

**Report of the National Audit of
Dementia Care in General
Hospitals 2011**

**Executive Summary and
Recommendations**



**Royal College
of Physicians**

**Alzheimer's
Society**

Leading the
fight against
dementia

Commissioned by:



HQIP

Healthcare Quality
Improvement Partnership



**Royal College
of Nursing**

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**Royal College of
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Executive summary

Background

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

Key questions for the audit were:

- What structures and resources do hospitals have in place to enable them to identify and meet the care needs of people with dementia? (Measuring the ability to care)
- What evidence can be assembled to show that people with dementia in the hospital have received an acceptable standard of care? (Measuring the quality of care)

This led to the development of a two part audit:

- a hospital level, 'core' audit;
- a ward level, 'enhanced' audit.

Key findings from both parts of the audit are presented here.

Audit standards

A literature review identified source documents for the audit. These included:

- national reports and guidelines;
- standards, guidelines and recommendations issued by professional bodies;
- reports and recommendations issued by organisations representing service users and carers.

A secondary review identified key areas of concern for service users (patients) and carers (see 'Patient and carer priorities', page 31 in the full report). The identified priorities were used in compiling the standards for audit on which data collection tools were based (www.nationalauditofdementia.org.uk).

Appendix 5, on page 214 in the full report, sets out how standards were classified and used for local reporting.

Method

Audit tools producing measurable criteria were produced and piloted in 2009, prior to national roll-out in 2010.

Core audit tools

Each hospital was asked to complete:

- i. **a hospital organisational checklist** to audit the service structures, policies, care processes and key staff that impact on service planning and provision for people with dementia;
- ii. **a retrospective casenote audit** of the records of 40 patients with a diagnosis or current history of dementia, audited against a checklist of standards that relate to their admission, assessment, care planning/delivery and discharge.

Enhanced audit tools

Each participating ward was asked to complete:

- i. **a ward organisational checklist** concerning staffing, support and governance at a ward level;
- ii. **a ward environmental checklist** to gather information about aspects of the ward physical environment known to impact on people with dementia;
- iii. **staff questionnaires** to gather feedback from ward staff about awareness of dementia and about support offered to patients with dementia on their ward;
- iv. **carer/patient questionnaire** that evaluates carers' experience of the support received from ward staff and patients' overall perception of the quality of care on the ward;
- v. **observation of care interactions** to evaluate the quality of the hour-to-hour provision of care to people with dementia.

Data collection was carried out between March 2010 and April 2011. 89% of eligible hospitals representing 99% of Trusts/Health Boards in England and Wales participated in the audit.

For further information about data collection, see page 41 in the full report.

Summary findings

Chapters in the main body of the report represent findings by theme including data from both hospital and ward level audit where relevant. The key results are summarised and presented in this section with recommendations.

Overall compliance with standards by participating hospitals

Analysis of the core audit data showed a national picture of a low level of performance.

Table 1: Standards met in the core audit tools

Standards met	Casenote audit (N = 50)	Organisational checklist (N = 80)
Highest	25 (50%)	69 (86 %)
Lowest	0	19 (24%)
Median	3 (6%)	38 (48%)

The standards were classified by 'type', into type 1 (essential), type 2 (expected) and type 3 (aspirational). None of the hospitals met all standards identified as type 1 – the highest number of these standards met in the organisational checklist was 20/21 and in the casenote audit 14/28 (See page 214 in the full report for more details).

There is wide variation between participating hospitals on key standards. For example, although the data from the total sample of casenotes shows that a nutritional assessment had been undertaken for 70% of patients nationally, the proportion of patients receiving the assessment ranged from 3% to 100% between hospitals.

There is little correlation between the two elements of the core audit, indicating that the presence of a hospital policy or procedure is not a good marker of actual practice. This finding was borne out at the level of individual standards. For example, at hospital level the percentage of casenotes showing that a mental state assessment had been carried out was not significantly different between those hospitals that had a policy specifying the assessment and those that did not. (See in particular the 'Assessment' chapter on page 68 and 'Discharge planning and discharge' chapter on page 145 in the full report).

