while a small cohort of people may genuinely benefit from antipsychotic medication, non-pharmacological interventions must always be used as the first-line response to behaviours that challenge. As part of this audit, data was collected from case notes on the prescription and use of antipsychotics for people with dementia. Figure 6 depicts this information, showing pre-admission existing prescriptions and new prescriptions in hospital, as well as case notes that have evidence of having both existing prescriptions, and new prescriptions in hospital.

Figure 6-Prescription of antipsychotic medication recorded in case notes (n=238)

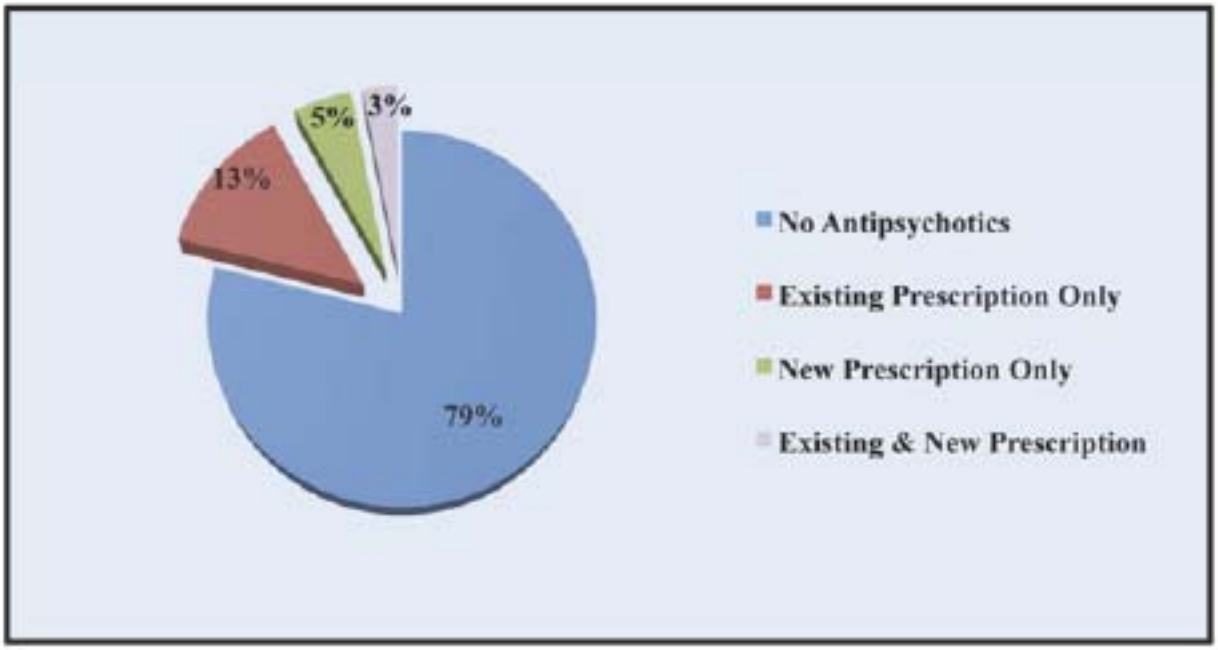


Figure 6 shows that 21% (51/238) of patients had antipsychotic medication at some point during their admission, whether prescribed in hospital or not, and that overall, almost 9% (21/238) of people received a new prescription for antipsychotic medication in hospital.

The findings are comparable to those from the second round of the England and Wales audit (2013) in that 18% of people with dementia had antipsychotic medication at some point during the admission, just fewer than 10% had an existing prescription only, 6% were given a new prescription only, and only 2% had an existing prescription *and* a new prescription given. These findings reflect far better than those in the baseline Republic of Ireland audit (2014) in which 41% of people with dementia had antipsychotic medication during their hospital admission.

As was found in the Republic of Ireland (2014) and England and Wales (2013), people admitted from a nursing home were more likely to be taking antipsychotic medication on admission than those admitted from home:

- 10% (13/125) of people admitted from a home environment had an existing prescription for antipsychotic medication.
- 22% (23/106) of people admitted from a nursing home had an existing prescription for antipsychotic medication.

Hospital admission must be seen as an opportunity for physicians to review medications for people with dementia, particularly those being admitted from nursing homes.

Reasons for the Prescription of Antipsychotic Medication

For the 21 people who were newly prescribed antipsychotic medication during their admission, this audit investigated if there was a reason recorded for the prescription in their case notes.

- 95% (20/21) of case notes had a reason recorded for the new prescription of antipsychotic medication in hospital.

This finding compares positively to the findings in England and Wales (2013, 59%) and the Republic of Ireland (2014, 50%).

The reasons recorded for the prescription of antipsychotic medication can be seen in table 2. The most common reason recorded was 'agitation', followed by 'aggressive/threatening behaviour.' This audit did not specifically examine whether or not non-pharmacological approaches were attempted before antipsychotic medication was prescribed, however it is evident that Northern Ireland is at least on par with England and Wales (2013) in terms of reducing the numbers of prescriptions being made, and it is likely that non-pharmacological approaches are now being employed more frequently in hospitals in Northern Ireland. An emphasis should be kept on using non-pharmacological interventions as the first line approach to behaviours that challenge to continue changing the culture of care.

Table 2 – Reasons for the Prescription of Antipsychotic Medication

Main Reason	n	%
Immediate Risk of Harm to Self/Others	1	5
Agitation	11	55
Aggressive/Threatening Behaviour	4	20
Disturbance through Wandering, Mannerisms, Tics	2	10
Other	2	10
Total	20	100%

Conclusion

There is good access to mental health liaison services that are equipped with the specialised skills to meet the needs of people with dementia in hospitals in Northern Ireland; however, access could be improved by providing these services in the evenings and at weekends. All but one hospital have a protocol in place to govern the use of interventions for challenging behaviour, suitable for use in patients who present with BPSD. Protocols could be improved by including evidence based guidelines for the prescription and administration of antipsychotic drugs. There were relatively low levels of new prescriptions for antipsychotics (9%), and a reason was recorded for all but one of these new prescriptions. This suggests that staff in hospitals in Northern Ireland have been making an effort to change the culture of care, and are most likely beginning to use non-pharmacological approaches as a first line approach to managing BPSD as recommended by Banerjee (2009). Efforts must continue to be made to ensure that practice is in line with policy on the matter of antipsychotics.

Recommendations

1. Liaison Psychiatry and Psychiatry of Old Age services should be available on a daily basis, including evening and weekends, for the treatment and referral of people with dementia in acute hospitals. Further, all services should be able to provide emergency/urgent assessment.
2. All hospitals should have a protocol in place governing the use of interventions for behaviours that challenge, suitable for people with dementia.

3. **Hospital protocols governing the use of interventions for behaviours that challenge should include evidence based guidelines for the prescription and administration of antipsychotic drugs.**
4. **All hospitals should ensure that there is a process/system in place for auditing the prescription and use of antipsychotic medication in people with dementia, with a view to minimizing the number of potentially inappropriate prescriptions.**
5. **Hospital admission should be used as an opportunity for clinicians to review the use of antipsychotic medication in people with dementia who have an existing prescription on admission.**

Nutrition

Summary

- 91% of patients with dementia had a nutritional status assessment performed during their admission.
- 79% had their BMI/weight recorded.
- All 12 hospitals reported having protected mealtimes in place in all wards that admit adults, while 92% of wards reported operating a successful protected mealtime system.
- All wards with protected mealtimes reported that the system allows for family/carers to visit and assist with feeding during mealtimes.
- 94% of wards have systems in place to signal to staff on the ward that a patient may need help with eating e.g. red tray system.
- 92% of wards can provide adapted utensils and cutlery to encourage patients to eat as independently as possible.
- Wards have good access to Speech and Language Therapy, Dietetics, and Occupational Therapy with the vast majority of wards reporting access at least five days per week.
- However, wards reporting not having access to Speech and Language Therapy or Dietetics at the weekends.

Nutritional Assessment

The international prevalence of malnutrition in hospitals is between 19–63% of adult patients (Naylor et al. 1996, Adams et al. 2008; Bavelaar et al. 2008; Russell & Elia, 2011), and older patients in hospitals have the highest prevalence of malnutrition compared to older patients in other care settings (Omar, 2015). While many patients are admitted to hospital already malnourished, often patients' nutritional status deteriorates in hospital, with up to two-thirds of patients losing weight (McWhirter and Pennington, 1994; Coxall et al. 2008).

People with dementia are a particularly high risk group for malnutrition, with the incidence of eating disability as high as 41% of those with middle-stage dementia, and increasing as the disease advances (Slaughter et al., 2011). In people with dementia, malnutrition increases the risk of morbidity and mortality, leads to greater lengths of hospital stay, and increases the overall cost of healthcare provision (in Jeffries et al., 2011).

According to the NICE guidelines on nutrition for adult hospital in-patients, every person should receive a nutritional status assessment on admission, have their BMI/weight recorded, and should be screened at least weekly thereafter.

This audit investigated the assessment of nutrition and aspects of care relating to nutrition in people with dementia:

- 91% (216/238) of patients with dementia had a nutritional status assessment performed during their admission.
- 79% (169/214) of patients had their BMI/weight recorded.

While this is a promising picture of assessment, and better than was found in England & Wales (2013) and the Republic of Ireland (2014), there is room for improvement as all people with dementia should have this information recorded in their case notes.

Mealtimes on the Ward

Many older patients require assistance at mealtimes, and people with dementia in hospital are more dependent on others for basic activities including eating and drinking, than older people without dementia (O' Connell et al., 2011) A 'protected mealtime' is 'free from unnecessary and avoidable interruptions, providing an environment conducive to eating, and helping staff to provide patients with support and assistance with meals' (Murray, 2006). Protected mealtimes can reduce distraction on the ward and allow staff to focus on ensuring that patients receive the level of help and support that they require (Hunt, 2007; Webster et al., 2009).

The results of this audit at hospital-level indicate that:

- All 12 acute hospitals in Northern Ireland reported having protected mealtimes in *all* wards that admit adults.
- 42% (5/12) of hospitals reported that there was a system or process in place to review/monitor wards' adherence to the protected mealtimes.

As part of the audit, mealtime practices, including protected mealtimes, were investigated at ward level:

- 92% (33/36) of ward managers reported that they operate successful protected mealtime systems on their wards.

- All wards (n=36) reported that there is a system in place to ensure that staffing levels are sufficient at mealtimes to aid people with dementia to eat and choose food, if necessary e.g. scheduling staff breaks around patient mealtimes.
- Every ward with a protected mealtime (33/33) reported that the system allows for carers to visit and assist with feeding during mealtimes.
- 94% (34/36) of wards have systems in place to signal to staff on the ward that a patient may need help e.g. the red tray system.
- 92% (33/36) of wards can provide adapted utensils and cutlery to encourage patients to eat as independently as possible.
- All wards (n=36) can provide food to patients who are hungry between mealtimes.

Overall, at ward level there are adequate systems in place across the majority of wards that serve to improve/maintain nutrition for people with dementia. All wards should consider operating and reviewing a protected mealtime system, and continue to explore initiatives that would improve dementia care as it relates to nutrition.

Specialist Services Input

Dysphagia or difficulty in swallowing develops in almost all patients with dementia over the course of the condition (Kyle, 2011), and according to NICE guidelines (2010) patients who exhibit symptoms of dysphagia should be assessed as soon as possible. Enquiring about and observing swallowing difficulties should be central to the nursing assessment of all older people with dementia; however it is important that specialist services are available to provide input, including Speech and Language Therapy, Dietetics, and Occupational Therapy. Specialist input, diagnosis and advice on management can have a substantial effect for people

with a range of conditions including dementia, and is likely to reduce the risk of adverse outcomes associated with dysphagia, eating and swallowing difficulties (RCSLT, 2009).

In this audit:

- 92% (11/12) of acute hospitals in Northern Ireland reported that they have a policy, guideline or system in place serving to ensure that people with dementia have an assessment of their swallow function during their admission.

The availability of services at ward level specialising in care as it relates to aspects of nutrition, was also investigated:

- All 36 wards audited have access to Speech and Language Therapy five days per week (Monday to Friday, no access at weekends).
- All 36 wards audited have access to Dietetics five days per week (Monday to Friday, no access at weekends).
- 97% (35/36) of wards have access to Occupational Therapy at least five days per week.

This level of ward access to the above specialist services should be maintained, however dementia care could be greatly improved by creating access to these services at weekends. The Royal College of Speech and Language Therapists have recommended that people with dementia should have access to an assessment for dysphagia seven days per week, and highlighted that the absence of assessment for dysphagia at weekends could be posing a risk to patient care and nutrition. Further, there is disagreement between policy and practice in relation to nutrition; while 92% of hospitals reported having guidelines regarding swallow function to ensure that people with dementia receive an assessment, having limited or no

access to specialist services at weekends means that not all people with dementia will receive an assessment during their admission.

Conclusion

This audit found that acute hospitals in Northern Ireland are aware of the importance of assessing the nutritional status of people with dementia. All wards demonstrated an understanding of the efficacy of a protected mealtime, and almost all wards reported that they successfully operate such a system. Furthermore, the majority of wards have systems in place to ensure that patients that need help with eating receive that help, and for maintaining the patients' baseline level of independence. Finally, wards have good access to specialist services for more complex cases, such as Speech and Language Therapy, Dietetics, and Occupational Therapy at least five days per week. However, these services should also be made available at weekends to ensure that all patients with dementia receive the assessments that they require. While the assessment and recording of BMI/weight could be improved upon, overall, these findings are indicative of good practice relating to nutrition in dementia care.

Recommendations

1. All people with dementia must receive an assessment of their nutritional status while in hospital and this must be clearly recorded in their case notes along with an assessment of BMI/weight.
    - There should also be a record of missed/uneaten meals, the level of assistance required with eating/drinking, and any other relevant factors that may increase the risk of malnutrition.

2. All staff working on wards that admit adults should receive training in the administering of a standardised assessment of nutrition e.g. the Malnutrition Universal Screening Tool (MUST).
3. All staff working on the wards should receive dysphagia awareness training.
4. All wards should have systems in place to signal to the staff working on the ward that a person with dementia may need special assistance with eating/drinking at mealtimes e.g. the red tray system.
5. All wards should be able to secure access to adapted utensils and cutlery to encourage people with dementia to eat and drink as independently as possible while in hospital to ensure that hospital-associated disability related to eating does not occur.

Information and Communication

Summary

- 58% of hospitals have clear guidelines around asking the carer about the extent to which they prefer to be involved with the care and support of the person with dementia.
- 62% of carers who should have had an assessment of their current needs prior to discharge had one performed.
- Only 58% of case notes have evidence indicating that the appropriate place of discharge was discussed with the family/carer prior to discharge.
- One-third (63/189) of families/carer received a copy of the discharge summary before leaving the hospital.
- 47% of families/ carers received 24 hours or less notice of discharge.
- 97% of wards reported that a healthcare professional responsible for coordinating the care of the person with dementia is identified to the patient and their family/carer as their point of contact during the admission.
- 10% of case notes contained a section dedicated to collecting information pertinent to providing person-centred care for the person with dementia.
- 42% (5/12) of hospitals have a system in place across the hospital to ensure that staff from other areas outside of the ward are aware of the person's dementia when they need to access treatment areas outside of the ward.
- Most wards (34/36) identified 'handover' as the system used for communicating information about the patients to other staff involved in the care of the person with dementia.

The audit aimed to assess hospital and ward level systems that facilitate collecting and sharing information, including information about the person with dementia, their diagnosis, and supports on discharge for both the patients and their carers. The recording of this type of information in the case notes was also assessed.

Involvement of Family & Carers

Caring for someone with a diagnosis of dementia can become stressful at times, and as the disease progresses, families and carers can feel increasingly burdened. Family and carers also need to be supported throughout the disease and information provision can serve to empower carers.

Qualitative reports have described how carers feel that access to information about dementia and the local services and supports available to assist with care is important (McHugh et al., 2012). Carers have also reported how they feel ignored and excluded when it comes to decisions made by staff in the acute hospital, and how they perceived hospital discharge to be poorly planned and co-ordinated (Jamieson et al., 2014; Lowson et al., 2013).

Hospital admission is a critical time for the person with dementia and their family/carer; it should be seen as an opportunity to assess carer's needs and provide them with education and information on the resources available. This would not only serve to reduce burden and anxiety, but would facilitate the person with dementia remaining in the community for as long as possible. Furthermore, carers are useful resources for healthcare professionals providing acute care for the person with dementia, and their input is central to informing good dementia care (Bradway & Hirschman, 2008).

Overall, poor communication between healthcare professionals, and older patients and their families/carers, seems to be a prevalent theme in studies focused on hospital care (Allen, Cherry & Palmore, 2009; Anderson, Allan, & Finucane, 2000; Bauer et al., 2009).

In investigating communication with families/carers at the hospital level, this audit found:

- 58% (7/12) of hospitals reported that there are clear guidelines around asking the carer about the extent to which they prefer to be involved with the care and support of the person with dementia whilst in hospital.
- 92% (11/12) of hospitals reported having guidelines around asking the carer about their wishes, and their ability to provide care and support to the person with dementia post-discharge.
- 67% (8/12) of hospitals reported that they involve people with dementia and their families/carers, and their experiences in hospital, in the training for ward staff.

Communication with family/carers regarding discharge was also investigated:

- 58% of case notes (109/189) had evidence indicating that the appropriate place of discharge and support needs were discussed with the carer/ relative, and only 24% (45/189) with the patient.
- 62% (66/107) of carers who should have had an assessment of their current needs, had one in advance of discharge.
- 47% (91/192) of families/carers received 24 hours or less notice of discharge.
- One-third (63/189) of families/carer received a copy of the discharge summary before leaving the hospital.

These results indicate a lack of involvement of families/carers during the admission and the discharge process. They are reflective of the findings in the literature which report that

families and carers perceive hospital discharge to be poorly coordinated and executed, and generally 'ad hoc' (Bauer et al., 2011). A systematic review of the literature concluded that positive relationships between hospital staff and family/carers are fostered when families are involved in decision-making, and care and discharge planning, and when there is effective communication between the multidisciplinary team and the families/carers (Haelser et al., 2010). In this way, families/carers must be considered an integral part of the planning and delivery of good quality dementia care, and should be treated accordingly.

Information Available on the Ward

Research in this area has indicated the importance of family/carers receiving a comprehensive orientation on admission to a service/facility (Haesler et al., 2010). In terms of communicating with families and carers, this audit also looked at the information available on the ward to familiarise themselves with the ward routine, and make them feel comfortable in the setting:

- All 36/36 wards reported that information is routinely provided to patients and their family/carers on ward routines including mealtimes and visiting hours. All provide this information verbally, and 92% (33/36) provide written information on this on admission.
- 94% (34/36) of wards provide information on the hospital complaints procedure, with 32/34 wards able to provide written information on this where necessary.
- 67% (24/36) of wards can provide information on patient advocacy services, with 17/24 wards able to provide written information on this where necessary.
- 97% (35/36) of wards reported that a healthcare professional responsible for coordinating the care of the person with dementia is identified to the patient and their carers/relatives as their point of contact during the admission.

