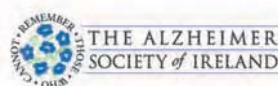




Report of the Irish National Audit of Dementia Care in Acute Hospitals 2014

The
ATLANTIC
Philanthropies





Report of the
Irish National Audit of
Dementia Care in
Acute Hospitals 2014

Report Prepared by

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On behalf of

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Report Authorship and Governance

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The audit was jointly funded by Atlantic Philanthropies and the Meath Foundation.

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Foreword

The design and delivery of care in our acute hospitals predates our evolving understanding that older people, and in particular those with dementia and delirium, are proportionately the key groups that they serve. This is reflected in a current focus on acute illness, with relatively little adaptation for cognitive impairment, multiple illness and frailty. The environment is clinical, sometimes sterile, and the systems are designed to promote efficient and cost-effective care. Those not affected by cognitive impairment who are admitted to hospital can adapt to the rigid routines and complex interactions in hospital, where a patient may be bombarded with questions, meet multiple new staff members each day, and be given large amounts of complex new information to take on board, not to mention the possibility of extensive tests, high noise levels, and sometimes, sleep deprivation.

But a person with dementia may not be able to adapt to this environment, particularly when unwell, and may find it frightening and confusing. The person with dementia may become anxious, more confused, and less able to be independent in activities of daily living. Investing in staff training, resources and good design can improve the experience for the person with dementia and their family, and is likely to result in a speedier and more effective transition from the community to hospital and back again. However, it has not been clear to what extent such a vital investment has been made in the Irish hospital system.

Following in the footsteps of other countries such as England, Scotland, Northern Ireland, Norway and Australia, the Irish government has acknowledged the need to make dementia a priority in terms of policy at this time. In recognition of the growing number of people with dementia in Ireland, and the consequent need for guidelines and standards to be put in place around dementia, the Department of Health has committed, under the Programme for Government, to the development of a National Dementia Strategy, which will be published in 2014.

This report contains the findings of the first national audit of dementia care in Ireland's acute hospitals (INAD), performed from April to September 2013, jointly funded by Atlantic Philanthropies and the Meath Foundation. Recommendations from this report have been submitted for inclusion in the National Dementia Strategy.

This audit has found a large number of areas where changes are necessary to improve the quality of dementia care in Irish hospitals. However, some inspiration can be drawn from the fact that the quality of dementia care in acute hospitals in Ireland is generally on par with the quality of care found in the baseline audit of dementia care in acute hospitals in the UK, performed in 2010. The second round UK audit in 2012 found significant improvements as a result of the findings and recommendations of the baseline audit. It is our vision that the findings and recommendations of this audit will make a similar impact on the quality of dementia care in acute hospitals in Ireland.



Dr. Suzanne Timmons



Prof. Desmond O'Neill

Co-chairs of the Steering Group of the Irish National Audit of Dementia

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Executive Summary

Background

National and international research confirms that an admission to an acute hospital can be distressing and disorientating for a person with dementia, and is often associated with a decline in their cognitive ability and levels of functioning around activities of daily living (Cunningham, 2006; Covinsky et al., 2011). In recognition of the need to increase awareness and enhance services for people living with dementia in Ireland, the Department of Health and Children are currently developing the Irish National Dementia Strategy, due to be published in 2014.

In response to the need for more Irish data on dementia care in acute hospitals, the first Irish National Audit of Dementia care in acute hospitals (INAD) was undertaken in 2013 to measure criteria relating to care delivery known to impact on people with dementia admitted to hospital. The results from this audit have fed into the development of the Irish National Dementia Strategy.

The INAD project represents a joint initiative between The Centre for Gerontology and Rehabilitation, University College Cork; The Centre for Ageing, Neuroscience and the Humanities, Trinity College Dublin; and the HSE Quality and Patient Safety Directorate, and is funded by Atlantic Philanthropies and The Meath Foundation. The project is overseen by a multidisciplinary steering committee and advisory group.

Methodology

As there are no dementia specific standards in place in Ireland for dementia care in acute hospitals, the audit measured current practice against international best practice guidelines. The audit tool was adapted from the first National Audit of Dementia Care in general hospitals in the UK, with the kind permission of the Healthcare Quality Improvement Partnership (Royal College of Psychiatrists, 2011).

All 35 acute public hospitals that admit adults with known or suspected dementia were included in the audit (Appendix A). In order to capture a comprehensive picture of dementia care policies and practices, four audits were conducted in each hospital.

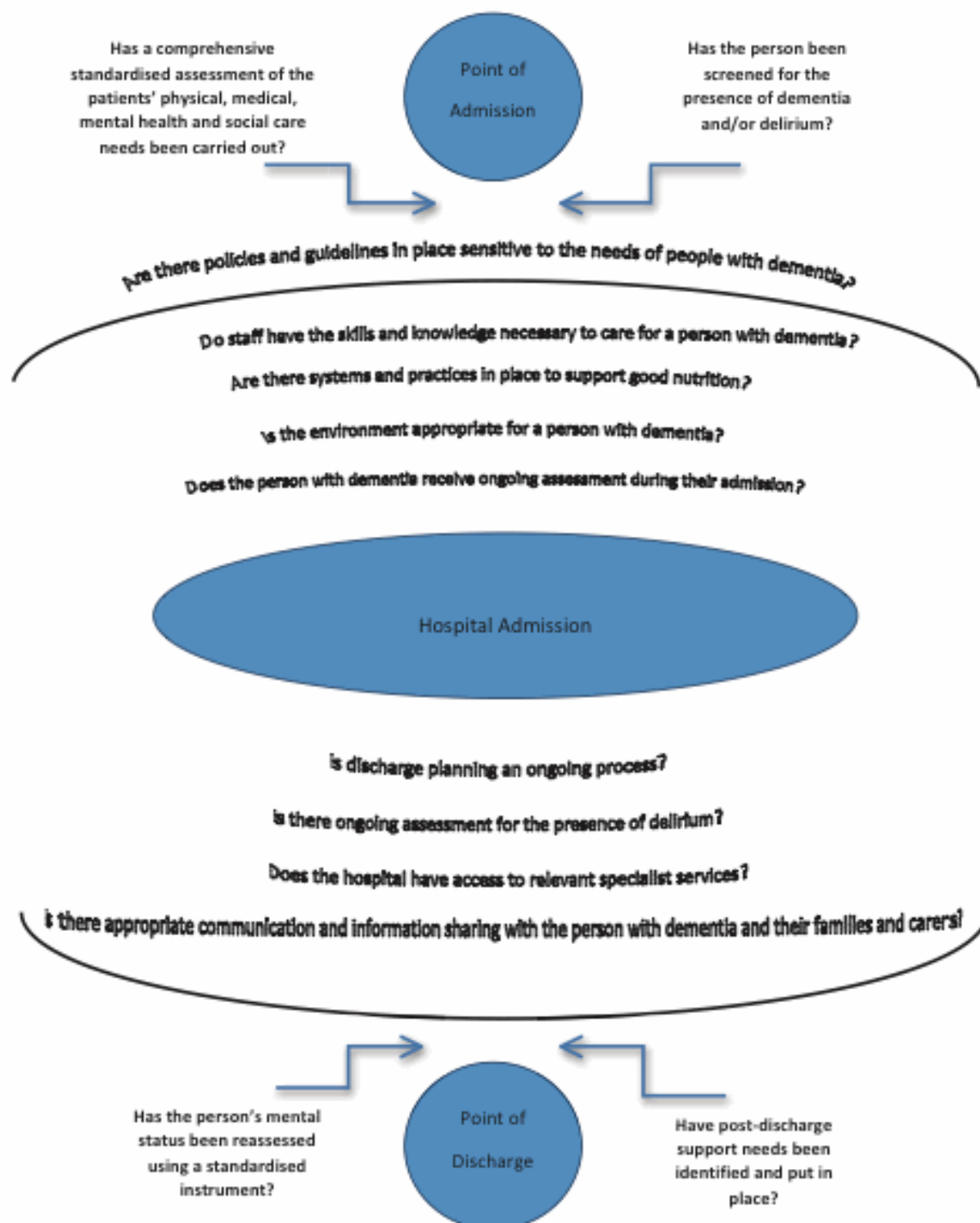
- I. The Organisational Audit collected data on dementia-related policies, protocols, structures, processes and key staff that impact on service delivery for people with dementia. Data was

collected through interviews with Hospital Managers/Chief Executive Officers, Directors of Nursing and/or Geriatricians.

- II. The Healthcare Record Audit examined 20 healthcare records (HCRs) in each hospital. The audit collected data on assessments carried out on or during admission, discharge planning and coordination, and referral to specialist services. The majority of hospitals (76%) were audited by independent auditors, while 24% self-audited their HCRs.
- III. The Ward Organisational Audit collected information on staffing, services available and systems/structures to support the person with dementia. Two to three medical, surgical or orthopaedic wards were selected in each hospital for audit. Data was collected through interviewing the ward managers on selected wards.
- IV. The Environmental Audit collected information on aspects of the wards' physical environment which are known to impact on people with dementia. Ward environmental audits were carried out by the INAD Project Coordinator and INAD Research Assistant.

All data was collected between April and September 2013. Data from all four audits were combined and are reported under ten headings below; Governance, Assessment, Mental Health and Liaison Psychiatry, Nutrition, Information and Communication, Staff Training, Staffing and Staff Support, Physical Ward Environment, Discharge Planning and Discharge, and Palliative Care. In all cases valid percentages are presented, i.e. missing data is excluded from the calculation. Unless otherwise specified, all variation in denominator values are due to missing data.

Audit Summary





Key Recommendations

The findings from the audit resulted in 47 detailed recommendations to ensure policies and practices in the acute care setting are appropriate for the care of a person with dementia. These recommendations are listed by theme on pages 22-26 of the Executive Summary. Below are six key recommendations;

1. Each acute hospital has responsibility for developing a training and knowledge strategy to ensure that all staff are provided with basic training in dementia awareness, and a locally agreed specified proportion of ward staff receive higher level training (including dementia champions).
2. Liaison Psychiatry, Liaison Psychiatry of Old Age, and Geriatric Medicine services should be in place in all acute hospitals to provide access for the treatment and referral of people with dementia. These services should have a named consultant providing the liaison service who has dedicated time in his/her job plan for the provision of same. Response times to referral should be a key performance indicator for these services.
3. Based on evidence from best practice, each hospital should develop and implement policies and systems for the prevention, identification and treatment of delirium.
4. An assessment of mental status should be an integral part of the acute admission of people with dementia, utilising standardised assessment tools and collateral history. All staff responsible for the assessment of older people need to have training in the assessment of mental status using standardised measures.
5. A period of treatment in hospital should be highlighted as an appropriate point for review by an appropriate expert of any use of antipsychotic medication. Guidelines currently being developed by The College of Psychiatrists of Ireland will provide guidance on the use of antipsychotics and the circumstances in which prescription of antipsychotics is appropriate.
6. National guidelines on dementia friendly ward designs should be developed, to be incorporated as standard into all refurbishments and new builds. At ward level managers and dementia champions should ensure that simple and effective improvements to the environment are made to all wards admitting adults, including appropriate signage and visual aids to support orientation and continence and adequate space and resources to support activity and stimulation.



Summary of Results by Theme

Governance

The theme of governance relates to whether the policies, guidelines and systems in place in a hospital take into account and are sensitive to the needs of people with dementia. The organisational audit collected data on hospital policies, guidelines and resources available to support high quality person-centred dementia care. The healthcare record (HCR) audit identified trends in demographics and length of stay.

- 94% of hospitals (33/35) have no dementia care pathway in place.
- 6% of hospitals (2/34) could identify people with dementia when reviewing readmissions and 38% (13/34) could identify people with dementia when reviewing delayed discharges/transfers.
- The majority of wards can provide access at least five days a week to specialist services such as Liaison Psychiatry, Geriatric Medicine, Occupational Therapy, Physiotherapy, Specialist Infection Control and Specialist Palliative Care. There is more limited access to Psychiatry of Old Age, Specialist Continence Services, Psychology and Social Work Services.
- 35% (128/363) of people with dementia who were admitted from home were discharged to long-term residential care while 45% (164/363) of people with dementia who were admitted from home were discharged home.
- There was variation in the average length of stay depending on place of admission and place of discharge:
 - The average length of stay for a person with dementia admitted from and discharged to their home was 22 days
 - The average length of stay for a person admitted from home and discharged to a nursing home was 59 days
 - The average length of stay for a person admitted from and discharged to a nursing home was 17 days.

The findings indicate that current reporting and review structures could be used more effectively to monitor appropriateness of hospital policies and systems for people with dementia. In order to ensure the needs and voice of patients with dementia are heard and taken into consideration, hospital management teams need to develop dementia specific pathways of care and appoint appropriate personnel to lead dementia care in the acute hospital. Findings also indicate a need for more supports, resources and integrated care planning with community agencies and services.

Assessment

A comprehensive assessment of physical, mental health and social care needs is essential to ensure best outcomes for the person with dementia. While many hospitals have guidelines in place for comprehensive assessment procedures, the healthcare record (HCR) audit indicated that many assessments are not routinely carried out.

- 76% of patients (496/656) had a problem list recorded in their HCR, 87% (570/657) had current medication recorded and 96% (633/658) had comorbid conditions recorded.
- 62% of hospitals (21/34) reported that a standardised assessment of functioning was carried out on all patients, though only 36% of patients (236/653) had a standardised assessment of functioning recorded in their HCR.
- 63% of hospitals (22/35) reported that the multidisciplinary assessment includes a routine assessment of mental status, though only 43% of patients (283/658) had a standardised mental status test recorded in their HCR.
- 30% of patients (196/659) had an assessment for recent changes or fluctuations in behaviour that may indicate the presence of delirium.
- 14% of patients (64/468) had their level of cognitive impairment summarised and recorded at discharge, 24% (47/194) had symptoms of delirium (where present) summarised for discharge, and 27% (37/139) had persistent behavioural and psychological symptoms of dementia (where present) summarised and recorded at discharge.
- Many hospitals reported no access, or inadequate access, to social workers.

The results suggest that while there are reasonably high levels of medical and functional assessments being carried out, more consistent assessments ought to be performed and recorded to ensure patients are appropriately monitored and the most positive outcomes possible are identified and achieved. There is evidence of a lack of comprehensive assessment of mental status to detect depression, delirium and worsening in dementia status. The importance of including relevant mental health information at discharge needs to be highlighted to all staff involved with discharge, given the higher risk for accelerated cognitive decline with a pre-existing dementia, and the risk of recurrence for those who develop delirium.

Mental Health and Liaison Psychiatry

People with dementia have particular mental health needs and during an acute admission may require access to specialist mental health services. Routine assessment, monitoring and review are necessary to ensure mental health needs are appropriately responded to and managed.

- All hospitals reported having access to liaison psychiatric services, while 71% of hospitals (25/35) reported they can provide access to a liaison psychiatry of old age service.
- There is variation between hospitals in how these services are structured and delivered.
- In many hospitals, psychiatry of old age services are being delivered by community-based services, who are not formally commissioned to deliver a liaison service to the acute hospital.
- 32% of hospitals (11/34) have 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.
- 41% of patients (271/656) had an antipsychotic medication administered at some point during their admission.
- 46% of patients (100/216) admitted from a nursing home and 19% of patients admitted from home were already prescribed antipsychotic medication.
- 16% of patients (109/657) were given a new regular prescription for antipsychotic medication.

The results indicate the need for more consistent provision of liaison psychiatry of old age services nationally as many hospitals have inadequate access to specialist mental health services for older people. There is also a need for guidelines to be developed and implemented on the use of restraint and promoting restraint-free environments in acute hospitals. The relatively high use of antipsychotics indicates a need for improved review and monitoring of the use of antipsychotics in the acute setting.

Nutrition

Good nutrition and hydration are essential for wellbeing and for recovery from illness, surgery or accident. People with dementia often face particular challenges in maintaining adequate nutrition and hydration. It is therefore essential that adequate systems for monitoring and promoting good nutrition practices are in place in the acute setting.

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- 76% of patients (496/651) had a nutritional assessment recorded in their HCR, though only 39% (259/658) had their weight or BMI recorded.
 - 50% of hospitals (17/34) have protected mealtimes on all wards that admit adults with known or suspected dementia. Wards' adherence to protected mealtimes is reviewed and monitored in 27% of hospitals (9/33).
 - 35% of wards (27/77) have a system in place to signal the need for increased assistance with eating.
 - 92% of wards (71/77) can provide food to patients between mealtimes.
 - 20% of wards (15/77) have opportunities for patients to socially interact at mealtimes.
 - 94% of hospitals (33/35) reported having access to specialist assessment and advice on helping patients with dementia in their swallowing and eating.

The findings indicate that there is good awareness of the importance of nutrition at ward level, though there is a need to improve monitoring and recording of weight/BMI. Protected mealtimes have been introduced in half of hospitals, though many hospitals reported facing a number of challenges in the implementation of this system. There is an opportunity for hospitals to capitalise on the nutrition initiatives being implemented across the country by sharing best practice and learning. The lack of standardised instruments to measure dependency, combined with reduced staffing levels, may impact on the ability of staff to ensure all patients are given the support they need to eat at mealtimes. Hospitals reported good access to specialist services.

Information and Communication

Good information sharing and communication with the person with dementia, families and carers is a key aspect of person-centred dementia care. The organisational audit looked at procedures and guidelines in place for collecting appropriate information, while the HCR audit examined what information was collected and recorded. Information and communication systems at ward level were also identified.

- 30% of hospitals (10/33) have guidelines asking the carer about their wishes and ability to provide care and support to the person with dementia post discharge.
- 6% of hospitals (2/34) have clear guidelines on making sure the carer knows what information will be shared with them and why, while 27% of wards (21/77) reported they discussed with carers and the person with dementia when personal and healthcare information would be shared with carers.

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- One hospital (1/35) has a form dedicated to collecting information about the person with dementia from a carer or relative.
 - 99% of wards (76/77) identified handover as the system used for communicating appropriate personal information and any behavioural or communication needs specific to the person with dementia.
 - 79% of wards (61/77) provide information about ward routines such as mealtimes and visiting hours, while 15% of wards (12/77) provide information on the hospital complaints procedure.

There is a need for more structured guidelines on communicating with families and carers to ensure this group can access appropriate information about a patient's current medical condition, and their anticipated care and support needs on discharge. There is clearly a lack of formal structures to collect and communicate pertinent information about the person with dementia necessary for the delivery of person-centred care. Current systems of communication need to be formalised to ensure relevant information is routinely given to people with dementia and their carers on admission.

Staff Training

Dementia specific training and education is vital to ensure that front-line staff have the skills, knowledge and awareness to respond appropriately to, and care holistically for, a person with dementia. The organisational audit looked at whether dementia training had been available in the hospital, either formally or informally. Whether there were arrangements in place to allow staff to attend training was explored through the ward audits.

- 21% of hospitals (7/33) have a knowledge and training framework that identifies necessary skill development in working with and caring for people with dementia.
- 6% of hospitals (2/33) include dementia awareness in their staff induction programmes and no hospital has mandatory dementia awareness education for staff.
- Just over half of hospitals had provided dementia awareness training to doctors (54%, 18/33) and nurses (52%, 16/31) in the last 12 months. Far fewer hospitals had provided training to healthcare assistants (29%, 9/31), allied healthcare professionals (16%, 5/31) or support staff (10%, 3/31).
- Just under half of hospitals had provided training to doctors on approaches to behaviours that challenge (48%, 16/33), while nearly two-thirds had provided this training to nurses

(65%, 20/31). 55% of hospitals (17/31) reported providing this training to healthcare assistants (HCAs).

- There was little training in the area of communication with less than 10% of hospitals providing training in hearing/visual impairments to nurses, doctors or HCA's. 6% of hospitals (2/33) had provided training to doctors in communication skills specific to people with dementia, 26% (8/31) had provided this training to nurses, while 13% (4/31) had provided this training to HCAs.
- 41% of hospitals (13/33) had provided training to doctors in assessment of capacity, 22% (7/32) had provided this training to nurses, while 3% (1/32) had provided training in assessment of capacity to HCAs.
- 27% of hospitals (9/33) had provided training to doctors in assessing risk before the use of restraint or sedation, 42% (13/31) had provided this training to nurses, and 29% (9/31) had provided this training to HCAs.
- At ward level, 38% of wards (29/77) had arrangements in place to allow staff to attend training relating to the care of people with dementia.

There is clearly a need for more dementia specific education and training across a range of competencies for all staff. Even where training has been made available in the last 12 months, it is often delivered informally and is not accessible to all staff in the hospital. The development of policies and guidelines for high quality dementia care must be accompanied by increased awareness amongst frontline staff of how to recognise, respond to, and meet the unique needs a person with dementia may have.

Staffing and Staff Support

Adequate staffing levels and staff support are necessary elements to providing essential care to patients in an acute setting. The ward organisational audit looked at staffing levels, systems for measuring dependency levels and skills mix, and what supports are available to staff on the ward.

- 69% of wards (53/76) have at least one vacancy in their permanent nursing staff. Vacancies are filled using either hospital pool (31%, 27/77) or agency staff (52%, 40/77).
- 35% of wards (27/77) reported having unfilled registered nursing staff vacancies.
- 17% of wards (13/77) have a system to ensure that all factors that affect nursing staff numbers and skill mix are taken into consideration and staffing levels are reviewed on a daily basis.

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- Clinical supervision was available to nurses on 38% of wards (29/77), and to HCAs on 26% of wards (20/77).
 - Few wards had appraisal and mentorship programmes for nurses (20%, 15/77), or HCAs (8%, 6/77).
 - Very few ward staff had access to peer support groups (12%, 9/77) or reflective practice groups (5%, 4/77).
 - While 32% of hospitals (11/34) reported having a dementia champion in place at ward level, only 16% of wards (12/77) reported having access to guidance and support from a dementia champion for nursing staff, and 5% of wards (4/77) had access for HCAs.
 - 96% of wards (74/77) have access to administrative staff during the week.

The ability of the hospital to provide essential care to people with dementia may be negatively impacted by the high number of vacancies in permanent staff, leading to the common use of hospital pool and agency staff, combined with unfilled vacancies on over one third of wards. In addition, very few wards have the tools to measure their dependency levels and skills mix on a daily basis. There is also a need for more consistent systems for supporting staff development.

Physical Ward Environment

The ward environment is designed to manage acute conditions, focused on surveillance, security and infection control. The resulting environment, which often has many competing stimuli, can be very distressing for the person with dementia. However, there is growing recognition of the range of adaptations that can be made at ward level to make the immediate environment more suitable for people with dementia. The ward environmental audit examined aspects of the physical ward environment known to impact on people with dementia.

- The majority of wards did not have environmental cues to help the person with dementia orientate themselves; 56% of wards (43/77) had no clocks visible, 93% of wards (72/77) had no calendar visible, while 84% of wards (65/77) had no personal objects visible.
- 74% of wards (57/77) did not have signs to locate the toilets visible from the patient's bed or door of their room.
- 43% of wards (33/77) had no signs on their toilet doors while 33% of wards (25/77) had no signs on their bathroom doors.

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- 74% of wards (57/77) provided gender-specific toilets and bathrooms for patient use, and 61% (47/77) provided facilities so that patient have a choice about bathing or assisted bathing.
 - No wards labelled items such as soap dispensers, bins or hand dryers.
 - All toilets and bathrooms had alarm bells. These were visible and in reach on 62% of wards (48/77).
 - 46% of wards (35/77) had a day room or patients' lounge.
 - The flooring in the majority of wards was appropriate, with floors on 92% of wards (72/77) being plain/subtly patterned, 82% of wards (63/77) had floors that were subtly polished rather than high gloss, and 88% of wards (68/77) had floors that had a non-slip surface.

A number of areas were identified where changes could be made to make the ward environment more suitable for a person with dementia, many of which have minimal resource implications and some which would need to be carried out on a larger scale and have more substantial resource implications. Changes to the ward environment will need to be made in conjunction with increased awareness amongst staff of the needs of people with dementia, and of the benefits of providing a suitable and supportive environment.

Discharge Planning and Discharge

Adequate and appropriate discharge planning is vital, as inadequate discharge practices are linked to adverse outcomes and an increased risk of readmission. The organisational audit collected information on discharge policies and systems within the hospital while the HCR audit examined how discharge practices were recorded.