Summary of results by theme

1. Governance

The theme of governance relates to the set up and running of hospitals and whether the systems and resources an organisation has in place can take into account and meet the needs of people with dementia.

This chapter presents findings from the organisational checklist on key policies, guidelines and resources in the hospital, and from the ward organisational checklist on availability of services at ward level.

- 6% of hospitals had a care pathway in place for people with dementia at the time of audit and 44% of hospitals had a care pathway in development.
- Less than a quarter of hospital Boards/Trust Executive Boards regularly look at information about delayed discharges of people with dementia and only 8% review re-admissions of people with dementia.
- The majority of hospitals had access to intermediate care services that would admit people with dementia. Only 50% of hospitals had direct access to intermediate care which would avoid admission to hospital.
- Access at ward level to specialist service input, such as social services, liaison psychiatry and occupational therapy, was generally available in “office hours” – Monday to Friday during the day, with the important exception of specialist continence services. Availability during evenings or weekends was limited for most services.

The evidence collected showed a lack of leadership both at Trust/Health Board level and at hospital level, in terms of identifying champions and leads, and identifying required resources. Trust Boards/Health Boards require better intelligence and information relating to the admission, care, treatment and discharge of people with dementia to make the necessary improvements to processes and overall governance to consistently deliver a good standard of care throughout the hospital.

2. Assessment

People with dementia admitted to hospital should have a comprehensive assessment of their physical and mental health needs, plus assessment relating to their ongoing care, to ensure the best recovery outcomes and safer discharge. Hospital guidelines or procedures often set out the range of assessments that should be expected. The results of the casenote audit showed that important elements of assessment were not routinely carried out.

- Information collected at hospital level around multidisciplinary assessment for people with dementia shows that:
 - 84% of hospital assessment guidelines/procedures included assessment of functioning (this includes basic activities of daily living, instrumental activities of daily living, activity/exercise status, gait and balance). However, only 26% of casenotes showed that an assessment of functioning had been carried out.
 - 96% of hospital assessment procedures included assessment of nutritional status. However, only 70% of casenotes showed that an assessment of nutritional status had been carried out.
 - 75% of hospital assessment procedures included assessment of mental state. However, only 43% of casenotes showed that a standardised mental status test had been carried out.
 - 96% of hospital assessment procedures included social assessment and 91% reported that assessment includes environmental assessment. However, 72% of casenotes showed a formal care provision assessment, and 65% of casenotes showed a home safety assessment had been carried out.
- 13% of casenotes showed no formal pressure sore risk assessment.
- 19% of casenotes did not show that the patient was asked about any continence needs as part of the assessment.
- 24% of casenotes did not show that the patient was asked about the presence of any pain as part of the assessment.

The findings demonstrate a gap between policy and practice. Adherence to multidisciplinary assessment procedures should be clarified and reinforced.

3. Mental health and liaison psychiatry

People with dementia in hospital require access to specialist mental health services, and these should be provided by a liaison team. The team should be able to provide a response to emergency or urgent referrals as well as routine referrals. The audit organisational checklist collected information about the availability and make up of liaison services.

- 90% of hospitals had access to a liaison psychiatry service, and in most cases this service was provided by a team, rather than a single practitioner.
- Around a third of hospitals who have access to a liaison psychiatry service are able to provide an out-of-hours service during evenings or weekends.

- Casenote audit data showed that patients with dementia referred to liaison psychiatry were often not seen in a timely manner, with nearly a third of urgent referrals waiting over 4 days to be seen.

On discharge from hospital, people with dementia should have ongoing needs, including mental health needs, reviewed and summarised so that appropriate treatment and care can continue to be provided. The audit of casenotes collected information about mental health needs review at discharge.

- Only 28% of casenotes contained summaries of persistent behavioural and psychological symptoms of dementia at discharge.
- Of the total sample, only 6% of people with dementia had their level of cognitive impairment measured on admission and on discharge. This is lowest of all for people who lived in care homes before admission and returned there afterwards – 3% of the total sample, or 8% of those admitted from care homes.