Information Collected about the Person with Dementia

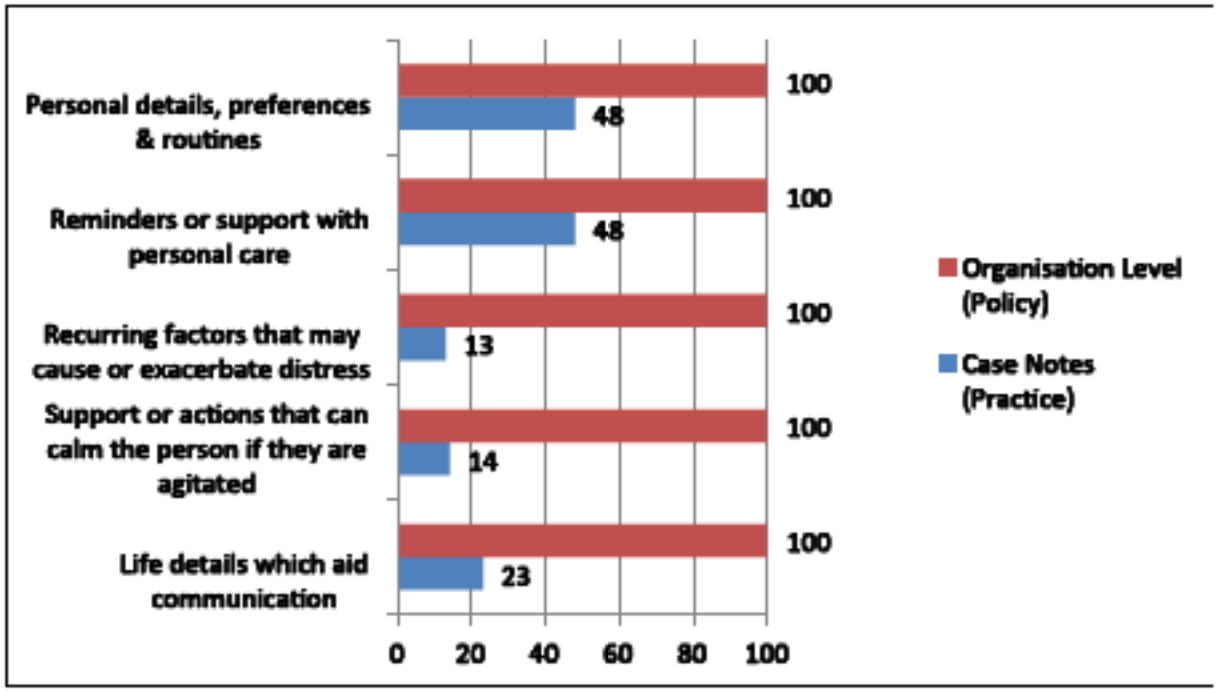
The person with dementia may not be able to effectively communicate their wants and needs to healthcare staff. When needs go unmet, behaviours that challenge can ensue causing stress for patients, healthcare staff and family/carers. In order to provide person-centred dementia care, it is necessary to collect psychosocial information about the person from the family/carer. An example of such a document is the Alzheimer Society's 'This is Me' pro-forma. According to the Alzheimer's Society, documents that collect information such as this 'enable health and social care professionals to see the person as an individual and deliver person-centred care that is tailored specifically to the person's needs'. We investigated the use of such a document both at hospital level and in the case note review:

- At an organisational level, 25% of hospitals (3/12) reported having a formal system in place for gathering information pertinent to caring for a person with dementia.
- However, only 10% (23/240) of case notes had a section dedicated to collecting information from the carer about the person with dementia.

Compared to the second round of the England and Wales audit (2013) in which 45% of patients had such a document in their case notes, this shows a poor picture regarding the collection of information pertinent to the care of the person with dementia.

Figure 7 below depicts the information collected about the person with dementia (n=23) using such a document in the case notes, and compares this to hospital level data (n=3) on the information that should be collected about the patient with dementia using the hospitals' formal system. Here, a gap between hospital policy and practice is illustrated once again.

Figure 7 - Information that should be collected about the patient with dementia using a formal system according to hospital guidance (n=3), compared with actual information collected about patients with dementia (n=23), recorded in their case notes.



Of the 23 people with such a document in their case notes, less than half (48%) had information collected regarding personal details, preferences and routines, or about reminders/support required regarding personal care. Very few (13%) had information collected about factors that might cause or exacerbate distress, or that might calm the person if they become agitated (14%). Just under one-quarter had details about the patient's life recorded that would aid staff in communicating with them. In contrast, all hospitals that use such a document reported that it does request all of these types of information. This indicates that even when there are such documents in patients' case notes, the correct type of information that would allow for the provision of person-centred care is not always collected by staff. The case note reviewers often commented that the documents did prompt this type of

information; however staff did not always populate sections that did not relate to personal care or routines.

These results highlight the possibility that staff may not be fully-equipped with the skills or resources required to provide person-centred dementia care in acute hospitals and the findings are symptomatic of the culture of care in acute hospitals. Cowdell (2010a, 2010b) concludes that care on hospital wards is focused on physical needs, routine and meeting compliance targets, and rarely on the person and their individual needs. This is of concern and highlights the need for staff education and training to facilitate a change in attitudes and practices relating to dementia care and ensure that person-centred care becomes the standard approach in acute hospitals.

Communication between Staff

People with dementia are often not admitted due to the dementia itself (Parks et al., 2004), and mild-moderate dementia often goes unrecognised in this setting. In this way, systems that signal to hospital staff that a person has dementia, and consequently may have specific care needs, can be important for improving the quality of dementia care. In this audit we found that:

- 75% (9/12) of hospitals have a system in place across the hospital 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. All hospitals with a system in place reported using a visual indicator, symbol or marker.
- 42% (5/12) of hospitals have a system in place across the hospital to ensure all staff from *other areas* outside of the ward are aware of the person's dementia when they

need to access treatment areas outside of the ward. All hospitals with a system in place reported using a visual indicator, symbol or marker.

At ward level, ward managers were asked about the systems in place to communicate the specific care needs of the person with dementia:

- 94% (34/36) of wards identified handover as the system used for communicating personal information (e.g. routines, preferences, support needed with personal care) to staff involved in the care of the person with dementia.
- 94% of wards also reported that handover was used to communicate information regarding any behavioural or communication needs specific to the person with dementia to other staff on the ward providing care for the person.
- Again, 94% of wards reported that if a patient with dementia with behavioural and communication needs were leaving the ward with a member of hospital staff from outside the ward (e.g. a porter), that a staff member from the ward (or a family member/carer) would be sent with the patient.

Conclusion

These findings indicate that while good basic information relating to hospital admission is widely available at ward-level, the communication of information relating to people with dementia and their care is only fair across a number of areas in acute hospitals in Northern Ireland. Despite wards reporting that families/carers have a staff member as a point of contact, families and carers are often not central to decisions regarding patient care and discharge planning, with many carers not having their needs assessed prior to discharge, and receiving little information on discharge destination or date until the day of discharge.

Furthermore, most families/carers leave hospital without being provided with a discharge summary containing information about the admission, necessary for planning and obtaining appropriate supports in the community. Another area of concern is the lack of psychosocial and personal information recorded about the person with dementia that would allow for the provision of person-centred dementia care. At hospital-level, guidance must be provided to staff on systems for communicating information pertinent to the care of the person with dementia, and ensuring that families and carers are appropriately included in any dialogue relating to patient care and decision-making.

Recommendations

1. Clear guidelines should be developed, implemented and reviewed around the communication of healthcare information and the involvement of families/carers in the care of the person with dementia and decisions relating to their discharge.
2. A single healthcare professional should be appointed to act as a point of contact for the person with dementia and their family/carers during the admission, and should be responsible for ensuring that the family/carers are involved in conversations and decisions relating to care and discharge, if this is what they want.
3. A document/form for collecting personal information about the person with dementia (e.g. 'This is Me'/'Patient passport') should be completed with the help of family/carers for every person with dementia. This document should include guidance on how best to communicate with them, and should be kept in the case notes. This form should prompt the collection of vital information about the patient that is central to the provision of person-centred care e.g. the patients' preferences/routines,

reminders or support needed with personal care, factors that may cause or exacerbate distress, and calm the person if they are agitated.

- Staff should receive basic training in the use of such a document, and the importance of such information to increasing the quality of care provision.

4. All hospitals should have a system or visual maker in place so that all hospital staff can identify people with dementia throughout the hospital, which can be particularly important when patients need to access treatment areas off the ward. An example of such a system is the butterfly symbol from the Butterfly Scheme.

Staff Training

- Less than half of hospitals have a knowledge and training framework/strategy that allows for the identification of necessary skill development among their staff caring for people with dementia.
- No hospital has mandatory dementia awareness training for staff.
- Dementia awareness training has been provided by the majority of hospitals in the 12 months previous to the audit for doctors (58%), registered nurses (59%), healthcare staff (67%), and allied health professionals (75%).
- 42% of hospitals provided their doctors, nurses and healthcare staff with training in communication skills specific to people with dementia in the previous 12 months.
- 83% of doctors received training in the assessment of capacity in the previous 12 months.
- 67% of hospitals provided training in the management of behaviours that challenge for both doctors and nurses in the previous 12 months.
- The majority of hospitals provided training on the assessment of risk when considering the use of restraint/sedation for doctors (67%), nurses (75%) and healthcare staff (75%) in the previous 12 months.
- 81% of wards could provide cover to allow staff to attend training relating to the care of people with dementia.

Dementia Awareness Training

Research findings have long indicated a need for improved dementia education and training for nurses and other healthcare staff in acute services (Coffey et al., 2014; Leung & Todd, 2010). Lack of staff training in dementia care has a significant impact on quality of care, and can lead to widespread use of chemical and physical restraint, inadequate nutritional support, and increased staff burden (Alzheimer's Society, 2009; Moyle et al., 2012).

A recent study reported that nursing staff (n=968) within NHS trusts in England and Wales reported that they perceived training in dementia care to be under-provided and inadequate. The majority of nurses specifically highlighted a lack of education and knowledge in dealing with challenging behaviour, recognising pain in dementia, understanding the risks associated with restraint/sedation, assessing cognitive ability, and communicating appropriately with a person with dementia. Furthermore, some did not understand the role of certain services in the provision of dementia care (Gandesha et al., 2012).

This audit looked at the presence of knowledge and training frameworks within hospitals in Northern Ireland:

- Less than half of hospitals (42%, 5/12) reported that they have a knowledge and training framework/strategy that identifies necessary skill development among their staff caring for people with dementia.
- The majority of hospitals' induction programmes include dementia awareness training (67%, 8/12).
- No hospital reported having mandatory dementia awareness training for staff.
- Over half of hospitals reported providing their doctors (58%, 7/12), registered nurses (59%, 7/12), healthcare staff (67%, 8/12) and allied health professionals (75%, 9/12)

with dementia awareness training in the previous 12 months, while 33% (4/12) of hospitals provided this training to support staff in the previous 12 months.

This audit also looked at more specific types of training relevant to the provision of dementia care, which was offered to healthcare staff in hospitals.

Communication Skills

People with dementia experience communication difficulties such as problems findings words, incoherent speech, repetition, and poor attention and recall, particularly as the condition progresses. They may also have visual/hearing impairments that can affect how they communicate and how they understand others. Developing skills to communicate appropriately with people with dementia is important for healthcare staff working in acute hospitals.

In the absence of communication skills specific to dementia, the needs of the person with dementia can go unmet, leading to challenging behaviours (Keady & Jones, 2010). Communication barriers can also adversely influence quality of life, quality of care, and the relationships experienced (Kitwood, 2008). Hospitals were asked if they had provided training around communication skills, specific for people with dementia:

- Less than half of hospitals (5/12) provided their doctors, nurses and/or health care staff with communication skills training in the previous 12 months, while 4/12 hospitals provided communication training to allied health professionals.
- Most hospitals had provided their doctors (67%, 8/12) and nurses (75%, 9/12) with training in supporting people with visual/hearing impairments in the previous 12 months, while healthcare staff (50%, 6/12) and allied health professionals (42%, 5/12) were provided with less training in this area.

Cognitive Ability and Mental Capacity

The Bamford Review (2007) document 'A Comprehensive Legislative Framework', recommended that a single legislative framework for the reform of the current Mental Health Order (1986) and that new mental capacity legislation to be introduced. At present, there is no specific legislation in place governing mental capacity in Northern Ireland. However, the Department of Health, Social Services and Public Safety, together with the Department of Justice, have drafted a Mental Capacity Bill. For those that are deemed to lack mental capacity, the drafted bill aims to ensure that any substitute decision-making is done in the best interest of the person in question. The proposed bill provides for lasting powers of attorney, advance directives and advocacy support where a substitute decision-maker is appointed.

In order to determine if a person with dementia has the capacity to make decisions that are in their best interest, it must be established that they can understand and retain the information relevant to the decision and weigh up the information to make an informed decision. In acute hospitals, situations can arise where it becomes necessary to carry out an assessment of mental capacity on a person with dementia. As part of the audit, the training provided by hospitals to staff in the assessment of capacity was investigated:

- The majority of hospitals had provided their doctors with training in the assessment of capacity in the previous 12 months (83%, 10/12), while 33% (4/12) of hospitals made this training available for nursing staff.

Behaviours that Challenge

Behaviours that challenge or behavioural and psychological symptoms of dementia are common in this population and almost all people with dementia will experience such symptoms at some point during the course of their condition (Savva et al., 2009). Behaviours that challenge can lead to adverse outcomes such as carer burden and early institutionalisation (Pinquart et al., 2003, Ballard et al., 2000). In hospital, staff can experience behaviours as stressful, and can experience significant burden as a result.

Furthermore, lack of understanding in relation to behaviours that challenge, can lead to inappropriate restraint and sedation. Staff training around the management of behaviours is vital to ensuring that patients' needs are met, staff burden is reduced, and that the overall risk of poor patient outcomes is reduced. The provision of training in the management of behaviours that challenge was investigated:

- More nurses (67%, 8/12) and healthcare staff (67%, 8/12) than doctors (42%, 5/12) have been provided with training in the management of behaviours that challenge, including aggression and extreme agitation, by hospitals in the previous 12 months.
- One-third of hospitals (4/12) provided training on managing behaviours that challenge for allied health professionals in the previous 12 months.

Assessment of Risk before the Use of Restraint

Physical and chemical restraint are commonly used to control challenging behaviour (Hofmann & Hahn, 2014; Moyle et al., 2012; McCloskey, 2004), and this is often not in the patients' best interests (Powell, 2000). Physical restraint prevents free movement and should

be used only to protect the patient or those around them from harm however, as a number of adverse outcomes have been linked to this practice including muscular atrophy, immobilisation, neural lesions, fractures, cognitive decline and even death (Huang et al., 2009; Berzlanovich et al., 2007, 2012; Wang et al., 2005).

Chemical restraint, in the form of atypical antipsychotics, as well as other psychoactive medications, is often used to sedate people with dementia, and Banerjee (2009) noted how these medications are widely being prescribed to deal with behavioural and psychological symptoms generally, rather than just for psychosis. This is not acceptable practice given that the evidence suggests that antipsychotic medications actually have 'a limited positive effect' in treating these symptoms, but can cause substantial harm to people with dementia.

The implication here is that healthcare staff may not be aware of or fully understand the risks associated with the inappropriate use of restraint and sedation. As part of this audit, the provision of training around the assessment of risk before the use of restraint or sedation was investigated:

- The majority of hospitals have provided training on assessing risk before using restraint or sedation for doctors (67%, 8/12), nurses (75%, 9/12) and healthcare staff (75%, 9/12) in the previous 12 months.
- This training was made available by less than half of hospitals (42%, 5/12) for allied health professionals in the same time frame.

Staff Cover

In addition to assessing the availability and provision of training relating to dementia care, the ability for staff to attend any such training was also assessed. Ward managers were asked

if arrangements could be made for cover to allow ward staff to attend training relating to dementia care;

- 81% (29/36) of ward managers reported that staff cover could be provided to allow staff to attend training relating to dementia care, if sufficient notice was given.

Conclusion

In providing dementia care in acute hospitals, it is not sufficient to just meet physical care needs. People with dementia also have psychosocial care needs, sometimes complex, that require staff to draw on specialised skills. Poor availability of training and education relating to dementia care means that staff in the acute setting often lack the awareness, knowledge and practical skills to provide the type of care that people with dementia require. Unfortunately, poor training inevitably leads to sub-optimal care and increased risk of adverse patient outcomes. Although training is some areas of dementia care was good, such as capacity assessment for doctors and induction training including dementia awareness, it is important going forward that staff training in dementia care is made a priority at an organisational level, with all hospitals in Northern Ireland committing to making a framework/strategy that allows them to easily identify and rectify gaps in training.

Recommendations

1. Basic dementia training should be mandatory for all hospital staff.
2. Hospitals should ensure that dementia awareness training is a mandatory component of the induction programme for new staff.

3. **Specialist training in aspects of dementia care should be completed by staff working on wards that admit adults, with a locally agreed percentage of staff on these wards completing even higher level training e.g. dementia champion training.**
4. **In particular, specialist training in communicating effectively with a person with dementia should be completed by staff.**
5. **Each hospital should have a training and knowledge strategy in place that would allow for the identification of gaps in staff training relating to dementia care.**

Staffing and Staff Support

Summary

- The mean number of registered nursing vacancies per ward is 2.12 and the mean number of healthcare staff vacancies per ward is 0.93.
- The maximum number of vacancies was 8.31.
- 78% of wards have at least one vacancy in their permanent nursing and healthcare staff.
- Vacancies are most often filled by hospital pool/bank (nurses, 94%, healthcare staff, 92%) and slightly less often by agency staff (nurses, 72% healthcare staff, 69%).
- 97% of wards have an agreed minimum staffing level across shifts.
    - 87% of these wards report that minimum staffing levels are generally met.
- Nursing staff have good access to appraisal/mentorship (97%), clinical supervision (94%) and the guidance of a dementia champion at ward level (64%).
- Healthcare staff have similar access to appraisal/mentorship (94%) and access to guidance from a dementia champion (64%), but poorer access to clinical supervision.
- 83% of wards do not offer peer support groups to staff, and 86% do not offer reflective practice groups.

Staffing and Skill Mix

There is evidence to suggest that there is an association between low staffing levels in hospitals and patient mortality and other adverse patient outcomes (Needleman et al., 2002, 2011; Lang et al., 2004). In a study by Aiken et al. (2002a), hospitals with the most favourable staffing levels had consistently lower 30-day mortality and failure-to-rescue rates than those hospitals with below optimal staffing levels. This study also reported that nurses working within hospitals that have optimal staffing levels reported less job dissatisfaction, nurse burnout and problems with the quality of patient care. Kalisch et al. (2010) also concluded that for nursing staff, perceptions of adequate staffing leads to greater job satisfaction. Staff skill mix/grade can also impact upon patient outcomes (Twigg et al., 2012) and is an important staffing consideration.