- 94% of hospitals (33/35) have a discharge policy in place.
- 94% of hospitals (29/31) reported that their discharge policy states that discharge should be an actively managed process which begins within 24 hours of admission. However, 72% of HCRs (387/536) had no evidence documented of discharge planning being initiated within 24 hours of admission.
- 86% of hospitals (30/35) reported having a named person who takes overall responsibility for complex needs discharge, and this includes people with dementia.
- 37% of HCRs (198/532) had documentation to show that a named person coordinated the discharge plan.

-
- 32% of HCRs (174/535) had support needs, identified during admission, included in the discharge plan or summary.
 - 21% of HCRs (110/527) had evidence that place of discharge was discussed with the person with dementia.
 - 87% of hospitals (27/31) reported that their discharge policy states that relatives and carers should be informed and updated about the prospective discharge date, while 41% of HCRs (221/535) had evidence that families/carers received 24 hours or more notice of discharge.

Though there are no dementia specific standards in place in Ireland at the moment, the HSE Code of Practice for Integrated Discharge Planning (IDP) is relevant to this audit. While the majority of hospital policies are compliant with the standards laid out in the code of practice for IDP, the audit found a gap between policy and practice in many areas. The discharge planning processes and the recording of same need to be improved, to ensure that the person with dementia is being discharged to a setting that has the appropriate resources and supports to care for them. In addition, the person with dementia and their families/carers need to be involved in the discharge process.

Palliative Care

The HCR audit looked at referral to palliative care services and whether a person was on an “end of life” care pathway. As nearly half of deaths in Ireland each year (48%) occur in the acute hospital, there is a need for hospitals to provide appropriate palliative care and end of life care.

- 8% of patients (51/660) died whilst in hospital.
- 6% of patients (37/629) were receiving end of life care, or were being managed according to an end of life care pathway.
- 9% of patients (44/466) were referred to specialist palliative care services, over half of whom (26/44) died whilst in hospital.
- One referral for family/carer bereavement support was recorded.

The findings indicate that approximately 1 in 12 patients admitted to acute hospital with dementia will die during that admission, highlighting the need for a co-ordinated palliative care approach. Early assessment and documentation of a person with dementia's End of Life Care needs and preferences in the acute setting is needed in the form of Advance Care Planning.



Recommendations by Theme

Governance

1. A dementia care pathway, moulded to existing acute, rehabilitation, care of older people, stroke, mental health, palliative care and end of life care pathways, should be developed and implemented at a local level in each acute hospital. A senior clinician to be appointed to lead the development, implementation and monitoring of the dementia care pathway.
2. Hospital management team should regularly review hospital policies and procedures, including discharge policies, as they relate to people with dementia.
3. In order to inform the ongoing review of hospital policies and procedures, management teams need to identify the cohort of people with dementia in their reviews of readmissions, delayed discharges, in-patient hospital falls, treatments and discharges.
4. Hospital management, with guidance from the senior clinician, should identify dementia champions across the hospital who have appropriate knowledge, skills and awareness of dementia.
5. The role of and access to patient advocacy services needs to be clarified and communicated at a local level through the hospital management team and senior clinician.
6. Research is needed to help determine the impact that a lack of resources and inequitable availability of services has on the quality of care for people with dementia. Further research is also needed to explore the reasons for the trends identified regarding discharge destination.
7. All hospitals should be re-audited after three years to evaluate the development of hospital policies and practices as they relate to the care of people with dementia.

Assessment

8. All acute hospitals should have access to a geriatric service a minimum of five days per week (Geriatrician and appropriate multi-disciplinary support), for the referral and treatment of people with dementia. These services should have a named consultant geriatrician providing the liaison service who has dedicated time in his/her job plan for the provision of same. Response times to referral should be a key performance indicator for these services.
9. Adherence to multidisciplinary assessment procedures should be clarified and reinforced. Standardised assessments of functional ability to be carried out to identify potential for rehabilitation: the forthcoming national implementation of the interRAI (Single Assessment Tool) system will provide a national template for such assessments (McDermott-Scales et al., 2014).

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10. An assessment of mental status should be an integral part of the acute admission of people with dementia, utilising standardised assessment tools and collateral history.
 - o In addition, routine cognitive screening should be performed with standardised instruments, for all people 65 and older on admission to an acute hospital in order to identify patients with here-to-fore undiagnosed dementia and/or delirium.
 - o All staff responsible for the assessment of older people need to have specific training in the assessment of mental status using standardised measures.
 11. Based on evidence from best practice, it is imperative to develop and implement policies and systems in each acute hospital for the prevention, identification and treatment of delirium.
 12. Guidelines to ensure appropriate and timely referral for social and environmental assessment ought to be developed.
 13. A number of hospitals identified difficulties related to having no social work support. Exploration of the impact of this lack of service on the availability and quality of social and environmental assessments, and the resulting impact on the person with dementia is needed as a priority.
 14. Guidelines for the assessment of carer needs should be developed: the carer section of the national interRAI (SAT) programme may be helpful in this regard (McDermott-Scales et al., 2014).

Mental Health and Liaison Psychiatry

15. Liaison Psychiatry and particularly Liaison Psychiatry of Old Age services should be in place in all acute hospitals to provide daily access for the treatment and referral of people with dementia. These services should have a named consultant psychiatrist/psychiatrist of old age providing the liaison service who has dedicated time in his/her job plan for the provision of same. Response times to referral should be a key performance indicator for these services.
16. A separate process for auditing the use and prescription of antipsychotic medication in the acute setting should be developed.
17. A restraint policy for the acute services needs to be developed on a national level, taking into account the recommendations of the 2011 Department of Health Policy 'Towards a Restraint Free Environment in Nursing Homes' and the findings of the 2011 audit of the HSE 'Policy on Use of Physical Restraints in Designated Residential Care Unit for Older People'. Individual hospitals should appoint a clinical lead with responsibility for implementation and monitoring of the policy/standards.

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18. The role of psychology services in the care of the person with dementia needs to be highlighted, and appropriate services should be developed to further support and promote good mental health and holistic care for the person with dementia.
 19. Systems need to be developed to ensure that appropriate information on cognitive impairment and delirium are included in the hospital discharge summary, including information/training for staff on the significance of the identification of cognitive impairment and its causes.
 20. A period of treatment in hospital should be highlighted as an appropriate point for review by an appropriate expert of any use of antipsychotic medication. Guidelines on dementia care currently being developed by The College of Psychiatrists of Ireland will provide guidance on the use of antipsychotics and the circumstances in which prescription of antipsychotics is appropriate.

Nutrition

21. Dementia specific education and training should be provided to all staff to support the routine use of a standardised nutritional assessment tool (e.g. MUST or MNA), including the routine monitoring and recording of weight/BMI, and the development of standardised approaches to supporting patients who require assistance with eating.
22. Ward managers should be provided with appropriate instruments to assess the staffing levels required to support mealtimes, including assessment of the additional support needs of people with dementia.
23. 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.
24. Protected mealtimes to be established in all wards. Best practice and learning from hospitals with established protected mealtimes should be shared.

Information and Communication

25. Guidelines for the involvement of patients, families and carers should be developed and implemented.
26. A single named healthcare professional should be appointed as a point of contact for each person with dementia and their families. This person would then have responsibility for ensuring the family or carer is involved in the care plan and decisions about discharge.

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27. The feasibility of introducing a personal information document (e.g. patient passport) to articulate the normal everyday needs of the person, and to assist staff in delivering person-centred care should be explored.
 28. Explore the appropriateness of implementing systems to ensure that people with dementia can be identified by staff both on the ward, and staff from outside the ward when accessing other treatment areas.
 29. Information on advocacy services, complaints procedures and discharge processes should be routinely given to people with dementia and their families/carers.
 30. Systems for appropriately communicating all pertinent information to support the delivery of person-centred care by all staff on the ward and throughout the hospital need to be developed.

Staff Training

31. Given the high number of adults with known or suspected dementia admitted to acute hospitals, basic dementia specific training should be mandatory for all staff that care for or come into contact with adults in the acute hospital setting.
32. Each acute hospital has responsibility for developing a training and knowledge strategy to ensure 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.
33. Arrangements must be put in place at ward level to allow staff to attend training relating to the care of people with dementia. Appropriate education programmes currently available should be provided to and promoted amongst all staff in the acute settings, e.g. The National Dementia Education Programme.
34. Dementia awareness training should be included in all staff induction programmes.

Staffing and Staff Support

35. Care of those with dementia requires appropriate levels of suitably trained staff, avoiding both vacant posts and temporary staff to the greatest extent possible.
36. Guidance is needed on how staffing levels should be determined, including consideration of measures of acuity and dependency sensitive to the care of people with dementia.
37. Staff working with people with dementia should have access to staff support systems such as formal appraisal and mentorship programmes, clinical supervision, peer support groups and reflective practice groups.

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38. The CEO/Hospital Manager of each site 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 or Dementia Champions.

Physical Ward Environment

39. National guidelines on dementia friendly ward designs should be developed, 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 to promote social interaction.
40. Ward managers and Dementia Champions should ensure that simple and effective improvements to the environment are promoted in all wards admitting adults, including appropriate signage and visual aids to support orientation and continence, personalising bed areas, and adequate space and resources to support activity and stimulation.

Discharge Planning and Discharge

41. All hospitals should have a systematic discharge and transfer policy in place.
42. Through a formal reporting process, identify factors contributing to delayed discharges, with particular reference to people admitted from home and discharged to a nursing home/residential care setting.
43. There is a need for increased awareness of, and adherence to, the processes and documentation required for appropriate discharge planning.
44. Mental health status, symptoms and behaviours relevant to the person's dementia noted during admission, and any on-going mental health needs, to be summarised and recorded at discharge.

Palliative Care

45. Guidelines should be developed for the recording and communication of assessments of the person's wishes and preferences regarding end of life care.
46. Acute hospitals need to be aware of the work of the Irish Hospice Foundation and the Alzheimer's Society of Ireland as it relates to improving end of life and palliative care for people with dementia and implement best practice guidelines as they become available.
47. Guidelines on dementia-appropriate advance care planning should be developed.



Introduction

Dementia is a term which describes a range of conditions which cause damage to brain cells, affecting memory, thinking, language, perception, mood and personality. It is a progressive condition, with deterioration likely to occur in all domains (Cahill et al., 2012). In 2009 it was estimated that there were 35.6 million people with dementia world-wide. By 2050 this figure is estimated to rise to over 115 million (Alzheimer's Disease International, 2009). In Ireland it has been estimated that there were approximately 41,700 people with dementia in 2006. These numbers are projected to rise to between 140,580 and 147,000 by 2041 (Cahill et al., 2012).

Traditionally, dementia was defined in bio-medical terms with a focus on the physical causes and symptoms of the condition. Since the mid-nineties a range of alternative perspectives on dementia, psychosocial, socio-political and public health, have highlighted how this condition affects each person differently and the impact that contextual, environmental and cultural factors can have on the person's subjective experience of their condition (Cahill et al., 2012). These multiple perspectives have resulted in a broader understanding of dementia and a recognition of the complex and changing needs of the person with dementia and their families/carers throughout the disease trajectory.

Dementia is associated with increased use of medical services. Indeed, cognitive impairment and confusion are significant co-morbidities among hospitalised older people (Moyle et al., 2008). While it is difficult to estimate how many people with dementia occupy acute hospital beds at any given point in time due to the poor recording, recognition and diagnosis of this condition, estimates suggest that up to 25% of all patients in a typical general hospital may have dementia (Cahill et al., 2012). This estimate is in line with recent research carried out in teaching hospitals in Cork, which found that 29% of people aged over 70 admitted to five acute public hospitals had dementia. Interestingly only 40% of patients were recorded as having dementia or cognitive impairment at the time of admission, some of whom had at least moderately severe cognitive deficits (Trawley et al., 2013). In a UK study, Sampson et al. (2009) found that the prevalence of dementia amongst patients in an acute hospital is likely to increase with age, reporting that 42% of patients aged over 70 with an unplanned medical admission had dementia.

Hospital admission is associated with functional decline in older people with dementia (Hoogerduijn et al., 2006) and hospital associated disability occurs in approximately one third of patients over 70 years of age, even when the illness that necessitated the admission is successfully treated (Covinsky et al., 2011). Dementia is also associated with longer hospital stays (Lyketsos, 2000), higher risk of

institutionalisation (AIHW, 2004), and increased incidence of behaviours that challenge (Cunningham, 2006). Overall an episode of acute hospital care can impact negatively on the quality of life of the patient with dementia (Moyle et al., 2010). In addition, nursing staff in acute hospitals have reported that caring for a person with dementia can be a challenging and frustrating experience, particularly where there is a long delay in discharge (O’Toole, 2012). Finally, the economic impact of delayed discharges must be acknowledged, as dementia as a secondary diagnosis can significantly contribute to the cost of admission (Lyketsos et al., 2000). The cost of dementia care in acute hospitals in Ireland is estimated to be just over €21 million per annum (Cahill et al., 2011)

In recognition of the growing number of people with dementia and the need to improve services which provide care to people with dementia, a number of countries worldwide have developed national strategies for dementia. The majority of these strategies incorporate improvements for the care of people with dementia in acute general hospitals as key policy objectives, from focusing on reducing unnecessary hospital admissions to reducing hospital length of stay through careful and timely discharge planning (Cahill et al., 2012). The Irish National Dementia Strategy, which is due to be published in 2014, aims to increase awareness, ensure early diagnosis and intervention and enhance services for people living with dementia (DoHC, 2012). As part of the development process for the strategy, a review of the research evidence was collated and published in 2012 under the title ‘Creating Excellence in Dementia Care’ (Cahill et al., 2012). In recognition of the prevalence of dementia in general hospitals and the negative impact a hospital admission can have on the person with dementia, an entire chapter of this review was dedicated to services for people with dementia in acute care settings.

Irish National Audit of Dementia (INAD) Care in Acute Hospitals 2013

In response to the need for more Irish data on dementia care in acute hospitals, the first Irish National Audit of Dementia (INAD) care in acute hospitals was undertaken to measure criteria relating to care delivery which are known to impact on people with dementia admitted to hospital. The audit was largely based on the recently published National Audit of Dementia Care in general hospitals in the UK (Royal College of Psychiatrists, 2011) and adapted for the Irish setting. The INAD project represents a joint initiative between The Centre for Gerontology and Rehabilitation, University College Cork; The Centre for Ageing, Neuroscience and the Humanities, Trinity College Dublin; and the HSE Quality and Patient Safety Audit Service (QPSA) (Appendix B). Funding was sought from and granted by Atlantic Philanthropies and The Meath Foundation, and a

multidisciplinary steering committee and advisory group were established in 2013 to oversee the audit (Appendix C).

Though this audit has been conducted before the introduction of national guidelines for best practice, it is envisaged that the data from this first audit will act as a benchmark for future improvements in hospital policy, procedure and practices as they relate to the care of people with dementia. In other countries, such as the UK, the publication and communication of National Dementia Audit results and recommendations (Royal College of Psychiatrists, 2011) led to significant improvements in the quality of care that patients received, as evident at second-round follow-up audit (Royal College of Psychiatrists, 2013). Data and recommendations from this audit were submitted to guide the development of the National Dementia Strategy as it relates to acute hospitals.



Methodology

In order to build a comprehensive picture of dementia care in acute hospitals, four separate audits were conducted in the 35 hospitals that admit adults with acute medical illness (Appendix A):

- (1) The Organisational Audit collected data on the governance and delivery of dementia care in each hospital, protocols/guidelines in place relating to dementia assessment and mental health needs, discharge and transfer policies, whether the hospital had formal systems for collecting information pertinent to the person with dementia, systems and guidelines for the recognition of dementia in the hospital, dementia specific training, learning and development, specific resources supporting people with dementia, liaison psychiatry services, liaison psychiatry of old age services and geriatric medicine services available in the hospital (Appendix D).
- (2) The Healthcare Record Audit examined 20 healthcare records from each hospital to gather information on assessments (multidisciplinary assessments, mental state assessments, social and environmental assessments, information about the person with dementia, and the use of antipsychotics), discharge (assessment before discharge, discharge coordination and multidisciplinary input, discharge planning, and support for carers and family around discharge) and referral to liaison psychiatry, liaison psychiatry of old age, geriatric medicine and/or palliative care services (Appendix E).
- (3) The Ward Organisational Audit collected information on staffing, access to services, information available on the ward, nutrition and systems for information and communication (Appendix F).
- (4) The Ward Environmental Audit looked at the physical environment including ward size and layout, signage, the floors, bed and rest areas, accessibility of toilet and bathing facilities, and whether the environment promoted independence for the person with dementia (Appendix G).

Initial notification of the audit was sent out by members of the audit team from the HSE Quality and Patient Safety Audit Services (QPSA) and hospitals were then contacted individually by the project coordinator to arrange individual site visits. Data for the organisational audit was collected by interviewing the Hospital Manager/Chief Executive Officer (CEO), the Director of Nursing (DON), or a Geriatrician. Input from all three stakeholder groups was often necessary to complete the audit tool.

Data collection for the healthcare record audit was carried out between 31st May and 1st July 2013. The decision to audit 20 healthcare records from each hospital was based on the need to ensure data was collected from all participating hospitals in a cost effective and timely manner. A total of 660 healthcare records (HCRs) were audited from 34 hospitals, an average of 19 HCRs per hospital

(HCR data was not available for Letterkenny General Hospital due to flood damage). The majority of hospitals (76%) were audited by independent auditors external to the hospital practice, either members of the audit team from QPSA or Registrars/ Specialist Registrars from another hospital. Twenty four percent (24%) of hospitals self-audited, mainly due to geographical and staff resource restrictions. All Registrars/Specialist Registrars involved in the data collection completed audit training with the project coordinator prior to commencing the audit, and a guidance document was prepared for their use (Appendix H).

Healthcare records were identified through the Hospital Inpatient Enquiry (HIPE) system using the following criteria; any diagnosis of dementia; minimum length of stay of 5 days; dates of discharge (or death) between 01st September 2012 and 31st January 2013 (see Appendix H for details). While the majority of hospitals submitted 20 HCRs as per the audit guidelines, a small number of hospitals (11%) submitted less than 20 HCRs as they were unable to meet the inclusion criteria. In these instances the search was broadened to include HCRs meeting the criteria between 1st January 2012 and 31st January 2013. However, even with the broadened search category, some hospitals were unable to identify 20 HCRs. While it is possible that some hospitals did not have twenty patients with dementia who had a length of stay of five days or more in 2012, it is more likely that this difficulty lay in the way patient details were coded in HIPE.

In addition, a quality assurance process was implemented whereby five HCRs from each hospital were re-audited, either by members of the audit team from QPSA or by the project coordinator. Inter-rater reliability was assessed using Cohen's Kappa coefficient in conjunction with percentage agreement for each item on the audit tool.

Ward organisational and ward environmental audits were carried out in 2-3 randomly selected medical, surgical or orthopaedic wards in the 35 participating hospitals. Data were collected from a total of 77 wards around the country. Data for the ward organisational audit were collected by interviewing ward managers while the environmental audit was conducted through direct observation. All ward level audits were conducted by the project coordinator and project research assistant.

The results from the four audits have been combined and are reported under ten headings below; Governance, Assessment, Mental Health and Liaison Psychiatry, Nutrition, Information and Communication, Staff Training, Staffing and Staff Support, Physical Ward Environment, Discharge Planning and Discharge, and Palliative Care. In all cases valid percentages are presented, i.e. missing data is excluded from the calculation. Unless otherwise specified, all variations in denominator values are due to missing data.



Results

Governance

Summary

- 94% of hospitals (33/35) have no dementia care pathway in place.
- The majority of hospitals do not utilise existing sources of information to provide management with data to ensure that hospital policies and procedures reflect the needs and experiences of people with dementia.
- 37% of hospitals (13/35) reported that they had a named officer with designated responsibility for the protection of vulnerable adults, which would include people with dementia. Many hospitals do not have a social worker in post.
- A very small number of hospitals can provide advocacy (7/35) and/or interpreting services (1/33) which meet the needs of people with dementia.
- The majority of wards can provide access, at least five days a week, to specialist services such as Liaison Psychiatry, Geriatric Medicine, Occupational Therapy, Physiotherapy, Specialist Infection Control and Specialist Palliative Care. There is more limited access to Psychiatry of Old Age, Specialist Continence Services, Psychology and Social Work Services.
- Data on length of stay and discharge destination suggest there is a need for more supports, resources and integrated care planning in the community.

A Care Pathway for Dementia within the Hospital

The importance of developing appropriate care pathways for people with dementia is a common theme in a number of National Dementia Strategies around the world, though there are differences between countries in terms of emphasis on stages of the care pathway (Irving et al., 2012). The majority of hospitals in Ireland (94%) had no dementia care pathway in place; though two of these hospitals (6%) are in the process of developing a dementia care pathway. Two hospitals (6%) in Ireland have a dementia care pathway in place.

Of the four hospitals with a dementia pathway in place or in development, the responsibility for implementation / review of the pathway lies with a consultant geriatrician/specialist physician in elderly care in three hospitals, while there is no senior clinician responsible for implementation/ review in the fourth hospital.

Integration of the Dementia Care Pathway with other Relevant Pathways

Of the four pathways that are in place or are currently being developed, three are adaptable for use within the acute care pathway and all were adaptable for use within the end of life care pathways. The dementia pathway was adaptable for use within the palliative care pathways in just two hospitals, as the other two hospitals did not have a palliative care pathway.

It would appear that where pathways are being developed, there is an awareness of the need to ensure that the pathway will readily integrate with other pathways in the acute setting. While it is essential that acute hospitals develop dementia care pathways to guide clinical and administrative activities while the person is in hospital, their hospital admission is just one point in their journey. Integrated care pathways (ICPs) chronologically map the key steps to be taken throughout the person's care journey (Rees et al., 2004) and research evidence suggests that a move towards more integrated working in terms of planning and service delivery across all the various settings of dementia care would help ensure the best use of resources and achieve better outcomes for those with dementia (Irving et al., 2012).

The model of care for Specialist Geriatric Services published by the National Clinical Programme for Older People in 2012 describes a pathway for access to and the continuum of care in the acute hospital setting for older people. This model emphasises the importance of greater integration of the geriatric medicine services with community and primary care services. Genio is an independent organisation whose aim is to support and scale solutions to social problems in Ireland. Through Genio funded projects, further research into the optimal mechanisms and processes involved in the

development of a complete and holistic integrated dementia care pathway linking home, community and hospital services will be explored and reported over the next three years, and should give greater clarity to this matter.

Informing Hospital Policies and Procedures

People with dementia have prolonged hospital stays (AIHW, 2004; Alzheimer's Society, 2009) and inadequate care planning at discharge can leave the person with dementia susceptible to rehospitalisation (Cummings, 1999). INAD examined whether hospitals collect information on people with dementia when reviewing their readmissions, delayed discharges/transfers and discharge policy, in order to ensure that hospital policies and procedures reflect the experience and particular needs of people with dementia. While management teams in the majority of hospitals regularly review data collected on readmissions and delayed discharges/transfers, few hospitals identify people with dementia as a group within existing reporting procedures.

- 6% of hospitals (2/34) stated they could identify people with dementia when reviewing readmissions.
- 38% of hospitals (13/34) stated they could identify people with dementia when reviewing delayed discharges/transfers.
- 16% of hospitals (5/32) stated they had a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia.

Cognitive impairment, including dementia, is known to increase risk of falls in older people (HSE, 2008). While the majority of respondents anecdotally reported that they were aware that cognitive impairment was a contributing factor for many of their in-hospital falls, only 11 hospitals (33%) could identify people with dementia when reviewing in-hospital falls.

INAD also looked at how individual hospitals utilised existing sources of information to provide hospital management with data on the quality of care delivered to people with dementia.

- The management team receive feedback from clinical leads for older people and people with dementia in 15% of hospitals (5/34).
- Complaints are analysed by age in 15% of hospitals (5/33).

Incorporating the collection of dementia specific information into existing reporting procedures could help ensure that hospital policies and procedures are more cognisant of the needs of people with dementia and provide guidance for appropriate care and support for this particular group.

Designated Support for the Person with Dementia

INAD explored whether hospitals identified key workers to provide information and advice to patients with dementia and their carers. Less than half of all hospitals had staff identified who could support people with dementia and their carers throughout their hospital stay. In addition, this role was undertaken by a range of professionals, including social workers, liaison public health nurses and allied healthcare professionals, suggesting an ad hoc approach to supporting people with dementia and their families while in hospital.