People with dementia are at heightened risk of developing symptoms such as agitation, distress, or behaviour can become aggressive when in hospital. This can be due to the hospital environment, aspects of care, illness or injury, or a downturn in the dementia condition. These symptoms are often collectively known as “challenging behaviour” or “behaviour that challenges”. The NICE guidelines⁵ and the *Common Core Principles*⁴ clearly set out the approach that should be taken, in which the use of medication should be a last resort or when there is immediate risk of harm. The organisational checklist asked about protocols governing the approach to challenging behaviour, agitation and distress and the audit of casenotes collected information about prescription of antipsychotics.

- 34% of hospitals reported having adequate protocols in place for the treatment and management of patients with behavioural and psychological symptoms of dementia leading to challenging behaviour.
- 28% of people with dementia received antipsychotic medication in the hospital. 12% of people with dementia were newly prescribed this medication during this admission to hospital. Reasons for prescription were not recorded in 18% of these cases.
- 30% of people living in care homes and 14% of people living elsewhere were already taking antipsychotics on admission.

Overall the audit shows widespread provision of liaison psychiatry. However, a lack of availability at evenings and weekends is likely to impact on the time taken by services to respond to an emergency or urgent referral. It may also affect ability to carry out assessment or to see patients who require onward referral for diagnosis.

A lack of mental health assessment during admission and at discharge shows that mental health needs are still often overlooked in general hospitals. This needs to be urgently addressed as a clinical governance issue. In particular, hospitals should look at anticipating challenging behaviour and ensure that it is managed with awareness and understanding, ensuring that guidelines and protocols are reviewed and updated and training for staff is in place. Where antipsychotic medication is prescribed, a reason should be clearly recorded and all medication should be reviewed regularly. Equivalent attention should be given to people with dementia living in care homes in review and assessment.

4. Nutrition

The importance of improving nutrition in hospital, particularly for older or more vulnerable patients, has been highlighted in many reports. The audit of casenotes found that people with dementia had not always received a nutritional assessment, and that systems in place to aid people with eating and drinking were not always adequately resourced.

- 96% of hospitals have a procedure for multidisciplinary assessment which includes nutritional assessment. However, only 70% of the casenotes in the sample included this assessment, and only 63% of these casenotes had a record of the patient's weight.
- 92% of hospitals have established protected mealtimes, and 97% of wards audited said that this was in place. However, only 74% of wards have a system to ensure staffing levels are sufficient at mealtimes to aid people with dementia to eat and choose food if necessary.
- 93% of wards could provide food between mealtimes, and 66% of staff agreed the ward can provide meals and snacks to patients at any time.
- Nearly all hospitals had access to specialist assessment and advice on helping patients with dementia in their swallowing and eating.

The audit results suggest much could be done at hospital level and ward level to improve nutritional standards, including providing standardised assessment, and recording of weight over time; providing support to assist patients at mealtimes; making food available at other times; and ensuring full implementation of protected mealtimes (i.e. allowing carers or family to assist but not allowing interruption for clinical or care purposes).

5. Information and communication

The theme of information and communication arises throughout the audit. Involvement of carers in this process and the ability of the hospital to use personal information to provide better care were identified as priority topics for patients and carers. The organisational checklist looked at procedures in place to collect and communicate key information and the audit of casenotes looked at information collected. At ward level, wards were asked about information provision and staff were surveyed about the use of personal information and ward contacts for families and carers.

- 40% of hospitals had a clear procedure for information sharing with families and only around half of hospitals were found to have guidelines for the involvement of families for discharge and support arrangements.
- 88% of wards in the enhanced audit had a system for communicating personal information about patients with dementia.
- 43% of the casenotes had a section dedicated to collecting information from a carer, friend or relative, and around 40% of the casenotes were organised so that information about the person's dementia and about care and support needs could be quickly found in a specified place.
- Only 24% of casenotes contained information about factors that might cause distress to the person with dementia.
- 92% of wards could provide information on what to expect in hospital and almost all of the wards made patients and carers aware of the complaints procedure.
- 61% of wards said a responsible healthcare professional was identified to the family as a contact for help and information, but only 45% of staff reported that patients are allocated a named professional as a contact.

There is clearly a lack of guidance in hospitals for the involvement of families in discharge and support arrangements, and this is related to the findings that families are not routinely involved in the care of the patient with dementia and are often not given a named healthcare professional to contact for help.