This audit investigated the level of staffing and the skill mix on wards that admit adults in acute hospitals in Northern Ireland. Ward managers were asked to provide details on the number of whole time equivalent (WTE) nursing staff (including band 7) and healthcare staff that *should* be working on the ward i.e. that are allocated to the ward currently. They were also asked how many nursing and healthcare staff were actually working on the ward at that time, in order to calculate staffing levels.

- The mean number of registered nurses allocated to wards was 24.29, while the mean number actually working on the wards was 22.17, leaving a mean of 2.12 nursing vacancies per ward, with a minimum of 0 vacancies and a maximum of 8.31 across wards.

- The mean number of healthcare staff allocated to the wards was 9.59 and actually working on the wards was 8.66, leaving 0.93 vacancies with a minimum of 0 and a maximum of 3.2.
- 78% (/36) of wards had at least one vacancy amongst their permanent nursing and healthcare staff.
- The skill mix among the staff was considered when planning the staffing roster on 92% (33/36) of wards, with the help of the 'E-Rostering' system that is now in place in most wards.
- Most ward managers (97%, 35/36) reported having an agreed minimum staffing level across all their shifts, and 89% (31/35) of these said that the agreed minimum staffing levels are generally met.

Ward managers were also asked how nursing or healthcare staff vacancies were typically filled:

- Three wards reported that their nursing vacancies are not currently filled, while most reported that nursing vacancies are filled by the hospital pool/bank (94%, 34/36) and/or by agency staff (72%, 26/36).
- For healthcare staff, 4/36 wards reported that vacancies are not filled, and a similar pattern of use of hospital pool/bank (92%, 33/36) and/or agency staff (69%, 25/36) was reported.
- Almost all ward managers (97%, 35/36) reported having a working system for reporting and monitoring when they use the hospital pool/bank and/or agency staff.

While it is promising that most wards have access to some level of temporary staffing to fill vacancies, it is possible that using the hospital pool and/or agency staff, who are not familiar with the ward and the systems in place, will hinder the planning and delivery of good

dementia care. Particularly in the case of agency staff, it is not always possible to determine the type of training they have received relating to dementia care.

Administrative Support

This audit also examined the administrative support on wards admitting adults. All wards had some level of administrative support available:

- 56% (20/36) had support on a full time basis five days per week, while 44% (16/36) had part-time support.
- One-third of wards (12/36) had administrative support at the weekends.

Systems for Supporting Staff

It is important that healthcare professionals working on hospital wards feel supported in their role. For nursing staff, correlations have been found between job satisfaction and management support (Kovner et al., 2006), communication with supervisors and peers, recognition, fairness, and control over practice (Blegen, 1993). For healthcare assistants, excessive workload (Mather & Bakas, 2002, Crickmer, 2005), not being recognized and valued for contributions (Spilsbury & Meyer, 2004, Crickmer, 2005) and supervisor support (Decker et al., 2009) have been identified as factors that impact upon job satisfaction.

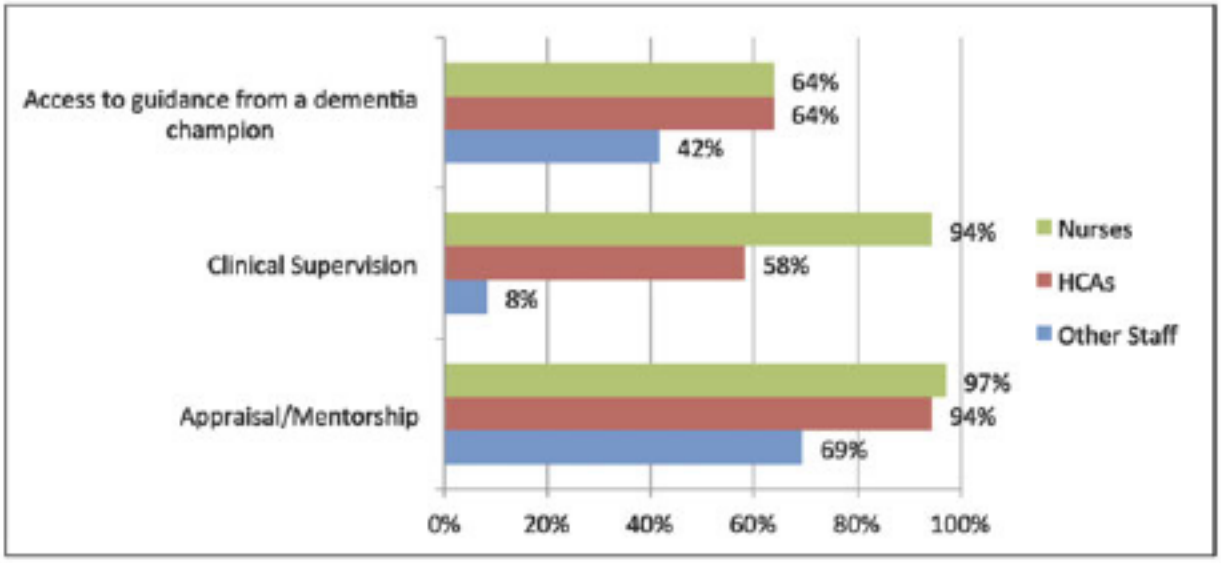
Figure 8 shows that registered nursing staff have the most access to systems for supporting their professional development, with 97% having access to an appraisal at least yearly and 94% are provided with clinical supervision sessions. Healthcare staff have similarly good access to these systems; however, wards are considerably less likely to offer clinical supervision to this group (58%) than they are to nursing staff.

Dementia Champion

'Dementia champions' are healthcare professionals with specialised training in the care of people with dementia. They also act as advocates for people with dementia and their families/carers, provide information and support to their colleagues working in healthcare settings, and take a leadership role in promoting the ongoing development of best practice in dementia care. The benefits of training a number of staff per hospital to become dementia champions, that could in turn give training to other hospital staff, would be exponential and would serve to dramatically improve the quality of dementia care. This audited investigated the level of access that ward staff have to dementia champions:

- 64% (24/36) of ward managers reported that both nursing and healthcare staff have access to the guidance and advice of a 'dementia champion' with the expertise and training to provide instruction on best dementia care to staff on the ward.

Figure 8 - Systems for Supporting Staff Development



Reflective Practice, Peer Support Groups

Reflective practice has become a popular theory of professional knowledge acquisition for nurses and healthcare professionals (Kinsella, 2009). Experiential learning and reflection on practice is central to improving clinical judgement and can play an important part in maintaining good evidence-based practice (Bulman & Schutz, 2013). Peer support is defined as the mutual support provided between colleagues that enables one to deal with work-related or other stress (Guillaume & McMillan, 2002), and it promotes the psychosocial health and resilience of nursing staff (Ye & Wang, 2007).

- Peer support groups were *not* available to staff working on 83% (30/36) of wards, with only six wards (17%) offering peer support groups to healthcare staff and five wards (14%) offering this to registered nursing staff providing care for people with dementia.
- Reflective practice groups were also *not* commonly offered on wards, with only 11% (4/36) of wards making groups available to their registered nurses and 14% (5/36) to their healthcare staff who provide dementia care.

Conclusion

The majority of wards have at least one vacancy in their permanent nursing and healthcare staff, with an average number of just over 2 nursing vacancies per ward. There is evidence of large variation in staffing levels between wards and hospitals, with some wards having no vacancies, and one ward having over eight vacancies. Low staffing levels can increase the risk of adverse patient outcomes and nurse burden. It is also important that staff feel supported in their roles; while there is good access to clinical supervision, and

appraisal/mentorship, going forward, better access to the guidance and support of hospital dementia champions, as well as reflective practice and peer support groups, would serve to significantly improve care and reduce staff burden.

Recommendations

1. The issue of staffing should be carefully considered by management at hospital and ward level to ensure that there is sufficient staffing on wards that admit adults to meet the particular care needs of people with dementia;
    - Nursing and healthcare staff vacancies should be filled as soon as possible with staff that have completed training in dementia care.
    - The use of temporary hospital bank and agency staff should be minimized.
    - Indicators of staffing sufficiency including patient outcomes, falls, delayed discharges/transfers, malnutrition, etc. should be reviewed by hospital management regularly.
2. Guidelines should be developed for determining optimal staffing levels on wards that admit adults, including people with dementia, that take into account the specific care needs and dependency of people with dementia.
3. Systems for supporting nursing and healthcare staff that work with people with dementia should be in place in all hospitals, including but not limited to staff appraisal, mentorship, clinical supervision, peer support groups and reflective groups.

Physical Ward Environment

Summary

- 58% of wards had no day room/lounge that patients could use, while 69% had no space for active patients to walk around safely.
- Keys areas such as the nursing station were not clearly marked on 53% of wards, signs to locate toilets were only visible to patients from their bed areas on 11% of wards, and only one ward had a colour scheme to aid navigation.
- 94% of toilet doors carried signs.
- Clocks and calendars/orientation boards were not visible to patients on 28% and 92% of wards respectively.
- On 25% of wards, messages from relatives and personal objects/items were visible to patients.
- Most floors (69%) were plain/subtly patterned.
- No ward had flooring level changes such as steps or slopes.
- 92% of wards were adapted to assist mobility difficulties, with all 36 having handrails in the toilets and being able to provide equipment to assist mobility.

People with dementia admitted to hospitals experience significant distress (Cowdell, 2010b; Nolan, 2007), have greater lengths of stay in hospitals than those without dementia (Guijarro et al., 2010; King et al., 2006), are at risk of adverse health outcomes (Andrews, 2013; Sampson et al., 2009), and place significant financial burden on health service providers (NHS Confederation, 2010). Among the reasons cited for this is the unsuitability of the physical ward environment in acute hospitals for people with dementia (Andrews, 2013).

Admission to this environment can be particularly stress-inducing for people with dementia due to their poor ability to adapt to new settings (Ziesel et al., 2003; Marshall, 2009). People with dementia have also reported this setting to be confining (Wiersma & Pedlar, 2008). Given the reduced spatial orientation and coping skills associated with the condition (Digby & Bloomer, 2014; Marquardt & Dr-Ing, 2011) the ward environment can lead to increased confusion, agitation, withdrawal and wandering (Cohen-Mansfield, 2001; Barnes, 2006; Marshall, 2009; Marquardt & Dr-Ing, 2011, McCloskey, 2004), even if excellent care is provided (Andrews, 2013).

There is currently a shift in thinking around design for hospital environments, and how to ensure they are more 'dementia-friendly' (Marshall, 2001; Davis et al., 2009), in an effort to reduce distress and adverse outcomes. Marshall (2001) described how a suitable ward environment should offset the impairments of dementia by compensating for disability, reinforcing personal identity, maximising independence, enhancing self-esteem, and welcoming family/carers. The ward environment module of this audit examined aspects of the built environment including; layout, size, space, orientation, flooring, colours, and features of the ward that compensate for some of the impairments of dementia and thus promote greater independence.

Ward Layout, Size and Space

Lack of privacy and personal space can lead to frustration, agitation and aggression in people with dementia (Zeisel et al., 2003). Also lack of common space for socialising and walking is linked to aggression, and physical and verbal agitation (Zeisel et al., 2003). Thus, the layout of the ward is an important issue to be considered in the care of the person with dementia.

- The mean number of patient beds per ward was 25.7 (SD=9.1), with a minimum of 6 and a maximum of 60.
- There was on average, 8.7 (SD=6.5) single rooms per ward.
- Only 8% (3/36) of wards had any mixed bays, but all three wards noted that an effort is made to avoid this, and have only single sex bays where possible.
- Single sex toileting facilities were available on almost all wards (97%, 35/36).
- 6% (2/36) of wards' toileting facilities were not big enough for assisted toileting.
- On wards that had bathing facilities (8/36), all were big enough for assisted bathing.
- Over half of wards (58%, 21/36) had no day room or lounge area that patients could use, while 69% (25/36) of wards had space for active patients with dementia to walk around safely, where they are visible to healthcare staff and staff are visible to them.

Orientation

Signposting, Visual Access Cues & Colour Schemes

People with dementia can experience a significant deterioration in their spatial orientation (Digby & Bloomer, 2014; Marquardt & Dr-Ing, 2011) and when admitted to new environments (e.g. a hospital ward) they can become confused, agitated, withdrawn and begin

to wander (Cohen-Mansfield, 2001; Barnes, 2006; Marshall, 2009; Marquardt & Dr-Ing, 2011). Signposting is important to improve orientation (Fleming et al., 2014), and is associated with a reduction in behaviours (Bianchetti et al., 1997). Research findings suggest that when facilities are made visible on the ward, they are more likely to be used by people with dementia, which is important for maintaining activities of daily living e.g. the toilet is eight times more likely to be used when it is in view (Namazi & Johnson, 1991a).

- Key ward areas such as the nursing station were clearly marked on less than half of wards (47%, 17/36).
- Signs or maps were present on 78% (28/36) of wards, however only 54% (15/36) of these were suitable in design (large, bold, and distinctive) for people with dementia.
- Signs to locate the toilets were visible to patients from their bed area on only 11% (4/36) of wards.
- A colour scheme to help patients navigate the environment was present on only one ward.
- The toilet doors did not carry signs on 6% (2/36) of wards, and one ward with a bath had no sign on the bathroom door.
- None of the toilet facilities (including soap dispensers, bins and hand dryers) were labelled for patients with dementia on 86% (31/36) of wards.
- Door handles were a different colour to the doors on 22% (8/36) of wards, and all toilet and bathroom doors were a different colour to the walls on 56% (20/36) of wards.

Temporal and Personal

Familiarity is essential and necessary for orientating people with dementia to their own identity. The visibility of personal belongings has been linked with maintaining

functional ability and reduced aggression and anxiety (Annerstedt, 1997), and family/carers should be encouraged to provide familiar items by hospital staff.

- On just one-quarter (9/36) of wards, messages from relatives and personal objects/items were visible to patients from their bed area.

This audit also investigated the presence of temporal cues on the ward, visible from the patients' bed, which would help people with dementia to orientate themselves to the date and time.

- Clocks were not visible to patients with dementia on 28% (10/36) of the wards audited.
- 92% (33/36) of wards had no calendars or orientation boards.

Flooring

Visual problems such as contrast sensitivity, visuospatial orientation, and colour perception are highly prevalent in people with dementia (Rogers & Langa, 2010) and so the colour, style and slope of flooring should be a particularly important consideration on hospital wards. This audit found that:

- None of the 36 wards had any level changes such as slopes or steps.
- The majority of floors were plain (69%, 25/36) and did not contain busy patterns that might have a negative effect on patients with dementia.
- Exactly half (18/36) of wards had non-glossy or mildly polished flooring, while the other half had glossy floors, which may disorientate some people with dementia.
- All 36 wards had non-slip flooring.

Promoting Independence on the Ward

Hospitalisation is a risk factor for functional decline, and confinement to the bed area for older people during their admission contributes to this. Lower physical activity in older hospitalised patients has been linked to functional decline, increased length of stay and higher re-admission rates (Boyd et al., 2008; Brown, Friedkin, & Inouye, 2004). It is thus important that the physical ward environment encourages and promotes independence and enables patients in as many ways possible. This audit found that:

- The majority of wards (92%, 33/36) were adapted to assist mobility difficulties, with handrails along the corridors.
- All 36 wards can provide equipment to assist mobility such as walking frames and wheelchairs.
- All wards also had handrails in the toilets.
- Most wards (94%, 34/36) had large handles on taps and doors.
- The majority of wards also had raised toilets seats (97%, 35/36).
- Most wards (94%, 34/36) could provide hearing aids such as amplifiers, communicators, hearing loops and batteries for devices.
- Call bells/alarms were visible and in-reach in almost all toilets/bathrooms (97%, 35/36) and bed areas (92%, 33/36).

Conclusion

The overall purpose of an acute hospital is to care for people of all ages who are acutely ill and suffering from a wide range of conditions. It is therefore no surprise that the physical

ward environment is not currently tailored for people with dementia. In the coming years, however, people with dementia will occupy a large and growing proportion of acute hospital beds, and so the adaptation of the physical ward environment must become a priority.

This audit has identified areas for improvement regarding the ward environment, including better orientation cues, signposting and visual access cues, colour schemes for navigation, and better use of space to encourage mobility and reduce confinement to the bed area. It has also illustrated that the flooring, signage in certain areas (e.g. toilet doors), and the ability of the ward to support and enable people with dementia to be more independent is promising and can be developed for further improvement. This area again highlights the importance of training and education, so that staff can understand the importance of the role that the ward environment plays in compensating for the disabilities that the person with dementia can experience during hospital admission.

Recommendations

1. Regional guidelines on dementia friendly ward design should be developed and incorporated as standard into all hospital refurbishments and new builds.
2. Hospital and ward level management in conjunction with dementia champions should focus on improving orientation for people with dementia on hospital wards; all key areas should be clearly marked, colour schemes should be used to discriminate between areas, all toilet/bathroom doors must carry dementia-friendly signs, visual access cues should be visible that would direct people with dementia to ward facilities, including the toilet, from their bed areas, and clocks should be visible to all patients.

3. Staff should encourage the display of personal objects in the bed area of the person with dementia.
4. Staff on all wards should promote independence and social interaction by encouraging people with dementia that are mobile to use safe spaces on the ward to mobilise and reduce confinement to the bed area.

Discharge and Discharge Planning

Summary

- All 12 hospitals reported having a discharge policy which states that discharge should be an actively managed process which begins within 24 hours of admission.
    - However, the case note review revealed that discharge planning was only initiated within 24 hours of admission for 16% (31/193) of patients.
- All 12 hospitals reported that the discharge policy states that relatives and carers should be informed and updated about the prospective discharge date.
    - However, the case note review revealed that almost half (47%) of families/carers received 24 hours or less notice of discharge.
- 83% of hospitals reported having a named person who takes overall responsibility for complex needs discharge, and this includes people with dementia.
- 26% of case notes had no evidence of a discharge plan.
- A named person coordinated the discharge plan for only 55% of people with dementia.
- 16% of case notes showed evidence that the patients' level of cognitive impairment using a standardised instrument was summarised and recorded at the point of discharge.
- 55% of case notes had the cause of cognitive impairment recorded at discharge.
- Of those with delirium and BPSD during the admission, 43% and 25% respectively had the symptoms summarised and recorded for discharge.

Discharge and Transfer Policy

Discharge planning and co-ordination can be a complicated process for hospital staff working with older people with dementia in hospitals, because the condition can give rise to complex physical and psychosocial needs. The discharge process is central to preparing the family/carer for receiving the person with dementia back to their pre-admission abode equipped with adequate resources and supports, and to assisting with post-discharge transitions e.g. new admissions to long-term care. Discharge planning is essential for the welfare of the patient and the service, as inadequate planning practices are associated with poor patient outcomes and an amplified risk of hospital readmission (Bauer et al., 2009). The present findings indicate that:

- All 12 hospitals have a discharge policy in place.
- All 12 hospitals reported that the discharge policy states that discharge should be an actively managed process which begins within 24 hours of admission.
    - However, the case-note review revealed that discharge planning was only initiated within 24 hours of admission in 16% (31/193) of patient case-notes.
- 92% (11/12) hospitals reported that the policy states that discharge should take place during the day.
- All 12 hospitals reported that the discharge policy states that relatives and carers should be informed and updated about the prospective discharge date.
    - However, the case-note review indicated that almost half (47%, 91/192) of families/carers received 24 hours or less notice of discharge.
- 75% (9/12) hospitals reported that information about discharge and support (written in accessible formats including plain English, and available in other languages) is made available to patients and their families/carers.