- 37% of hospitals (13/35) reported that they had a named officer with designated responsibility for the protection of vulnerable adults, which would include people with dementia.
- 40% of hospitals (14/35) reported they have 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.

The responsibilities generally assigned to a social worker would often be undertaken by a hospital based Occupational Therapist or a liaison Public Health Nurse. Almost half (48%) of wards audited reported having no access to a Social Worker. 20% of hospitals had a named lead in dementia who could provide advice and guidance to staff around caring for and supporting a patient with dementia.

Interpreting Services, Advocacy and Faith Specific Support

In the healthcare record (HCR) audit, one patient was documented as having another European language as their first language, English was documented as the first language in 71% of HCRs, while first language was not documented in 28% of HCRs. However, the number of non-Irish nationals in Ireland is continuing to grow, with a 6% increase in immigration from April 2012 to April 2013 (CSO, 2013). Furthermore, nearly half of all immigrants coming to Ireland are from the 12 new EU accession states (CSO, 2007). As these people make their homes in Ireland, and age in this country, the need for interpreting services that meet the needs of people with dementia will also increase.

- One hospital had access to an interpreting service which meets the needs of people with dementia.

The audit also explored whether hospitals had access to patient advocacy services. Advocacy services can be HSE-delivered or independent, and provide support to a person with dementia and their family. However, confusion existed around the role the hospital played in providing patient

advocacy services, what was meant by patient advocacy services, and whether advocacy services were available in the particular hospital. Many nursing staff felt that they acted as advocates on behalf of all their patients, while some hospital managers referred to national advocacy services as fulfilling this role.

- 20% of hospitals (7/35) reported having access to advocacy services with experience and training in working with people with dementia.
- 5% of wards (4/77) routinely provide information on patient advocacy services, either verbally or in a written/pictorial format.

There is clearly a need for guidelines on what constitutes a dementia specific patient advocacy service and where staff may direct patients to access appropriate services and advice.

Many staff found it difficult to answer the question on whether they had access to relevant faith specific support as the majority had not been in a position where this was required. Anecdotally, staff reported that faith specific support was often accessed through the patient's family. While a number of wards reported having a list of contacts that would allow them to access faith specific support, staff commented that they would have no way of knowing if these people have experience of dealing with vulnerable adults, such as people with dementia.

- 5% of wards (4/77) were able to provide access to relevant faith-specific support from someone with experience of supporting vulnerable adults.

Access to Specialist Services at Ward Level

As part of the ward organisational audit, participating wards were asked about the range of professionals or services available to them. Access to these services is necessary to cater for the complex needs of older people admitted to hospital, especially frailer older people and people with dementia. Table 1 below illustrates the availability of services at ward level.

Table 1: Availability of Services at Ward Level, N=77

Service	4 days or less	Mon – Fri (day)	Mon – Fri (day & evening)	Mon – Sun (day)	Mon – Sun (day & evening)	No Access
Liaison Psychiatry	3%	39%	3%	4%	47%	4%
Psychiatry of Old Age	3%	57%	1%	6.5%	6.5%	26%
Geriatric Medicine	-	52%	-	2%	30%	16%
Occupational Therapy	-	79%	-	-	-	21%
Social Worker	-	52%	-	-	1%	47%
Pharmacy	1%	32%	-	37%	30%	-
Physiotherapy	1%	51%	-	35%	13%	-
Dietetics	5%	87%	1%	-	-	7%
Speech & Language	10%	80%	1%	-	-	9%
Psychology	-	9%	-	-	-	91%
Specialist Infection Control	3%	63%	-	13%	20%	1%
Specialist Tissue Viability	16%	54%	-	-	1%	29%
Specialist Continence Services	8%	26%	-	-	-	66%
Specialist Palliative Care	8%	18%	3%	10%	58%	3%

Pharmacy and Physiotherapy were the only two services to which all wards had some level of access. Dietetics (87%), Occupational Therapy (79%) and Speech and Language Therapy (80%) were the services most consistently available Monday-Friday (daytime), across all wards. While the majority of

wards reported they had good access to liaison psychiatry, just over a quarter of wards had no access to psychiatry of old age. While 11% of hospitals reported not having access to geriatric medicine (see page 49 for details), and all hospitals reported having access to liaison psychiatric services (see page 53 for details), a slightly higher percentage of wards reported not having access to these services. This suggests a discrepancy between management and staffs' awareness/ perception of what services are available in the hospital.

The results also highlighted a significant lack of psychology services (91% of wards reported no access), specialist continence services (66% of wards reported no access) and social work services (47% of wards reported no access). The lack of these services has particular implications for people with dementia considering the often complex social needs of the person with dementia, the link between depression and dementia (Castilla-Puentes et al., 2010), and the importance of providing supportive continence care for people with dementia (Andrews, 2013).

The findings clearly indicate inequity in terms of accessibility of services between hospitals. Even where there is good weekday accessibility to services, the lack of weekend provision has implications for continuity of care and could delay urgent referrals and pre-discharge assessments.

Continuity of Care and Outcomes

It has been well documented that people with dementia often have far worse outcomes than those without dementia after an admission to an acute hospital (Cahill et al., 2012). Hospitalisation-associated disability occurs in approximately one third of patients over seventy years of age, even where the illness that necessitated the hospitalisation is successfully treated (Covinsky et al., 2011). It has been found that cognitive impairment upon admission and cognitive decline during hospitalisation are associated with an increased risk of functional decline in older patients (Pedone et al., 2005). Dementia services in Ireland are fragmented and under-resourced which can lead to people seeking admission to long stay care sooner than might otherwise be necessary (Cahill et al., 2012).

Similar to research carried out in Scotland (Alzheimer Scotland, 2009), INAD found that over a third of patients admitted from home were discharged to a residential care setting.

- 45% of people (164/363) admitted from home were discharged home.
- 35% of people (128/363) admitted from home were discharged to a nursing home.

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- 4% of people (14/363) admitted from home were discharged to a rehabilitation unit, and 4% of people (14/363) were discharged to convalescent care. The remaining 12% were discharged to other facilities.

This may be partly due to the deskilling and functional decline associated with hospitalisation for older people (Thompson et al., 2010; Pedone et al., 2005). In a study on cognitive impairment in hospital patients in Limerick, Hickey et al. (1997) found that the majority of cognitively impaired patients did have medical conditions which precipitated their admission. In analysing the high number of patients with significant cognitive impairment in long stay hospitals the authors concluded that dementia is a major factor for institutionalisation of older people where the necessary community supports are lacking. In 2007, the 'HSE Acute Hospital Bed Review' recommended the provision of a comprehensive range of appropriate alternatives to acute hospital care through the strengthening of services in the community, which would help hospital inpatients to return home more quickly, and in some cases avoid acute admission altogether. In the same year the 'HSE Acute Hospital Bed Capacity Review: A Preferred Health System in Ireland to 2020' outlined a preferred system model of health services delivery which included the reconfiguration of community services to facilitate earlier discharge and avoid unnecessary acute hospital admissions. Though these recommendations led to major changes in the structure of health services in Ireland, including the evolution of Primary, Community and Continuing Care (PCCC) services, results from this audit suggest a continuing lack of community and extended care supports following acute hospital admission.

- The average length of stay for a person with dementia admitted from and discharged to their own home was 22 days.
- The average length of stay for a person with dementia admitted from home and discharged to a nursing home was 59 days.
- The average length of stay for a person with dementia admitted from and discharged to a nursing home was 17 days.

A number of studies have shown that out-reach and improved community based dementia services can reduce the use of hospitals by people with dementia (Cahill et al., 2012). In 2007, the HSE Acute Hospital Bed Review found that 39% of patients surveyed were outside the criteria defined in the Appropriateness Evaluation Protocol, and could have potentially been treated in an alternative setting on the day of care, if appropriate alternatives were available. These results highlight the need for more supports, resources and integrated care planning with community services to avoid prolonged hospital admissions and to ensure people with dementia and their families are

appropriately supported throughout the transition from home to long term care if, and when, they make that decision.

The discharge destination for the person with dementia also appeared to impact on assessments carried out during admission. Similar to findings from the first round of audit in the UK, the Irish National Audit of Dementia (INAD) healthcare record (HCR) audit found that people who were admitted from and discharged to a residential care setting were less likely to have a standardised mental status test than people who were admitted from home. Those admitted from home and discharged to a nursing home were more likely to have a social and environmental assessment carried out, required as part of the assessment of need for the Nursing Home Support Scheme.

- 52% of people (85/164) admitted from and discharged to their own home had mental status test scores recorded in the HCR.
- 71% of people (89/126) admitted from home and discharged to a nursing home had mental status test scores recorded in the HCR.
- 20% of people (39/190) admitted from and discharged to a nursing home had mental status test scores recorded in the HCR.

In addition, 'patient being discharged to nursing/residential care' was one of the two most common reasons recorded for not initiating early discharge planning within 24 hours of admission. These findings suggest that there is variation in assessments being carried out for people being admitted from and discharged to residential care settings, and people being admitted and discharged to other destinations. People from residential care are receiving less comprehensive assessments whilst in hospital and are discharged earlier. Anecdotally, some nursing home residents had repeated re-admissions during the period relevant to this study. Further investigation is needed to determine why these differences exist and how this impacts on the patient with dementia and staff in residential care settings.

Conclusion

These findings show that the majority of acute hospitals are not providing guidance on the appropriate care and management of people with dementia at an organisational level. In addition to developing care pathways for dementia, acute hospitals will need to be aware of developments nationally in integrated care pathways and follow emerging best practice in this area. In order to ensure the needs and voice of patients with dementia are heard and taken into consideration, health service senior management and hospital management must appoint appropriate personnel to lead

dementia care in the acute hospital. In addition, dementia specific information must form part of current data collection systems and be used to ensure policies and procedures are appropriate for this cohort of patients. Further research is needed to determine the impact that the variation in availability of services and support between hospitals has on the delivery of patient care. The reasons for the trends identified in terms of assessment of mental status, lengths of stay and discharge planning for people discharged to various settings must be viewed in terms of quality of care for people with dementia.

Recommendations

1. A dementia care pathway, moulded to existing acute, rehabilitative, care of older people, stroke, mental health, palliative care and end of life care pathways, should be developed and implemented at a local level in each acute hospital. A senior clinician to be appointed to lead the development, implementation and monitoring of the dementia care pathway.
2. Hospital management team should regularly review hospital policies and procedures, including discharge policies, as they relate to people with dementia.
3. In order to inform the ongoing review of hospital policies and procedures, management teams need to identify the cohort of people with dementia in their reviews of readmissions, delayed discharges, in-patient hospital falls, treatments and discharges.
4. Hospital management, with guidance from the senior clinician, should identify dementia champions across the hospital who have appropriate knowledge, skills and awareness of dementia.
5. The role of and access to patient advocacy services needs to be clarified and communicated at a local level through the hospital management team and senior clinician.
6. Research is needed to help determine the impact that a lack of resources and inequitable availability of services has on the quality of care for people with dementia. Further research is also needed to explore the reasons for the trends identified regarding discharge destination.
7. All hospitals should be re-audited after three years to evaluate the development of hospital policies and practices as they relate to the care of people with dementia.



Assessment

Summary

- 76% of patients (496/656) had a problem list recorded in their HCR, 87% (570/657) had current medication recorded and 96% (633/658) had comorbid conditions recorded.
- There is a good deal of variation in the implementation and documentation of physical assessments such as functional assessments and recording of weight/BMI.
- 43% of patients (283/658) had a standardised mental status test carried out on or during admission.
- 6% of hospitals (2/34) have guidelines in place for the diagnosis and management of delirium.
- Few patients received assessments for recent changes in mood (14%, 94/658), or recent changes that may indicate the development of behavioural and psychological symptoms of dementia (14%, 89/644).
- Poor access to social workers may be impacting on the low number of social and environmental assessments being carried out.
- 89% of hospitals (31/35) provide access to a geriatric medicine service which can provide assessment and treatment to older adults throughout the hospital.

Physical Assessment

The healthcare record (HCR) audit showed reasonably high levels of medical assessments being carried out:

- 76% (496/656) had a problem list recorded.
- 96% (633/658) recorded co-morbid conditions.
- 87% (570/657) recorded current medication.

The HSE Standards and Recommended Practices for Healthcare Records Management (2011) states that “the content of the healthcare record provides an accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and out- comes”(p.23). In order to comply with this standard all hospitals should have 100% recording of the above basic assessments.

Standard 3.3.13 states that “records provide information on physical, psychological and social factors that may affect the service user” (Standards and Recommended Practices for Healthcare Records Management, 2011, p.25). However, this audit found a good deal of variation in the administration and documentation of physical assessments e.g. assessments of functioning and recording of weight/BMI, which are necessary for maximising rehabilitation potential and ensuring the most positive outcomes are achieved.

Covinsky et al. (2011) found that at least 30% of patients over 70 hospitalised for a medical illness are discharged with an activities of daily living (ADL) disability they did not have before becoming acutely ill. Risk factors for loss of independence in ADLs during hospitalization include advanced age, cognitive impairment, and ADL impairments at admission (Covinsky et al., 2003; Pedone et al., 2005; Hoogerdiijn et al., 2006).

- 62% of hospitals (21/34) reported that an assessment of functioning using a standardised instrument is routinely carried out.
- Only 36% of patients (236/653) had a standardised assessment of functioning recorded in the HCR.

It was noted that many hospitals use a modified version of the Roper-Logan Tierney model for nursing assessment on admission. While these screening instruments ensure a comprehensive assessment of ADLs is carried out on admission, the assessments are not standardised and therefore cannot be used to measure rehabilitation potential or track functional decline during hospital stay.

People with dementia experience particular challenges in maintaining adequate nutrition and hydration due to memory difficulties, visual agnosia and receptive and expressive dysphasia (Heath et al., 2010). In the UK, four out of ten people admitted to hospital are malnourished on arrival (NHS Confederation, 2010). Therefore, assessing the nutritional status of patients with dementia upon admission is vital. The organisational audit found that the majority of hospitals are cognisant of the importance of recording nutritional status and weight/BMI.

- 97% of hospitals (33/34) reported that nutritional assessments were routinely carried out on people with dementia.
- 88% of hospitals (30/34) reported that the person's weight or BMI are recorded as part of the assessment.

However findings from the HCR audit indicate a gap between policy and practice in terms of nutrition.

- 76% of HCRs (496/651) had a nutritional assessment recorded.
- 39% of HCRs (259/658) had weight or BMI recorded.

The audit team also noted that assessment of nutritional status was not standardised between or within hospitals, with some hospitals/wards doing a minimal assessment as part of the nursing admission checklist and others carrying out a formal nutritional assessment on all patients e.g. the Malnutrition Universal Screening Tool (BAPEN, 2003).

Low levels of mobility are common during hospitalisation for older adults (Fischer et al., 2011) and are a contributory factor to functional decline in older patients. However, increased physical activity may improve mobility (Said et al., 2012). Strategies for reducing functional decline whilst in hospital include conducting comprehensive and interdisciplinary geriatric assessment of physical status at admission, and encouraging activity during hospitalisation with structured exercise, progressive resistance strength training, and walking programs (Boltz & Sherry, 2012).

- 89% of patients (585/657) had an assessment of mobility carried out.

It should be noted that these assessments were not standardised, and while some assessments of mobility were carried out by a physiotherapist, others would be carried out by the nurse during the admission process.

- 84% (557/659) had an assessment of continence needs carried out during their admission.

It has been estimated that 40%-50% of hospitalised people over the age of 65 are incontinent, with many becoming incontinent within a day of hospitalisation (Creditor, 1993). While the percentage of

patients asked about their continence needs was reasonably high, the finding that 65% of wards reported having no access to specialist continence services would call into question the ability of the hospital to fully respond to complex continence needs.

Older people who are not very mobile are at increased risk of developing pressure sores/ ulcers (Alzheimer Society Ireland, 2011), and hours spent in bed are a predictor of pressure ulcer development in older hospitalised patients (Olson et al., 1996). Therefore, pressure sore risk assessment is necessary for all older patients with dementia.

- 87% of patients (575/660) had a standardised pressure sore risk assessment carried out, most commonly the Waterlow Score for Pressure Ulcer Risk Assessment.

People with more severe dementia often cannot describe pain, though they may display behavioural consequences of untreated pain. Pain should be recognised and treated appropriately. Pain should therefore be routinely assessed, but just under a quarter of HCRs (23%) showed that the person had not been asked about the presence of pain.

Mental Assessment

Comprehensive assessment of older people in the acute hospital should include a sufficiently thorough assessment of mental state to detect depression, delirium and dementia (Royal College of Psychiatrists, 2011). Significant cognitive impairment is often undetected before admission to general hospital (Sampson et al., 2009, Trawley et al., 2013), and assessment for dementia is often not considered for older people attending A&E (Bentley and Meyer, 2004). A recent study found that one in five patients in an acute general hospital have delirium, though less than half of patients (44%) had their confusion documented in their medical notes (Ryan et al., 2013). The organisational audit demonstrated that more could be done at an organisational level to ensure appropriate assessments of mental status are carried out in acute hospitals:

- 63% of hospitals (22/35) reported that the multidisciplinary assessment includes an assessment of mental status.
- 63% of hospitals (22/35) reported that the multidisciplinary assessment includes a collateral history from a carer/relative.
- Only one hospital (1/35) has a policy or guideline stating that a screening assessment of mental state is carried out on all patients over the age of 65 admitted to the hospital.

Some respondents commented that they feel it would be unnecessarily stigmatising to carry out an assessment of mental state on all people over the age of 65 admitted to an acute hospital. Even if standard screening is introduced, appropriate follow up processes would need to be in place. Currently only 23% of hospitals have a system 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.

In light of the fact that the HCR audit focused on people who had a definite diagnosis of dementia, less than half had appropriate assessments of mental status recorded.

- 43% of patients (283/658) had a standardised mental status test carried out on or during admission.

This finding is in line with another Irish study which found that only 55% of patients with dementia who died on an acute medical ward had a Mini Mental Status Exam (MMSE) carried out during their hospital admission (Afzal et al., 2010). In addition to standardised assessments of mental status, a collateral history must form part of a comprehensive cognitive assessment (Lawlor, 2002).

- 44% (287/658) had a collateral history taken with confirmation of cognitive decline.
- 25% (166/658) had a collateral history taken which noted time since onset of memory problems.
- 27% (176/658) had a collateral history taken which noted the nature of progression of the condition.
- 35% (233/658) had a collateral history taken which noted evidence of loss of function.

Though not included in the audit tool, anecdotally the audit team reported that collateral histories often focused on the acute reason for admission rather than aspects of the person's dementia history. This lack of information about the person's dementia, combined with the relatively low rate of mental status assessments being carried out, may impact on staff's ability to respond appropriately to the person with dementia and/or to accurately identify the presence of delirium. Delirium is associated with a range of medical conditions and is an independent predictor of poor outcomes including increased length of stay and mortality (National Institute for Health and Clinical Excellence, 2010). Advancing age and a pre-existing cognitive impairment are independently associated with a higher prevalence of delirium. A recent study found that in an acute general hospital, patients' delirium was recognised by nurses in 64% of cases and less than half (44%) had their confusion documented in the medical notes (Ryan et al., 2013). The audit also highlighted that hospitals are not giving due consideration to the issue of delirium.

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- No hospital had a policy or guideline in place to ensure that patients with dementia or cognitive impairment are assessed for the presence of delirium at presentation, though 12% of hospitals (4/34) are currently developing such a policy.
 - 6% of hospitals (2/34) have a policy or guideline 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 trained and competent in the diagnosis of delirium. Three hospitals (8%) are currently developing their policies.
 - 70% of patients (463/659) had no assessment carried out for recent changes or fluctuations in behaviour that may have indicated the presence of delirium.
 - 17% of patients (113/660) were clinically assessed for delirium.

There was a high level of disagreement between auditors as to what constituted evidence that an assessment for fluctuations in behaviour was performed, suggesting that auditors had difficulty identifying what an assessment for delirium might look like. This reflects the confusion noted around this question during the audit training, where Registrars/Specialist Registrars were uncertain what constituted an assessment for fluctuations in behaviour. The low number of assessments for delirium that are carried out, combined with poor collateral history, indicate that staff may not have the information necessary to determine whether a patient's behaviour is appropriate for them or not.

It is estimated that 25% to 35% of those with dementia will experience significant depression during the course of their illness (Aalten et al., 2005). However, depression in older people can be difficult to recognise as it can present without feelings of sadness or low mood (Gendron, 2013), and is further complicated by the overlapping symptoms and behaviours of depression and dementia (Maynard, 2003). Physically ill patients with depression are less likely to comply with their treatment, have longer hospital stays, higher healthcare costs and poorer quality of life than those without depression (Expert Group on Mental Health Policy, 2006). Therefore, it is vital that hospitals assess mood using a standardised instrument.

- 11% of hospitals (4/35) reported that the multidisciplinary assessment includes an assessment of mood using a standardised instrument.
- 14% of patients (94/658) received an assessment for recent changes in mood.

It has been estimated that two thirds of people with dementia experience some Behavioural and Psychological Symptoms of Dementia (BPSD) at any one point in time. The occurrence of BPSD is often the triggering event for recognition of dementia and referral to services, and greatly increases caregiver burden and distress (Lawlor, 2002).

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- 14% (89/644) received an assessment of recent changes that may indicate the development of behavioural and psychological symptoms of dementia.

Social Care Needs

The HSE Code of Practice for Integrated Discharge Planning States that “the estimated length of stay shall be identified by the admitting consultant in conjunction with the multi-disciplinary team, during pre-assessment, on the post- take ward round or within 24 hours of admission to hospital and shall be documented in the patient’s healthcare record” (p.31). The recommended practice in order to meet this standard includes an assessment of the presence of a carer, the home environment and social issues, including financial arrangements, which may impact on the patient’s stay.

The majority of hospitals reported that comprehensive social and environmental assessments were carried out as part of the multidisciplinary assessment, despite many hospitals not having access to a social worker. Some hospitals reported that an Occupational Therapist or a Liaison Public Health Nurse carried out their social and environmental assessment, while other hospitals reported that aspects of social and environmental assessments are carried out as part of the routine nursing admission.

- 91% of hospitals (30/33) reported that the social and environmental assessment includes support provided to the person ‘informally’.
- 85% of hospitals (28/33) reported that the social and environmental assessment included formal care provision assessment.
- 30% of hospitals (10/33) reported that the social and environmental assessment included a financial support assessment.
- 79% of hospitals (26/33) reported that the social and environmental assessment included a home safety assessment.

A number of hospitals commented that a financial support assessment would only be carried out where necessary, i.e. where an application for residential care was needed. However, there are a number of benefits available to people with dementia and their families carers which they may not be aware of, and which have the potential to make a significant difference to their quality of life.

The HCR audit found the need for a social and environmental assessment was identified in only a small number of healthcare records. The impact which the lack of social workers may have had on this finding is unknown. However, it is unlikely that a need will be identified in hospitals where staff already know there is no service available to meet that need.

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- 24% of HCRs (161/660) identified the need for a social and environmental assessment.
 - 21% of patients (136/660) received a social and environmental assessment.
 - 16% of patients (109/660) received an assessment of formal and informal care provision.
 - 9% of patients (60/660) received a financial support assessment.
 - 9% of patients (58/660) received a home safety assessment.

This may be in part due to the significant lack of social work resources reported in many hospitals. Only 3% of people admitted from a residential care setting and discharged back to residential care had a social and environmental assessment carried out, suggesting that there is an assumption that the residential setting is suitable for the needs of the person with dementia, though this may not always be the case.

Geriatric Medicine

Comprehensive Geriatric Assessment is fundamental to services designed to meet the needs of older people. The model of care for specialist geriatric services, published by the National Clinical Programme for Older People in 2012, suggests that focusing on older person groups with particular syndromes e.g. dementia, may be a way to identify and target those most in need of assessment. The model outlines in detail the structure of the specialist geriatric team, integration with other acute, community and residential services, governance of the service and delivery of education and continuing professional development. The need to integrate specialist geriatric services with all acute hospital services is highlighted, as often people with dementia will not be admitted to a dedicated older person care ward as their admission will be related to a co-morbidity rather than to their dementia (Cahill et al., 2012).