Although it is reported at ward level that there are systems for recording and communicating some basic personal information about patients with dementia to help them feel more settled in hospital, the collection of this information does not form a systematic part of the patient's assessment. Of particular note is the fact that patients' families or carers are not asked about behaviours that may indicate distress or what strategies may be useful in helping the patient feel safe and calm. If this information was readily available to the clinical team it could reduce the incidence of untoward behaviour disturbance and avoid the need for prescriptions of antipsychotic medication.

More clarity is needed on the purpose and use of personal information. Hospitals need clear guidelines on the information that should be collected, and on supporting staff to share and use information and involve carers appropriately, according to the best interests of the person with dementia.

6. Staff training

The ability of staff members to engage with people with dementia, to provide clear information and understand how to deliver care in the way most suited to the person with dementia, can ensure that care is provided consistently and can lead to a qualitatively different experience of care (see chapter 10, page 153 in the full report). Awareness and understanding of dementia shown by the frontline staff providing daily care was identified as a priority for patients and carers. The organisational checklist audit found that training frameworks and strategies to address essential skills were not generally in place, and staff responses also pointed to deficiencies in training.

- Only 5% of hospitals had mandatory training in awareness of dementia for all staff, and 23% of hospitals had a training and knowledge framework or strategy identifying the necessary skill development in working with and caring for people with dementia.
- 32% of staff said they had sufficient training/learning and development in dementia care, including awareness training and skills based training.
- 26% of hospitals had a training strategy specifying that staff working with people with dementia are trained to anticipate challenging behaviour and are taught how to manage violence, aggression and extreme agitation, including de-escalation techniques and methods of physical restraint. Less than half the staff surveyed said they had sufficient learning and development/training in these areas.
- 23% of hospitals had a training strategy specifying that staff of all grades and disciplines have access to communication skills training involving older service users. Half the staff surveyed said they had sufficient learning and development/training in this area.
- Training in person-centred care was felt to be sufficient by 67% of staff, and about one half of staff said training in involving people with dementia and their carers in decisions on care and treatment was sufficient.
- 66% of staff said they had sufficient training/learning and development in introduction to adult protection policy and procedures. However, less than half the staff said they had sufficient training or learning and development in the Mental Capacity Act and in how to assess capacity.
- Most staff from all job roles agreed that further training would be beneficial and would improve the level of care received by people with dementia.

The number of staff agreeing on the need for further training in relation to awareness of dementia was striking. The data and comments on training received in particular aspects of care reveal that further training is needed across all job roles for a range of competencies related to the care of people with dementia.

7. Staffing and staff support

The provision of essential care to patients in general hospital wards requires a level of staffing which is determined by an assessment of the general level of care and support need on the ward, combined with information on qualification and skill mix, numbers of staff per occupied bed, unfilled posts and turnover, sickness and absence. The audit collected data about the numbers of staff (whole time equivalent) per 10 beds and about the ratio between registered nurses and healthcare assistants, and also asked ward staff about their experience in terms of whether they felt there was enough staff to provide for the patients in their care.

- Variations across wards in relation to both staffing numbers and skill mix indicate a lack of consistency in the determination of staffing levels.
- 93% of wards have a system to ensure minimum staffing levels are in place. However, less than a third of staff considered staffing was sufficient to meet patient needs.
- 99% of hospitals had a recognised system to record potential risk to patient care due to insufficient staffing numbers. Around half the staff felt that the system deals with reports in a timely way.
- Over 90% of registered nurses and healthcare assistants had access to mentorship and appraisal. Clinical supervision is provided less consistently with 60% of wards offering this to registered nurses, but less than 40% of wards providing this support for healthcare assistants.

It is important that a systematic approach is taken to assessing ward staffing requirements suitable to meet the needs of patients. For wards admitting people with dementia this should include consideration of the time and attention necessary for care. Also key to supporting staff in their caring role is providing leadership via key roles such as Dignity Leads and Dementia Champions, and ensuring access to mentorship, supervision and appraisal.