- One hospital had a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia.

Moving people with dementia between wards in a hospital can be disorientating and should be handled with care. There were fewer policies in place governing transfer practices than discharge practices:

- 42% (5/12) of hospitals reported that the transfer policy states that people with dementia should only be moved for reasons pertaining to their care.
- 25% (3/12) of hospitals reported that the transfer policy states that any move should take place during the day.
- 58% (7/12) of hospitals reported that the transfer policy states that families/carers should be kept informed of any moves within the hospital.

Discharge Planning & Coordination

Discharge planning involves the development of individualised plans for patients prior to leaving hospital, with a view to containing costs, ensuring continuity of care, and improving outcomes for patients. It is a process that must be actively managed, and aims to coordinate services in order to ensure that patients' needs continue to be met post-discharge (Katikireddi et al., 2009).

Having a discharge coordinator has been shown to result in an improved discharge planning process, a reduction in problems experienced by patients after discharge, and in perceived need for medical and healthcare services (Houghton et al., 1996). A systematic review of the literature concluded that a structured discharge plan tailored to the individual patient is likely

to reduce hospital length of stay and readmission rates, and lead to an increase in patient satisfaction (Shepperd et al., 2013). In relation to discharge planning and coordination, this audit found that:

- 83% (10/12) of hospitals reported having a named person who takes overall responsibility for complex needs discharge and this includes people with dementia.
    - All 10 hospitals also reported that this person has experience of working with people with dementia and their carers.
    - 7/10 hospitals reported that this person has training in the ongoing needs of people with dementia.
- The case note review indicated that a named person coordinated the discharge plan for only 55% (106/194) of people with dementia.
- 26% of case notes had no discharge plan documented.
- Only 47% (92/194) of people with dementia had a single plan for discharge with clear and updated information.
- Only 33% (63/189) of families/carers received a copy of the discharge plan/summary at the point of discharge.

Assessment before Discharge

At the point of discharge, an overall summary of the admission should be completed containing information on the current health of the patient including any recovery or decline, the dementia condition, comorbidities, medications, and any outstanding issues that need to be addressed in the community or long-term care going forward. In particular, details about issues or conditions which are associated with poor outcomes should be summarised at the

point of discharge, to minimise the adverse effects on the person with dementia. Delirium, for example, is highly prevalent in people with dementia admitted to acute hospitals and is associated with a range of poor outcomes (Cork Dementia Study, 2015). It is thus paramount for continuity of care that such information is summarised for discharge, so that it can be concisely and accurately communicated to healthcare professionals in primary care and residential care as required. Information about the dementia condition should be summarised for discharge also.

This audit looked at the information recorded at the point of discharge for people with dementia in acute hospitals:

- 16% (30/193) of case notes showed evidence that the patients' level of cognitive impairment, using a standardised assessment, was summarised and recorded at the point of discharge.
- 55% (106/193) of case notes showed evidence that the patients' cause of cognitive impairment was summarised and recorded for discharge.
- Of those who had symptoms of delirium during the admission, only 43% (27/63) had the symptoms summarised for discharge.
- Of those who had persistent behavioural and psychological symptoms of dementia, only 25% (10/40) had the symptoms summarised for discharge.

These results are very similar to the findings in England and Wales (2013) where only 19% had their level of cognitive impairment recorded and 48% of those with symptoms of delirium had them summarised for discharge, and better than the Republic of Ireland (2014, 12% and 24% respectively). The recording of behavioural and psychological symptoms of dementia was better in England and Wales (2013) at 43% and in the Republic of Ireland (2014) at 27%.

Conclusion

While hospitals policies regarding discharge are generally strong, hospitals must regularly review their discharge policies and practices, as they relate to people with dementia, with a view to ensuring that practice is in line with policy. Stronger policy is needed regarding transfer policies in hospitals in Northern Ireland, to guide staff on best practice in the moving and transfer of patients with dementia. Discharge planning and coordination require improvement; every person with dementia admitted to hospital should have a discharge plan, and the plan should be initiated within 24 hours of admission to ensure that the appropriate resources and supports are in place for them upon discharge. Significant improvements need to be made in Northern Ireland in the recording of information at the point of discharge, to ensure continuity of care and reduce the risk of poor outcomes.

Recommendations

1. All patients with dementia should have a discharge plan in place, and planning should be initiated within 24 hours of admission.
2. Families and carers should be informed about the prospective discharge destination and date, should receive adequate notice of discharge, and should receive a discharge summary at the point of discharge.
3. The level and cause of cognitive impairment should be summarised and recorded at the point of discharge, along with comorbidities and other healthcare information pertinent to ensuring continuity of care post-discharge.

Palliative Care

Summary

- 9% (22/240) of people with dementia died in hospital during the admission.
- 10% (24/240) of patients were noted to be receiving end of life care, or were being managed according to an end of life care pathway.
    - Of those who died, 82% (18/22) were receiving end of life care, or being managed according to an end of life care pathway.
- 8% (18/237) of patients were referred to specialist palliative care during the admission.
    - 39% (7/18) of these people with dementia died in hospital.
- 41% (96/237) of patients with dementia had a decision for/against resuscitation documented in their case notes.
- 10% (24/240) of case notes had a record that the families/carers were offered bereavement support.

Palliative Care and End of Life Dementia Care

According to the World Health Organisation (2002), palliative care is defined as 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.' In this way, the basic goal of palliative care is to help patients with serious illnesses feel better throughout the course of the disease.

In hospitals, general palliative care can be provided for those affected by life- limiting illnesses as an integral part of standard clinical practice by healthcare professionals. Specialist palliative care however is a specialist service provided by those who have undergone specialised training in the care of individuals with more complex and demanding palliative care needs.

End of life care refers to care as it relates to dying, death and bereavement, and is provided specifically in the final stages of the disease. The goals of end-of-life care are to maintain the comfort, choices, and quality of life of a person who is recognised to be in the terminal phase of their condition, and to support the family/carers through the final stages of the illness (e.g. providing counselling).

Up to 46% of people with dementia currently die in hospitals (Houttekier et al., 2010), indicating that acute hospitals need to be able to provide good quality palliative and end of life care for the person with dementia. This can be particularly challenging for people with dementia, because the disease trajectory can be uncertain and vary significantly from person to person. Furthermore, palliative care approaches were not developed for people with non-

malignant disease, and people with dementia are less likely than those without to be referred to specialist palliative care teams (Sampson et al., 2006, 2011).

The findings of this audit indicate that:

- 9% (22/240) of patients with dementia died during the admission.
- 10% (24/240) of patients were noted to be receiving end of life care, or were being managed according to an end of life care pathway.
    - Of those who died, 82% (18/22) were receiving end of life care, or being managed according to an end of life care pathway.
- 8% (18/237) of patients were referred to specialist palliative care during their admission.
    - 39% (7/18) of those referred to specialist palliative care died in hospital.

In the Republic of Ireland audit (2014), 8% of people with dementia died, similar to the 9% found here, but lower than in the England and Wales (2013) audit (13%). However, in the current audit, those who died in hospital were far more likely to have been receiving end of life dementia care (82%), compared to those in the Republic of Ireland (45%). In terms of referral to specialist palliative care, the current findings (8%) were also similar to the Republic of Ireland (9%), however those referred to SPC in Northern Ireland were less likely to die in the hospital during that admission (39%), compared to in the Republic of Ireland (59%).

Decisions for/against Resuscitation

Cardiopulmonary resuscitation (CPR) can be initiated on any patient who has stopped breathing or has no pulse; however it is not always appropriate to initiate resuscitation,

because this can be a normal part of the dying process. There are instances in which the decision to resuscitate a patient is inappropriate, e.g. when the patient is in the terminal phase of a condition and is expected to die shortly. Critically, up to half of survivors of resuscitation in acute hospitals and will have new functional or neurological impairment (in Conroy et al., 2006), indicating the importance of such a decision. In the current audit:

- 41% (96/237) of patients with dementia had a decision for/against resuscitation documented in their case notes.
- Of those patients noted to be receiving end of life care, 92% (22/24) had a decision for/against resuscitation documented.
- Of those patients who were referred to specialist palliative care during the admission, 90% (16/18) had a decision for/against resuscitation recorded.

The most recent guidance on the issue of resuscitation has been given by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2014); it places emphasis on 'high-quality communication and the recording of CPR decisions' (p. 2) for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest, including people with dementia. Failure to make timely and appropriate decisions may result in unwanted attempts at CPR as the person dies, and this is not acceptable practice. In 2012, the National Confidential Enquiry into Patient Outcome and Death called for a change in approach in the United Kingdom, stating that decisions for/against resuscitation should be recorded for *all* acute hospital admissions.

The issue of making a decision for/against resuscitation also highlights the advantages of creating an advance care directive in the early stages of the dementia condition, to guide the type of care that the patient would and would not like to receive as the condition progresses.

Bereavement Support

Finally, in line with the principles of palliative and end of life care, the families and carers of people with dementia should be offered bereavement support (Van der Steen et al., 2013). The findings of this audit indicate that:

- 10% (24/240) of charts had a record that the families/carers were offered bereavement support.
    - Of those who died, 17% (4/24) were offered bereavement support.
    - Of those referred to specialist palliative care, 21% (5/24) were offered bereavement support.
    - Of those noted to be receiving end of life care, 25% (6/24) were offered bereavement support.

Conclusion

The above findings indicate that almost 10% of patients with dementia died in hospital during their admission, highlighting the importance of dementia palliative and end of life care in acute hospitals in Northern Ireland. The majority of those with dementia who died were noted to be receiving end of life care (82%). Of those who died, 92% had a documented decision for/against resuscitation. Few families/carers were offered bereavement support. These findings also highlight the monumental importance of advance care planning, and having the person with dementia and their family/carer discuss and make decisions about the care that they will receive in the future, before they lose the capacity to make decisions relating to their care by themselves. Systems should be put in place at hospital-level to ensure

that the families/carers of people with dementia are offered bereavement support as necessary.

Recommendations

1. Advance care planning discussions should be encouraged for people with dementia and their families who have not previously considered future care decisions up to the point of hospital admission, particularly for those in the early stages of the condition.

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Appendix A

Participating Hospitals

Belfast Health & Social Care Trust

- Belfast City Hospital
- Royal Victoria Hospital
- Mater Infirmorum Hospital

South Eastern Health & Social Care Trust

- Ulster Hospital
- Lagan Valley Hospital
- Downe Hospital

Northern Health & Social Care Trust

- Antrim Area Hospital
- Causeway Hospital

Southern Health & Social Care Trust

- Craigavon Hospital
- Daisy Hill Hospital

Western Health & Social Care Trust

- Altnagelvin Hospital
- South West Acute Hospital

Appendix B

NIAD Leads & Audit Team

NIAD Leads

Centre for Gerontology and Rehabilitation, University College Cork;

Dr Suzanne Timmons, Consultant Geriatrician, Mercy University Hospital & St Finbarr's Hospital & Senior Lecturer, University College Cork.

Public Health Agency:
Ms Eleanor Ross, Nurse Consultant & Dementia Strategy Implementation Group Lead.

Health & Social Care Board:
Mr Seamus McErlean, Commissioning Social Care Lead for Older People and Adult Services, & Dementia Strategy Implementation Group Lead.

NIAD Audit Team

Centre for Gerontology & Rehabilitation, University College Cork;

Ms Emma O' Shea, Project Coordinator

Mr Edmund Manning, Research Nurse

Appendix C

NIAD Steering Committee and Advisory Group

NIAD Steering Committee

Dr Brid Kerrigan	Consultant Psychiatrist of Old Age, South Eastern HSC Trust
Dr Assumpta Ryan	Lecturer Nursing Division, Ulster University
Dr Cathy Patterson	Consultant Geriatrician, Belfast HSC Trust
Ms Bernadine McCrory	Director of the Alzheimer's Society
Dr April Heaney	Consultant Geriatrician, South Eastern HSC Trust
Dr David Craig	Consultant Geriatrician, Southern HSC Trust
Dr Paul Gallagher	Consultant Geriatrician, Health Service Executive
Ms Pauline Casey	Head of Service and Lead nurse for Older Peoples Mental Health, Western HSC Trust
Ms Majella Magee	Service Improvement Lead for Older Peoples Mental Health, Western HSC Trust

NIAD Advisory Group

Dr Des O Neill	Consultant Geriatrician, Health Service Executive
Ms Pat Cullen	Director of Nursing, Public Health Agency
Dr Stephen Todd	Consultant Geriatrician, Western HSC Trust
Ms Alison McCullough	Policy Officer, Royal College of Speech & Language Therapy
Ms Kate Lesslar	Policy Officer, College of Occupational Therapy
Mr Philip Bartley	Clinical Service Lead, Northern HSC Trust
Ms Karen Harvey	Acting Head of Mental Health Services for Older People
Ms Rachel Gibbs	Professional Lead for Occupational Therapy, South Eastern HSC Tru
Dr Djamil Vahidassr	Consultant Geriatrician, Northern HSC Trust
Dr Conor Barton	Consultant Psychiatrist of Old Age, Belfast HSC Trust
Dr Louise Sands	General Practitioner, Lisburn Health Centre

Appendices

Dr Bernadette McGuiness	**Consultant Geriatrician, Belfast HSC Trust**
Dr Sean Kennelly	**Consultant Geriatrician, Health Service Executive**
Dr Sean Doherty	**Consultant Psychiatrist of Old Age, Northern HSC Trust**
Ms Gillian McCorkell	**Nurse Research Lead, Western HSC Trust**
Dr Áine Abbott	**General Practitioner, Western HSC Trust**

Appendix D

Northern Ireland Audit of Dementia
Care in Acute Hospitals

ORGANISATONAL CHECKLIST

This checklist looks at structures, policies and processes, and key posts relevant to the care, treatment and support of people with dementia in a general hospital. Standards have been developed based on the UK National Audit of Dementia Care, adapted for the Northern Ireland health services. A full bibliography for the standards in this audit can be found at www.nationalauditofdementia.org.uk

Refer to the guidance document for help in answering the questions.

The checklist should be completed by the nominated audit lead with input from the Trust CE (or equivalent managerial level), Director of Acute Services, Director of Nursing and nominated senior consultant geriatrician or psychiatrist.

At the end of the questionnaire you will find a comment box. Use this to make any further comments on your answers to the questions.

Enter your hospital code:

This is the code allocated by the project team and is held by the audit lead contact. It will consist of 3 letters and 2 numbers, e.g. 11XYZ. If you do not know the hospital code, please get in touch with the audit lead from your hospital or contact the NIAD audit co-ordinator on 00 353 87 7551275

SECTION 1: GOVERNANCE

1. A care pathway for patients with dementia is in place:

Yes ⇒ Go to Q1a
No ⇒ Go to Q1b
In development ⇒ Go to Q1a

1a. The care pathway is adaptable for use within or fitted to the following existing care pathways:
a) Acute

Yes **No**

b) Palliative

Yes **No**

c) End of life

Yes **No**

If no, please outline why in comment box at end of section

1b. A senior clinician is responsible for implementation and/or review of the care pathway:
They may also have responsibility for other areas.

Yes ⇒ Go to Q1c
No ⇒ Go to Q2

1c. Please identify the senior clinician who leads the work of the hospital on this:

o Clinical/Medical Director

o Director of Acute Services

o Director of Nursing

o Consultant Geriatrician/Specialist Physician in Elderly Care

o Consultant Psychiatrist

o Old Age Psychiatrist

o Consultant Physician

o Nurse Consultant

o Allied Healthcare Professional oOther, please specify

2. There is a named officer with designated responsibility for the protection of vulnerable adults

oYes **oNo**

3 The Senior Management Team regularly reviews information collected on:

Answer "Yes" if review is scheduled on a regular basis, e.g. quarterly or other specified interval.

3a. Re-admissions, in which patients with dementia can be identified in the total number of patients readmitted

o Yes **o No**

3b. Delayed discharge/transfers, in which patients with dementia can be identified in the total number of patients with delayed discharge/transfers.

o Yes **o No**

4. The Management Team regularly reviews the number of in-hospital falls and the breakdown of the immediate causes, and patients with dementia can be identified within this number

Answer "Yes" if review is scheduled on a regular basis, e.g. quarterly or other specified interval.

o Yes **o No**

5 The Management Team regularly receives feedback from the following:

Answer "Yes" if reporting and feedback is scheduled on a regular basis, e.g. quarterly or other specified interval.

5a. Clinical Leads for older people and people with dementia including the Nurse Consultant

o Yes **o No**

5b.Complaints– analysed by age

o Yes **o No**

6. There is a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia *Answer*

"Yes" if reporting and feedback is scheduled on a regular basis, e.g. quarterly or other specified interval.

o Yes **o No**

7. Nursing staff have access to a recognized process to record and report risks to patient care if they believe ward staffing is inadequate.

oYes **o No**

7. Other staff have access to a recognized process to record and report risks to patient care if they believe ward staffing is inadequate.

oYes o No

8. There are champions (agents of change) for dementia at:

a) Directorate level

o Yes o No

b) Ward level

o Yes o No

All wards:

o Yes o No

Do you have any comments to make on Section 1: Governance?

SECTION 2: DELIVERY OF CARE

This section asks whether there are systems in place to ensure that people with dementia receive a comprehensive assessment with the following components: This can be contained within systems/policies for assessment of older people, ***including*** people with dementia. It need not be a separate system, process or policy unless people with dementia are excluded from such documents.

9. Multidisciplinary Assessment includes:

9a Problem List	**o Yes o No**
9b. Co-morbid Conditions	**o Yes o No**
9c. Current Medication Including Dosage and Frequencies	**o Yes o No**
9d. Assessment of functioning using a standardized instrument- i.e. basic activities of daily living, instrumental activities of daily living, mobility	**o Yes o No**

9e. Assessment of mental state using a standardised instrument – i.e. mental status (cognitive) testing o Yes o No

9e1. Assessment of mood using a standardised instrument o Yes o No

9e2. Assessment of communication o Yes o No

9e3. Standardized assessment of pain o Yes o No

9e4. Assessment of collateral history from a relative/ o Yes o No

9f. Nutritional status o Yes o No

9g. Assessment of swallow function o Yes o No

10 As part of initial assessment, the patient's BMI (Body Mass Index) or weight is recorded, wherever possible:
Answer "Yes" if it is specified that this is done wherever possible, e.g. patient is willing and there are no medical reasons not to carry this out.

o Yes o No

11a. Social and environmental assessment includes support provided to the person 'informally':
E.g. from friends, relatives, neighbours or support groups and organisations.

o Yes o No

11b. Social and environmental assessment includes care provision assessment:
E.g. formal input from care agencies, home help etc.

oYes o No

11c. Social and environmental assessment includes financial support assessment:
E.g. relevant disability benefits, medical card, or other available support in place, or referral made to support /social worker to carry out such assessment.

o Yes o No

11d. Social and environmental assessment includes home safety assessment:
E.g. information requested from patient, relative, carer or GP regarding environment risk factors; request for OT follow up if required.

o Yes o No

12. Protected mealtimes are established in <u>all</u> wards that admit adults with known or suspected dementia:

Answer "Yes" if this applies to all wards admitting adults with known or suspected dementia.

o **Yes** ⇒ Go to Q12a
No ⇒ Go to Comment box end of Section 2

12a. Wards' adherence to protected mealtimes is reviewed and monitored:
E.g. there is a local system for reporting and monitoring this.

o Yes **o No**

Do you have any comments to make on Section 2: Delivery of Care?