- 89% of hospitals (31/35) provide access to a geriatric medicine service which can provide assessment and treatment to adults throughout the hospital.

There are four hospitals in Ireland that currently have no access to a specialist geriatric medicine service. Three of these hospitals have a consultant physician with an interest in elderly care in post, while one hospital has no geriatrician or consultant with a special interest in elderly care.

- 63% of hospitals (22/35) have a geriatric medicine service that can provide emergency or urgent assessment to adults throughout the hospital.
- 77% of hospitals (27/35) have a named consultant providing the liaison service.

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- 71% of hospitals (25/35) reported that the consultant geriatrician has dedicated time in his/her job plan for the provision of the liaison service, or that the liaison service is integral to their job.
 - 46% of hospitals (16/35) reported that geriatric medicine is provided by a specialist team.
 - 40% of hospitals (14/35) reported that all healthcare professionals who are part of the liaison geriatric medicine service have dedicated time for consults.

The times that services were available varied depending on the number of staff in the service. Where geriatricians were on call out of hours on a medical call rota with other general consultant physicians, this was not considered to be an out of hour's geriatric medicine service.

- 88% of hospitals (31/35) stated they have liaison geriatric medicine available during the day.
- 23% of hospitals (8/35) stated they have access to the liaison geriatric medicine service in the evenings.
- 23% of hospitals (8/35) stated they have access to the liaison geriatric medicine service at the weekends.

The majority of teams were based on-site (68%), while a small number (12%) were based part-time on-site and part-time off site. The lack of geriatric medicine services out of hours has implications for continuity of care and could delay urgent referrals and pre-discharge assessments.

Conclusion

While there are high levels of medical and physical assessments being carried out and recorded in most areas, the lack of a standardised approach to assessment was noted in some areas. More consistent and standardised medical and physical assessments ought to be performed and recorded in order to ensure patients are appropriately monitored and the most positive outcomes possible are identified and achieved. There was relatively poor evidence of appropriate assessments being carried out for dementia, delirium and mood. There is clearly a need for increased awareness of the importance of incorporating assessments of mental status into routine multidisciplinary assessment procedures. That some hospitals are operating without the services of a Geriatrician is also cause for concern.

Recommendations

8. All acute hospitals should have access to a geriatric service a minimum of five days per week (Geriatrician and appropriate multi-disciplinary support), for the referral and treatment of people with dementia. These services should have a named consultant geriatrician providing the liaison service who has dedicated time in his/her job plan for the provision of same. Response times to referral should be a key performance indicator for these services.
9. Adherence to multidisciplinary assessment procedures should be clarified and reinforced. Standardised assessments of functional ability to be carried out to identify potential for rehabilitation: the forthcoming national implementation of the interRAI (Single Assessment Tool) system will provide a national template for such assessments (McDermott-Scales et al., 2014).
10. An assessment of mental status should be an integral part of the acute admission of people with dementia, utilising standardised assessment tools and collateral history.
 - a. In addition, routine cognitive screening should be performed with standardised instruments, for all people 65 and older on admission to an acute hospital in order to identify patients with here-to-fore undiagnosed dementia and/or delirium.
 - b. All staff responsible for the assessment of older people need to have specific training in the assessment of mental status using standardised measures.
11. Based on evidence from best practice, it is imperative to develop and implement policies and systems in each acute hospital for the prevention, identification and treatment of delirium.
12. Guidelines to ensure appropriate and timely referral for social and environmental assessment ought to be developed.
13. A number of hospitals identified difficulties related to having no social work support. Exploration of the impact of this lack of service on the availability and quality of social and environmental assessments and the resulting impact on the person with dementia is needed as a priority.
14. Guidelines for the assessment of carer needs should be developed: the carer section of the national interRAI (SAT) programme may be helpful in this regard (McDermott-Scales et al., 2014).



Mental Health and Liaison Psychiatry

Summary

- While all hospitals reported having access to general liaison psychiatric services, there is a good deal of variation in how these services are delivered.
- 18% of hospitals (6/33) had a named Consultant Psychiatrist who specialises in the care and treatment of older people.
- 71% of hospitals (25/35) reported they can provide access to specialist liaison psychiatry of old age services. Again there is a great deal of variation in how these services are delivered as many are provided by community based services without dedicated time or resources for hospital liaison.
- There is poor recognition of and recording of mental health needs at discharge.
- 32% of hospitals (11/34) have a protocol governing the use of interventions for patients displaying violent or challenging behaviour, aggression and extreme agitation, while a further 18% (6/34) are currently developing their protocol. However, not all policies have the elements necessary to make them suitable for the treatment and management of behaviours that challenge for people with dementia.
- 41% of patients (271/656) received antipsychotic drugs at some point during admission.
- 46% of patients (100/216) admitted from a residential care setting and 19% of patients (68/362) admitted from home had an existing prescription for antipsychotic drugs.
- Agitation was the most common reason recorded for the prescription of antipsychotics, either a new regular prescription or PRN.

Liaison Psychiatry

Liaison mental health services provide clinical services, education, and research in general hospital settings. The presence of such services can improve the identification and treatment of mental health problems in the general medical and A&E setting leading to reduced morbidity, reduced hospital admission, reduced inappropriate physical investigations and improved quality of life (Expert Group on Mental Health Policy, 2006). The 2006 'A Vision for Change' report recommended that every acute admitting hospital in Ireland should have access to a multidisciplinary liaison mental health service comprising of a consultant liaison psychiatrist, a doctor in training, two clinical psychologists, five clinical nurse specialists and two administrators. At the time there were nine liaison mental health teams operating nationally. An overview of liaison psychiatry services in 2010 found that while there were liaison psychiatry services provided in most hospitals throughout the country, only eight hospitals had liaison teams (Mental Health Commission, 2010). The findings of this audit are in line with the mental health commission report as all hospitals reported that they can provide access to a liaison psychiatry service which can provide assessment and treatment to adults throughout the hospital, though there is some variation in how these services are delivered.

- 83% of hospitals (30/35) reported that the liaison psychiatric service can provide emergency or urgent assessment.
- 71% of hospitals (25/35) have a named consultant psychiatrist delivering the service, the majority of whom (80%, 20/25) have dedicated time in their job plan for the provision of the liaison service.

One hospital noted that while the team do provide emergency assessment in the hospital, dementia is not considered as an urgent assessment. Where there is no named consultant, the service is often delivered by a range of healthcare professionals, including registrars, Senior House Officers (SHOs), liaison psychiatric nurses and the crisis nurse services. Often the service is not formally commissioned but provided on an ad hoc basis.

- 18% of hospitals (6/33) have a named consultant psychiatrist who specialises in the care and treatment of older people.
- 68% of hospitals (23/34) reported that their liaison psychiatry service provided mental health care to working age adults and older people.

The audit also looked briefly at whether these services were delivered by a specialist mental health team.

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- 73% of hospitals (25/34) reported that liaison psychiatric services are provided by a specialist mental health team.
 - 58% of hospitals (19/33) reported that liaison psychiatric services are delivered by a specialist mental health team who have dedicated time to provide the liaison service.

However, it is unlikely that these specialist mental health teams would meet the criteria outlined in 'A Vision for Change' (Expert Group on Mental Health Policy, 2006) as only 9% of hospitals reported having access to a psychologist.

- 100% of hospitals (34/34) reported that liaison psychiatric services are available during the day.
- 56% of hospitals (19/34) reported that liaison psychiatric services are available in the evening.
- 56% of hospitals (19/34) reported that liaison psychiatric services are available at weekends.

Just over half of liaison psychiatric services are based on-site. Comments received indicate that often community services are also providing acute hospital liaison.

- 65% of hospitals (22/34) reported that the liaison psychiatric team is based on-site.
- 29% of hospitals (19/34) reported that the liaison psychiatric team is based off-site.
- 6% of hospitals (2/34) reported that the team are based part-time on site and part-time off site.

Three hospitals noted that patients often have to be transferred to another hospital for assessment.

Psychiatry of Old Age

The 2006 report of the expert group on mental health policy 'A Vision for Change' recommended that everybody "aged 65 years or over with primary mental health disorders, or with secondary behavioural and affective problems arising from dementia, should be cared for by a mental health services for older people team" (p.115). The report also recommended that these services should be person-centred and promote self-determination for older people. Major gaps in service provision were identified, including incomplete multidisciplinary representation in almost all existing mental health services for older people, and a lack of specialised assessment and treatment in most acute admission settings. This is in line with findings from international research which shows that few countries have well developed old age psychiatry services (Draper, 2000). The results of this audit highlight a lack of consistency in the availability and provision of liaison psychiatry of old age services

to acute hospitals in Ireland. 71% of hospitals (25/35) reported that they can provide access to a liaison Psychiatry of Old Age (LPOA) service though only 31% of hospitals (11/35) have a LPOA service which can provide emergency or urgent assessment. Variations in how services are delivered were also identified.

- 66% of hospitals (23/35) have a named consultant psychiatrist of old age providing the liaison service, with 52% of these professionals (12/23) having dedicated time to deliver the service.
- 37% of hospitals (13/35) reported having a liaison POA service provided by a specialist mental health team.
- 20% of hospitals (7/35) reported having a POA team who have dedicated time for the delivery of the service.

Even where a team is in place, it is unlikely that these teams meet the criteria outlined in 'A Vision for Change' due to the lack of psychology services identified nationally. In addition, the lack of dedicated time has a significant impact on service delivery. In many instances POA is being delivered by community based services, who are not formally commissioned to deliver services to the acute hospitals. This arrangement is unsatisfactory to all involved, as the community psychiatry of old age service does not have the resources necessary to deliver an appropriate liaison service to the acute hospitals, and staff on the wards find it frustrating as they cannot rely on the liaison service. Some ward managers reported that they avoid referral to these services where possible as the waiting times are so long. Unfortunately 'A Vision for Change' only addresses community services for older adults with mental health problems, and does not provide clear guidance on the level of liaison psychiatry of old age services needed for acute hospitals.

Some hospitals reported that POA can deliver liaison services to inpatients who are from their community catchment area, while the general psychiatric liaison services provide services to people presenting to ED and older people admitted from outside of the community catchment area. However such arrangements may lead to inequitable service provision. A number of hospitals commented that the provision of dedicated resources would be greatly beneficial to the delivery of appropriate and equitable POA services. Liaison POA services have less availability than general liaison psychiatric services.

- 71% of hospitals (25/35) reported that liaison POA services are available during the day.
- 11% of hospitals (4/35) reported that liaison POA services are available in the evening.
- 2% of hospitals (2/35) reported that liaison POA services are available at weekends.

Where POA services are available (n=25), the majority are based off-site.

- 28% of hospitals (7/25) reported that LPOA services are based on-site.
- 64% of hospitals (16/25) reported that LPOA services are based off-site.
- 8% of hospitals (2/25) reported that LPOA services are based both on-site and off-site.

Where there is no liaison POA service, the majority of hospitals (90%, 9/10) reported that mental health input is provided by another psychiatrist.

Recognition of Mental Health Needs at Discharge

The HSE Code of Practice for Integrated Discharge Planning recommends that discharge information should include a description of unresolved ongoing problems listed on the hospital care plan. This would include mental health assessments and relevant behaviours noted during the admission as this information is particularly relevant to ensure community services and families/carers can access appropriate treatment and supports after discharge.

Only one hospital had a section or prompt in the hospital discharge summary for mental health diagnosis and management. This lack of attention to mental health status at discharge is reflected in findings from the HCR audit. There were 121 patients who were not eligible for this section of the HCR audit as they had (a) died in hospital, (b) were receiving end of life care, or (c) were transferred to another hospital, or psychiatric ward, or palliative care, or rehabilitation.

- 12% of HCRs (64/532) had the patient's level of cognitive impairment, using a standardised assessment, summarised and recorded at point of discharge.
- 43% of HCRs (229/536) had the cause of cognitive impairment summarised and recorded at the point of discharge.

In the majority of records the patient's level of cognitive impairment was not assessed prior to discharge, hence only 12% of HCRs had the level of cognitive impairment summarised and recorded at discharge. The cause of cognitive impairment was recorded in all HCRs, though this was summarised and recorded in the discharge summary in just 43% of cases.

- 24% of HCRs (47/194) had symptoms of delirium (where present) summarised for discharge.
- 27% of HCRs (37/139) had persistent behavioural and psychiatric symptoms of dementia (where present) summarised and recorded at discharge.

The importance of including this relevant information at discharge needs to be highlighted to all staff involved with discharge, given the higher risk for accelerated cognitive decline with a pre-existing dementia, and the risk of recurrence for those who develop delirium.

Governance and Mental Health

Hospital admission, combined with unfamiliar surroundings and memory problems, can be frightening and disorientating for those with dementia. This can lead to behaviour which is perceived as 'disruptive', 'difficult' or 'challenging' (Cunningham, 2006). While most people with dementia will not display behaviours that challenge whilst in hospital, this group are at increased risk of displaying such behaviours due to the illness or injury, delirium, the environment or the dementia condition itself (National Audit of Dementia, 2011). Caring for people with dementia and responding appropriately to behaviours that are challenging requires time, particular skills and resources, often not present in the acute hospital environment. Without the appropriate resources and skills hospitals often use nursing 'specials' (an additional staff member to sit with a patient, sometimes a member of hospital security) as a way of reducing risk of harm to the person or those around them (Cahill et al., 2012). In some instances staff may resort to using physical and/or chemical restraint as a way of responding to particular behaviours in order to protect either the person with dementia or others around them (Saarnio et al., 2011; Alzheimer Society of Ireland, 2010). Restraint is the act of removing another person's freedom and may be experienced as highly demeaning and distressing for the person with dementia. Therefore, best practice recommends that restraint be used only as a final option (Alzheimer Society of Ireland, 2010; Dept. of Health and Ageing, 2012) and staff need guidance on responding appropriately to behaviours that challenge and assessing if there is a genuine need for minimal restraint to be put in place.

- 50% of hospitals (17/34) have, or are developing, a protocol 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 BPSD.
- 32% (11/34) have the policy in place while 18% of hospitals (6/34) are currently developing a policy.

However, even where a protocol is in place, it does not always have the elements necessary to make it appropriate for the treatment and management of behaviours that challenge for people with dementia. Of those hospitals with a protocol in place or in development:

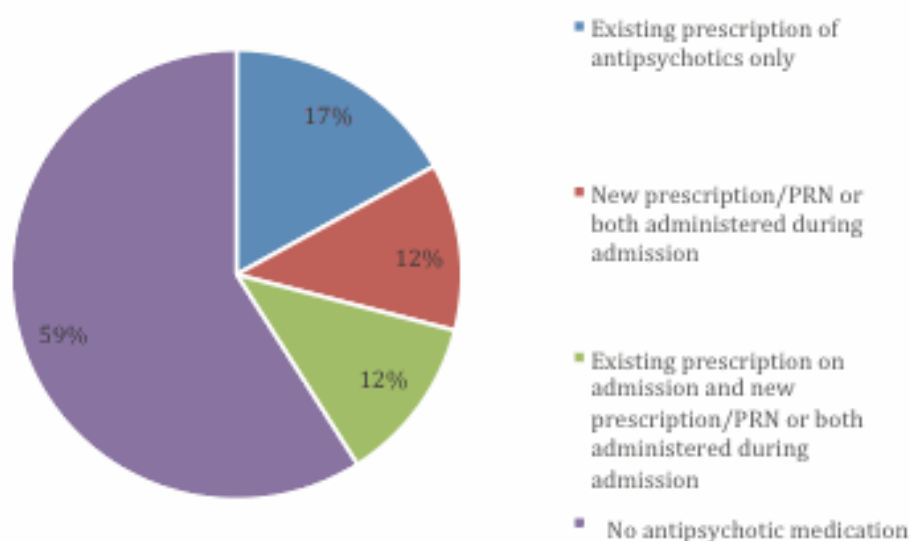
-
- 82% (14/17) reported that their protocol specifies that restraint and sedation are only used as a final option, and specifies the consideration of physical causes which may cause behaviours that challenge.
 - 65% (11/17) reported that their protocols consider environmental factors such as noise, lack of activity and disorientation, and specify the possibility of using techniques of reassurance, de-escalation and distraction.
 - 53% (9/17) reported that their protocols specify 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.
 - 35% (6/17) reported that their protocol has specific evidence based guidelines for the prescription and administration of antipsychotic drugs.

Further work is needed to ensure that all hospitals develop and implement protocols governing the use of interventions for patients displaying violent or challenging behaviour, which is suitable for use with patients who have dementia.

Prescription of Antipsychotic Medication

The use of antipsychotic drugs to treat neuropsychiatric symptoms in patients with dementia can have a positive impact on quality of life and is justified when used carefully (van de Ven-Vakhteva, 2013). However a report by Bannerjee in 2009 found that antipsychotics were being overprescribed in the UK, resulting in a number of adverse effects including increased mortality. This has led to the Department of Health in the UK aiming to reduce the use of antipsychotics by two thirds by 2015. The audit examined the use of antipsychotics, both existing prescriptions and in-hospital prescriptions. 41% of patients were administered antipsychotic drugs at some point during admission, with just over half of patients (59%) not on antipsychotics. The chart below illustrates the antipsychotic data from the HCR audit.

Figure A: Use of Antipsychotic Medication, N=656



People admitted from a nursing home were much more likely to be taking antipsychotic medication than people admitted from other places of residence.

- 19% of patients (68/362) admitted from their own home were already prescribed antipsychotic medication.
- 46% of patients (100/216) admitted from nursing homes were already prescribed antipsychotic medication.

Given the lower number of mental health assessments carried out on people admitted from nursing homes, and their shorter lengths of stay, it is possible that this cohort would also be less likely to have a medication review during their admission. However, the high number of people on an existing antipsychotic medication admitted from nursing homes would suggest that routine / regular / scheduled reviews of antipsychotic medication would be highly appropriate for this group. In 2008 the Health Information and Quality Authority (HIQA) published National Quality Standards for Residential Care Settings for Older People in Ireland. The standards require that each resident on long-term medication is reviewed by his/her medical practitioner on a three-monthly basis, in conjunction with nursing staff and the pharmacist, with special consideration given to the use of antipsychotic medication (HIQA, 2008). However, an acute admission also provides an important opportunity to review these medications, which have high associated morbidity.

A number of new prescriptions for an antipsychotic medication were also made.

- 23% of patients (152/657) were prescribed an antipsychotic medication via PRN during their admission.

- 19% of patients (125/657) were administered an antipsychotic medication via PRN during their admission.
- 16% of patients (109/657) were given a new regular prescription for antipsychotic medication.

Further examination of the data on new prescriptions showed that approximately half of patients who were given a new, regular prescription already had an existing prescription for antipsychotic medication on admission (8%, 54/657), while half had not been taking antipsychotics on admission (8%, 55/657). This means that 12% of patients (55/469) who were not taking antipsychotic medication on admission received a new, regular prescription (excluding PRN) during their admission.

The audit also asked for the main or primary recorded reason for antipsychotic prescription, either for a new regular prescription or a PRN. A reason for the prescription of an antipsychotic medication was recorded in only 50% of cases. The reasons recorded are as follows:

Table 2: Reasons for the Prescription of Antipsychotics

Main/Primary Reason	n
Co-morbid psychotic disorder	3
Immediate risk of harm to self or others	1
Severe distress not responsive to other intervention	2
Need to carry out investigation and/or treatment and/or nursing care	1
Agitation	89
Anxiety	4
Aggressive/threatening behaviour	11
Disturbance through noise	1
Disturbance through wandering, obsessive behaviour, mannerisms, tics	6
Delirium	12
Hallucinations	2
End of life	3
Depression/low mood	5
Other	5
Total	145

Two of the most common reasons recorded were agitation and aggressive/threatening behaviour. Unfortunately, the audit tool did not collect information on whether alternative non-pharmacological approaches had been tried in these cases, so it is impossible to determine whether the use of antipsychotics in these instances was appropriate. However, it is a matter for concern that the reason for the use of antipsychotics was recorded in only 50% of cases.

Conclusion

While all hospitals reported some level of access to liaison psychiatric services, the variance found in how these services are delivered is not in line with best practice recommendations. There was less availability and more variation in how liaison psychiatry of old age services are being delivered, leading to many hospitals not having adequate access to specialist mental health services for older people. There is a need for the majority of hospitals to have more focus on mental health needs at discharge to ensure appropriate support and services are in place following discharge. There is also a need for guidelines on the use of restraint and promoting a restraint free environment in acute hospitals to be developed and implemented. The relatively high use of antipsychotics indicates a need for improved review and monitoring of the use antipsychotics in the acute setting.

Recommendations

15. Liaison Psychiatry and particularly Liaison Psychiatry of Old Age services should be in place in all acute hospitals to provide daily access for the treatment and referral of people with dementia. These services should have a named consultant psychiatrist/psychiatrist of old age providing the liaison service who has dedicated time in his/her job plan for the provision of same. Response times to referral should be a key performance indicator for these services.
16. A separate process for auditing the use and prescription of antipsychotic medication in the acute setting should be developed.
17. A restraint policy for the acute services needs to be developed on a national level, taking into account the recommendations of the 2011 Department of Health Policy 'Towards a Restraint Free Environment in Nursing Homes' and the findings of the 2011 audit of the HSE 'Policy on Use of Physical Restraints in Designated Residential Care Unit for Older People'. Individual hospitals should appoint a clinical lead with responsibility for implementation and monitoring of the policy/standards.
18. The role of psychology services in the care of the person with dementia needs to be highlighted and appropriate services should be developed to further support and promote good mental health and holistic care for the person with dementia.
19. Systems need to be developed to ensure that appropriate information on cognitive impairment and delirium are included in the hospital discharge summary, including information/training for staff on the significance of the identification of cognitive impairment and its causes.
20. A period of treatment in hospital should be highlighted as an appropriate point for review by an appropriate expert of any use of antipsychotic medication. Guidelines on dementia care currently being developed by The College of Psychiatrists of Ireland will provide guidance on the use of antipsychotics and the circumstances in which prescription of antipsychotics is appropriate.



Nutrition

Summary

- 76% of patients (496/651) had a nutritional assessment carried out during their admission; 39% (259/658) had their weight or BMI recorded.
- 50% of hospitals (17/34) have protected mealtimes established on all wards that admit adults with known or suspected dementia.
- 35% of wards (27/77) have a system in place to signal the need for increased assistance with eating and 92% of wards (71/77) can provide food to patients between mealtimes.
- 20% of wards (15/77) provide patients with opportunities to socially interact at mealtimes, such as a single dining table on the ward or a separate ward dining room.
- 94% of hospitals (33/35) reported having access to specialist services to help people with dementia in their swallowing and eating.

Nutritional Assessments

Nutrition and hydration are vital for health and wellbeing and for recovery from illness, surgery or accident while malnutrition is associated with adverse outcomes such as higher complication rates, impaired wound-healing and increased length of hospital stay (Agarwal et al., 2012). In the UK, four out of ten people admitted to hospital are malnourished on arrival (NHS Confederation, 2010), while a US study found that the prevalence of malnutrition in the acute hospital setting was 38.7% (Kaiser et al., 2010). People with dementia experience particular challenges in maintaining adequate nutrition and hydration due to memory difficulties, visual agnosia and receptive and expressive dysphasia (Heath et al., 2010). Therefore, assessing the nutritional status of patients with dementia is vital. The majority of hospitals (97%) reported that nutritional assessments were routinely carried out on people with dementia, and 88% reported that the person's weight or BMI is recorded as part of that assessment. However results from the HCR audit were less encouraging:

- 76% of patients (496/651) had a nutritional assessment carried out during their admission.
- 39% of patients (259/658) had their weight or BMI recorded.

The audit team also noted that assessment of nutritional status was not standardised between or within hospitals, with some hospitals/wards doing a minimal assessment as part of the nursing admission checklist, and others carrying out a standardised assessment on all patients.

Mealtimes on Wards

Due to the busy nature of acute wards, mealtimes and nutrition are often given less importance than other aspects of care (Dewing, 2003). It is vital that hospitals provide meals that fit the dietary needs of their patients, and ensure they have the necessary support to eat them (NHS Confederation, 2010). Because of the pressure of other work, patients who require assistance sometimes have to wait a long time for their meal, leading to the food being cold and unappetising (Archibald, 2006).