8. Physical ward environment

An environment which helps people with dementia to orient themselves to their surroundings and guide themselves around the ward can provide reassurance, help maintain independence and avert distress. The environmental checklist audited important aspects of the environment in participating wards relating to the care experience for people with dementia.

- 56% of wards stated that patients with dementia are able to see a clock from their bed area, but only 5% of wards stated patients were able to see a calendar from their bed area which would help improve orientation.
- 56% of wards reported that information (words and pictures) on signs is in clear contrast to the background, and 38% of wards reported that signs/maps are large, bold and distinctive.
- 15% of wards use colour schemes to help patients with dementia find their way around the ward.
- Large toilets and bathrooms allowing for assistance were provided in most wards and there was also a choice of bathing facilities available.
- Space for patients with dementia to walk around was available in 69% of wards. Rooms or designated areas providing a break from the ward environment were only available in 47% of wards.
- 59% of wards reported that personal items were not always situated where the patient could see them at all times.
- Flooring that may cause confusion for people with dementia, such as busy patterns or high gloss surfaces, seems to be avoided in most hospital wards.

In terms of the physical environment, attention to orientation both in the ward (signage, use of colour) and the bed area (positioning of familiar personal items) could improve the experience of people with dementia. Use of space to provide breaks from the ward environment could also contribute, as on busy wards people experiencing confusion may have no opportunity to escape noise and bustle. Evidence from observations of care also suggested that attention to noise and creating a warm, friendly atmosphere are important considerations in the care of people with dementia.

9. Discharge planning and discharge

Attention to the discharge process is essential to ensure safe discharge with the appropriate ongoing care and support for people with dementia. The organisational checklist looked at discharge policies and organisation, and the audit of casenotes looked at discharge planning carried out for the sample of patients with dementia.

- 94% of hospitals have a commitment to begin planning for discharge within the first 24 hours of admission, but in about half of the audited casenotes this had not taken place, and it was not possible to specify a reason.
- Around half of the casenotes audited stated a named discharge co-ordinator, with responsibility for managing the process and consulting with all relevant parties, was involved in the discharge process.

- 67% of casenotes contained an up-to-date discharge plan and 58% of casenotes showed evidence that any support needs had been identified in the discharge plan. Only 41% of casenotes stated that a copy of the plan had been passed on to patients or carers.
- 75% of casenotes recorded that an assessment of the carer's current needs had taken place before discharge, and 80% of casenotes showed evidence that the place of discharge and support needs had been discussed with the carer/relative.

It is encouraging that the majority of casenotes show evidence of attention to the carers' needs, and that most showed involvement of the carer when discussing discharge and support. However, it is less encouraging that in half the casenotes discharge planning had not begun at admission, for no stated reason. There was no named co-ordinator of discharge in the same proportion of casenotes. Providing a copy of the discharge plan to the person with dementia or carer is important to ensure that discharge discussions are understood.

Early discharge planning is important to facilitating timely discharge and lessening the time spent by the person with dementia in the acute environment and could also produce savings in cost. The Alzheimer's Society has calculated that savings in excess of £80 million could be produced if the length of stay for people with dementia in hospital was reduced by one week.²

10. Observations of care – Person, Interaction and Environment (PIE)

The review of aspects of care prioritised by older people and carers emphasised the importance of care which is person centred – treats the person with dementia as an individual and takes into account their perspective within a supportive environment. This guided the content of the observational tool. Person, Interaction, Environment represent the elements of knowing and using information about the patient as a person in care, the quality of staff-patient interaction, and the effect of the immediate environment. The observations for this audit were carried out in each case by staff from the hospitals in which participating wards were situated. The overall finding from ward observations is that care and communication is generally reactive and based on an organisationally set, task-driven routine rather than being person-focused, flexible and proactive.

- On most hospital wards there is little evidence of a person-centred ward approach or 'culture', or that the care received by patients is generally person-centred.
- The content of the staff/patient encounter is mainly task related and delivered in a largely impersonal manner.