SECTION 3: DEMENTIA ASSESSMENT / MENTAL HEALTH NEEDS

13. There are policies or guidelines in place to ensure that patients with dementia or cognitive impairment are assessed for the presence of delirium at presentation:

This relates to national/international guidelines such as UK NICE delirium guideline CG103 which specifies that people at risk of developing delirium should be assessed for recent fluctuations in behaviour.
See http://www.nice.org.uk/cg103

Yes
No
In development

14. There are policies or guidelines in place to ensure that patients with dementia or cognitive impairment with behaviour changes suggesting the presence of delirium are clinically assessed by a healthcare professional that is trained and competent in the diagnosis of delirium:

Yes
No
In development

15. There are systems in place to ensure that where dementia is suspected but not yet diagnosed, this triggers a referral for assessment and differential diagnosis either in the hospital or in the community (memory services, geriatric medicine, old age psychiatry):

Answer "Yes" if either referral for assessment as an in-patient or referral for assessment as an out-patient is triggered by suspected dementia and this is specified in local policy or protocol.

Yes **No**

16. There is a policy or guideline stating that a cognitive assessment is carried out on all patients over the age of 65 admitted to hospital:

Yes **No**

17. There is 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 in patients who present behavioural and psychological symptoms of dementia (BPSD)

Answer "Yes" if there is a local protocol which includes people with dementia.

Yes ⇒ **Go to Q17a**
No ⇒ **Go to Q18**
In development ⇒ **Go to Q17a**

17a. The protocol specifies that restraint and sedation is used only as a final option: *Answer "Yes" if the protocol emphasises the patient's best interest and other interventions that should be tried first (except in extremity).*

o Yes **o No**

17b. The protocol specifies consideration of physical causes which may cause challenging behaviour in people with dementia:
E.g. pain, retention, delirium.

Yes **No**

17c. The protocol considers environmental factors such as noise, lack of activity, disorientation:

Yes **No**

17d. The protocol specifies the possibility of using techniques of reassurance, de-escalation, distraction:

Yes **No**

17e. The protocol specifies the risks that must be assessed and taken into account before any use of restraint or sedation in people with dementia and the frail elderly:
Answer "Yes" if the protocol lists the particular needs and risk factors for people with dementia and older people where restraint and sedation are used.

Yes **No**

17f. The protocol has specific evidence based guidelines for the prescription and administration of antipsychotic drugs

Yes **No**

18. There is a section or prompt in the general hospital discharge summary for mental health diagnosis and management:

Answer "Yes" if the discharge summary prompts to include any mental health diagnosis and/ or management.

Yes **No**

Do you have any comments to make on Section 3: Dementia Assessment/Mental Health Needs?

SECTION 4: DISCHARGE AND TRANSFER POLICIES

19. The discharge policy states that discharge should be an actively managed process which begins within 24 hours of admission:

Answer "Yes" if the discharge policy states that discharge planning should begin within 24 hours.

Yes **No**

20. The discharge policy specifies that:

a) Discharge should take place during the day

Yes **No**

b) Relatives and carers should be informed and updated about the prospective discharge date

Yes **No**

21. Information about discharge and support (written in accessible formats including plain English, and available in other languages) is made available to patients and their relatives:
This could be a leaflet, patient booklet, etc.

Answer "Yes" if written information about overall discharge arrangements and post discharge support is given to patients and their relatives and the hospital has access to arrangements to provide translated or other format versions.

Yes, available in English and other accessible formats, and in other languages/formats ⇒ Go to Q21a
Yes, but available in English only ⇒ Go to Q21a
No ⇒ Go to Q22

21a. The discharge policy specifies that this information is made available to patients and their relatives on admission:

Yes **No**

22. The transfer policy specifies that:

The transfer policy can be part of the discharge policy.

a) People with dementia should be moved only for reasons pertaining to their care and treatment

Yes **No**

b) The move should take place during the day

Yes **No**

c) Relatives and carers should be kept informed of any moves within the hospital

Yes **No**

Do you have any comments to make on Section 4: Discharge and transfer policies?

SECTION 5: INFORMATION

23. There is a formal system (pro-forma or template) in place for gathering information pertinent to caring for a person with dementia:

Answer "Yes" if there is a dedicated or a generally used system, which is also used with people with dementia. This can be a form, template or checklist. It should prompt the collection of information and ensure it is consistently presented. Examples include Patient Passports, "This is Me" booklet.

Yes ⇒ Go to Q23a
No ⇒ Go to Comment box end of Section 5

23a 1) Information collected by the pro-forma includes personal details, preferences and routines:

This could include details of preferred name, need to walk around at certain times of day, time of rising/retiring, likes/dislikes regarding food etc.

Yes **No**

23a 2) Information collected by the pro-forma includes reminders or support with personal care:

This could include washing, dressing, toileting, hygiene, eating, drinking, and taking medication.

Yes **No**

23a 3) Information collected by the pro-forma includes recurring factors that may cause of exacerbate distress :

This could include physical factors such as illness or pain, and/or environmental factors such as noise, darkness.

Yes **No**

23a 4) Information collected by the pro-forma includes support or actions that can calm the person if they are agitated:

This could include information about indicators especially non-verbal, of distress or pain; any techniques that could help with distress, e.g. reminders of where they are, conversation to distract, or a favourite picture or object.

Yes **No**

23a 5) Information collected by the pro-forma includes details of life history which aid conversation:

This could include family situation (whether living with other family members, spouse living, pets etc), interests and past or current occupation.

Yes **No**

23b. The form prompts staff to approach carers or relatives to collate necessary information:

Yes **No**

Do you have any comments to make on Section 5: Information?

SECTION 6: RECOGNITION OF DEMENTIA

24. There is a system in place across the hospital that ensures that all staff in the ward or care area are aware of the person's dementia or condition and how it affects them:

Answer "Yes" if there is a visual identifier, e.g. in case notes, for dementia, or other flagging system that ensures dementia is quickly identified.

Yes ⇒ **Go to Q24a**
No ⇒ **Go to Q25**

24a. Please say what this is:

o **A visual indicator, symbol or marker**
Alert sheet
A box to highlight or alert dementia condition in the notes or care plan
Other, please specify: _____

25. There is a system in place across the hospital that ensures that staff from other areas are aware of the person's dementia or condition whenever the person accesses other treatment areas: *E.g. for assessment.*

Answer "Yes" if there is a visual identifier, e.g. in case notes for dementia, or other flagging system that ensures dementia is quickly identified.

Yes ⇒ **Go to Q25a**
No ⇒ **Go to Q26**

25a. Please say what this is:

A visual indicator, symbol or marker
Alert sheet
A box to highlight or alert dementia condition in the notes or care plan
Other, please specify: _____

26. The patient's notes are organised in such a way that it is easy to:

Answer "Yes" if information about dementia, memory problems and confusion, and the care plan are consistently kept in the same part of the file.

a) Identify any communication or memory problems

Yes **No**

b) See the care plan

Yes **No**

27. There is a system in place to ensure that carers are advised about the care support available

The system, policy or guideline need not be specific to carers of people with dementia, but includes carers of people with dementia in the hospital.

Yes **No**

28. There are clear guidelines regarding involvement of carers and information sharing. This includes:

The system, policy or guideline need not be specific to carers of people with dementia.

a) Making sure the carer knows what information will be shared with them

Yes **No**

b) Asking the carer about the extent they prefer to be involved with the care and support of the person with dementia whilst in the hospital

Yes **No**

c) Asking the carer about their wishes and ability to provide care and support of the person with dementia post discharge

Yes **No**

Do you have any comments to make on Section 6: Recognition of Dementia?

SECTION 7: TRAINING, LEARNING AND DEVELOPMENT

29. There is a training and knowledge framework or strategy that identifies necessary skill development in working with and caring for people with dementia:

Yes **No**

30. Staff induction programmes include dementia awareness:

Yes **No**

The following questions are about training that is provided to acute healthcare staff who are involved in the care of people with dementia (or suspected dementia):

Training provision can refer to in-house training, knowledge sharing sessions, induction, online training, or other scheduled learning event including ward based training provided by a specialist practitioner e.g. dementia champion, liaison nurse

31a. Dementia awareness training:
Tick all that apply for each of the staff groups

	Mandatory	Provided on Induction	Provided in the last 12 months *(either in-house or externally)*	Not provided in last 12 months
Doctors	o	o	o	o
Nurses	o	o	o	o
HCAs	o	o	o	o
Other allied healthcare professionals, e.g. physiotherapists, dieticians	o	o	o	o
Support staff in the hospital, e.g. housekeepers, porters, receptionists, catering	o	o	o	o

31b. How to support people with hearing/visual impairments:
Tick all that apply for each of the staff groups.

	Included in the hospital training programme in the last 12 months	Made available via external provision in the last 12 months	Not available in the last 12 months
Doctors	o	o	o
Nurses	o	o	o
HCAs	o	o	o
AHPs	o	o	o

31c. Assessment of capacity
Tick all that apply for each of the staff groups.

	Included in the hospital training programme in the last 12 months	Made available via external provision in the last 12 months	Not available in the last 12 months
Doctors	o	o	o
Nurses	o	o	o
HCAs	o	o	o
AHPs	o	o	o

31d. Communication skills specific for people with dementia:
Tick all that apply for each of the staff groups.

	Included in the hospital training programme in the last 12 months	Made available via external provision in the last 12 months	Not available in the last 12 months
Doctors	o	o	o
Nurses	o	o	o
HCAs	o	o	o
AHPs	o	o	o

31e. Approaches to behaviour that challenges including management of aggression and extreme agitation:
Tick all that apply for each of the staff groups.

	Included in the hospital training programme in the last 12 months	Made available via external provision in the last 12 months	Not available in the last 12 months
Doctors	o	o	o
Nurses	o	o	o
HCAs	o	o	o
AHPs	o	o	o

31f. Assessing risk whenever the use of restraint or sedation is considered:
Tick all that apply for each of the staff groups.

	Included in the hospital training programme in the last 12 months	Made available via external provision in the last 12 months	Not available in the last 12 months
Doctors	o	o	o
Nurses	o	o	o
HCAs	o	o	o
AHPs	o	o	o

32. Involvement of people with dementia and carers and use of their experiences is included in the training for ward staff:
This could be a presentation from a person with dementia and carer; use of patient/carer diaries; use of feedback from questionnaires, audits and complaints relating to people with dementia.

Yes **No**

Do you have any comments to make on Section 7: Training learning and development?

SECTION 8: SPECIFIC RESOURCES SUPPORTING PEOPLE WITH DEMENTIA

33. The hospital has access to intermediate care units, which will admit people with dementia:

Yes **No**

33a. Access to intermediate care services allows people with dementia to be admitted to intermediate care directly, and avoid unnecessary hospital admission:
Yes **No**

34. There is a named lead (e.g. nurse specialist) in dementia care in the hospital to provide guidance, advice and consultation to staff:

Answer "Yes" if there is a named person whom staff can consult on providing dignified, person-centred care, including when caring for people with dementia.

Yes **No**

35. There is a named person who takes overall responsibility for complex needs discharge and this includes people with dementia:

Answer "Yes" if there is a named person who can have input into discharge and support and advise those staff planning individual discharge for people with dementia, including coordinators.

Yes ⇒ **Go to Q35a**
No ⇒ **Go to Q36**

35a. This person has training in ongoing needs of people with dementia:

Yes **No**

35b. This person has experience of working with people with dementia and their carers:

Yes **No**

36. There is a social worker or other designated person responsible for working with people with dementia and their carers, and providing advice and support, or directing to appropriate organisations or agencies:

This could include help with: Problems getting to and from hospital; benefits; residential and nursing care; help at home; bereavement support, difficulties for carers/relatives such as illness, disability, stress or other commitments that may affect their ability to visit or to continue care.

The role should involve responsibility for support and advice as stated, but need not be limited to work with people with dementia and their carers.

Yes **No**

37. There is access to specialist assessment and advice on helping patients with dementia in their swallowing and eating:

Yes ⇒ **Go to Q37a**
No ⇒ **Go to Q38**

37a. Specialist assessment and advice can be obtained from:

a) Speech and Language Therapist	**Yes**	**No**
b) Dietician	**Yes**	**No**
c) Other	**Yes**	**No**

38. There is access to an interpreting service which meets the needs of people with dementia in the hospital:

Answer "Yes" if interpreting services can be accessed where workers have experience in working with people with dementia.

Yes **No**

39. There is access to advocacy services with experience and training in working with people with dementia:
Answer "Yes" if advocates (e.g. chaplain, patient advocate) have experience in working with people with dementia and have training in involvement of users and carers

Yes **No**

Do you have any comments to make on Section 8: Resources supporting people with dementia?

SECTION 9: LIAISON PSYCHIATRY

40. The hospital provides access to a liaison psychiatry service which can provide assessment and treatment to adults throughout the hospital:

Answer "Yes" if there is a liaison psychiatry service which can provide assessment and treatment to adults.

Yes ⇒ **Go to Q41**
No ⇒ **Go to Comment box end of Section 9**

41. The liaison service provides emergency/urgent assessment:

Answer "Yes" if the liaison service is commissioned to provide emergency/urgent assessment to adults throughout the hospital.

Yes **No**

42. There is a named Consultant Psychiatrist:
Answer "Yes" if there is a named consultant psychiatrist providing liaison alone or as part of a team.

Yes ⇒ **Go to Q42a**
No ⇒ **Go to Q43**

42a. The Consultant Psychiatrist has dedicated time in his/her job plan for the provision of this service:

Yes **No**

42b. The Consultant Psychiatrist specialises in the care and treatment of older people:

Yes **No**

43. Liaison psychiatry is provided by a specialist mental health team:

Answer 'Yes' if there is a team providing liaison psychiatry, rather than a single practitioner.

Yes ⇒ **Go to Q43a**
No ⇒ **Go to Q44**

43a. The psychiatry liaison service in your hospital regularly provides:

Routine mental health care to working age adults
Routine mental health care to older people
Routine mental health care to working age adults and to older people

43b. Please indicate the times when liaison psychiatry is available:

If provision is via a single team covering both working age and older adults, please complete answers for both.

Day = 9-5, Monday to Friday; Evening = after 5, Monday to Friday; Weekend = Saturday/Sunday

	Working age adults	Older adults
a) Day		
b) Evening		
c) Weekend		

43c. Please indicate where the liaison psychiatry team is based:

	Working age adults	Older adults
a) On site (in this hospital)		
b) Off site	**o**	

43d. Do all healthcare professionals who are part of the liaison psychiatry service have dedicated time?

Yes **No**

Q44 is only applicable if Q43 = No

44. If there is no specialist mental health team, who does provide liaison psychiatry/mental health input?

Old Age Consultant Psychiatrist
Other Psychiatrist
Nurse
Nurse Consultant
Other

Do you have any comments to make on Section 9: Liaison psychiatry?

SECTION 10: LIAISON PSYCHIATRY OF OLD AGE

45. The hospital provides access to a liaison psychiatry of old age (POA) service which can provide assessment and treatment to adults throughout the hospital:

Answer "Yes" if there is a liaison POA service which can provide assessment and treatment to older adults.

Yes ⇒ **Go to Q46**
No ⇒ **Go to Comment box end of Section 10**

46. The liaison POA service provides emergency/urgent assessment:

Answer "Yes" if the liaison POA service is commissioned to provide emergency/urgent assessment to adults throughout the hospital.

Yes **No**

47. There is a named Consultant Psychiatrist of Old Age:

Answer "Yes" if there is a named consultant psychiatrist providing liaison alone or as part of a team.

Yes ⇒ Go to Q47a
No ⇒ Go to Q48

47a. The Consultant Psychiatrist of Old Age has dedicated time in his/her job plan for the provision of consultation service:

Yes **No**

48. Liaison POA is provided by a specialist mental health team:

Answer 'Yes' if there is a team providing liaison psychiatry, rather than a single practitioner.

Yes ⇒ Go to Q48a
No ⇒ Go to Q49

48a. Please indicate the times when liaison POA is available:

Please tick all that apply. Day = 9-5, Monday to Friday; Evening = after 5, Monday to Friday; Weekend = Saturday/Sunday

a) Day
b) Evening
c) Weekend

48b. Please indicate where the liaison POA team is based:

a) On site (in this hospital) **o**
b) Off site **o**

48c. Do all healthcare professionals who are part of the liaison POA service have dedicated time?

Yes **No**

Q49 is only applicable if Q48 = No

49. If there is no specialist POA team, who does provide liaison psychiatry/mental health input into older adults?

Other Psychiatrist
Nurse
Advanced Nurse Practitioner
Other

Do you have any comments to make on Section 10: Liaison POA?

SECTION 11: GERIATRIC MEDICINE

50. The hospital provides access to a geriatric medicine service which can provide assessment and treatment to adults throughout the hospital:

Answer "Yes" if there is a geriatric medicine service which can provide assessment and treatment to adults.

Yes ⇒ **Go to Q51**
No ⇒ **Go to comment box end of Section 11**

51. The geriatric medicine service provides emergency/urgent assessment:

Answer "Yes" if the geriatric medicine service is commissioned to provide emergency/urgent assessment to older adults throughout the hospital.

Yes **No**

52. There is a named Consultant Geriatrician providing liaison:

Answer "Yes" if there is a named consultant geriatrician providing liaison alone or as part of a team.

Yes ⇒ **Go to Q52a**
No ⇒ **Go to Q53**

52a. The Consultant Geriatrician has dedicated time in his/her job plan for the provision of this service:

Yes **No**

53. Geriatric Medicine is provided by a specialist team:

Answer 'Yes' if there is a team providing liaison geriatric medicine, rather than a single practitioner.

Yes ⇒ Go to Q53a
No ⇒ Go to comment box at end of section 11

53a. Please indicate the times when liaison geriatric medicine is available:

Day = 9-5, Monday to Friday; Evening = after 5, Monday to Friday; Weekend = Saturday/Sunday

a) Day o
b) Evening o
c) Weekend o

53b. Please indicate where the geriatric medicine team is based:

a) On site (in this hospital) o
b) Off site

53c. Do all healthcare professionals who are part of the liaison geriatric medicine service have dedicated time for consults?

Yes **No**

Do you have any comments to make on Section 11: Geriatric Medicine?