Half of hospitals (50%) have protected mealtimes established in all wards that admit adults with known or suspected dementia, and 27% of hospitals have a process to review and monitor the wards adherence to protected mealtimes. A number of hospitals reported that they are currently piloting protected mealtimes in some wards, while other hospitals reported that they feel it is impossible to introduce protected mealtimes. Even where protected mealtimes have been established, hospitals reported a number of difficulties encountered, including visitors regularly seeking access to wards at mealtimes and other disciplines not respecting the protected mealtimes (e.g. ward rounds running over into mealtimes, patients being taken for x-ray/scans at mealtimes). There may be an

opportunity for hospitals that have successfully implemented protected mealtimes to share the difficulties they encountered and how they overcame these difficulties, in order to support all hospitals to successfully implement protected mealtimes.

Additional information on mealtimes was collected at ward level.

- 43% of wards (33/77) reported that a protected mealtime system is in place which allows carers to visit and assist during mealtimes.
- 35% of wards (27/77) had a system in place that signalled the need for increased assistance with eating.

Where such a system was in place, wards generally used red trays or special food symbols hung above the bed or on the door of the room to signal the need for help with eating.

- 75% of wards (58/77) could provide adapted utensils to facilitate patients eating independently.
- 65% of wards (50/77) stated they had a system in place to ensure adequate staffing levels at mealtimes to support eating and choosing food if necessary.

A number of staff commented that their system involved staggering staff lunch breaks to ensure that all staff were “on the floor” at mealtimes. However, in light of the fact that very few wards use standardised instruments to measure dependency levels, such systems may be inadequate to ensure sufficient staffing at mealtimes. In addition, reduced staffing levels often mean that ward staff are unable to provide one to one assistance at mealtimes. In order to overcome this, many wards actively encourage families and carers to visit and assist at mealtimes. However some ward staff commented that they face great difficulties in ensuring all patients are given the support they need to eat at mealtimes.

- 92% of wards (70/76) reported that staff are encouraged to report patients missing/uneaten meals to ward managers.
- 92% of wards (71/77) were able to provide food to patients between mealtimes.

On some wards tea, toast and yoghurts are available between mealtimes, while on other wards a more substantial and larger range of food is available e.g. sandwiches and cereal.

- 20% of wards (15/77) had opportunities for patients to socially interact at mealtimes.

While one hospital had a designated room where patients could eat together, other ward managers expressed concerns regarding infection control if this practice was encouraged.

Specialist Input

It is common for people with dementia to have difficulties swallowing and eating. A referral to specialist services is sometimes necessary to support adequate nutritional intake. The majority of hospitals (94%) reported they have access to specialist assessment and advice on helping patients with dementia in their swallowing and eating.

- 94% (33/35) reported that specialist assessment and advice could be obtained from Speech and Language Therapists.
- 83% (29/35) reported that specialist assessment and advice could be obtained from a Dietician.
- 57% (20/35) reported that specialist assessment and advice could be obtained from other professionals, mainly Occupational Therapists.

At ward level, 79% of wards reported having access to Speech and Language Therapists five days a week, while 87% of wards reported having access to Dietetics five days a week.

Conclusion

The audit found that there is good awareness of the importance of nutrition in the acute setting and a number of hospitals are introducing initiatives such as protected mealtimes to maximise their patient's nutritional well-being. However some difficulties were identified, particularly in the poor recording of weight or BMI, and regarding sufficient staffing at mealtimes to aid people to eat. The majority of wards have good access to specialist services such as Speech and Language and Dietetics. There is an opportunity for hospitals to capitalise on the nutrition initiatives being implemented in hospitals across the country by sharing best practice and learning.

Recommendations

21. Dementia specific education and training should be provided to all staff to support the routine use of a standardised nutritional assessment tool (e.g. MUST or MNA), including the routine monitoring and recording of weight/BMI, and the development of standardised approaches to supporting patients who require assistance with eating.
22. Ward managers should be provided with appropriate instruments to assess the staffing levels required to support mealtimes, including assessment of the additional support needs of people with dementia.
23. 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.
24. Protected mealtimes should be established in all wards. Best practice and learning from hospitals with established protected mealtimes should be shared.



Information and Communication

Summary

- Very few hospitals have policies or guidelines in place around information sharing and how to involve families/carers in the care and treatment of the person with dementia during their admission.
- One hospital (1/35) has a formal system in place for collecting information about the person with dementia from a carer, family or relative.
- 99% of wards (76/77) identified handover as the system used to ensure all staff are aware of the person's condition and how it affects them.
- 79% of wards (61/77) provide information about ward routines such as mealtimes and visiting hours.
- 15% of wards (12/77) routinely provide information on the hospital complaints procedure.
- Few wards assign a single named nurse who is accountable for an individual patients' care.

Involvement of Families and Carers

Families/carers often experience difficulties when trying to access information about a patient's current medical condition and their anticipated care and support needs on discharge. This results in them acquiring information by randomly asking whoever is available to answer their questions, a frustrating experience for all involved (Bauer et al., 2011). While nurses working in the acute hospital setting in Ireland have emphasised the importance of working with families/carers to establish the necessary bond to lead to meaningful care (Nolan, 2006), only two hospitals have clear guidelines on making sure the carer knows what information will be shared with them and why. At ward level, 27% of wards reported that they discussed with carers and the person with dementia when personal and healthcare information would be shared with them. This question generally elicited a lot of discussion with ward managers and there was often a lack of clarity regarding best practice in this area. Some staff dealt with the issue of patient confidentiality as it arose e.g. if a relative/carer was looking for test results over the phone. Others referred all matters relating to this area to medical staff.

During a hospital admission, a person with dementia requires comprehensive care, addressing not only their medical condition, but also their functional, cognitive and social care needs (Bauer, 2011). In order to provide this level of care, staff need to work closely with families and carers. Clear communication and active collaboration are the most important components of building good staff-family relationships (Haesler et al., 2010), although the challenges in engaging with families/carers in the acute care context must be acknowledged (Nolan et al., 2004). Positive working relationships are unlikely to flourish unless they are underpinned by practical support from the organisation, including acknowledgement of the positive impact constructive relationships can have within the facility. (Haesler et al., 2010).

- 6% of hospitals (2/34) reported they have 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.
- 30% of hospitals (10/33) have guidelines around asking the carer about their wishes and ability to provide care and support to the person with dementia post discharge.
- 6% of hospitals (2/34) reported involving people with dementia and their carers, and their experiences, in the training for ward staff.

Information Collected About the Person with Dementia

Behaviours perceived as challenging such as agitation, aggression and shouting were once thought to be inevitable symptoms of dementia. However exploring behaviours that challenge from a person-centred perspective has led a number of research studies to conclude that these behaviours are often manifestations of an individual's attempt to communicate a need, or as the direct result of an unmet need (Keady & Jones, 2010). In the acute setting, person-centred assessment can enhance the quality of care for people with dementia and improve outcomes, keeping the person with dementia firmly at the centre of the assessment and intervention process. Knowing the person with dementia allows staff to listen, understand and respond appropriately, leading to patients being more accepting of treatments, displaying less behaviours that challenge, and having higher levels of well-being (Webster, 2011). A person-centred assessment is one that can identify the needs of people with dementia based on their life history and patterns of daily living. The audit examined whether acute hospitals had a section in the patient's notes dedicated to collecting information about the person necessary to facilitate a person-centred approach to their care.

Only one hospital in Ireland has a form dedicated to collecting information about the person with dementia from a carer, family or relative. The form is used only for people with advanced dementia and collects information on routines and preferences, reminders or support needed with personal care, recurring factors that may cause or exacerbate distress, support or actions that can calm the person when agitated, and details of life which aid communication.

The HCR audit also asked whether there was evidence of a formal system for collating information about the person with dementia necessary to their care. While 33 HCR audits confirmed that there was evidence that such a form was in place, this question had a very low Kappa value (0.03) as no two auditors agreed on a 'yes' answer. Combined with the knowledge from the organisational audit that only one hospital has such a form in place, it is likely that auditors misinterpreted this question. This is further supported by the high level of discussion generated during audit training around this section, as many of the Registrars/Specialist Registrars had never seen such a form and were unsure what it might look like. What is clear from these findings is that the idea of using a formal tool to collect the personal information necessary to facilitate high quality person-centred dementia care is a very new concept in acute hospitals in Ireland. This raises concerns about whether staff have the information, skills or resources to deliver person-centred care, or to effectively implement non-pharmacological interventions for behaviours that challenge.

In order to ensure continuity of care, all staff caring for the person with dementia require an appropriate level of knowledge about the person, as they may not be able to provide this

information themselves. Hospitals were asked whether they had a system in place across the hospital to ensure that all staff are aware of the person's dementia or condition and how it affects them.

- 9% of hospitals (3/34) responded that this information was communicated to staff on the ward through handover.
- 15% of hospitals (5/34) responded that this information was communicated to staff from other areas verbally, as the patient would always be escorted when accessing other treatment areas.

At ward level, handover was more consistently identified as the system used for communicating personal information regarding the person with dementia.

- 99% of wards (76/77) identified handover as the system they used for communicating appropriate personal information and any behavioural or communication needs specific to the patient with dementia.
- 29% of wards (22/77) identified escorting patients as the system used to communicate to other staff any behavioural or communication needs specific to the patient with dementia.

However, some difficulty lay in identifying what constituted an organised 'system'. Certainly relevant personal information and any communication or behavioural needs are discussed during handover. However, there are no criteria as to the type or scope of information discussed, and the lack of a formal system to collect personal information may lead to crucial information on personal routines, and what may agitate or calm a patient, being overlooked. In addition, while most wards ensured that the person with dementia was accompanied whenever they left the ward, either by a nurse, a healthcare attendant (HCA) or a porter; the majority felt that this practice was not consistent enough to constitute a system of communication. A number of hospitals also expressed reluctance to introduce any kind of visual indicator system for identifying patients with dementia (e.g. coloured wristband), as this may impact on patient's privacy and right to confidentiality, or may further stigmatise patients with dementia.

Information Available on the Ward

In order to reduce anxiety for the person with dementia and their families/carers it is essential that they are reassured and kept informed of events and procedures at the time of admission (Haesler, 2010). This practice will also serve to encourage positive family/carer involvement in the care and treatment of the person with dementia and facilitate good communication between staff and

families/carers. Orientation should include information about the ward and hospital routines, such as mealtimes, visiting hours, periods of rest/quiet and the local complaints procedure (Royal College of Psychiatrists, 2011).

- 79% of wards (61/77) provided information about ward routines such as mealtimes and visiting hours verbally.
- 26% of wards (20/77) provided this information in written format.
- 13% of wards (10/77) provided information in both formats.
- 5% of wards (4/77) provided information on the hospital complaints procedure verbally, 10% (8/77) provide this information in written format.

While only a few wards provide information on complaints at the patient's bedside, a lot of wards have the leaflets on the HSE complaints procedure available in the corridors.

The HSE Code of Practice for Integrated Discharge Planning states that "within one hour of patient admission to the ward, an appropriate and competent Nurse (or other) from the ward shall be identified and assigned to actively manage the patient pathway of care" (p31.). Having one particular healthcare professional responsible for coordinating care may help reduce confusion and anxiety for the person with dementia and their families/carers and facilitate continuity of care practices. The Alzheimer Society UK recommends that a healthcare professional responsible for co-ordinating the patient's care should be identified to the patient and their family. At ward level:

- 83% of wards (64/77) responded that a healthcare professional responsible for coordinating care was identified to the person with dementia and their relatives and carer as a point of contact.

However, further questioning showed that staff were alluding to the practice of the nurse on duty for a particular bay introducing her/himself to the patient each morning, rather than the idea of one specific nurse being accountable for that patients' care. In Ireland there is no one method of nurse allocation, and while some hospitals may choose to allocate one nurse to a particular group of patients to ensure continuity and coordination of care, the practice described above is more common.

Conclusion

The findings show that more needs to be done at an organisational level to provide structure and guidance to staff on how to effectively communicate with and involve families and carers in the care and treatment of the person with dementia during their hospital admission. This needs to be combined with information and education at ward level of the benefits for both staff and patients of providing person-centred care, and utilising the knowledge and personal history families and carers can provide. The importance of providing relevant and pertinent information to the person with dementia and their families throughout their admission also needs to be highlighted. Research into the most effective systems for communicating personal information relevant to the care of the patient with dementia whilst maintaining patient dignity and confidentiality needs to be carried out.

Recommendations

25. Guidelines for the involvement of patients, families and carers should be developed and implemented.
26. A single named healthcare professional should be appointed as a point of contact for each person with dementia and their families. This person would then have responsibility for ensuring the family or carer is involved in the care plan and decisions about discharge.
27. The feasibility of introducing a personal information document (e.g. patient passport) to articulate the normal everyday needs of the person, and to assist staff in delivering person-centred care should be explored.
28. Explore the appropriateness of implementing systems to ensure that people with dementia can be identified by staff both on the ward, and staff from outside the ward when accessing other treatment areas.
29. Information on advocacy services, complaints procedures and discharge processes should be routinely given to people with dementia and their families/carers.
30. Systems for appropriately communicating all pertinent information to support the delivery of person-centred care by all staff on the ward and throughout the hospital need to be developed.



Staff Training

Summary

- 21% of hospitals (7/33) have a knowledge and training framework or strategy that identifies necessary skill development in working with and caring for people with dementia.
- 6% of hospitals (2/33) include dementia awareness on their staff induction programmes and no hospital has mandatory dementia awareness education for staff.
- Just over half of hospitals stated that they have provided dementia awareness training to doctors (54%, 18/33) and nurses (52%, 16/31) in the last 12 months, with fewer hospitals providing the same training to healthcare assistants (HCAs)(29%, 9/31), allied health professionals (16%, 5/31) and support staff (10%, 3/31).
- Approximately half of hospitals stated that they have provided training in behaviours that challenge to doctors (48%, 16/33), nurses (65%, 20/31), and HCAs (55%, 17/31) in the past 12 months.
- Very few hospitals have provided training in communication in the past 12 months.
- 41% of hospitals (13/33) stated that they have provided training in capacity assessment to doctors in the past 12 months. 22% of hospitals (7/32) stated that they have provided training in this area to nurses.
- In relation to assessing risk before the use of restraint or sedation, 27% of hospitals (9/33) stated that they have provided training to doctors, 42% (13/31) to nurses, and 29% (9/31) to HCAs in the past 12 months.
- Only 38% of wards (29/77) have arrangements in place to allow staff to attend training relating to the care of people with dementia.

Dementia Care/Awareness

The acute hospital environment poses many challenges for people with dementia and the staff caring for them. Because of this, all levels of staff working in the acute setting have particular learning needs which must be addressed to equip them to provide skilled dementia care (Nolan, 2007). Unfortunately, there is a dearth of appropriate education and skills development among staff in acute hospitals in Ireland. A needs analysis conducted in 2010 found that staff working in Irish hospitals did not feel they had sufficient knowledge to care for the person with dementia adequately. This is perhaps not surprising, as 95% of nursing staff and 79% of healthcare assistants had received no training in dementia care (de Siún & Manning, 2010). There is some evidence that things have not changed much since then (Buckley et al., 2013). The findings from this audit suggest that dementia education and training is still not a priority in many Irish hospitals, despite the high prevalence of people with dementia in this setting.

- 21% of hospitals (7/33) have a knowledge and training framework or strategy that identified necessary skill development in working with, and caring for, people with dementia.
- 6% of hospitals (2/33) include dementia awareness on their staff induction programmes.

The lack of a knowledge or training framework may lead to fragmented and inconsistent training in this area, which in turn can potentially lead to confusion regarding best practice and ethos of care. It is also important that all staff working in the acute hospital receive dementia awareness education as people with dementia will come into contact with a range of staff including porters, technicians, nurses, healthcare assistants and consultants. However the audit found that where dementia awareness training is provided it is more likely to be delivered to nursing and medical staff.

- No hospitals have mandatory dementia awareness education/training for any staff.
- 54% of hospitals (18/33) stated they had provided dementia awareness (DA) training to doctors in the last 12 months.
- 52% of hospitals (16/31) stated they had provided DA training to nurses in the last 12 months.
- 30% of hospitals (9/31) stated they had provided DA training for healthcare assistants in the last 12 months.
- 16% of hospitals (5/31) stated they had provided DA training for allied health professionals in the last 12 months.
- 10% of hospitals (3/31) stated they had provided DA training for support staff in the last 12 months.

The lack of mandatory training is clearly impacting on the level of training being made available in the acute hospitals. Geriatricians often reported including dementia in their ward-based training, which increased the number of hospitals providing training to doctors, although this is clearly not systematic training of all doctors. Hospitals reported anecdotally that the majority of nursing and healthcare assistant training was provided through attending the National Dementia Education and Awareness Programme.

Behaviours that Challenge

People with dementia are more likely to perceive the acute hospital environment as frightening and disorientating, which can lead to behaviours which staff find challenging or disruptive (Cunningham, 2006). Responding to behaviours that challenge and addressing wandering and other safety issues were identified as two of the learning topics most needed by staff in acute hospitals (de Siún & Manning, 2010). Staff working in the emergency department (ED) identified particular challenges in responding appropriately to behaviours that challenge, as often there is no family present, the staff have no history available to them from a HCR, and there can be underlying complicating factors (e.g. alcohol) which all exacerbate distress and behaviours that challenge. It is important that staff are aware of the many potential causes of behaviours that challenge as often it is an expression of unmet need such as pain, discomfort, fear or boredom. Staff also need guidance on the most appropriate way to respond to each individual patient and their behaviour.

- 48% of hospitals (16/33) reported that they had provided training to doctors on approaches to behaviours that challenge, including management of aggression and extreme agitation (45% through in hospital training, 1% through external provision).
- 65% of hospitals (20/31) reported they had provided training to nurses on approaches to behaviours that challenge, including management of aggression and extreme agitation (39% through in hospital training, 26% via external provision).
- 55% of hospitals (17/31) reported that they had provided training for healthcare assistants on approaches to behaviours that challenge, including management of aggression and extreme agitation (32% through in hospital training, 23% via external provision).

Approximately half of hospitals reported providing some training around behaviours that challenge, though this training is not provided systematically to all staff. Given the complex variables which contribute to behaviours that challenge, the range of effective non-pharmacological approaches to managing such behaviours, and the negative impact behaviours that challenge can have on both

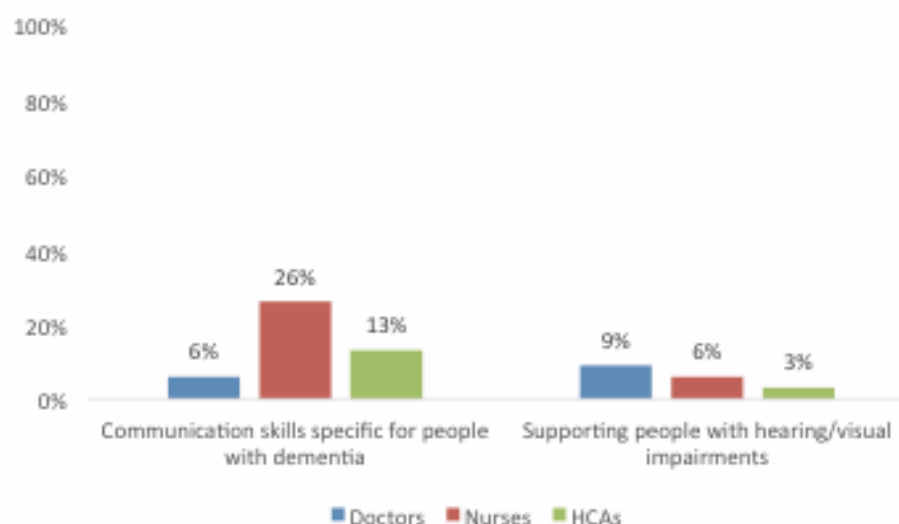
staff and the person with dementia, it is clear that more consistent and widespread training is needed in this area.

Communication

Communicating with a person with dementia may present a number of challenges, not only due to the level of cognitive impairment of the individual, but also due to hearing and visual impairments (National Audit of Dementia, 2011). Communication plays a key role in delivering person-centred care, is essential to establishing good relationships in care environments, and can reduce incidence of behaviours that challenge (De Vries, 2013). Communication skills training programmes have been found to have a positive impact on both verbal and non-verbal communication.

The audit looked at the training staff had received in the area of general communication skills specific for people with dementia and any training received in how to support people with hearing/visual impairments. Figure B below illustrates the results:

Figure B: Percentage of Hospitals Providing Training in Communication



As illustrated above, there are very low levels of training for all healthcare providers in the area of communication. It is possible that this lack of training may impact on levels of patient stress and incidents of behaviours that challenge, as staff are unlikely to have the skills necessary to communicate effectively with the person with dementia.

Capacity

The Assisted Decision Making (Capacity) Bill was published in Ireland in 2013, bringing the issues associated with mental and legal capacity into the spotlight. Under the new Bill, people found not to have the mental capacity to make a particular decision will not automatically lose legal capacity, as was the case under the Lunacy Act. Decision making capacity will be assessed on a particular issue and on a time-specific basis. People found not to have the mental capacity to make a decision will have the opportunity to make an assisted decision on that particular issue. The impact this new Bill will have on healthcare professionals carrying out assessments of capacity is as yet unclear.

- 41% of hospitals (13/33) had provided training in assessment of capacity to doctors in the last 12 months.
- 22% of hospital (7/32) had provided training in assessment of capacity to nurses in the last 12 months.
- 3% of hospitals (1/32) had provided training in assessment of capacity to HCAs in the last 12 months.

Some respondents commented that training in capacity was not appropriate for nursing and HCA staff. Anecdotally it was noted that in some hospitals all assessments of capacity were referred to the senior consultant and this was not considered an appropriate topic of education for more junior doctors. In other hospitals, all medical staff were given education and training around the assessment of capacity.

Assessing Risk before use of Restraint

A restraint free environment is seen as a basic human right for all, and the decision to use restraint should not be left to family members/carers or general staff (Alzheimer Society of Ireland, 2010; Dept. of Health and Ageing, 2012). The Australian Government have designed a tool kit to assist staff, which highlights the role of communication, consideration of causes and continuous review during the decision making process (Dept. of Health and Ageing, 2012). Similarly the policy document 'Towards a Restraint Free Environment in Nursing Homes,' published in 2011, highlights the importance of considering risk versus benefit, the importance of residents' views and the need to consider alternatives to the use of restraint (Dept. of Health and Children, 2011). Both documents stress the importance of organisational policies and procedures being underpinned by a restraint-free way of thinking. The audit looked at how many staff had received training in assessing risk whenever the use of restraint or sedation was considered.

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- 27% of hospitals (9/33) had provided training to doctors in assessing risk in the past 12 months.
 - 42% of hospitals (13/31) had provided training to nurses in assessing risk in the past 12 months.
 - 29% of hospitals (9/31) had provided training to HCAs in assessing risk in the past 12 months.

Although nearly half of hospitals provided training in this area to nurses, only 16% of hospitals that provided training to nurses and HCAs also had a policy or 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 BPSD. Similarly, only 9% of hospitals that provided training to doctors had this protocol in place.

Staff Cover

Staffing and resource constraints are a daily reality in almost all healthcare settings. Therefore, even where training is made available to hospitals, there may be difficulties in releasing staff to attend training/education sessions.

- 38% of wards (29/77) had arrangements in place to allow staff to attend training relating to the care of people with dementia.

Some ward managers commented that releasing staff to attend even mandatory training was difficult in the current climate, while others felt that dementia was not considered of high enough priority to allow staff to attend training. On some wards, staff were expected to attend training in their own time.

Conclusion

Providing appropriate person-centred care to people with dementia in the acute setting can be challenging for staff due to the unsuitability of the environment, and staffing and resource constraints. Caring for a person with dementia demands more than attending to their acute medical needs. It requires an understanding of the reality of the person with dementia, and insight into how to respond appropriately to them as an individual, rather than assuming their actions and behaviours are a result of their condition. In order to provide quality care, staff need specialist training to provide them with the necessary skills, knowledge and awareness of dementia. The

training topics examined in this audit are not considered an exhaustive list of appropriate training topics for staff caring for people with dementia. A National Dementia Education and Awareness Programme, which is suitable for staff working in the acute sector, is currently being rolled out nationally. In order to ensure that staff in acute hospitals receive the training and education they need around dementia, there is a need for more commitment at an organisational level combined with an awareness of the benefits of empowering staff to work well with people with dementia.