- There are periods of care-based activity interspersed with inactivity, leading to lack of attention, lack of stimulation and boredom for patients.
- The environment is often impersonal and not dementia friendly, with excess noise at times, and a lack of orienting cues, dementia aids or areas for socialising.
- There is inconsistency in the quality of communication. People with dementia experienced differences in the approach of individual staff members, or between groups of staff (such as pharmacy/housekeeping) or both. In some cases, some elements of care delivery were positive (explanations and information were consistently given to patients) while other elements of care delivery in the same ward were clearly not (staff not knowing the patient as a person, for example, using the name by which the patient preferred to be addressed, or allowing time to communicate).

“Pockets” of positive, person-centred care were found in the practice of individual staff members, or as elements of ward practice. Only a handful of wards (5/105) reported ward practice which was person-centred more often than not.

- No one hospital submitted data where **all** the participating wards were clearly described as being person-centred. This suggests that there is no evidence that wards which are more person-centred are sharing their approach across the organisation and, conversely, there is no evidence of an effective organisational system for implementing person-centred care in place in any one hospital.
- Ward type was not related to the quality of care delivery observed. Many hospitals had similar findings across all their participating wards while many others observed some key differences (suggesting both hospital and ward leadership factors come into play).
- The observers clearly articulated that all staff and staff groups need to be engaged more positively with patients. However, a whole ward team organisational approach is required – individual staff cannot by themselves provide a person-centred care experience for patients.

It is apparent that there is considerable scope to develop and enhance person-centred care for people with dementia. The aim should be to initiate a progression from the currently dominant culture of task based care to one in which there is an integral focus on the person. Taking a proactive approach and having a timely and attentive response to people with dementia also means that their discharge is likely to be more appropriately facilitated, impacting on costs, as identified by the Alzheimer’s Society².

Recommendations

Recommendations for National Clinical Directors for Dementia and Older People (England)/ Medical Director and Nurse Director (NHS Wales)

1. The National Clinical Directors for Dementia and for Older People (England) should promote the development of an overall competency framework to ensure that guidance on staff training contained in the *Common Core Principles*⁴ is implemented across all secondary care settings. In addition to providing 100% of staff with basic dementia awareness training and updates, local frameworks should promote and evidence enhanced and specialist levels of knowledge, e.g. that 50% of front line workers should have or be working towards, enhanced knowledge of dementia care, and that 10% of front line workers should have or be working towards specialist knowledge. The Medical Director and Nurse Director for NHS Wales should promote development of a framework along similar lines in secondary care settings to support and enable the pathway/interventions set out in 1000 Lives Plus.
2. The National Clinical Directors for Dementia and for Older People (England) should ensure the *Common Core Principles*⁴ and NICE guidance⁵ on the use of antipsychotic medication is disseminated to general hospitals and that there is a process that separately audits prescribing in general hospitals. A period of treatment in hospital should be highlighted as an appropriate point for reviewing any use of antipsychotic medication. The Medical Director of NHS Wales should ensure that the review targets for psychotropic medication set out in 1000 Lives Plus are fully addressed in secondary care settings.

Recommendations for the Department of Health/Welsh Government Department for Health, Social Services and Children, General Medical Council and Nursing and Midwifery Council

1. The Department of Health, Welsh Government Department for Health, Social Services and Children, NHS Estates, and NHS Wales Shared Services Partnership, should provide guidance on dementia friendly ward design, to be incorporated as standard into all refurbishments and new builds, including safe walking spaces and the use of colour, lighting, signage, orientation cues and space used to promote social interaction.
2. The General Medical Council and Nursing Midwifery Council should develop appropriate curricula for enhanced and specialist skills in dementia care, including requirements in undergraduate & postgraduate medical and nursing curricula.

Recommendations for Professional Bodies

1. The Royal College of Physicians, the Royal College of Psychiatrists and the British Geriatrics Society should recommend brief screening tools for cognitive function and delirium for the assessment of people with dementia and older people in the general hospital.
2. The Royal College of Nursing should provide guidance to Trusts/Health Boards on how staffing levels should be determined, including consideration of measures of acuity and dependency sensitive to the care of people with dementia.
3. The Royal College of Physicians with the British Geriatrics Society should recommend brief tools for the standardised assessment of functional ability and for the assessment of pain in people with dementia. The Royal College of Physicians and the British Geriatrics Society should liaise with other Royal Colleges about including these assessments in the management of surgical patients and others.
4. The Royal College of Psychiatrists, Royal College of Nursing, Royal College of Physicians with the British Geriatrics Society, should provide guidance on any circumstances in which PRN (as required) prescription of antipsychotics is appropriate.