SECTION 12: NEUROLOGY

50. The hospital provides access to a neurology service which can provide assessment and treatment to adults throughout the hospital:

Answer "Yes" if there is a neurology service which can provide assessment and treatment to adults.

Yes ⇒ **Go to Q51**
No ⇒ **Go to comment box end of Section 11**

51. The neurology service provides emergency/urgent assessment:

Answer "Yes" if the neurology service is commissioned to provide emergency/urgent assessment to older adults throughout the hospital.

Yes **No**

52. There is a named Consultant Neurologist providing liaison:

Answer "Yes" if there is a named consultant neurologist providing liaison alone or as part of a team.

Yes ⇒ **Go to Q52a**
No ⇒ **Go to Q53**

52a. The Consultant Neurologist has dedicated time in his/her job plan for the provision of this service:

Yes **No**

53. Neurology is provided by a specialist team:

Answer 'Yes' if there is a team providing liaison neurology, rather than a single practitioner.

Yes ⇒ **Go to Q53a**
No ⇒ **Go to comment box at end of section 11**

53a. Please indicate the times when liaison neurology is available:

Day = 9-5, Monday to Friday; Evening = after 5, Monday to Friday; Weekend = Saturday/Sunday

a) Day o
b) Evening o
c) Weekend o

53b. Please indicate where the neurology team is based:

a) On site (in this hospital) **o**
b) Off site

53c. Do all healthcare professionals who are part of the liaison neurology service have dedicated time for consults?

Yes **No**

Do you have any comments to make on Section 12: Neurology?

If you have any queries, please contact:

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Appendix E

Northern Ireland Audit of Dementia Care in Acute Hospitals

AUDIT OF CASE NOTES

Background
This audit tool asks about assessments, discharge planning and aspects of care received by people with dementia during their stay in hospital. Standards have been drawn from national and professional guidance. Before completing this tool, please read the guidance document and have your hospital code to hand.

Patient Sample
The first 30 consecutive cases discharged from the hospital between 01/01/2014 and 30/04/2014 that meet the following criteria:

1.Have a diagnosis of dementia. Note, the patient may have a diagnosis coded at any level, i.e. primary, secondary or subsidiary, or identified as having a current history of dementia (see guidance document for list of diagnostic codes).

2.Have stayed at the hospital for at least 5 days.

At the end of each section you will find a comment box. Use this to make any further comments on your answers to the questions.

Enter your hospital code:

*This is the code allocated by the project team and is held by the audit lead contact. It will consist of 3 letters and 2 numbers, e.g. 11XYZ. If you do not know the hospital code, please get in touch with the audit lead from your hospital or contact the audit co-ordinator on **00 35387 755 1275***

Has the patient been in hospital for 5 days or longer?
This includes the date of admission. If the patient has NOT been in hospital for 5 days or longer, they are not eligible for audit.

☐ **Yes** ☐ **No** ⇒ **This case note is not eligible and you cannot continue**

Enter number for this patient:

Please refer to the guidance document on how to select case notes for audit
If case note is a data reliability check please add 'Rel' at the end of the number.
For example, if you are re-auditing case note number 5, please enter 5rel.

Has this case note been selected as a data reliability check?

If this case note is one of the five case notes that has been chosen for the inter-rater reliability checks, please select "yes".

☐ **Yes**
☐ **No**

In case we need to contact you regarding this entry, please provide us with your contact details:

Name, Job title:

Email address:

Telephone:

SECTION 1: INFORMATION ABOUT THE PATIENT

1. Enter the age of the patient: *This is the age of the patient in whole years **at discharge**. To calculate age using date of birth, you can use this website:* *http://www.mathcats.com/explore/age/calculator.html*

2. Select the gender of the patient:

- ☐ **Male**
- ☐ **Female**

3. Select the ethnicity of the patient:

- ☐ **White Irish**
- ☐ **Any Other White Background**
- ☐ **Black**
- ☐ **Asian**
- ☐ **Mixed Race**
- ☐ **Chinese**
- ☐ **Not documented**
- ☐ **Other Ethnic Group**

4. Select the first language of the patient:

- ☐ **English**
- ☐ **Irish**
- ☐ **Other European Language**
- ☐ **Asian Language**
- ☐ **Not Documented**
- ☐ **Other**

5.Please identify the speciality of the ward that this patient spent the longest period on during this admission:

- ☐ **Cardiac**
- ☐ **Care of the Elderly**
- ☐ **Critical Care**
- ☐ **General Medical**
- ☐ **Nephrology**
- ☐ **Obstetrics/Gynae**
- ☐ **Oncology**
- ☐ **Orthopaedics**
- ☐ **Stroke Unit**
- ☐ **Surgical**
- ☐ **Psychiatry**
- ☐ **Intensive Care Unit**
- ☐ **Psychiatry of Old Age**
- ☐ **Neurosurgery**
- ☐ **Neurology**
- ☐ **Palliative Care Bed**
- ☐ **Acute Medical Assessment Unit**
- ☐ **Other**
- ☐ **Other Medical**

6.Did the patient die whilst in hospital?

- ☐ **Yes**
- ☐ **No**

7.Did the patient self-discharge from hospital?

- ☐ **Yes**
- ☐ **No**

8.Was the patient receiving end of life care/on an end of life care pathway?

- ☐ **Yes**
- ☐ **No**

9.What was the date of admission and the date of discharge? *Please enter in DD/MM/YYYY format. The discharge date should fall between 01/07/2012 and 31/12/2012.*

If the patient died whilst in hospital, please enter the date of death in the discharge box.

Admission date: ____/____/_____

Discharge date: ____/____/_____

(or date of death if the patient died whilst in hospital)

10.Please indicate the place in which the person was living or receiving care before admission:

"Own home" can include sheltered, supported or warden controlled accommodation.

"Transfer from *another hospital" means any hospital other than the one for which you are submitting this case note.*

- ☐ **Own home**
- ☐ **Rehabilitation Unit**
- ☐ **Residential Care/Nursing Home**
- ☐ **Community Hospital**
- ☐ **Carer's home**
- ☐ **Convalescent/Respite Care**
- ☐ **Psychiatric ward**
- ☐ **Hospice**
- ☐ **Intermediate care**
- ☐ **Transfer from another hospital**

Q11 is not applicable if Q6 = "Yes" (the patient died)

11. Please indicate the place in which the person was living or receiving care after discharge:

Own home can include sheltered or warden controlled accommodation. "Transfer to another hospital" means any hospital other than the one for which you are submitting this case note.

- ☐ **Own home**
- ☐ **Rehabilitation Unit**
- ☐ **Residential Care/Nursing Home**
- ☐ **Community Hospital**
- ☐ **Carer's home**
- ☐ **Convalescent/Respite Care**
- ☐ **Psychiatric ward**
- ☐ **Hospice**
- ☐ **Intermediate care**
- ☐ **Transfer from another hospital**

Do you have any comments to make on Section 1: Information about the patient?

SECTION 2: ASSESSMENT

This section asks about the assessments carried out during the admission episode (or pre-admission evaluation), or during the patient's stay.

12. Has the patient's mental health history been recorded - dementia or other conditions or symptoms?

Answer "Yes" if dementia of other conditions or symptoms (e.g. Alzheimer's disease, depression, memory problems, psychiatric disorder) are recorded as Mental Health History (or past psychiatric history, etc), or under past patient medical history.
Answer "No" if left blank

Answer "N/A" if section for mental health history is marked N/A and patient had not been diagnosed before this admission.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

COMPREHENSIVE ASSESSMENT OF THE OLDER PERSON

Also known as Comprehensive Geriatric Assessment. This can be carried out on or after admission, i.e. once the patient becomes well enough. Elements of assessment may also have been carried out immediately prior to admission, in A&E or during pre-admission assessment.

***NB** elements of assessment may be found in medical and in other notes, e.g. nursing assessment, OT assessment, or sometimes Social Worker interview, e.g. financial assessment, carer input.*

MULTIDISCIPLINARY ASSESSMENT

13. The multidisciplinary assessment includes problem list:

- ☐ **Yes**
- ☐ **No**

14.The multidisciplinary assessment includes comorbid conditions:

Answer "N/A" if it was recorded that there were no comorbid conditions.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

15.The assessment includes a record of current medication, including dosage and frequency:

- ☐ **Yes, there is a record of current medication that was being taken**
- ☐ **Yes, there is a record that no medication was being taken**
- ☐ **No record**

16. An assessment of mobility was performed by a healthcare professional:

This refers to an assessment of gait, balance, mobility carried out by a doctor, nurse or other qualified professional, e.g. physiotherapist, occupational therapist. Answer "N/A" if this could not be assessed for recorded reasons.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

16a. An assessment of communication was performed by a healthcare professional:

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

17.An assessment of nutritional status was performed by a healthcare professional:

Assessment carried out by a doctor, nurse or other qualified professional, e.g. dietician. Answer "N/A" if this could not be assessed for recorded reasons.

- ☐ **Yes** ⇒ **Go to Q17a**
- ☐ **No** ⇒ **Go to Q18**
- ☐ **N/A** ⇒ **Go to Q18**

17a. The assessment of nutritional status includes recording of BMI (Body Mass Index) or weight:

Answer "N/A" if this could not be assessed for recorded reasons, e.g. patient too unwell.

- ☐ **Yes, there is a recording of the patients/ BMI or weight**
- ☐ **No, there is no recording of the patients' BMI or weight**
- ☐ **N/A**

17b. The assessment of nutritional status includes identification of any help needed with eating/drinking.

- ☐ **Yes**
- ☐ **No**

17c. If help needed with eating/drinking is identified, is this recorded in the care/management plan?

- ☐ **Yes**
- ☐ **No**

18. Has a formal pressure sore risk assessment been carried out and score recorded?

This should be assessment using a standardised instrument such as Waterlow.

- ☐ **Yes**
- ☐ **No**

19.As part of the multidisciplinary assessment has the patient or carer been asked about any continence needs?

This can be the initial nursing assessment. Answer "N/A" if this could not be assessed for recorded reasons.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

20. As part of the multidisciplinary assessment has the patient been asked about the presence of any pain?

*Answer "Yes" where the notes show that there has been an **enquiry** about any pain and response recorded. Answer "N/A" if this could not be assessed for recorded reasons.*

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

20a. Has a standardised assessment of pain suitable for a patient with dementia been carried out (e.g. PAINAD, Abbey Pain Scale)

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

21. Has an assessment of functioning, using a standardised assessment, been carried out?

This should be assessment using a standardised instrument such as Barthel or other instrument. Answer "Yes" where this has been carried out and a score recorded.

- ☐ **Yes**
- ☐ **No**

MENTAL STATE ASSESSMENT

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22. Has a standardised cognitive assessment been carried out?

This should be assessment using a standardised instrument such as MMSE, AMT.

Answer "N/A" if this could not be assessed for recorded reasons.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

23. Has a collateral/witness history been recorded indicating:

a) Confirmation of cognitive decline **o Yes** **o No**

b) Time since onset of memory problems **o Yes** **o No**

c) Nature of progression **o Yes** **o No**

d) Evidence of loss of function **o Yes** **o No**

24. Has an assessment been carried out for recent changes or fluctuation in behaviour that may indicate the presence of delirium?

This refers to the assessment at presentation (for example, as set out in NICE CG103 Delirium Guideline which specifies that people at risk should be assessed for indications of delirium.This includes people with dementia/cognitive impairment. See http://www.nice.org.uk/cg103)

☐ **Yes, and there were indications that delirium may be present⇒ Go to Q24a**

☐ **Yes, but there was no indication that delirium may be present⇒ Go to Q24b**

☐ **No assessment has been carried out ⇒ Go to Q24b**

24a. Has the patient been clinically assessed for delirium by a healthcare professional?

This refers to the full clinical assessment when indicators of delirium are identified, as specified in the CG103 Delirium Guideline. See http://www.nice.org.uk/cg103

☐ **Yes**

☐ **No assessment has been carried out**

24b. Has a screening or assessment been carried out for recent changes in mood?

☐ **Yes**

☐ **No**

24c. Has an assessment been carried out for recent changes that may indicate the development of behavioural and psychological symptoms of dementia (BPSD)?

☐ **Yes**

☐ **No**

SOCIAL AND ENVIRONMENTAL ASSESSMENT

To answer the following questions on social and environmental assessment, you may need to access social worker notes.

25. Has a need for care assessment by a health & social care professional been identified?

- o **Yes** ⇒ Go to 25a
- ☐ **No** ⇒ Go to Q26
- ☐ **Already receiving input from a social worker** ⇒ Go to Q26
- ☐ **Cannot get hold of this information** ⇒ Go to Q26

25a. Has a care assessment by a health & social care professional been requested?

- ☐ **Yes** ⇒ Go to Q25b
- ☐ **No** ⇒ Go to Q26

25b. Has a care assessment by a health & social care professional been carried out?

- ☐ **Yes** ⇒ Go to Q25b1
- ☐ **No** ⇒ Go to Q26

25b1. Did the assessment include an assessment of support provided to the person "informally"

E.g. from carers, family, friends.

Answer "Yes" if details of such support are recorded or it is recorded that there is no such support being provided.

Answer "No" if this has not been assessed.

Answer "N/A" if notes state that the patient didn't need or refused such an assessment

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

25b2. Did the assessment include a formal care provision assessment?

E.g. from care agencies, community team input.

Answer "N/A" if notes state that the patient didn't need or refused such an assessment, or information is already known and present in notes.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

25b3. Did the assessment include a financial support assessment?

E.g. relevant disability benefits or other available support in place, or referral made to health & social care professional to carry out such assessment (including assessment for carer's allowance, medical card etc.).

Answer "N/A" if notes state that the patient didn't need or refused such an assessment, or information is already known and present in notes.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

25b4. Did the environmental assessment include a home safety assessment?

E.g. information requested from patient, relative, carer or GP regarding environment risk factors; request for OT follow up if required.

Answer "N/A" if notes state that the patient didn't need or refused such an assessment, information is already known and present in notes.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

INFORMATION ABOUT THE PERSON WITH DEMENTIA

This sub section looks at whether there is a formal system in place for collating information about the person with dementia necessary to their care. **NB** this system need not be in use only for patients with dementia.

This could be an assessment proforma, or prompted list of questions for a meeting with the carer or next of kin, producing information for the care plan. It could also be a personal information document (e.g. "This is Me", patient passport).

26. Does the care assessment contain a section dedicated to collecting information from the carer, next of kin or a person who knows the patient well?

- ☐ **Yes** ⇒ **Go to Q26a**
- ☐ **No** ⇒ **Go to Q27**

26a. Has information been collected about the patient regarding personal details, preferences and routines?

This could include details of preferred name, need to walk around at certain times of day, time of rising/retiring, likes/dislikes regarding food etc.

Answer "No" if sections of the form are left blank/there is no way of identifying whether information has been requested.

Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

26b. Has information been collected about the patient regarding reminders or support with personal care?

This could include washing, dressing, toileting, hygiene, eating, drinking, and taking medication.

Answer "No" if sections of the form are left blank/there is no way of identifying whether information has been requested.

Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

26c. Has information been collected about the patient regarding recurring factors that may cause or exacerbate distress?

This could include physical factors such as illness or pain, and/or environmental factors such as noise, darkness. Answer "No" if sections of the form are left blank/there is no way of identifying whether information has been requested.

Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

26d. Has information been collected about the patient regarding support or actions that can calm the person if they are agitated?

This could include information about indicators especially non-verbal, of distress or pain; any techniques that could help with distress e.g. reminders of where they are, conversation to distract, or a favourite picture or object.

Answer "No" if sections of the form are left blank/there is no way of identifying whether information has been requested.

Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

26e. Has information been collected about the patient regarding details of life history which aid conversation?

This could include family situation (whether living with other family members, spouse living, pets etc), interests and past or current occupation.

Answer "No" if sections of the form are left blank/there is no way of identifying whether information has been requested.
Answer "Yes" if there is no carer/relative/friend and information is not available and recorded as such.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

Q27 is only applicable if Q11 = Own home OR carer's home

27. Has information about support on discharge been given to the patient and/or the carer?

This is the local hospital information leaflet explaining the normal arrangements for discharge, follow up where required, what the patient and/or their carers need to do and what notice, support and advice they can expect.

Answer "No" if this is not recorded/not known.

- ☐ **Yes**
- ☐ **No**

DISTRESS, AGITATION AND BEHAVIOUR THAT CHALLENGES

The purpose of this section is to look at whether, and how, antipsychotics are used in managing symptoms of dementia.
Antipsychotic drugs : Amisulpride, Aripiprazole, Asenapine, Benperidol, Chlorpromazine,Clozapine, Flupentixol, Fluphenazine, Haloperidol, Levomepromazine/methotrimeprazine,Olanzapine, Paliperidone, Pericyazine, Perphenazine, Pimozide, Prochlorperazine,Promazine, Quetiapine, Risperidone, Sertindole, Sulpiride, Trifluoperazine, Zotepine,Zuclopenthixol, Zuclopenthixol dihydrochloride. Please refer to BNF or MIMS for relevant drug trade names also.

28.Has this patient had antipsychotic drugs at any point during admission (whether or not prescribed in the hospital)?
This could be an existing prescription, a new prescription or via a PRN.

- ☐ **Yes** ⇒ **Go to Q28a**
- ☐ **No** ⇒ **Go to Comment box end of Section 2**
- ☐ **Information cannot be found/drug chart missing** ⇒**Go to end of Section 2**

28a. Was there documentation of "challenging behaviours" (e.g. wandering, calling out, pacing, aggression, hitting etc) in the case notes?

☐ **Yes** ➡ Go to Q28a ☐ **No** ➡ Go to Comment box end of Section 2

28b. On admission, was the patient taking antipsychotics due to an existing regular prescription?

Answer "Yes" if up to the point of admission there was a prescription in place for an antipsychotic drug.

☐ **Yes**
☐ **No**
☐ **Information cannot be found**

28c. Was a PRN prescription for antipsychotics in place for this admission?

Answer "Yes" if a PRN prescription has been put in place for use during the admission.

☐ **Yes** ⇒ Go to Q28b1
☐ **No** ⇒ Go to Q28c
☐ **Information cannot be found** ⇒ Go to Q28c

28c1. Was an antipsychotic administered via PRN?

Answer "Yes" if any antipsychotic drugs have been administered under the PRN prescription.

☐ **Yes**
☐ **No**
☐ **Information cannot be found**

28d. Was a new or additional prescription made for an antipsychotic?

Answer "Yes" where: an antipsychotic has been prescribed during the admission that is not regularly prescribed (other than PRN above) OR where an increased dosage has been prescribed of an antipsychotic regularly prescribed OR if any antipsychotic is prescribed and it is not known whether this is a new prescription.