Recommendations

31. Given the high numbers of adults with known or suspected dementia admitted to acute hospitals, basic dementia specific training should be mandatory for all staff who care for, or come into contact with, adults in the acute hospital setting.
32. Each acute hospital has responsibility for developing a training and knowledge strategy to ensure 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.
33. Arrangements must be put in place at ward level to allow staff to attend training relating to the care of people with dementia. Appropriate education programmes currently available should be provided to and promoted amongst all staff in the acute settings, e.g. The National Dementia Education Programme.
34. Dementia awareness training should be included in all staff induction programmes.



Staffing and Staff Support

Summary

- 35% of wards (27/77) reported having unfilled registered nursing staff vacancies.
- 92% of wards (71/77) have agreed minimum staffing levels, which are met on 76% (54/71) of wards.
- 17% of wards (13/77) have a system to ensure that all factors that affect nursing staff numbers and skill mix are taken into consideration.
- Clinical supervision was the most common system in place for staff development, available to nurses on 38% of wards (29/77), and to HCAs on 26% of wards (20/77).
- Few wards have appraisal or mentorship programmes available for nurses (20%, 15/77) or HCAs (8%, 6/77).
- 12% of wards (9/77) have access to peer support groups, while 5% (4/77) have access to reflective practice groups.
- 32% of hospitals (11/34) reported having a dementia champion in place at ward level, though 16% of wards (12/77) reported having access to guidance and support from a dementia champion for nursing staff, and 5% (4/77) had access for HCAs.
- 96% (74/77) of wards have access to administrative staff during the week.

Staff Numbers and Skill Mix

Wards were asked to provide information on the number of registered nursing posts and health care assistant posts (WTE) that *should* be on the ward, and that were *actually* on the ward. Data collected indicates that while the average number of registered nursing posts that were assigned to the wards was 21.5, the average number of registered nursing posts actually on the wards was 19.7. There was a smaller drop in healthcare assistant posts, with the average number of posts assigned to the wards being 3.5, and the average number actually on the wards being 3.3. However these figures must be interpreted with caution, as many ward managers found it difficult to calculate the WTE staffing numbers because a large number of staff are working reduced hours, or are job sharing. In addition, many ward managers were unsure of the number of posts allocated to the ward.

Though ward managers had some difficulty in calculating exact WTE posts, it is certain that 69% of wards had at least one vacancy in their permanent staff. In order to fill nursing vacancies, 31% of wards used hospital pool staff and 52% of wards used agency staff. A small number of wards (8%) use both types of staff to fill their vacancies. Unfortunately the use of hospital pool and agency staff can result in inconsistencies in the delivery of care. Temporary staff are also less likely to receive training in the needs of people with dementia. Despite the widespread use of hospital pool and agency staff, over a third of wards audited have unfilled nursing vacancies.

- 35% of wards (27/77) reported having unfilled registered nursing staff vacancies.

In order to fill healthcare assistant vacancies, 21% of wards used hospital pool staff and 25% used agency staff. Once again there were a number of unfilled vacancies, with 26% of wards having unfilled healthcare assistant posts. Anecdotally, two hospitals reported using healthcare assistants to fill registered nursing staff vacancies. The majority of hospitals have a system for monitoring and reporting the use of hospital pool and agency staff; nursing administration most commonly fulfils this role.

- 92% of wards (71/77) have agreed minimum staffing levels across all shifts.
- Only 76% of these wards (54/71) meet the agreed minimum staffing levels.

The audit tool also asked whether there was a system in place to ensure that all factors that affected nursing staff number and skill mix were taken into consideration, and staffing levels were reviewed on a daily basis.

- Only 17% of wards (13/77) had a system to ensure that all factors that affected nursing staff number and skill mix were taken into consideration, and staffing levels were reviewed on a daily basis.

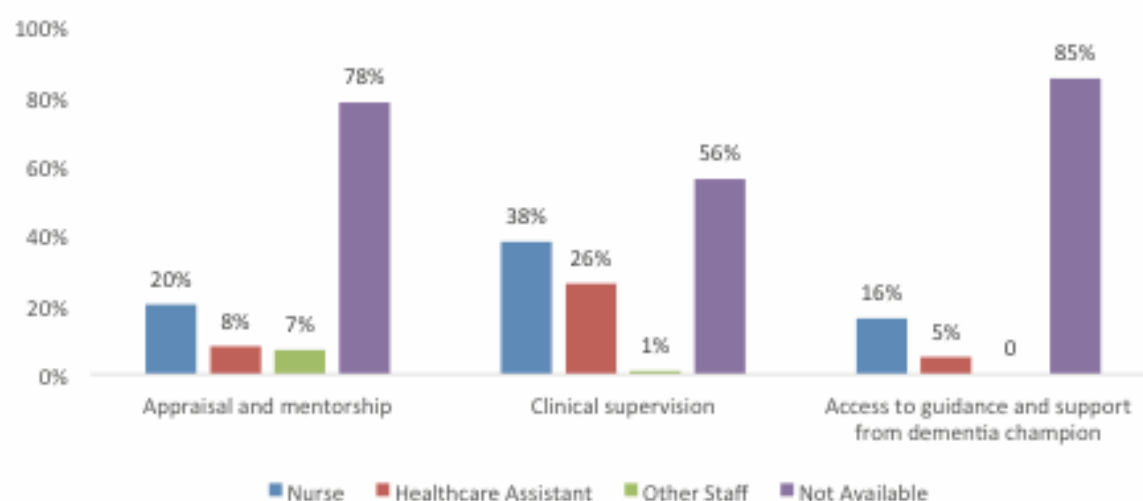
The majority of wards reported that they had no instruments for determining dependency levels objectively. Therefore, the number of staff assigned to the ward was calculated 2-4 weeks in advance when the off-duty roster was done by the ward manager. In a small number of wards, dependency levels were checked on a daily basis and used to identify the need for additional staff when required. Two hospitals reported that they had a system whereby staff were shared between two wards, and the allocation of staff could change on a daily basis in line with the dependency levels on each ward. Both hospitals reported that this system worked well for them.

Without information on dependency levels, it is not possible to calculate whether staffing levels are sufficient to meet the needs of higher dependency patients, including patients with dementia. However the findings that over a third of all wards audited had unfilled vacancies in their staffing levels, and only 76% of wards meet their minimum staffing levels on a daily basis suggests that staffing levels could be negatively impacting on the quality of care for people with dementia while in the acute hospital. The audit also found that all hospitals reported having a process for staff to record and report risks to patient care if they believe ward staffing is inadequate. However during discussions with ward managers, some expressed the view that resources are so scarce that even where additional staff are requested, it is not always possible for nursing administration to provide the necessary staff.

Support for Staff

In order to ensure that nurses have the support to develop and maintain the competence necessary for their professional practice, the Nursing and Midwifery Board of Ireland (NMBI) recommend that nurse managers must ensure there are systems to provide that support (An Bord Altranais, 2010). Clinical supervision is one such means of developing professional practice. However research suggests that there is some confusion between managerial supervision and clinical supervision (An Bord Altranais, 1999). The current audit also found some confusion amongst ward managers regarding what precisely defined appraisal, mentorship and clinical supervision. Systems for supporting staff development that were in place are illustrated in Figure C below.

Figure C: Systems for Supporting Staff Development



Few wards had systems in place for staff development. The most common system identified was clinical supervision. However the type of supervision available varied from ward to ward as some was provided on an ad hoc, informal basis while others had more formal systems in place. In addition, on 88% of wards staff did not have access to peer support groups, while on 95% of wards staff did not have access to reflective practice groups.

Dementia Champion

Cahill et al. (2012) report that having a hospital based dementia champion to advise and instruct front-line staff on psychosocial interventions and best practice for patients displaying behaviours that challenge would be hugely beneficial. A small number of hospitals had 'dementia champions' in place. For the purposes of this audit, dementia champions were defined as people with the knowledge and skills necessary to promote best practice in dementia care, advocate on behalf of the person with dementia, and drive improvements in hospital policies and procedures in line with the principles of person-centred dementia care.

- 23% of hospitals (8/34) stated they have a dementia champion in place at directorate/managerial level.
- 32% of hospitals (11/34) stated they have a dementia champion in place at ward level.

Many hospitals were unfamiliar with the term 'dementia champion' and were unclear as to the potential benefits of this role. A NFQ level 9 dementia champion programme entitled 'Advancing Person Centred Management in Dementia Care' has been available in Dublin City University (DCU)

since 2011, and is open to and relevant to staff from a number of settings including mental health, acute and residential care. It is envisaged that graduates of the module will work as champions for the rights and needs of people with dementia in their services. To date approximately 25-30 staff from the acute setting have completed the programme. However, not all staff currently identified as dementia champions in acute hospitals have completed this training.

Administrative Support

The importance of having administrative support on wards is highlighted in the Productive Ward Model. This model looks at streamlining the way services deliver care, focusing on effective use of staff time and patient safety. The model works to ensure nursing staff have the time they need to provide appropriate care for patients, including people with dementia. The Productive Ward: *Releasing Time to Care*[™] has been piloted on a number of acute hospital wards in Ireland since 2010 (HSE, 2013). The audit found that the majority of wards (96%) have access to some administrative staff during the week, with 64% of wards having access to full time administrative staff, and 33% of wards having access to part-time administrative staff. Only 8% of wards have access to administrative staff support at the weekends.

Conclusion

The audit found that staff numbers and skill mix may be negatively impacted by the common use of hospital pool and agency staff, combined with unfilled vacancies on one third of wards. In addition very few wards can measure their dependency levels and staff skill mix on a daily basis. While over a third of wards reported that clinical supervision is available to nursing staff, there is clearly a need for more consistent systems for supporting staff development. The benefits and importance of having a dementia champion to provide advice and guidance to staff and advocate on behalf of the person with dementia needs to be highlighted. While the vast majority of wards have access to administrative staff, a third of wards have only part-time access. The importance of having sufficient administrative support is particularly well recognised on wards piloting the productive ward programme.

Recommendations

35. Care of those with dementia requires appropriate levels of suitably trained staff, avoiding both vacant posts and temporary staff to the greatest extent possible.
36. Guidance is needed on how staffing levels should be determined, including consideration of measures of acuity and dependency sensitive to the care of people with dementia.
37. Staff working with people with dementia should have access to staff support systems such as formal appraisal and mentorship programmes, clinical supervision, peer support groups and reflective practice groups.
38. The CEO/Hospital Manager of each site 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 or Dementia Champions.



Physical Ward Environment

Summary

- The majority of wards did not have environmental cues to help the person with dementia orientate themselves; 56% of wards (43/77) had no clocks visible from the patients bed, 93% of wards (72/77) had no calendar visible, while 84% of wards (65/77) had no personal objects visible.
- 74% of wards (57/77) did not have signs to locate the toilet visible from the patient's bed/door of their room.
- Few wards used colour schemes or labelling of items to assist the patient with dementia.
- 66% of wards (51/77) had space for active patients with dementia to walk up and down, though many had concerns about the person wandering off the ward.
- 46% of wards (35/77) had a patient lounge or day room available.
- The flooring in the majority of hospitals was appropriate for a person with dementia, with 92% of wards (72/77) having floors that were plain/subtly patterned, 82% of wards (63/77) having floors that were subtly polished rather than high gloss, and 88% of wards (68/77) having floors that had a non-slip surface.

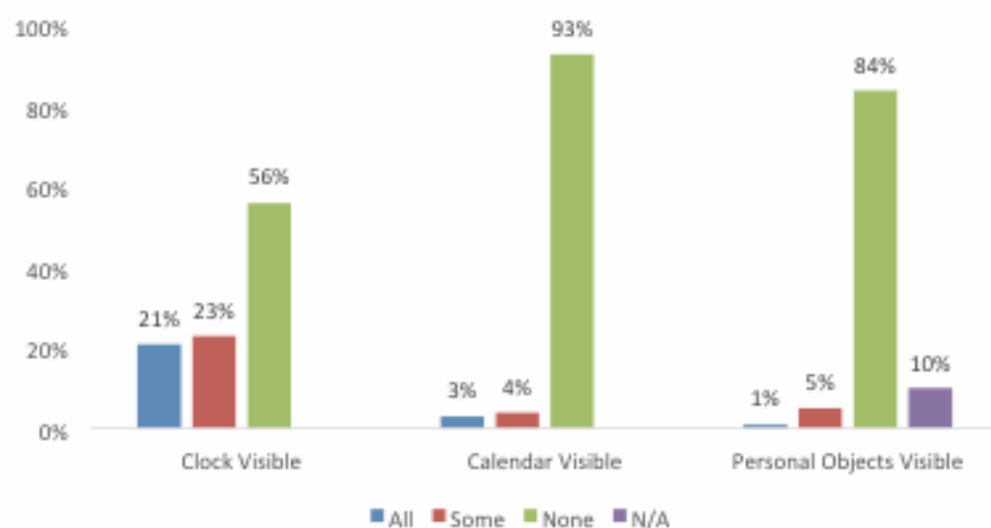
Admission to an acute hospital can be distressing and disorientating for a person with dementia (Cunningham, 2006), and behaviours and symptoms associated with their condition may be exacerbated as a result of the changed environment. The acute environment is designed to manage acute conditions and ward design is therefore focused on surveillance, security and infection control (Digby & Bloomer, 2013). The result is many competing stimuli which can be very stressful for the person with dementia (McCloskey, 2004), and can result in agitation, withdrawal, navigation difficulties and wandering (Digby & Bloomer, 2013).

In recent years a number of studies have focused on ways of making the acute environment more suitable to caring for a person with dementia. Accommodating the persons' need to walk and be active, providing visual cues to facilitate way finding and providing meaningful activity are all ways of promoting well-being and reducing agitation and distress. The Kings Fund has identified seven domains to help make hospital wards more dementia friendly in their Enhanced Healing Environment Assessment Tool. They include encouraging eating and drinking and promoting meaningful activity, well-being, mobility, continence and independence, orientation and promoting calm and security.

Orientation

The audit tool looked at the immediate surroundings of the person with dementia. In the majority of cases there were few objects visible from the patient's bed that would help them to orientate themselves, as illustrated in Figure D below.

Figure D: Environmental Cues for Orientation



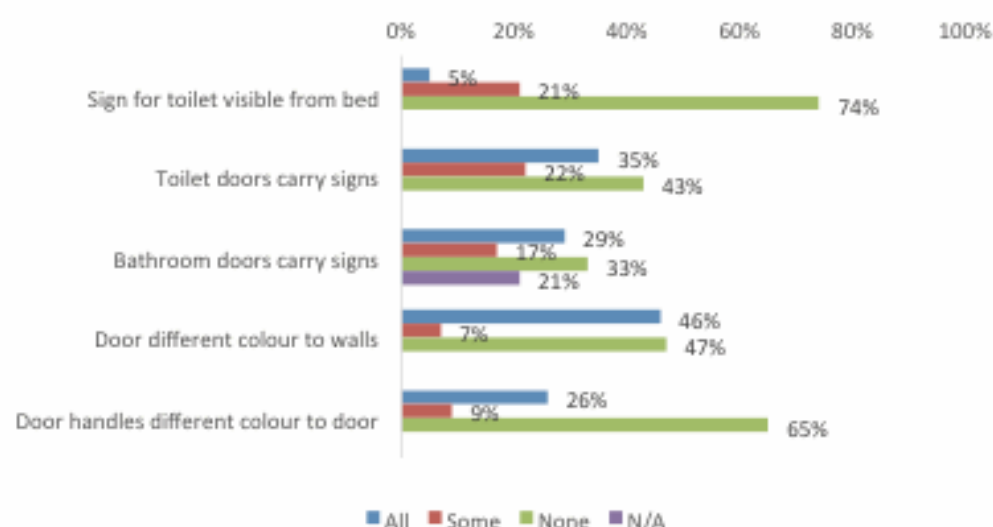
Personal objects included messages from families/friends and self-care items. It was not possible to determine the presence of such cues on wards where there was no one with dementia. The audit team noted that staff were often unaware of the potential value of having these objects visible to the person as a means of helping them orientate to their surroundings.

No hospital used colour schemes to help people with dementia find their way around the hospital. Just under half of hospitals (42%) have key areas (e.g. nurses station) clearly marked. The majority of hospitals (65%) had signs/maps to help direct and orientate patients. While the information on the majority of these signs (71%) was in clear contrast to the background, only 12% of them were large, bold and distinctive, making them appropriate for a person with dementia.

Accessible Toilet and Bathing Facilities

Loss of continence is an area of functional decline often associated with hospital admission for people with dementia (Covinsky, 2011; Pedone et al., 2005). It is recognised that having the right environmental design can help maintain independence and promote dignity in personal care for the person with dementia. Providing environmental cues is an integral aspect of this, and therefore the audit examined the presence of environmental cues for toileting and personal care. The findings are illustrated in Figure E below.

Figure E: Environmental Cues for Locating Toilets and Bathrooms



As illustrated above, signs to locate the toilet were not visible from the patient’s bed area/door of their room on the majority of wards (74%). Only 35% of wards had signs on all their toilet doors. Even fewer wards (29%) had signs on all their bathroom doors. A number of recorded comments indicate that where a sign was present on the toilet/ bathroom door, it was not always appropriate for the person with dementia due to its small size or use of symbols. There are a number of effective actions that can be taken to facilitate people with dementia to retain independence in toileting and bathing activities. These include leaving the toilet door open so the toilet itself is visible from the person’s bed (Digby & Bloomer, 2013), or hanging a picture of a toilet on the door.

Toilet and bathroom doors were a different colour to the walls in 46% of wards, while door handles were a different colour to the door in just 26% of wards. No wards had items such as the soap dispenser, bin or hand dryer clearly labelled with pictures as well as words, while only one ward had toilet paper that was a different colour to help it to stand out. Hand rails were present in the majority of wards (91%), while large handles (on taps and doors) were present in 75% of wards. A raised toilet seat was present in only 42% of wards.

The majority of wards had a toilet big enough for assisted toileting, though in 49% of wards this toilet may not have been the one situated closest to the person’s bed. The majority of wards (74%) provided gender specific toilets and bathrooms for patient use, and provided facilities so that patients have a choice about bathing or assisted bathing (61%).

All toilets/bathroom had alarm bells, though these were visible and in reach in 62% of wards, and visible but not in reach in 38% of wards.

Promoting Independence

In examining whether the ward environment promoted independence, the audit looked at whether there was a space for active people with dementia to walk up and down where they were visible to staff and staff were visible to them. In the majority of wards (66%), there was space in the corridors for patients to walk up and down. Many staff expressed concerns regarding the safety of the patient when walking up and down and the ease with which patients could wander off many of the wards. However, research has shown that attempts to restrict the movement of people who regularly wander will only frustrate or agitate them (McCloskey, 2004). Therefore, installing door systems that will give the person freedom to wander without a risk to their safety is needed on many acute hospital wards.

Almost two thirds of wards (64%) were adapted to assist people with limited mobility by providing hand rails along the corridors. However equipment was often placed against the walls, obstructing the handrails and creating safety issues for people with mobility difficulties. Few wards (22%) could provide hearing aids, though the majority of wards (75%) could provide adapted utensils to encourage patients to assist themselves with their meal and eat independently. Staff often commented that such utensils would be provided by Occupational Therapy (OT). However, it is unclear whether patients who are not referred to OT would be provided with such utensils.

On the Ward

Just under half of hospital wards (46%) had a day room or patients' lounge where patients could sit to get a break from the busy ward environment. The availability of such a room can be invaluable for the person with dementia. Research has shown that people with dementia can find being left alone and isolated in a single room as distressing as being overstimulated on a busy ward (McCloskey, 2004). A patients' lounge can provide a homely environment which may be more comforting and familiar to the person with dementia, where they have the opportunity to socially interact away from the unfamiliar and unsuitable ward environment. However, the audit team noted that due to resource constraints, many patients' lounges were sparsely furnished and often had equipment stored in them. These spaces could be invaluable for both patients and staff if used and furnished appropriately.

When asked whether patients were situated on the ward where they were visible to staff and staff were visible to them, the most common response (57%) was 'some patients'. Anecdotally, ward staff

reported that patients who were agitated or who might wander would always be situated where they were visible to staff, while quieter patients, or those who were immobile, may not be. In addition, the demand on beds affected where patients with dementia were situated. On 16% of wards, all patients were situated where they were visible to staff and staff were visible to them, and on 27% of wards they were situated where they were not visible to staff. Although no information was gathered formally on the reasons for this, on some wards the ward layout was such that there were no beds where patients were visible to staff and staff were visible to them, while on other wards these beds were used for people who were acutely unwell.

Flooring

The colours and patterns used for floors can have a substantial impact on a person with dementia due to the visual dysfunction and impaired colour and depth perception common to the condition (Digby & Bloomer, 2013). The flooring in the majority of hospitals was appropriate for a person with dementia, with 92% of floors plain/subtly patterned, 82% of floors subtly polished, and 88% of floors with non-slip surfaces. Only two wards had level changes, one of which was clearly marked, one of which was not.

Conclusion

The environment in the acute hospital is designed with its primary purpose in mind, caring for people who are acutely unwell. However, with the number of people with dementia being admitted to acute hospitals continuing to grow, the need to adapt ward environments to reduce distress and the accompanying behaviours that challenge has become an important aspect of acute hospital care. There are a number of changes that can be made at ward level to promote well-being for people with dementia, many small with minimal resource implications, others which need to be carried out on a larger scale with more substantial resource needs. The audit identified a number of key areas where changes could be made. However, these changes will need to be made in conjunction with increased awareness among staff as to the needs of people with dementia and the benefits of providing a suitable and supportive environment.

Recommendations

39. National guidelines on dementia friendly ward designs should be developed, 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 to promote social interaction.
40. Ward managers and Dementia Champions should ensure that simple and effective improvements to the environment are promoted in all wards admitting adults, including appropriate signage and visual aids to support orientation and continence, personalising bed areas, and adequate space and resources to support activity and stimulation.



Discharge Planning and Discharge

Summary

- 72% of HCRs (387/536) had no evidence documented of discharge planning being initiated within 24 hours of admission.
- 86% of hospitals (30/35) reported having a named person who takes overall responsibility for complex needs discharge, and this includes people with dementia.
- 39% of HCRs (209/535) had a single plan for discharge with clear updated information.
- 32% of HCRs (174/535) had support needs identified during admission included in the discharge plan or summary.
- 58% of hospitals (18/31) reported that information about discharge and support is made available to patients and their relatives/carers.
- 41% of families/carers (221/535) received 24 hours or more notice of discharge.

The Discharge Policy

The majority of older people are admitted to hospital for medical reasons. However, by the time their condition is stabilised, arrangements for their discharge become dependent on many other issues, including the ability to undertake basic self-care, their social circumstances, and the availability and access to home-care packages and nursing home beds (National Clinical Programme for Older People, 2012). Adequate and appropriate discharge planning and execution is vital, as inadequate practices are linked to adverse outcomes and an increased risk of readmission (Bauer et al., 2009). While there are no dementia specific standards in place for discharge planning at this time, the 2008 HSE Code of Practice for Integrated Discharge Planning (IDP) is relevant to this audit. The IDP Code states that “patient assessment regarding potential for delayed discharge shall begin either prior to admission or at first presentation to the hospital” (p.30). The organisational audit found that the majority of hospitals (94%) have a discharge policy in place.

- 6% of hospitals (2/35) have no discharge policy in place.
- 94% of hospitals (29/31) reported that their discharge policy states that discharge should be an actively managed process which begins within 24 hours of admission.
- 72% of HCRs (387/536) audited had no evidence documented of discharge planning being initiated within 24 hours of admission.

A small number of HCRs (12%) had a documented reason why discharge planning could not be initiated. The two most common reasons recorded were 'patient acutely unwell' and 'patient being discharged to nursing/residential care'.

While very few hospitals had a separate transfer policy, a small number had policies relating to transfers both within the hospital and between facilities referred to in their discharge policy.

- 16% of hospitals (5/32) have a transfer policy that states that people with dementia should only be moved for reasons pertaining to their care and treatment.
- 12% of hospitals (4/32) have a transfer policy that states that the move should take place during the day.
- 48% of hospitals (15/31) have a transfer policy that states that relatives and carers should be kept informed of any moves within the hospital.