Recommendations for Commissioning Boards/Health Boards

1. Commissioning Boards/Health Boards should ensure that liaison psychiatry services are in place to provide adequate access over 24 hours for treatment and referral of people with dementia in hospital. This should include the ability to provide an emergency or urgent response⁶. Response times to referral should be a key performance indicator for these services.

Recommendations for the Trust Board/Board of Governors/Board of the Health Board

1. The Trust Board/Board of Governors/Board of the Health Board should ensure that review of key policies and procedures include the needs and perspective of people with dementia is undertaken, requiring the following as evidence:
 - Clinical information on admission rates, falls, treatment and discharges, in which people with dementia can be identified;
 - The appointment of a Senior Clinician Lead for Dementia with designated time in their job role to develop, implement and review the dementia pathway;

- Information from a local sample of casenotes of people with dementia tracked through admission, demonstrating adherence to the pathway;
 - Measurement of nutritional status (weight and BMI) at admission and discharge for people with dementia;
 - Evidence of measures of frequency of assessment for pressure sore risk and pain for people with dementia;
 - Measures of cognitive functioning and delirium at admission for people with dementia;
 - Evidence from audit of in-hospital prescription of antipsychotics that prescription is in line with guidance.
2. Trusts should consider including this information in their Quality Accounts. Health Boards should consider including this information in their Quality and Safety Committee Reports.

Recommendations for the Chief Executive

1. The Chief Executive Officer should ensure that the Trust/Health Board identifies a Senior Clinician in each hospital to take charge of developing, implementing and monitoring the care pathway for dementia.
2. The Chief Executive Officer should ensure that it is within the remit of the senior clinician to identify Dementia Champions in each department in the hospital and at ward level.
3. The Chief Executive Officer should ensure that key leadership roles and support from specialist staff are in place to ensure delivery of dignified, skilled and compassionate care, for example Dignity Leads, Dementia Champions, Older People's Nurse Consultants.
4. The Chief Executive Officer should review policies and procedures in place to ensure that they clearly set out guidance for interventions for challenging behavioural and psychological symptoms of dementia in line with NICE guidance. In-hospital prescription of antipsychotics should be routinely audited for clear indicators that prescription is in line with guidance and this information should be presented to the Trust Board/Board of the Health Board.
5. The Chief Executive Officer should ensure that non-reporting of nutritional status, missed meals or other risk to nutrition is considered a safeguarding issue for people with dementia and reported in accordance with guidance.

6. The Chief Executive Officer should review Trust/Health Board discharge policies with particular reference to the needs of people with dementia/their carers to ensure that they describe the task of discharge co-ordination, and the importance of carer assessments.
7. The Chief Executive Officer should ensure that notification of discharge is a routinely collected statistic for reporting to the Governing/Executive Board/Board of the Health Board. This should be presented as the percentage of discharges of people with dementia where less than 24 hours notice has been given/divided by all discharges of cases receiving less than 24 hours notice (unscheduled care).
8. The Chief Executive and Trust Board/Health Board should promote the role of public/patient governors and non-executive directors (Independent Board Members in Wales) in reviewing the environment and comfort for people with dementia on the wards. Reviews could make use of a checklist of standards and feedback from patients, carers and visitors and include looking at placement of signs, availability of personal items, and the quality of the food.

Recommendations for Directors of Nursing and Medical Directors

1. The Director of Nursing should require Ward Managers to carry out an assessment of staffing levels required to support mealtimes, including assessment of the additional support needs of people with dementia, and Ward Managers should review this on a regular basis.
2. The Medical Director, Director of Nursing and Head of Therapy Directorate should ensure the provision of education and training to support the routine use of the MUST tool (or alternative recommended nutritional assessment tool) and monitoring nutritional intake must be provided to all staff, including Healthcare Assistants.
3. The Medical Director, Director of Nursing and Head of Therapy Directorate should ensure that all staff responsible for the assessment of older people have had training in the assessment of mental state using standardised measures.
4. The Medical Director, Director of Nursing and Head of Therapy Directorate should develop the training and knowledge strategy such that all staff are provided with basic training in dementia awareness and a locally agreed and specified proportion of ward staff receive higher level training.
5. The Director of Nursing should make sure that comprehensive systems for guidance, supervision and support are in place for staff on the ward caring for people with dementia, including:

- supervision, mentorship and appraisal for registered nurses and healthcare assistants;
- access to peer support and reflective practice groups.