- ☐ **Yes**
- ☐ **No**
- ☐ **Information cannot be found**

Q29 + Q30a are only applicable if 28b1 = "Yes" OR 28c = "Yes"

29. Was a reason recorded for prescription of antipsychotics? *Refer to medical record and drug presciption record.*

- ☐ **Yes⇒ Go to Q29a**
- ☐ **Not recorded in notes ⇒ Go to Comment box end of Section 2**

29a. What was the main or primary reason recorded for prescription of antipsychotics? *Tick one*

- ☐ **Comorbid psychotic disorder**
- ☐ **Immediate risk of harm to self/others**
- ☐ **Severe distress not responsive to other intervention**
- ☐ **Need to carry out investigation and/or treatment and/or nursing care**
- ☐ **Agitation**
- ☐ **Anxiety**
- ☐ **Aggressive/threatening behaviour**
- ☐ **Disturbance through noise**
- ☐ **Disturbance through wandering, obsessive behaviour, mannerisms, tics**
- ☐ **Delirium**
- ☐ **Hallucinations**
- ☐ **Delusions**
- ☐ **End of life**
- ☐ **Depression/low mood**
- ☐ **Other**

30. Was there more than one reason recorded for the prescription of antipsychotics?

- ☐ **Yes** ⇒ **Go to Q30a**
- ☐ **No** ⇒ **Go to Comment box end of Section 2**

30a. What are the other reasons recorded for prescription of antipsychotics?

Tick any that apply

- ☐ **Comorbid psychotic disorder**
- ☐ **Immediate risk of harm to self/others**
- ☐ **Severe distress not responsive to other intervention**
- ☐ **Need to carry out investigation and/or treatment and/or nursing care**
- ☐ **Agitation**
- ☐ **Anxiety**
- ☐ **Aggressive/threatening behaviour**
- ☐ **Disturbance through noise**
- ☐ **Disturbance through wandering, obsessive behaviour, mannerisms, tics**
- ☐ **Delirium**
- ☐ **Hallucinations**
- ☐ **Delusions**
- ☐ **End of life**
- ☐ **Depression/low mood**
- ☐ **Other**

Do you have any comments to make on Section 2: Assessment?

SECTION 3: DISCHARGE

This section does not apply to all patients, please read carefully the information below before continuing.

If any of the responses below apply, you will not be asked any questions in the Discharge Section and can move onto Section 4:

Q6 = "Yes" (patient died in hospital)
Q7 = "Yes" (patient self-discharged from hospital)
Q8 = "Yes" (patient was receiving end of life/on end of life care pathway)
Q11 = "Transferred to another hospital" OR "Psychiatric ward" OR "Palliative Care" OR "Intermediate care" OR "Rehabilitation"

ASSESSMENT BEFORE DISCHARGE

This section asks about appropriate discharge planning and procedures including support and information for patients and carers.

31a. At the point of discharge the patient's level of cognitive impairment, using a standardised assessment, was summarised and recorded:

This should be a cognitive screen carried out subsequent to any carried out during initial assessment or pre-admission assessment, and whilst assessing readiness for discharge, e.g.MMSE, AMT. This includes discharge correspondance from nursing and medical staff.

- ☐ **Yes**
- ☐ **No**

31b. At the point of discharge the cause of cognitive impairment was summarised and recorded:

This could be a condition diagnosed before this admission to hospital or identified during the admission.

- ☐ **Yes**
- ☐ **No**

32. Have there been any symptoms of delirium?

This refers to symptoms noted during the admission.

Answer "Yes" if symptoms present during admission are noted.

Answer "no" if there is no record.

☐ **Yes** ⇒ **Go to Q32a** ☐ **No** ⇒ **Go to Q33**

32a. Have the symptoms of delirium been summarised for discharge?

☐ **Yes**
☐ **No**

33. Have there been any persistent behavioural and psychiatric symptoms of dementia (wandering, aggression, shouting) during this admission?

This refers to symptoms noted during the admission.

Answer "Yes" if symptoms present during admission are noted.

Answer "no" if there is no record.

☐ **Yes** ⇒**Go to Q33a**
☐ **No** ⇒ **Go to Q34**

33a. Have the symptoms of behavioural and psychiatric symptoms of dementia been summarised for discharge?

☐ **Yes**
☐ **No**

Q34 is only applicable if Q28 = "Yes"

34. Is there any record in the discharge summary/notes that there is a prescription of antipsychotics that is being continued post discharge?
This refers to any antipsychotics the patient was taking whilst in hospital that were not stopped on discharge.

☐ **Yes**
☐ **No**

DISCHARGE COORDINATION AND MDT INPUT

35. Did a named person coordinate the discharge plan?

E.g. the person that coordinated the plan for this individual and signed it off.

- ☐ **Yes**
- ☐ **No**
- ☐ **There is no discharge plan**

35a. Is there evidence in the notes that the discharge coordinator/ person planning discharge has discussed appropriate place of discharge and support needs with the person with dementia?

This can be together as a summary or recorded as separate discussions.

Answer "N/A" if the person with dementia has refused discussion and this is recorded or it has not been possible to carry this out for another documented reason.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

35b. Is there evidence in the notes that the discharge coordinator/ person planning discharge has discussed appropriate place of discharge and support needs with the person's carer/relative?

This can be together as a summary or recorded as separate discussions.

Answer "N/A" if the carer/relative has refused discussion and this is recorded or it has not been possible to carry this out for another documented reason OR there is no carer.

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

35c. Is there evidence in the notes that the discharge coordinator/ person planning discharge has discussed appropriate place of discharge and support needs with the consultant responsible for the patient's care? *This can be together as a summary or recorded as separate discussions.*

- ☐ **Yes**
- ☐ **No**

35d.Is there evidence in the notes that the discharge coordinator/ person planning discharge has discussed appropriate place of discharge and support needs with other members of the multidisciplinary team?

This can be together as a summary or recorded as separate discussions.

- ☐ **Yes**
- ☐ **No**

36. Has a single plan for discharge with clear updated information been produced? *This refers to the discharge plan with summarised information for the use of the patient, carer, GP and community based services. The question asks whether nursing and medical/surgical information has been put together as a single plan and mental health information is included.*

- ☐ **Yes**
- ☐ **No**

37. Are any support needs that have been identified documented in the discharge plan or summary? *This asks about whether the referrals and recommendations about future care, treatment and support are contained in the discharge plan or summary, e.g. help needed with Activities of Daily Living, referral to Occupational Therapy. Answer "N/A" if no discharge plan or summary has been produced.*

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

38. Has the patient and/or carer received a copy of the plan or summary?

Answer "Yes" if there is a single plan and the patient/carer has received a copy OR if there is a "GP" version" with information about medicines to be taken, referrals, etc, and the patient/ carer has received a copy.
Answer "No" if the only information recorded as given to the patient/carer is not specific to their ongoing care and treatment (e.g. generic leaflets about social services) OR if the patient/carer receives no information

- ☐ **Yes**
- ☐ **No**
- ☐ **Unknown, information to answer this question is not available**

DISCHARGE PLANNING

39. Was discharge planning initiated within 24 hours of admission?
Answer "N/A" if there is a recorded reason why discharge planning could not be initiated within 24 hours of admission.

- ☐ **Yes** ⇒ **Go to Q40**
- ☐ **No** ⇒ **Go to Q40**
- ☐ **N/A** ⇒ **Go to Q39a**

39a. Please select the recorded reason why discharge planning could not be initiated within 24 hours:

- ☐ **Patient acutely unwell**
- ☐ **Patient awaiting assessment**
- ☐ **Patient awaiting history/results**
- ☐ **Patient awaiting surgery**
- ☐ **Patient presenting confusion**
- ☐ **Patient on end of life care**
- ☐ **Patient transferred to another hospital**
- ☐ **Patient unresponsive**
- ☐ **Patient being discharged to nursing/residential care/**
- ☐ **Other**
- ☐ **Not recorded**

SUPPORT FOR CARERS AND FAMILY

40.Carers or family have received notice of discharge and this is documented: *Carers or family here refers to relative, friend or next of kin named as main contact or involved in caring for the patient. It does not refer to the patient's case worker from social services or residential care. Answer, indicating notice period, regardless of the destination of the patient on discharge.*

- ☐ **Less than 24 hours**
- ☐ **24 hours**
- ☐ **24 ± 48 hours**
- ☐ **More than 48 hours**
- ☐ **No notice at all**
- ☐ **No carer, family, friend**
- ☐ **Not documented**

41.An assessment of the carer's current needs has taken place in advance of discharge: *Answer "N/A" if the carer did not want, or did not need to meet about this (e.g. has had a recent assessment, all support services already in place, or the person they care for is moving to another place of care) OR there is no carer.*

- ☐ **Yes**
- ☐ **No**
- ☐ **N/A**

Do you have any comments to make on Section 3: Discharge?

SECTION 4a: LIAISON PSYCHIATRY

This section is relevant to those patients who have been referred to a liaison psychiatry service during their stay.

42. Has any referral been made to psychiatric consultation/liaison?

Answer "No" if there was no referral made for this patient, or if the patient already had mental health input and so referral to the service was not necessary.

- ☐ **Yes** ⇒ **Go to Q43**
- ☐ **No** ⇒ **Go to Q42a**
- ☐ **No liaison service available in the hospital** ⇒ **Go to Q42a**
- ☐ **Not documented** ⇒ **Go to Comment box end of Section 4**

42a. Has any need for referral to liaison psychiatry been noted on admission or during further assessment?

- ☐ **Yes**
- ☐ **No**

42b. Has a follow up referral to community based mental health services been made on discharge? *Answer "N/A" is the patient is already in regular contact with community based mental health services, e.g. visited by outreach team, regularly attends appointments at a memory service.*

- ☐ **Yes** ⇒ **Go to Question 43**
- ☐ **No** ⇒ **Go to Comment box end of Section 4**
- ☐ **N/A** ⇒ **Go to Comment box end of Section 4**

43. Is it stated whether the referral was emergency, urgent or routine?

Guidance on the definitions in this question is drawn from the UK Psychiatric Liaison Accreditation Network Quality Standards for Liaison Psychiatry Services.

***NB** the use of these definitions is not mandatory, and this question may be answered using the equivalent terms in use in your hospital/service.*

Emergency: An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.

Urgent: A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.

Routine: All other referrals, including patients who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge.

If there is no indication of the level of urgency, select 'Not stated´.

- ☐ **Emergency**
- ☐ **Urgent**
- ☐ **Routine**
- ☐ **Not stated**

44. Please indicate time between admission and assessment:
This refers to the initial assessment (in the event that there has been more than one).

- ☐ **Within 60 minutes**
- ☐ **Within 24 hours**
- ☐ **Within 24 - 48 hours**
- ☐ **Within 48 - 72 hours**
- ☐ **Within 72 - 96 hours**
- ☐ **Longer than 96 hours**
- ☐ **Not documented**
- ☐ **Patient died/was discharged**

45. What was the main reason given for referral? *Tick only one*

- ☐ **Cognitive assessment or review/dementia**
- ☐ **Confusion**
- ☐ **Aggression/agitation/anxiety**
- ☐ **Delirium**
- ☐ **Depression/low mood**
- ☐ **Psychosis (e.g. delusions/hallucinations/paranoia)**
- ☐ **Risk to others/risk to self**
- ☐ **Capacity assessment**
- ☐ **Discharge planning (includes assessment for nursing homes)**
- ☐ **Diagnosis**
- ☐ **Other (e.g. wandering, not eating, non-compliance)**
- ☐ **Not documented**

Do you have any comments to make on Section 4a: Liaison psychiatry?

SECTION 4b: PSYCHIATRY OF OLD AGE

This section is relevant to those patients who have been referred to a liaison Psychiatry of Old Age service during their stay.

46. Has any referral been made to Psychiatry of Old Age?

Answer "No" if there was no referral made for this patient, or if the patient already had mental health input and so referral to the service was not necessary.

- ☐ **Yes** ⇒ Go to Q47
- ☐ **No** ⇒ Go to Q46a
- ☐ **No liaison service available in the hospital** ⇒ Go to Q46a
- ☐ **Not documented** ⇒ Go to Comment box end of Section 4b

46a. Has any need for referral to Psychiatry of Old Age been noted on admission or during further assessment?

- ☐ **Yes**
- ☐ **No**

46b. Has a follow up referral to community based Psychiatry of Old Age services been made on discharge?

Answer "N/A" if the patient is already in regular contact with community based mental health services, e.g. visited by outreach team, regularly attends appointments at a memory service.

- ☐ **Yes** ⇒ Go to Question 47
- ☐ **No** ⇒ Go to Comment box end of Section 4b
- ☐ **N/A** ⇒ Go to Comment box end of Section 4b

47. Is it stated whether the referral was emergency, urgent or routine?
Guidance on the definitions in this question is drawn from the UK Psychiatric Liaison Accreditation Network Quality Standards for Liaison Psychiatry Services.

***NB** the use of these definitions is not mandatory, and this question may be answered using the equivalent terms in use in your hospital/service.*

Emergency: An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.

Urgent: A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.

Routine: All other referrals, including patients who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge.

If there is no indication of the level of urgency, select 'Not stated´.

- ☐ **Emergency**
- ☐ **Urgent**
- ☐ **Routine**
- ☐ **Not stated**

48. Please indicate time between admission and assessment:

This refers to the initial assessment (in the event that there has been more than one).

o	**Within 60 minutes**	o	**Within 24 hours**
o	**Within 24 - 48 hours**	o	**Within 48 - 72 hours**
o	**Within 72 - 96 hours**	o	**Longer than 96 hours**
o	**Not documented**	o	**Patient died/was discharged**

49. What was the main reason given for referral? *Tick only one*

- ☐ **Cognitive assessment or review/dementia**
- ☐ **Confusion**
- ☐ **Aggression/agitation/anxiety**
- ☐ **Delirium**
- ☐ **Depression/low mood**
- ☐ **Psychosis (e.g. delusions/hallucinations/paranoia)**
- ☐ **Risk to others/risk to self**
- ☐ **Capacity assessment**
- ☐ **Discharge planning (includes assessment for nursing homes)**
- ☐ **Diagnosis**
- ☐ **Other (e.g. wandering, not eating, non-compliance)**
- ☐ **Not documented**

Do you have any comments to make on Section 4b:Psychiatry of Old Age?

SECTION 4c: GERIATRIC MEDICINE

This section is relevant to those patients who have been referred to a geriatric medicine service during their stay.

50. Has any referral been made to Geriatric Medicine? *mAnswer "No" if there was no referral made for this patient, or if the patient already had geriatric medicine input and so referral to the service was not necessary.*

- ☐ **Yes** ⇒ **Go to Q51**
- ☐ **No** ⇒ **Go to Q50a**
- ☐ **No liaison service available in the hospital** ⇒ **Go to Q50a**
- ☐ **Not documented** ⇒ **Go to Comment box end of Section 4**

50a. Has any need for referral to Geriatric Medicine been noted on admission or during further assessment?

☐ **Yes** ☐ **No**

50b. Has a follow up referral to geriatric medicine services been made on discharge?
Answer "N/A" is the patient is already in regular contact with geriatric medical services or regularly attends appointments at a memory service.

☐ **Yes** ⇒ **Go to Question 51**
☐ **No** ⇒ **Go to Comment box end of Section 4**
☐ **N/A** ⇒ **Go to Comment box end of Section 4**

51. Is it stated whether the referral was emergency, urgent or routine?

The use of these definitions is not mandatory, and this question may be answered using the equivalent terms in use in your hospital/service.

Emergency: An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.

Urgent: A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.

Routine: All other referrals, including patients who require geriatric medicine assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge.

If there is no indication of the level of urgency, select 'Not stated´.

☐ **Emergency**
☐ **Urgent**
☐ **Routine**
☐ **Not stated**

52. Please indicate time between admission and assessment:

This refers to the initial assessment (in the event that there has been more than one)

o	**Within 60 minutes**	o	**Within 24 hours**
o	**Within 24 - 48 hours**	o	**Within 48 - 72 hours**
o	**Within 72 - 96 hours**	o	**Longer than 96 hours**
o	**Not documented**	o	**Patient died/was discharged**

53. What was the main reason given for referral? *Tick only one*

- ☐ **Cognitive assessment or review/dementia**
- ☐ **Confusion**
- ☐ **Aggression/agitation/anxiety**
- ☐ **Delirium**
- ☐ **Depression/low mood**
- ☐ **Psychosis (e.g. delusions/hallucinations/paranoia)**
- ☐ **Risk to others/risk to self**
- ☐ **Capacity assessment**
- ☐ **Discharge planning (includes assessment for nursing homes)**
- ☐ **Diagnosis**
- ☐ **Medical Advice**
- ☐ **Rehabilitation**
- ☐ **Other (e.g. wandering, not eating, non-compliance)**
- ☐ **Not documented**

Do you have any comments to make on Section 4c: Geriatric Medicine?

SECTION 4d: NEUROLOGY

This section is relevant to those patients who have been referred to Neurology during their stay.

50. Has any referral been made to Neurology?

Answer "No" if there was no referral made for this patient, or if the patient already had Neurology input and so referral to the service was not necessary.

- ☐ **Yes** ⇒ Go to Q51
- ☐ **No** ⇒ Go to Q50a
- ☐ **No liaison service available in the hospital** ⇒ Go to Q50a
- ☐ **Not documented** ⇒ Go to Comment box end of Section 4

50a. Has any need for referral to Neurology been noted on admission or during further assessment?

☐ **Yes** ☐ **No**

50b. Has a follow up referral to Neurology services been made on discharge? *Answer "N/A" is the patient is already in regular contact with Neurology services*

- ☐ **Yes** ⇒ Go to Question 51
- ☐ **No** ⇒ Go to Comment box end of Section 4
- ☐ **N/A** ⇒ Go to Comment box end of Section 4

51. Is it stated whether the referral was emergency, urgent or routine? *The use of these definitions is not mandatory, and this question may be answered using the equivalent terms in use in your hospital/service.*

Emergency: An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.
Urgent: A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.
Routine: All other referrals, including patients who require neurology assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge. If there is no indication of the level of urgency, select 'Not stated´.

- ☐ **Emergency**
- ☐ **Urgent**
- ☐ **Routine**
- ☐ **Not stated**

52. Please indicate time between admission and assessment:

This refers to the initial assessment (in the event that there has been more than one)

- ☐ **Within 60 minutes**
- ☐ **Within 24 hours**
- ☐ **Within 24 – 48 hours**
- ☐ **Within 48 – 72 hours**
- ☐ **Within 72 – 96 hours**
- ☐ **Longer than 96 hours**
- ☐ **Not documented**
- ☐ **Patient died/was discharged**

53.What was the main reason given for referral? *Tick only one*

- ☐ **Cognitive assessment or review/dementia**
- ☐ **Confusion**
- ☐ **Aggression/agitation/anxiety**
- ☐ **Delirium**
- ☐ **Depression/low mood**
- ☐ **Psychosis (e.g. delusions/hallucinations/paranoia)**
- ☐ **Risk to others/risk to self**
- ☐ **Capacity assessment**
- ☐ **Discharge planning (includes assessment for nursing homes)**
- ☐ **Diagnosis**
- ☐ **Medical Advice**
- ☐ **Rehabilitation**
- ☐ **Other (e.g. wandering, not eating, non-compliance)**
- ☐ **Not documented**

Do you have any comments to make on Section 4d: Neurology?

SECTION 4e: PALLIATIVE CARE NEEDS

54 a) Was a decision for resuscitation (either for resuscitation or not for resuscitation) documented in the medical notes this admission?