Some hospitals commented that despite the lack of policy, they were practicing good care. However, some wards reported practices such as moving the beds of patients with dementia into the corridor at night time so that they would be closer to the nurses' station, suggesting stronger policy is needed to guide staff on the appropriate moving and transfer of patients with dementia.

The Discharge Process

Discharge planning is a process that aims to improve the coordination of services to ensure the patient's needs continue to be met after discharge, thereby reducing both length of stay and unplanned readmissions (Katikireddi et al., 2009). Research indicates that assigning responsibility to a named individual for coordinating progress through the system results in improved and timely integrated discharge planning (HSE, 2008). The HSE Code of Practice for IDP states that "the healthcare record shall indicate that it is a Nurse (or HSCP/Other) facilitated discharge and the name of the Nurse (or HSCP/Other) shall be documented" (p. 31). The majority of hospitals reported employing a discharge coordinator to undertake these responsibilities.

- 86% of hospitals (30/35) reported having a named person who takes overall responsibility for complex needs discharge and this includes people with dementia. Of these hospitals;
- 10% (3/30) reported this person has training in the ongoing needs of people with dementia.
- 90% (27/30) reported that this person has experience of working with people with dementia and their carers.

Similar to the research findings of Day et al. (2009), most discharge coordinators had not had formal training but developed their skills on the job. However the role of the discharge coordinator is not standardised, and there is often variation in practices and documentation (Day et al., 2009). In addition most hospitals have a single discharge coordinator who deals with complex cases. For the majority of patients there was no named person documented in the HCR as coordinating discharge.

- 37% of HCRs (198/532) had documentation to show that a named person coordinated the discharge plan. 17% of HCRs (92/532) had no documented discharge plan.

Best practice recommends that in advance of discharge, specific information should be compiled into a single, up-to-date, discharge plan. The HSE Code of Practice for IDP outlines all the information which should be included in the discharge plan and states that "a copy of the transfer/discharge communication, which is completed before discharge, shall be sent to the patient, the patients GP, Public Health Nurse (PHN) and other healthcare providers (e.g. Residential Care Centre) and a further copy shall be retained in the healthcare record" (p.35).

- 39% of HCRs (209/535) had a single plan for discharge with clear updated information.

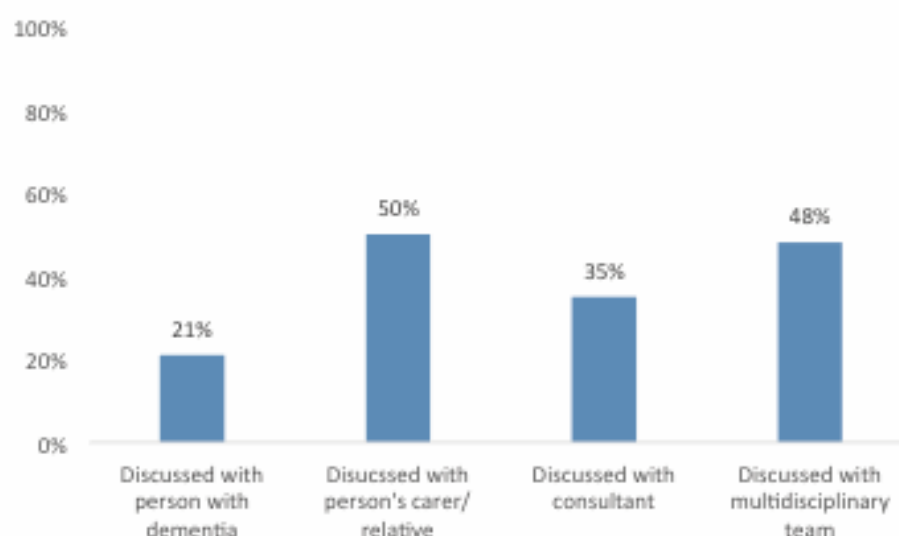
However this question had a low Kappa rating (0.39) and poor percentage agreement between auditors (64.6%). This question referred to a summary of all medical/surgical and nursing information, which included mental health information, brought together *prior* to discharge as a single plan. Therefore, the discharge summary, which in many hospitals is written up *after* discharge, would not be sufficient. However discussion in the audit training suggested that Registrars were often unclear about the difference between a discharge plan and a discharge summary.

The audit also looked at documentation in the discharge plan or summary. The Code of Practice for IDP states that each patient will be provided with an information pack containing relevant information such as patient/carer plan, a medication record and discharge information. It was found:

- 32% of HCRs (174/535) had support needs identified during admission included in the discharge plan or summary.
- 12% of HCRs (62/534) had evidence that the families/carers had received a copy of the discharge plan or summary.

Best practice standards for integrated discharge planning state that "integrated discharge planning shall include the patient and as appropriate, the family/ carer in the development and implementation of the patient's discharge plan" (p30). The results illustrated in Figure F below indicate poor compliance with this standard.

Figure F: Person with whom Place of Discharge was Discussed



Only 21% of HCRs had evidence that place of discharge was discussed with the person with dementia. The person's carer/relative and members of the multidisciplinary team were the two most common groups with whom place of discharge and support needs were discussed (50% and 48% respectively).

Time of discharge plays a crucial role in ensuring families and services are prepared to receive the person with dementia. While 84% of hospitals reported that their discharge policy states that discharge should take place during the day, many respondents commented on the difficulties encountered in meeting this standard due to a lack of transport. This impacts disproportionately on patients being transferred to another facility or returning to residential care, due to their reliance on the ambulance services for transport.

Support for Carers and Families on Discharge

Research has found that family carers often perceive the discharge planning process in a negative light, experiencing frustration at the lack of knowledge, poor communication and lack of involvement in the process (Bauer et al., 2011).

- 58% of hospitals (18/31) reported that information about discharge and support is made available to patients and their relatives.
- 33% of hospitals (11/33) have a system in place to ensure that carers are advised about the care support available.

-
- 40% of hospitals (14/35) have 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.
 - 30% of hospitals (10/33) have clear guidelines around about asking the carer about their wishes and ability to provide care and support to the person with dementia post discharge.

The HCR audit showed that in 50% of cases, place of discharge was discussed with the family/carer. While this figure is not in compliance with the Code of Practice for IDP, families/carers are the group with whom place of discharge is most commonly discussed.

Insufficient notice of discharge from hospital can create anxiety and distress for people with dementia and carers, who may not have had care arrangements confirmed. It also creates risk of the person with dementia returning home without the ongoing support they need (National Audit of Dementia UK, 2011). In recognition of this, the Code of Practice for IDP states that “the family/carers, GP and other PCCC service providers shall be contacted at least the day before discharge to confirm that the patient is being discharged” (p32).

- 87% of hospitals (27/31) reported that their discharge policy states that relatives and carers should be informed and updated about the prospective discharge date.
- 41% of HCRs (221/535) were compliant with this standard, with families/carers receiving 24 hours or more notice of discharge.
- 12% of HCRs (64/535) found showed that families/carers received less than 24 hours’ notice.
- 45% of HCRs (238/535) had no documentation to indicate families/carers had received notice of discharge.

The relatively poor levels of agreement between auditors for this question (Kappa value of 0.39; 52.5% agreement) may indicate a lack of standardised recording of communication with families/carers in HCRs.

- 55% of HCRs had documentation to show that an assessment of carer’s current needs had taken place in advance of discharge (where relevant).

Conclusion

There are currently a number of standards in place relating to discharge planning and processes. This audit found a gap between national standards, hospital policy and practice. Discharge planning processes need to be improved to ensure that the person with dementia is being discharged to a setting that has the appropriate resources and supports to care for them. In addition, the person with dementia and their families/carers need to be more involved in the discharge process.

Recommendations

41. All hospitals should have a systematic discharge and transfer policy in place.
42. Through a formal reporting process, identify factors contributing to delayed discharges, with particular reference to people admitted from home and discharged to a nursing home/residential care setting.
43. There is a need for increased awareness of and adherence to the processes and documentation required for appropriate discharge planning.
44. Mental health status, symptoms and behaviours relevant to the person's dementia noted during admission, and any on-going mental health needs, to be summarised and recorded at discharge.



Palliative Care

Summary

- 8% of patients (51/660) died whilst in hospital.
- 6% of patients (37/629) were receiving end of life care or were being managed according to an end of life care pathway.
- 9% of patients (44/466) were referred to specialist palliative care services, over half of whom (26/44) died whilst in hospital.
- One referral for family/carer bereavement support was recorded.

Palliative Care and End of Life Care

Palliative care is 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 (WHO, 2013). End of Life care refers to all aspects of the care relating to dying, death and bereavement which is provided towards the end of life (Irish Hospice Foundation, 2013).

While surveys suggest that the great majority of people would like to die at home, the reality is that nearly half of deaths in Ireland each year (48%) occur in the acute hospital. Therefore, there is a need for acute hospitals to provide appropriate palliative care and end of life care. Providing palliative care and end of life care to people with dementia can be particularly challenging due to the length and variation in the terminal phase and the progressive inability of the person with dementia to communicate and participate in decision-making about their care (HSE & IHF, 2008).

Quality standards for end of life care were developed by the Irish Hospice Foundation as part of the Hospice Friendly Hospitals Initiative in 2010. Though these standards are not statutory, they provide a comprehensive set of standards in four main areas: the hospital; the staff; the patient and the family. They are listed among the key resources in the National Standards for Safer Better Healthcare published by the Health, Information and Equality Authority (HIQA, 2011). Improving end-of-life care in acute hospitals would undoubtedly impact positively on people with dementia who die whilst in hospital. However, as research has shown that over three times as many people with dementia die during a hospital admission compared to similar people without a cognitive impairment (Sampson et al., 2009), the Alzheimer Society of Ireland recommends the development

of a dementia-friendly hospitals programme, along similar lines to the Hospice Friendly Hospitals Programme (MacConville, 2011).

The HCR audit found that 51 patients (8%) died while in hospital, 23 of whom (45%, 23/51) were receiving end of life care or on an end of life care pathway. In total 37 patients (6%) were receiving end of life care or were treated using an end of life care pathway. People with dementia are significantly less likely to be referred to palliative care services in an acute hospital, to be prescribed acute drugs and to have carers involved in decision making (Afzal et al., 2010). In this audit, 9% of patients (44/466) were referred to specialist palliative care services, over half of whom (59%, 26/44) died whilst in hospital.

The HSE National Consent Policy (2013) states that a decision whether or not to attempt resuscitation should be clearly and accurately documented in the individuals HCR, along with how the decision was made, the date of the decision, the rationale for it, and who was involved in discussing the decision. The HCR audit found that a decision for resuscitation was documented in 32.5% of HCRs.

The white paper defining optimal palliative care in older people with dementia, which was published by the European Association for Palliative Care (EAPS) in 2013, recommends that bereavement support should be offered as part of optimal treatment of symptoms and for providing comfort. Nevertheless, only one referral for family/carer bereavement support was recorded.

Conclusion

The findings indicate that approximately 1 in 12 patients admitted to acute hospital with dementia will die during that admission, highlighting the need for co-ordinated palliative care and end of life care in acute hospitals, addressing pain, nutrition, feeding, spiritual and psychosocial issues. Early assessment and documentation of a person with dementia's End of Life Care needs and preferences in the acute setting is needed in the form of Advance Care Planning, which should be communicated to relevant care settings in the event of discharge.

Recommendations

45. Guidelines should be developed for the recording and communication of assessments of the person's wishes and preferences regarding end of life care.
46. Acute hospitals need to be aware of the work of the Irish Hospice Foundation and the Alzheimer's Society of Ireland as it relates to improving end of life and palliative care for people with dementia, and implement best practice guidelines as they become available.
47. Guidelines on dementia-appropriate advance care planning should be developed.



References

Aalten, P., Van Valen, E., Clare, L., Kenny, G., & Verhey, F. (2005). Awareness in dementia: A review of clinical correlates. *Aging and Mental Health, 9*, 414-422.

Afzal, N., Buhagiar, K., Flood, J., & Cosgrave, M. (2010). Quality of end-of-life care for dementia patients during acute hospital admission: A retrospective study in Ireland. *General Hospital Psychiatry, 32*(2), 141-6.

Agarwal, E., Banks, M., Ferguson, M., Bauer, J., Capra, S., & Isenring, E. (2012). Nutrition care practices in hospital wards: Results from the nutrition care day survey 2010. *Clinical Nutrition, 31*, 995-1001.

AIHW. (2004). *The Impact of Dementia on the Health and Aged Care System*. Canberra: Australian Institute of Health and Welfare.

Alzheimer's Disease International. (2009). World Alzheimer Report 2009. London: Alzheimer Disease International. Retrieved from <https://www.alz.co.uk/research/files/WorldAlzheimerReport.pdf> [Accessed 20th December 2013]

Alzheimer Scotland. (2009). *Beyond Barriers: Developing a Palliative Care Approach for People in the Later Stages of Dementia, Project and Evaluation Reports*. Edinburgh: An Alzheimer Scotland Partnership Project, Alzheimer Scotland.

Alzheimer Society of Ireland. (2010). *Towards A Restraint Free Environment in Nursing Homes*. Dublin: Alzheimer Society of Ireland.

Alzheimer Society of Ireland. (2011). *Activities of Daily Living & Other Problems: Pressure sores*. Retrieved from <https://www.alzheimer.ie/Alzheimer/media/SiteMedia/Helpline%20and%20Information%20Resources/C14-Pressure-sores.pdf> [Accessed 14th Oct 2013]

Alzheimer's Society UK. (2009). *Alzheimer's Society Guide to Catering for People with Dementia*. London: Alzheimer's Society.

An Bord Altranais. (1999a). *Review of Scope of Practice for Nursing and Midwifery Interim Report*. Dublin: An Bord Altranais.

An Bord Altranais. (2010). *Guidance for New Nurse and Midwife Registrants*. Dublin: An Bord Altranais.

Andrews, J. (2013). Maintaining continence in people with dementia. *Nursing Times*, 109(27), 20-21.

Archibald, C. (2006). Meeting the nutritional needs of patients with dementia in hospital. *Nursing Standards*, 20(45), 41-45.

Banerjee, S. (2009). *The Use of Antipsychotic Medication for People with Dementia: Time for Action*. London: Department of Health.

BAPEN (2003). The Malnutrition Universal Screening Tool. The Malnutrition Advisory Group, a Standing Committee of BAPEN. Retrieved from http://www.hse.ie/eng/staff/PCRS/Online_Services/MUSTtool.pdf [Accessed 15th Oct 2013]

Bauer, M., Fitzgerald, L., & Koch, S. (2011). Hospital discharge as experienced by family carers of people with dementia: a case for quality improvement. *Journal of Healthcare Quality*, 33(6), 9-16.

Bentley, J., & Meyer, J. (2004). Repeat attendance by older people at accident and emergency departments. *Journal of Advanced Nursing*, 48 (2), 149–156.

Boltz, M., & Sherry, S.A. (Eds). (2012). *Reducing Functional Decline in Older Adults during Hospitalization: A Best Practice Approach*. New York: The Hartford Institute for Geriatric Nursing.

Buckley, M., Coffey, A., Tyrell, M., Bartley, M., Deenihan, C., Manning, E., Browne, V., Barrett, A., & Timmons, S. (2013). A multicentre survey of acute hospital nursing staff training in dementia care. *Irish Journal of Medical Science*, 182(6), 240-1.

Castilla-Puentes, R. C., & Habeych, M. E. (2010). Subtypes of depression among patients with Alzheimer's disease and other dementias. *Alzheimer's and Dementia*, 6, 63–9.

Cahill, S., O'Shea, E., & Pierce, M. (2012). *Creating excellence in dementia care: A research review for Ireland's national dementia strategy*. Dublin: DSIDC's Living with Dementia Research Programme.

CSO. (2007). *Statistical Yearbook of Ireland 2007*. Cork: Central Statistics Office.

Central Statistics Office. (2013). *Population and migration estimates April 2013*. Retrieved from <http://www.cso.ie/en/releasesandpublications/er/pme/populationandmigrationestimatesapril2013/#.UrGUvPRdXAO> [Accessed 8th Nov 2013]

Covinsky, K. E., Pierluissi, E., & Johnston, C. B. (2011). Hospitalization-associated disability: "She was probably able to ambulate, but I'm not sure". *Journal of the American Medical Association*, *306*(16), 1782–1793.

Creditor, M. C. (1993). Hazards of hospitalization of the elderly. *Annals of Internal Medicine*, *118*(3), 219-223.

Cummings, S. (1999). Adequacy of discharge plans and rehospitalisation among hospitalised dementia patients. *Health and Social Work*, *24*, 249–259.

Cunningham, C. (2006a). Understanding challenging behaviour in patients with dementia. *Nursing Standard*, *20*, 42–45.

Day, M.R., McCarthy, G., & Coffey, A. (2009). Discharge Planning: The Role of the Discharge Co-Ordinator. *Nursing Older People*, *21*(1), 26-31.

De Siún, A., & Manning, M. (2010). *National Dementia Project: Dementia Education Needs Analysis Report*. Dublin: Health Service Executive.

De Vries, K. (2013). Communicating with older people with dementia. *Nursing Older People*, *25*(4), 30-38.

Department of Health and Children. (2011). *Towards a Restraint Free Environment in Nursing Homes*. Dublin: Restraint Free Environment Working Group.

Department of Health and Ageing. (2012). *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care*. Retrieved from [http://www.health.gov.au/internet/main/publishing.nsf/Content/F97925A7FE1F7CBECA257BF001AFDED/\\$File/RESIDENTIAL%20Aged%20Care_PresFolderFA.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/F97925A7FE1F7CBECA257BF001AFDED/$File/RESIDENTIAL%20Aged%20Care_PresFolderFA.pdf) [Accessed 21st Nov 2013]

Dewing, J. (2003). The responsibilities of registered nurses towards people with dementia. In Marshall M (Ed). *Food Glorious Food: Perspectives on Food and Dementia*. London: Hawker Publications.

Digby, R., & Bloomer, M. J. (2013). People with dementia and the hospital environment: the view of patients and family carers. *International Journal of Older People Nursing*. doi: 10.1111/opn.12014.

Draper, B. (2000). The effectiveness of old age psychiatry services. *International Journal of Geriatric Psychiatry*, 15, 687 – 703.

Expert Group on Mental Health Policy. (2006). *A Vision for Change; Report of the Expert Group on Mental Health Policy*. Dublin: Stationary Office.

Fisher, S. R., Galloway, R., Kuo, Y. F., Graham, J. E., Ottenbacher, K. J., Ostir, G. V., & Goodwin, J. S. (2011). Pilot study examining the association between ambulatory activity and falls among hospitalized older adults. *Archives of Internal Medicine*, 92, 2090–2092.

Gendron, T., & Heck, A. (2013). What Do Long-Term Care Staff Know About the Differences Between Depression and Dementia? *Clinical Gerontologist*, 36(5), 411-420.

Haesler, E., Bauer, M., & Nay, R. (2010). Recent evidence on the development and maintenance of constructive staff-family relationships in the care of older people: A report on a systematic review update. *International Journal of Evidence-Based Healthcare*, 8 (2), 45-74.

Health Information and Quality Authority. (2012). *National Standards for Safer Better Healthcare*. Dublin: HIQA.

Health Information and Quality Authority. (2008). *National Quality Standards for Residential Care Settings for Older People in Ireland*. Dublin: HIQA

Health Service Executive. (2007). *Acute Hospital Bed Review: A Review of Acute Hospital Bed Use in Hospitals in the Republic Of Ireland with an Emergency Department*. Dublin: PA Consulting Group, Balance of Care Group.

Health Service Executive. (2007). *Acute Hospital Bed Capacity Review: A Preferred Health System in Ireland to 2020*. Dublin: PA Consulting Group.

Health Service Executive. (2008). *Code of Practice for Integrated Discharge Planning*. Limerick: National Integrated Discharge Planning Steering Committee.

Health Service Executive and The Irish Hospice Foundation. (2008). *Palliative Care for All: Integrating Palliative Care into Disease Management Frameworks*. Dublin.

Health Service Executive. (2008). *Strategy to Prevent Falls and Fractures in Ireland's Ageing Population*. Dublin: National Steering Group on the Prevention of Falls in Older People.

Health Service Executive. (2011). *HSE Standards and Recommended Practices for Healthcare Records Management*. Dublin: Quality and Patient Safety Directorate.

Health Service Executive. (2012). *Policy on the Use of Physical Restraints in Designated Residential Care Units for Older People*. Dublin: Quality and Patient Safety Directorate.

Health Service Executive. (2013). *The Productive Ward*. Retrieved from <http://www.hse.ie/productiveward/> [Accessed 28th Nov 2013]

Health Service Executive. (2013). *National Consent Policy*. Dublin: Quality and Patient Safety Directorate.

Heath, H., Sturdy, D., & Wilcock, G. (2010). *Improving Quality of Care for People with Dementia in General Hospitals*. London: Royal College of Nursing Publishing.

Hickey, A., Clinch, D., & Groarke, E.P. (1997). Prevalence of Cognitive Impairment in the Hospitalized Elderly. *International Journal of Geriatric Psychiatry*, 12, 27-33.

Hoogerduijn, J. G., Schuurmans, M.J., Duijnste, M.S.H., de Rooij, S.E., Grypdonck, M.F.H., & Kelly, I.A. (2006). A systematic review of predictors and screening instruments to identify older hospitalized patients at risk for functional decline. *Journal of Clinical Nursing*, 16, 46-57.

Irish Hospice Foundation. (2010). *Quality Standards for End-Of-Life Care in Hospitals: Making End-Of-Life Care Central to Hospital Care*. Dublin: Hospice Friendly Hospitals.

Irish Hospice Foundation. (2013). *Hospice, Palliative and End-Of-Life Care*. Retrieved from <http://hospicefoundation.ie/about-hospice-care/hospice-palliative-and-end-of-life-care/> [Accessed 11th Dec 2013]

Irving, K., & McGarrigle, L. (2012). *Integrated Care Pathways for People with Dementia: Exploring the Potential for Ireland and the Forthcoming National Dementia Strategy*. Dublin: The Alzheimer Society of Ireland.

Kaiser, M. J., Bauer, J. M., Rämisch, C., Uter, W., Guigoz, Y., Cederholm, T., Thomas, D. R., Anthony, P. S., Charlton, K. E., Maggio, M., Tsai, A. C., Vellas, B., & Sieber, C. C. (2010). Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment. *Journal of the American Geriatric Society*, 58, 1734-1738.

Katikireddi, S. V., & Cloud, G. C. (2009). Planning a patient's discharge from hospital. *British Medical Journal*, 338, 472-476.

Keady, J., & Jones, L. (2010). Investigating the causes of behaviours that challenge in people with dementia. *Nursing Older People*, 22(9), 25-29.

Lawlor, B. (2002). Managing behavioural and psychological symptoms in dementia. *British Journal of Psychiatry*, 181, 463-5.

Lyketsos, C., Sheppard, J., & Rabins, P. (2000). Dementia in elderly persons in a general hospital. *The American Journal of Psychiatry*, 157, 704-707.

Marshall, M. (2009). *Therapeutic Design for People with Dementia*. In *Dementia, Design and Technology* (Topo P. & Ostlund B. eds, 3-23). Amsterdam: IOS Press.

Maynard, C. (2003). Differentiate depression from dementia. *The Nurse Practitioner*, 28(3), 18-27.

McCloskey, R. (2004). Caring for patients with dementia in an acute care environment. *Geriatric Nursing*, 25, 139-144.

McDermott-Scales, L., Beaton, D., McMahon, F., Vereker, N., McCormack, B., Coen, R.F., & O'Keeffe, S.T. (2014). The National Single Assessment Tool (SAT) A Pilot Study in Older Persons Care- Survey Results. *The Irish Medical Journal*, 107(1)

Mental Health Commission. (2010). *Annual Report 2010*. Dublin: Mental Health Commission.

Moyle, W., Borbasi, S., Wallis, M., Olorenshaw, R., & Gracia, N. (2010). Acute care management of older people with dementia: A qualitative perspective. *Journal of Clinical Nursing, 20*, 420-428.

National Clinical Programme for Older People. (2012). *Specialist Geriatric Services Model of Care*. Dublin: National Clinical Programme for Older People Working Group.

National Institute for Health and Clinical Excellence. (2010). *Clinical Guideline 103—Delirium*. London: NICE.