Ward managers should be supported to ensure that these systems for support are available to all nursing staff.

6. The Director of Nursing should ensure ward managers are given responsibility and support to promote mealtimes as a social activity and provide appropriate equipment and an engaging environment, e.g. music, group tables or seating, use of familiar types of crockery and vessels.

Recommendations for the Senior Clinical Lead for Dementia

1. The Senior Clinical Lead for Dementia should ensure that the hospital has a care pathway in place for dementia that is adaptable for use within or fitted to existing acute care pathways, with the aim of making sure that the acute care and treatment provided by the hospital takes account of the needs of people with dementia at each stage of admission.
2. The Senior Clinical Lead for Dementia should ensure that champions represent the range of job roles working with people with dementia including those staff involved in day-to-day care provision.
3. The Senior Clinical Lead for Dementia should ensure that a named healthcare professional acts as a point of contact for people with dementia and their families during the admission to hospital. The named healthcare professional should ensure that the family, next of kin or appointee is involved in the care plan and in decisions about discharge.
4. The Senior Clinical Lead for Dementia should put in place procedures for clinical teams to follow to ascertain how the patient's next of kin should be involved in treatment decisions. This should take into consideration mental capacity, stated wishes and best interests decisions (as defined under the Mental Capacity Act)*, and should be communicated to the ward team and to the family carer.
5. The Senior Clinical Lead for Dementia should ensure that a personal information document (e.g. "This is Me"³) is in use throughout the hospital. This should be completed with the help of someone who knows the patient well. The document should include information such as the patient's preferred name; routines and preferences; whether the person needs reminders or support with personal care; recurring factors that may cause or exacerbate distress; support or actions that can calm the person if they are agitated. This document should be held in the

* www.bestinterests.org.uk

patient's notes as well as by the bed so that it is readily accessible to all those involved in the patient's care.

6. The Senior Clinical Lead for Dementia should implement systems of good practice to ensure that staff can identify people with dementia on the ward/during care and treatment and can provide an appropriate response to their needs (e.g. "Butterfly Scheme")*.

Recommendations for Ward Managers and Dementia Champions

1. Ward Managers should highlight to their teams the importance of involving people with dementia and their carers (where applicable) in discussions on care, treatment and discharge.
2. Ward Managers should ensure that all those involved in supporting people with dementia at mealtimes, including staff and volunteers, are provided with training or are skilled in recognising swallowing problems, the use of equipment and aids and encouraging nutritional/hydration intake.
3. Ward Managers should ensure that nutritional snacks and finger foods are readily available at mealtimes and between mealtimes on wards so that people with dementia are provided with options to enable them to maintain nutritional intake.
4. Ward Managers and Dementia Champions should ensure that simple and effective improvements to the environment are promoted in all wards admitting older people, including:
 - appropriate lighting and floor coverings plus aids to support orientation and visual stimulation¹;
 - personalising bed area;
 - adequate space and resources to support activity and stimulation.

Recommendations for Mental Health Providers

1. Mental health providers should self-assess their policies and practice of liaison teams and report to commissioners on equality of access for people with dementia.

* www.butterflyscheme.org.uk

Recommendations for the National Audit of Dementia Project Team

1. The National Audit of Dementia Project Team should seek to identify key examples of good practice in information provision and sharing with people with dementia and their carers.
2. The National Audit of Dementia Project Team should assess whether current provision for staff training is in line with recommendations made in Common Core Principles⁴ in the 2012 re-audit.

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Royal College of Psychiatrists' Centre for Quality Improvement
4th Floor • Standon House • 21 Mansell Street • London • E1 8AA

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