☐ **Yes** ☐ **No**

54 b) Was a referral made to Palliative Care?

☐ **Yes** ☐ **No**

54 c) Was a referral made for the family/ carer for bereavement support?

This may include referral to a health & social care professional, or to a specific bereavement support group.

- ☐ **Yes**
- ☐ **No**
- ☐ **No with documentation that family/carer didn't need this, or refused it, or patient had no family/ carer**

Do you have any comments to make on Section 4e?

SECTION 5: RECORD KEEPING

This section looks at whether information about the patient's dementia and support needs is readily accessible.

56.Is information about the person's dementia quickly found in a specified place in the file?

- ☐ **Yes**
- ☐ **No**

57.Is information about related care and support needs quickly found in a specified place in the file?

- ☐ **Yes**
- ☐ **No**

58. In your opinion, how would you rate the organisation of this case note?

- ☐ **The notes are well organised and it was easy to find all the information that I needed**
- ☐ **The notes are organised adequately, however it was not so easy to find all the information I needed**
- ☐ **The notes were not well organised, and it was a struggle to find all the information that I needed**
- ☐ **The notes were disorderly and it was extremely difficult to find any of the information I needed**

Do you have any comments to make on Section 5: Record keeping?

If you have any queries, please contact:

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Appendix F

Northern Ireland Audit of Dementia Care in Acute Hospitals

WARD ORGANISATIONAL QUESTIONNAIRE

Hospital code ☐☐☐

Ward code ☐☐☐

Adapted from the UK National Audit of Dementia, with permission: Copyright HEALTHCARE QUALITY IMPROVEMENT PARTNERSHIP, HQIP 2012

Section 1: Staffing

1 Please give the number of registered nursing posts (WTE) that should be on the ward. Include any that are vacant.

☐

2 Please give the number of health care assistant posts (WTE) that should be on this ward. Include any that are vacant.

☐

3 Please give the number of nurses actually working on this ward (whole time equivalent)

☐

4Please give the number of healthcare assistants actually working on this ward (whole time equivalent)

☐

5 **Are there any vacancies on this ward?**

o Yes o No

5a **Who are nursing vacancies filled by?** *(Tick all that apply)*

o Hospital Pool Staff o Agency staff o Vacancies are not filled

5b. **Who are healthcare staff vacancies filled by? (*Tick all that apply)***

o Hospital Pool Staff o Agency staff o Vacancies are not filled

6 **There is a system to routinely monitor and report the use of hospital pool and agency staff**

o Yes o No

7 **There is administrative staff support on the ward**

o Yes o No

7a **When is administrative staff support available on weekdays?**

o Monday – Friday (full time) o Monday – Friday (part time)

7b **Is there access to administrative support at weekends?**

o Yes o No

Comments on administrative support on the ward:

8 **The ward has an agreed minimum staffing level across all shifts**

o Yes ⇒ Go to Q8a

o No ⇒ Go to Q9

8a. **The agreed minimum staffing levels are met.**

o Yes o No

9 There are systems in place that ensure all factors that affect nursing staff numbers and skill mix are taken into consideration and staffing levels are reviewed on a daily basis *(e.g. taking account of sickness and absence; training and supervision; need for one to one care)*

o Yes **o No**

9a. **Please briefly describe these systems** *(e.g. what mechanism is used to ascertain staffing levels)*

9 There are arrangements for staff cover to allow staff to attend training relating to the care of people with dementia

o Yes **o No**

10 Systems for supporting staff development are in place including:

		Registered Nursing Staff	Healthcare Assistants	Other Staff (not including students)	No
11a	**Appraisal and mentorship**	o	o	o	o
11b	**Clinical supervision**	o	o	o	o
11c	**Access to guidance and support from dementia champions in the hospital**	o	o	o	o

11 Staff caring for people with dementia have access to peer support groups. *Tick all that apply*

o ***Registered*** **nursing staff** **o** ***Healthcare*** **assistants** **o Other staff** **o No**

12a. Staff caring for people with dementia have access to reflective practice groups. *Tick all that apply*

o ***Registered*** **nursing staff** **o** ***Healthcare*** **assistants** **o Other staff** **o No**

13 **The ward can provide access to relevant faith-specific support from someone with experience of supporting vulnerable adults** *(e.g. mental health or communication problems)*

o Yes **o No**

Do you have any comments to make on Section 1, Staffing?

Section 2: Access to Services

Please use the boxes to indicate when the following services are available:

Liaison Psychiatry:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14a1	Day	o	o	o	o	o	o	o
14a2	Evening	o	o	o	o	o	o	o

Psychiatry of Old Age:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14b1	Day	o	o	o	o	o	o	o
14b2	Evening	o	o	o	o	o	o	o

Geriatrician:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14c1	Day	o	o	o	o	o	o	o
14c2	Evening	o	o	o	o	o	o	o

Occupational Therapy:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14d1	Day	o	o	o	o	o	o	o
14d2	Evening	o	o	o	o	o	o	o

Social Work Support:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14e1	Day	o	o	o	o	o	o	o
14e2	Evening	o	o	o	o	o	o	o

Pharmacy:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14f1	Day	o	o	o	o	o	o	o
14f2	Evening	o	o	o	o	o	o	o

Physiotherapy:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14g1	Day	o	o	o	o	o	o	o
14g2	Evening	o	o	o	o	o	o	o

Dietetics:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14h1	Day	o	o	o	o	o	o	o
14h2	Evening	o	o	o	o	o	o	o

Speech and Language Therapy:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14i1	Day	o	o	o	o	o	o	o
14i2	Evening	o	o	o	o	o	o	o

Psychology/Neuropsychology:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14j1	Day	o	o	o	o	o	o	o
14j2	Evening	o	o	o	o	o	o	o

Specialist Infection Control Services:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14k1	Day	o	o	o	o	o	o	o
14k2	Evening	o	o	o	o	o	o	o

Specialist Tissue Viability Services:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14l1	Day	o	o	o	o	o	o	o
14l2	Evening	o	o	o	o	o	o	o

Specialist Continence Services:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14m1	**Day**	o	o	o	o	o	o	o
14m2	**Evening**	o	o	o	o	o	o	o

Specialist Palliative Care:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14n1	Day	o	o	o	o	o	o	o
14n2	Evening	o	o	o	o	o	o	o

Do you have any comments to make on Section 2, Access to Services?

Section 3: Information Available on the Ward

The ward provides patients with dementia and carers/relatives with information about:

		Yes, Verbal	Yes, Written/ Pictorial	No
15a	Ward routines such as mealtimes and visiting hours	o	o	o
15b	The hospital complaints procedure	o	o	o
15c	Patient advocacy services	o	o	o
15d	Personal and healthcare information and when this will be shared with carers	o	o	o

Do you have any comments to make on Section 3, Information Available on the Ward?

Section 4: Nutrition

16 **The ward operates a protected mealtime system**

☐ **Yes** ☐ **No**

17 **The protected mealtime system allows for carers to visit and assist during mealtimes**

☐ **Yes** ☐ **No**

18 **There is a system in place to signal the need for help with eating**

☐ **Yes** ☐ **No**

19 **There is a system to ensure that staffing levels are sufficient at mealtimes to aid people with dementia to eat and choose food if necessary**

☐ **Yes** ☐ **No**

20 **There is a system for staff to report patients missing/uneaten meals to the ward manager**

☐ **Yes** ☐ **No**

21 **There are opportunities for patients to socially interact** (*e.g. eat together)*

☐ **Yes** ☐ **No**

21a **Please comment on what these are:**

22 **The ward is able to provide food to patients between mealtimes**

☐ **Yes** ☐ **No**

Do you have any comments to make on Section 4, Nutrition?

Section 5: Information and Communication

23 **A healthcare professional responsible for coordinating care is identified to the person with dementia and carers/relatives as a point of contact**

☐ **Yes** ☐ **No**

24 **The name that the person with dementia prefers to be addressed by is recorded and communicated to staff involved in caring for or treating them**

☐ **Yes** ☐ **No**

25 **There is a system for communicating other personal information (such as routines, preferences and support needed with personal care) to staff involved in the care/treatment of the person with dementia.** *Support for personal care may be to do with specific situations (e.g. times of day when more support is needed, ability to eat/drink unprompted or unaided)*

☐ **Yes** ☐ **No**

Please say what this is:

26 **There is a system for communicating to ward staff any behavioural or communication needs specific to a patient with dementia. This might directly relate to memory problems** (*e.g. ability to answer queries about health accurately or to follow instructions, or other behavioural/psychological symptoms e.g. agitation or hallucination)*

☐ **Yes** ☐ **No**

Please say what this is:

27 **There is a system for flagging to other staff any behavioural or communication needs specific to a patient with dementia** (*e.g. whenever the person with dementia accesses other areas outside their ward for assessment or other*

treatment)

Yes

No

Please say what this is:

Do you have any comments to make on Section 5, Information and Communication?

If you have any queries, please contact:

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Appendix G

Northern Ireland Audit of Dementia Care in Acute Hospitals

ENVIRONMENTAL CHECKLIST

Hospital code

Ward code

Ward Size and Layout

Number of beds

Number of single sex bays

Number of mixed bays

Number of single rooms

Section 1: The Ward/Signage

Signs should display information in a consistent and simple way. They should be positioned on the ward so they can be easily seen by patients and designed so they are readable and easy to understand - clearly contrasted, placed at a suitable height on the wall etc.

1 **Colour schemes are used to help patients with dementia to find their way around the ward** *(e.g. different bays are painted in different colours to aid recognition)*
o Yes **o No**

2 **Key areas are clearly marked** *(e.g. the nursing station, the bathroom, any side rooms or waiting areas)*
o Yes **o No**

3 **Signs/maps are large, bold and distinctive**
o Yes **o No** **o N/A (no signs/maps)**

4 **Information (words and pictures) on signs is in clear contrast to the background**
o Yes **o No**

Section 2: Floors

5 **Level changes and contrasts (gentle slopes and steps) are clearly marked**
o Yes **o No** **o N/A**

6 **Floors are plain or subtly patterned, not 'busy'** (*e.g. without bold or high contrast design or pattern which could affect orientation)*
o Yes **o No**

7 **Floor surfaces are subtly polished rather than high gloss**
o Yes **o No**

8 **Floor surfaces are non-slip**
o Yes **o No**

Section 3: Bed/Rest Area

9 **Patients with dementia are situated on the ward where they are visible to staff and staff are visible to them**
o All patients **o Some patients** **o No patients**

10 **Patients with dementia are able to see a clock from their bed area**
o All patients **o Some patients** **o No patients**

11 **Patients with dementia are able to see a calendar from their bed area** *(this can be an orientation board)*
o All patients **o Some patients** **o No patients**

12 **For patients with dementia, messages from relatives and personal objects, including self-care items, are situated where the patient can see them at all times**
o All patients **o Some patients** **o No patients**

13 **A room/area is available for patients to use for a break from the ward environment** (*e.g. a 'quiet room', patient's lounge or seating area)*
o Yes **o No**

Any Comments on Bed/Rest Area (e.g. clocks/calendars on right time/date)

Section 4: Accessible Toilet and Bathing Facilities

14 **Signs to locate the toilet are visible from the patient's bed area/door of room**
o All **o Some** **o None**

15a. **Toilet doors carry signs**
o All **o Some** **o None**

15b. **Bathroom doors carry signs**
o All **o Some** **o None**

16 **Toilet and bathroom doors are a different colour to the walls**
o All **o Some** **o None**

17 **Items such as the soap dispenser, the bin, the hand dryer, are clearly labelled with pictures as well as words so that the patient**

can identify them
o All o Some o None

18 There are hand rails, large handles and a raised toilet seat to support patients
o Yes o No

19 Door handles are a different colour to the wall so that they stand out
o All o Some o None

20 Toilet paper is a different colour to the wall so that it stands out
o All o Some o None

21 The toilets are big enough for assisted toileting
o All o Some o None

22 The bathroom is big enough for assisted bathing
o Yes o No

23 Single sex toilet/washing facilities are provided for patient use
o Yes o No

24 Facilities are available so that patients have choices about bathing or assisted bathing *(e.g. at the sink, overhead showering, hand held shower head, full bath)*
o Yes o No

25 There are call/alarm buttons visible in the toilet/bathroom
o Visible and in reach
o Visible and not in reach
o Not visible

25a Call /alarm buttons visible and within reach at the bedside
o Visible and in reach
o Visible and not in reach
o Not visible

Section 5: Promoting Independence

26 There is space for active patients with dementia to walk up and down where they are visible to staff and staff are visible to them
o Yes o No

27 The ward is adapted to assist people with mobility difficulties *(e.g. large handles, hand rails)*

o Yes **o No**

28 **The ward can readily provide equipment to assist mobility** (*e.g. walking frames, wheelchairs)*

o Yes **o No**

29 **The ward can provide hearing aids such as amplifiers/communicators/hearing loops/batteries for personal aids or other assistive devices**

o Yes **o No**

30 **The ward can provide adapted utensils (cutlery) to encourage patients to assist themselves with their meal and eat independently**

o Yes **o No**

Any comments on the environmental checklist:

If you have any queries, please contact:

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Appendix H

Northern Ireland Audit of Dementia Care in Acute Hospitals

Case Note Audit Guidance Document

October 2014

Introduction

Thank you for taking part in the chart review module of the Northern Ireland Audit of Dementia Care in Acute Hospitals (NIAD).

All 12 acute hospitals in Northern Ireland are participating in this audit.

The audit consists of four modules in total:

- **Case Note Review audit**
- Hospital Organisation audit
- Environmental Checklist audit
- Ward Organisation audit

This document has been prepared as a guide for people carrying out the chart/case note audit.

We aim to review the records of 20 patients with a diagnosis (primary or secondary) of dementia, who have a length of stay greater than 5 days, against a checklist of standards which have been drawn from national and international best practice in dementia care.

Management of the Audit

The audit is led by Dr Suzanne Timmons, Centre for Gerontology & Rehabilitation, University College Cork, with Eleanor Ross, Nurse Consultant, Public Health Agency, and Seamus McErlean, Commissioning Lead for Older People & Adult Services, HSCB, as co-leads.

A number of professional bodies are collaborating on the project through membership on the NIAD Steering Committee or Advisory Group.

NIAD Steering Committee

Brid Kerrigan	Consultant Psychiatrist of Old Age, South Eastern HSC Trust
Assumpta Ryan	Lecturer Nursing Division, Ulster University
Cathy Patterson	Consultant Geriatrician, Belfast HSC Trust
Bernadine McCrory	Director, Alzheimer's Society
April Heaney	Consultant Geriatrician, South Eastern HSC Trust
David Craig	Consultant Geriatrician, Southern HSC Trust
Paul Gallagher	Consultant Geriatrician, HSE
Pauline Casey	Head of Service and Lead nurse for Older Peoples Mental Health
Majella Magee	Service Improvement Lead Older Peoples Mental Health, Western Trust

NIAD Advisory Group

Des O Neill	Consultant Geriatrician, HSE
Pat Cullen	Director of Nursing, Public Health Agency
Stephen Todd	Consultant Geriatrician, Western Trust
Alison McCullough	Policy Officer, Royal College of Speech & Language Therapy
Kate Lesslar	Policy Officer, College of Occupational Therapy
Philip Bartley	Clinical Service Lead, Northern HSC Trust
Karen Harvey	Acting Head of Mental Health Services for Older People
Rachel Gibbs	Professional Lead for Occupational Therapy, South Eastern HSC Trust
Djamil Vahidassr	Consultant Geriatrician, Northern HSC Trust
Conor Barton	Consultant Psychiatrist of Old Age, Belfast HSC Trust
Louise Sands	General Practitioner, Lisburn Health Centre
Bernadette McGuiness	Consultant Geriatrician, Belfast HSC Trust
Sean Kennelly	Consultant Geriatrician, HSE
Sean Doherty	Consultant Psychiatrist of Old Age, Northern HSC Trust
Gillian McCorkell	Nurse Research Lead, Western HSC Trust
Aine Abbott	General Practitioner, Western HSC Trust

NIAD Audit Team

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Completing the Case Note Audit

Each hospital is expected to submit 20 sets of audited case notes.

Estimated time to complete:

This is a complex data set. Feedback from the Irish National Audit of Dementia Care in Acute Hospitals (INAD) suggests that the first set of case notes audited will take up to an hour. Subsequent case notes will take 30-40 minutes to review.

Inter-rater reliability check

The audit team will be collecting inter-rater data. This will involve re-audit of 5 case notes that you will have audited. This will help to establish the reliability of data returned. Input from the original auditors will not be required in this process.

To facilitate this process is it essential that the medical record number is clearly recorded on the *coding sheet* provided, and that only the assigned patient code and not the MRN is recorded on the audit tool (demonstration). This is an important part of the audit.

Question routing

Some questions on the case note form are routed, depending on previous answers. e.g. if you answer "No" to question 17, An assessment of nutritional status was performed by a healthcare professional, you will not be asked to complete 17a, which asks for further information about the nutritional assessment. **Please be careful to take note of the routing**, and do not answer questions that you are directed to skip.

Comment Boxes

At the end of each section you will find a comment box. Use this to make any further comments on your answers to the questions, particularly if you were unsure of how to answer a particular question. These comment boxes can also be used to record relevant anecdotal information relating to the persons dementia and care seen in the notes but not captured with the tool.

Guidance to questions

If you need any further guidance before answering a question please contact Emma O' Shea on

+353 87 755 1275.

How the sample is selected

This is a retrospective audit of the records of patients with a diagnosis of dementia discharged from hospital (or died during admission) between 1st January 2014- April 30th 2014. If 30 charts cannot be sourced from this time period, we would ask that the difference be made up by also including charts from October 1st 2013– 31st December 2013.

Inclusion criteria for chart review

1. Primary or secondary diagnosis of dementia

2. **Length of stay must be 5 days or longer.**

Generating a list of eligible patient records

The following criteria are used to generate a list of eligible patient records:

1. **Any diagnosis of Dementia (primary or secondary). The ICD10 codes to be used for requested charts : F00, F01, F02, F03, F05.1.**
2. **Length of stay in Hospital is a minimum of 5 days (exclude those with 4 days or less).**
3. **Records in which patients were discharged between 1st January 2014- April 30th 2014. If 30 charts cannot be sourced from this time period, we would ask that the difference be made up by charts from October 1st 2013– 31st December 2013.**

Data return

Data collection forms should be returned in the addressed envelopes provided.

NB. Case Note Coding Sheets must be returned in a separate envelope. Please return the case note coding sheets to:

Ms Emma O' Shea,

Centre for Gerontology & Rehabilitation,

School of Medicine, UCC,

The Bungalow, Block 13,

St. Finbarr's Hospital,

Douglas Road,

Cork.

Timeline for data collection

All data should be collected and returned within 2 weeks of audit training.

Reporting

Local data will be made available to individual hospitals upon request. Key findings from collated anonymised data from the audit and recommendations will be presented in an overall report in 2015.

Notes

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Ulster University

College of Occupational Therapists

Royal College of Speech & Language Therapists

Trinity College Dublin
The University of Dublin

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