NHS Confederation. (2010). *Acute Awareness: Improving Hospital Care for People with Dementia*. London: NHS Confederation.

Nolan, L. (2006). Caring connections with older persons with dementia in an acute hospital setting – a hermeneutic interpretation of the staff nurse's experience. *International Journal of Older People Nursing, 1*, 208–215.

Nolan, L. (2007). Caring for people with dementia in the acute setting: A study of nurses' views. *British Journal of Nursing, 16*(7), 419-22.

Nolan, M., Davies, S., Brown, J., Keady, J., & Nolan, J. (2004). Beyond 'person-centred' care: A new vision for gerontological nursing. *International Journal of Older People Nursing, 13*, 45–53.

Olson, B., Langemo, D., Burd, C., Hanson, D., Hunter, S., & Cathcart-Silberberg, T. (1996). Pressure ulcer incidence in an acute care setting. *Journal of Wound Ostomy and Continence Nursing, 23*, 15.

O'Toole, J. (2012). Caring for People with Dementia in Irish Acute Services; A Phenomenological Study of Nurses' Lived Experience. *Unpublished Masters Thesis*

Pedone, C., Ercolani, S., Catani, M., Maggio, D., Ruggiero, C., Quartesan, R., Senin, U., Mecocci, P., & Cherubini, A. (2005). Elderly patients with cognitive impairment have a high risk for functional decline during hospitalization: The GIFA Study. *Journals of Gerontology Series A: Biological Sciences & Medical Sciences, 60*, 1576 –1580.

Rees, G., Huby, G., McDade, L., & McKechnie, L. (2004). Joint working in community mental health teams: Implementation of an integrated care pathway. *Health and Social Care in the Community, 12*(6), 527 - 536.

Roper, N., Logan, W., & Tierney, A. (1996). *The Elements of Nursing: A Model for Nursing Based On a Model for Living 4th Edition*. London: Churchill Livingstone.

Royal College of Psychiatrists. (2011). *Report of the National Audit of Dementia Care in General Hospitals*. Editors: Young, J., Hood, C., Woolley, R., Gandesha, A. & Souza, R. London: Healthcare Quality Improvement Partnership.

Royal College of Psychiatrists. (2013). *National Audit of Dementia care in general hospitals 2012-2013: Second round audit report and update*. Editors: Young, J., Hood, C., Gandesha, A., & Souza, R. London: Healthcare Quality Improvement Partnership.

Ryan, D.J., O'Regan, N.A., Ó Caoimh, R., Clare, J., O'Connor, M., Leonard, M., McFarland, J., Tighe, S., O'Sullivan, K., Trzepacz, P.T., Meagher, D., & Timmons, S. (2013). Delirium in an adult acute hospital population: predictors, prevalence and detection. *British Medical Journal Open, 3*:e001772.

Said, C., Morris, M., Woodward, M., Churilov, L., & Berhardt, J. (2012). Enhancing physical activity in older adults receiving hospital based rehabilitation: A phase II feasibility study. *BMC Geriatrics, 12*, 26.

Sampson, E. L., Blanchard, M. R., Jones, L., Tookman, A., & King, M. (2009). Dementia in the acute hospital: Prospective cohort study of prevalence and mortality. *British Journal of Psychiatry, 195*(1), 61–66.

Saarnio, R., Mustonen, U., & Isola, A. (2011). Challenging behaviour in the older with dementing illness in institutional care: Forms of challenging behaviour, frequency of challenging behaviour and nursing staff's modes of action. *Journal of Nursing Science, 23*, 46–56.

Thompson, F., Girling, D., Green, S., & Wai, C. (2010). 'Care of people with dementia in general hospital' in Downes, M. and Bowers (eds.) *Excellence in Dementia Care: Research into Practice*, Open University Press, Maidenhead, pp. 310-318.

Trawley, S., Barrett, A., Browne, V., Manning, E., Cahill, S., Linehan, J., O'Sullivan, K., Woods, N., Meagher, D., O'Regan, N., Clune, Y., Molloy, D.W., & Timmons, S. (2013). Dementia is prevalent in

older people admitted to acute hospitals, but often un-diagnosed: a prospective multicentre study. *Irish Journal of Medical Science*, 182(6), 280.

van der Steen, J. T., Radbruch, L., Hertogh, C. M. P. M., de Boer, M. E., Hughes, J. C., Larkin, P., Francke, A. L., Jünger, S., Gove, D., Firth, P., Koopmans, R. T. C. M., & Volicc, L. (2013). White paper defining optimal palliative care in older people with dementia: A Delphi study and recommendations from the European Association for Palliative Care. *Palliative Medicine*, 0(0), 1–13.

van de Ven-Vakhteeva, J., Bor, H., Wetzels, R.B., Koopmans, R.T.C.M., & Zuidema, S.U. (2013). The impact of antipsychotics and neuropsychiatric symptoms on the quality of life of people with dementia living in nursing homes. *International Journal of Geriatric Psychiatry*, 28(5), 530-538.

Webster, J. (2011). Improving care for people with dementia in acute hospital: The role of person-centred assessment. *Quality in Ageing and Older Adults*, 12(2), 86 – 94.

World Health Organisation. (2013). *WHO Definition of Palliative Care*. Retrieved from <http://www.who.int/cancer/palliative/definition/en/> [Accessed 3rd Dec 2013]



Appendix A

Participating Hospitals

- Beaumont Hospital, Dublin
- Connolly Hospital, Blanchardstown, Dublin
- Mater Misericordiae Hospital, Dublin
- Cavan General Hospital
- Our Lady of Lourdes Hospital, Drogheda
- Our Lady's Hospital, Navan
- St Columcille's Hospital, Loughlinstown, Dublin
- St James's Hospital, Dublin
- St Michael's Hospital, Dun Laoghaire
- St Vincents Hospital, Elm Park, Dublin
- Adelaide and Meath Hospital incorporating the National Children's Hospital, Tallaght
- Longford/Westmeath Regional Hospital, Mullingar
- Midland Regional Hospital, Portlaoise
- Midland Regional Hospital, Tullamore
- Naas General Hospital
- South Tipperary General Hospital, Clonmel
- St Luke's General Hospital, Kilkenny
- Waterford Regional Hospital, ardkeen
- Wexford General Hospital
- Bantry General Hospital
- Cork University Hospital
- Kerry General Hospital
- Mallow General Hospital
- Mercy University Hospital, Cork
- South Infirmary / Victoria Hospital, Cork
- Ennis General Hospital
- Nenagh General Hospital
- Regional Hospital (Dooradoyle) Limerick
- St John's Hospital, Limerick
- Letterkenny General Hospital
- Mayo General Hospital, Castlebar
- Portiuncula Hospital, Ballinasloe
- Roscommon County Hospital
- Sligo General Hospital
- University College Hospital, Galway



Appendix B

INAD Partners

Centre for Gerontology and Rehabilitation, University College Cork; Dr. Suzanne Timmons, (co-chair) Consultant Physician in Geriatric Medicine, Mercy University Hospital & St. Finbarr's Hospital & Senior Lecturer, Centre for Gerontology and Rehabilitation, School of Medicine, UCC; Dr. Paul Gallagher, Consultant Physician in Geriatric Medicine, Cork University Hospital & St. Finbarr's Hospital & Senior Lecturer, School of Medicine, UCC.

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INAD Steering Committee

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Quality and Patient Safety Directorate; Edwina Dunne, Director QPSA

Alzheimer Society of Ireland; Ms. Grainne McGettrick, Research and Policy Manager.

Office of the Nursing and Midwifery Services Directorate (ONMSD); Ms Mary Manning, Interim Director NMPDU Midlands.

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Association of Occupational Therapists of Ireland; Ms. Monica Devine, Chairperson, AOTI Advisory group for Older People.

INAD Advisory Group

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Irish Hospice Foundation, Hospice Friendly Hospitals Programme ; Dr Kathleen McLoughlin, National Audit and Review Co-ordinator (End of Life).

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Health Information and Quality Authority, John Farrelly, Head of Older Persons Programme.

Dept of Health, Services for Older People; Ms. Sinead Quill/ Mr Ronan Toomey.

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Dementia Services Information and Development Centre; Mr. Matthew Gibb, Senior Social Worker.

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National Audit of Dementia care in general hospitals (UK); Ms Chloë Hood, Programme Manager, Royal College of Psychiatrists' Centre for Quality Improvement.

Royal College of Physicians, London; Dr Kevin Stewart, Clinical Director, Clinical Effectiveness and Evaluation Unit (CEEU); UK National Audit Steering Group.

Appendix D



Irish National Audit of Dementia (care in general hospitals)

Organisational Audit

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 Irish 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 CEO (or equivalent managerial level), Director of Nursing and nominated consultant physician 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 2 letters and 2 numbers, e.g. 11XY. If you do not know the hospital code, please get in touch with the audit lead from your hospital or contact the INAD audit co-ordinator on 021 4627347

Adapted from the UK National Audit of Dementia, with permission: Copyright HEALTHCARE QUALITY IMPROVEMENT PARTNERSHIP, HQIP 2012

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:

- Clinical/Medical Director
- Director of Nursing
- Consultant Geriatrician/Specialist Physician in Elderly Care
- Consultant Psychiatrist
- Old Age Psychiatrist
- Consultant Physician
- Consultant Nurse
- Advanced Nurse Practitioner (ANP)/ Clinical Nurse Specialist (CNS)
- Other, please specify:

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

Yes No

3 The 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

Yes No

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

Yes 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.

Yes 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 Clinical Nurse Specialist/Advanced Nurse Practitioner

Yes No

5b. Complaints– analysed by age

Yes 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.*

Yes No

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

Yes No

8. There are champions for dementia at:

a) Directorate level

Yes No

b) Ward level

Yes 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 Yes No

9b. Co-morbid Conditions Yes No

9c. Current Medication Including Dosage and Frequencies Yes No

9d. Assessment of functioning using a standardised instrument- i.e. basic activities of daily living, instrumental activities of daily living, mobility Yes No

Answer "Yes" if functioning is assessed using a standardised instrument, e.g. Barthel or other instrument.

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

Answer "Yes" if cognitive assessments use standardised instruments, e.g. AMT, MMSE.

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

Answer "Yes" if mood assessed using a standardised instrument e.g. short form geriatric depression scale

9e2 Assessment of collateral history from a relative/ carer of onset and pattern of cognitive dysfunction, or presence of behavioural and psychological symptoms of dementia (BPSD) Yes No

Answer "Yes" if there is documentation of discussion of any aspect of above

9f Nutritional status Yes 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.

Yes No

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

Yes No

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

Yes 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.

Yes 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.

Yes No

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

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

- 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.

- Yes**
- 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 who 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 an assessment of mental state 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).

- Yes** **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 plain English or Irish, and available in other appropriate 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/ or Irish and can easily be provided in other languages/formats** [Go to Q21a](#)
- Yes, but available in English and / or Irish 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 details which aid communication:

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:

- 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCA's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other allied healthcare professionals, e.g. physiotherapists, dieticians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support staff in the hospital, e.g. housekeepers, porters, receptionists, catering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCA's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCA's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCA's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCA's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCA's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 transition care units, which will admit people with dementia:

Answer "Yes" if criteria for admission to intermediate care services do not exclude people on the basis of dementia, confusion, memory problems or mental health problems.

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	<input type="checkbox"/>	<input type="checkbox"/>
b) Evening	<input type="checkbox"/>	<input type="checkbox"/>
c) Weekend	<input type="checkbox"/>	<input type="checkbox"/>

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

	Working age adults	Older adults
a) On site (in this hospital)	<input type="checkbox"/>	<input type="checkbox"/>
b) Off site	<input type="checkbox"/>	<input type="checkbox"/>

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)
- b) Off site

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
b) Evening
c) Weekend

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

- a) On site (in this hospital)
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?

Appendix E



Irish National Audit of Dementia (care in general hospitals)

Healthcare Record Audit

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 01/07/2012 and 31/12/2012 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 HIPE 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.

Adapted from the UK National Audit of Dementia, with permission: Copyright HEALTHCARE QUALITY IMPROVEMENT PARTNERSHIP, HQIP 2012

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 2 letters and 2 numbers, e.g. XY11. If you do not know the hospital code, please contact the audit co-ordinator on 086 028 5359

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 HCR is not eligible and you cannot continue

Enter number for this patient:

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

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

Please refer to the guidance document on how to select HCRs for data reliability check. If this HCR is one of the five HCRs 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
- Black
- Mixed Race
- Not documented
- Any Other White Background
- Asian
- Chinese
- Other Ethnic Group

4. Select the first language of the patient:

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

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

- Cardiac
- Critical Care
- Nephrology
- Oncology
- Stroke Unit
- Psychiatry
- Psychiatry of Old Age
- Neurology
- Acute Medical Assessment Unit
- Care of the Elderly
- General Medical
- Obstetrics/Gynaecology
- Orthopaedics
- Surgical
- Intensive Care Unit
- Neurosurgery
- Palliative Care Bed
- 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 or warden controlled accommodation. "Transfer from another hospital" means any hospital other than the one for which you are submitting this HCR.

- | | |
|---|---|
| <input type="checkbox"/> Own home | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Rehabilitation Unit | <input type="checkbox"/> Psychiatric ward |
| <input type="checkbox"/> Residential Care/Nursing Home/
Community Hospital | <input type="checkbox"/> Palliative care |
| <input type="checkbox"/> Carer's home | <input type="checkbox"/> Transitional care |
| <input type="checkbox"/> Convalescent Care | <input type="checkbox"/> 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 HCR.

- | | |
|--|---|
| <input type="checkbox"/> Own home | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Rehabilitation Unit | <input type="checkbox"/> Psychiatric ward |
| <input type="checkbox"/> Residential Care/ Nursing Home/
Community Hospital | <input type="checkbox"/> Palliative care |
| <input type="checkbox"/> Carer's home | <input type="checkbox"/> Transitional care |
| <input type="checkbox"/> Convalescent Care | <input type="checkbox"/> Transfer to 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 (COMPREHENSIVE GERIATRIC ASSESSMENT)

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

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 been asked about any continence needs?

This can be the initial nursing assessment (a trigger question which prompts full bowel and Bladder assessment where necessary and the patient's understanding / acceptance of the question is assessed) 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

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

22. Has a standardised mental status test 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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Time since onset of memory problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Nature of progression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Evidence of loss of function | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 an 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 social worker been identified?

- 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 social worker been requested?

- Yes Go to Q25b
- No Go to Q26

25b. Has a care assessment by a social worker 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 support/social worker 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 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 which aid communication?

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. You may find information about the patient's medication on the on the drug chart or within the notes. See list below:

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 Comment box end of Section 2

28a. 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

28b. 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

28b1. Was an antipsychotic administered via PRN?

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

- Yes
- No
- Information cannot be found

28c. 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 prescription 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 correspondence 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/carers 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/carers is not specific to their ongoing care and treatment (e.g. generic leaflets about social services) OR if the patient/carers receives no information

- Yes
- No

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 history/results
- Patient presenting confusion
- Patient transferred to another hospital
- Patient being discharged to nursing/residential care
- Not recorded
- Patient awaiting assessment
- Patient awaiting surgery
- Patient on end of life care
- Patient unresponsive
- Other

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 ± 48 hours
- No notice at all
- Not documented
- 24 hours
- More than 48 hours
- No carer, family, friend

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" 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 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 during further assessment? or

- 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).

- Within 60 minutes
- Within 24 - 48 hours
- Within 72 - 96 hours
- Not documented
- Within 24 hours
- Within 48 - 72 hours
- Longer than 96 hours
- 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?

Answer "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)

- Within 60 minutes
- Within 24 - 48 hours
- Within 72 - 96 hours
- Not documented
- Within 24 hours
- Within 48 - 72 hours
- Longer than 96 hours
- 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)

Do you have any comments to make on Section 4c: Geriatric Medicine?

SECTION 4d: 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 social worker, 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

SECTION 4e: REFERRAL TO NEUROLOGY

55. If the patient is aged 64 years or younger, has any referral to Neurology been documented in the HCR?

If patient is aged 65 years or older, skip this question.

- Yes
- No
- No neurology service available in the hospital

Do you have any comments to make on Section 4d/e:Palliative care needs and referral to neurology?

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 HCR 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:

Ms Anna de Siún,

INAD Project Co-Ordinator

086 0285359

Annadesiun@gmail.com



Irish National Audit of Dementia (care in general hospitals)

Ward Organisational Audit

Hospital code

Ward code

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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)

4. Please give the number of healthcare assistants actually working on this ward (whole time equivalent)

5. Are there any vacancies on this ward?

- Yes No

5a Who are nursing vacancies filled by? (Tick all that apply)

- Hospital Pool Staff Agency staff Vacancies are not filled

5b. Who are healthcare staff vacancies filled by? (Tick all that apply)

- Hospital Pool Staff Agency staff Vacancies are not filled

6 There is a system to routinely monitor and report the use of hospital pool and agency staff

- Yes No

7 There is administrative staff support on the ward

- Yes No

7a When is administrative staff support available on weekdays?

- Monday – Friday (full time) Monday – Friday (part time)

7b Is there access to administrative support at weekends?

- Yes No

Comments on administrative support on the ward:	

8. The ward has an agreed minimum staffing level across all shifts

- Yes [Go to Q8a](#)
No [Go to Q9](#)

8a. The agreed minimum staffing levels are met.

- Yes 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)

- Yes No

9a. Please briefly describe these systems (e.g. what mechanism is used to ascertain staffing levels)

--	--

10. There are arrangements for staff cover to allow staff to attend training relating to the care of people with dementia

Yes No

11. Systems for supporting staff development are in place including:

	Registered Nursing Staff	Healthcare Assistants	Other Staff (not including students)	No
11a Appraisal and mentorship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11b Clinical supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11c Access to guidance and support from dementia champions in the hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Staff caring for people with dementia have access to peer support groups. Tick all that apply

Registered nursing staff Healthcare assistants Other staff
No

12a. Staff caring for people with dementia have access to reflective practice groups. Tick all that apply

Registered nursing staff Healthcare assistants Other staff
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)

Yes 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14a2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatry of Old Age:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14b1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14b2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Geriatrician:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14c1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14c2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Occupational Therapy:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14d1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14d2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social Work Support:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14e1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14e2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pharmacy:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14f1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14f2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physiotherapy:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14g1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14g2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dietetics:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14h1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14h2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Speech and Language Therapy:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14i1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14i2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Psychology/Neuropsychology:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14j1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14j2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specialist Infection Control Services:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14k1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14k2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specialist Tissue Viability Services:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14l1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14l2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specialist Continence Services:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14m1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14m2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specialist Palliative Care:

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
14n1	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14n2	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15b	The hospital complaints procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15c	Patient advocacy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15d	Personal and healthcare information and when this will be shared with carers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. Staff are encouraged 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?

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:

Ms Anna de Siún,

INAD Project Co-Ordinator

086 0285359

Annadesiun@gmail.com



**Irish National Audit of Dementia
(care in general hospitals)**

Environmental Audit

Hospital code	<input type="text"/>
Ward code	<input type="text"/>
Ward Size and Layout	
Number of beds	<input type="text"/>
Number of single sex bays	<input type="text"/>
Number of mixed bays	<input type="text"/>
Number of single rooms	<input type="text"/>

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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)

- Yes No

2. Key areas are clearly marked (e.g. the nursing station, the bathroom, any side rooms or waiting areas)

- Yes No

3. Signs/maps are large, bold and distinctive

- Yes No N/A (no signs/maps)

4. Information (words and pictures) on signs is in clear contrast to the background

- Yes No

Section 2: Floors

5. Level changes and contrasts (gentle slopes and steps) are clearly marked

- Yes No 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)

- Yes No

7. Floor surfaces are subtly polished rather than high gloss

- Yes No

8. Floor surfaces are non slip

- Yes 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

- All patients Some patients No patients

10 Patients with dementia are able to see a clock from their bed area

- All patients Some patients No patients

11 Patients with dementia are able to see a calendar from their bed area

(this can be an orientation board)

- All patients Some patients 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

- All patients Some patients 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)

- Yes 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

- All Some None

15a. Toilet doors carry signs

- All Some None

15b. Bathroom doors carry signs

- All Some None

16 Toilet and bathroom doors are a different colour to the walls

- All Some 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

- All Some None

18 There are hand rails, large handles and a raised toilet seat to support patients

- Yes No

19 Door handles are a different colour to the wall so that they stand out

- All Some None

20 Toilet paper is a different colour to the wall so that it stands out

- All Some None

21 The toilets are big enough for assisted toileting

- All Some None

22 The bathroom is big enough for assisted bathing

- Yes No

23 Single sex toilet/washing facilities are provided for patient use

- Yes 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)

- Yes No

25 There are call/alarm buttons visible in the toilet/bathroom

- Visible and in reach
 Visible and not in reach
 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

- Yes No

27 The ward is adapted to assist people with mobility difficulties (e.g. large handles, hand rails)

Yes No

28 The ward can readily provide equipment to assist mobility (e.g. walking frames, wheelchairs)

Yes No

29 The ward can provide hearing aids such as amplifiers/communicators/hearing loops/batteries for personal aids or other assistive devices

Yes No

30 The ward can provide adapted utensils (cutlery) to encourage patients to assist themselves with their meal and eat independently

Yes No

Any comments on the environmental checklist:

If you have any queries, please contact:

Ms Anna de Siún,

INAD Project Co-Ordinator

086 0285359

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Appendix H



**Irish National Audit of Dementia
(care in general hospitals)**

Healthcare Record Audit Guidance Document

April 2013

Introduction

Thank you for taking part in the Irish National Audit of Dementia (care in general hospitals).

All general acute and orthopaedic hospitals in the Republic of Ireland are participating. The audit consists of four modules;

- Healthcare Record (HCR) Audit
- Organisational Audit
- Environmental Audit
- Ward Organisational Audit

This document has been prepared as a guide for people carrying out the HCR audit, which will audit the records of 20 patients with a diagnosis or current history of dementia against a checklist of standards which have been drawn from national and international best practice.

Management of the Audit

This audit is a joint initiative between The Centre for Gerontology and Rehabilitation, University College Cork, The Centre for Ageing, Neuroscience and the Humanities, Trinity Centre for Health Sciences, Tallaght Hospital and the HSE Quality and Patient Safety Directorate.

A number of professional bodies are collaborating on the project through membership on the INAD Steering Committee or INAD Advisory Group.

INAD Audit Team

INAD National Coordinator

Ms. Anna de Siún

Phone: 086 0285359

E-mail: annadesiun@gmail.com

Quality and Patient Safety Audit Services;

Ms. Denise McArdle (lead)

Ms. Patricia Gibbons

Ms. Marie Gilligan

INAD Research Assistant

Ms Emma O'Shea

Completing the Healthcare Record Audit

Each hospital is expected to submit an audit of 20 sets of healthcare records (HCRs) of patients discharged with a known diagnosis or current history of dementia, identified through HIPE coding (see How to select your sample, p 7). One form is to be filled in per set of notes audited.

Estimated time to complete:

This is a complex data set. Feedback suggests that the first set of HCRs audited will take an hour or more. For subsequent sets the majority took thirty minutes or less.

Inter rater reliability check

As part of the reporting process for this audit, the audit team will be collecting inter rater data. This will involve re-audit by a member of the INAD Audit Team of the first five HCRs. 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 it is essential that the MRN is clearly recorded on the Healthcare Record Coding Sheet and the patient code is recorded on the data collection form. This is an important part of the audit. The process for identifying patient numbers for audit is described on page 7.

NB. Reliability (agreement between auditors) is not the same as validity (accuracy of measure). However establishing good agreement between auditors is an important part of the process of validation as valid data by definition will have to be reliable.

Question routing

Some questions on the HCR 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 question 17a, which asks for further information about the nutritional assessment.

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

Guidance to individual questions is included in the tool. If you need any further guidance before answering a question please contact the INAD Project Coordinator on 086 0285359.

How to select your sample

This is a retrospective audit of the records of patients with a diagnosis of dementia discharged from your hospital (or died during admission) between 1st September 2012 and 31st January 2013.

Generating a list of eligible patient records

The following criteria is used to generate a list of eligible patient records:

1. Any diagnosis of Dementia. HIPE CODES are **F00 to F03, F05.1, G30** (please see p10-12 below for details)
2. Length of stay in Hospital is a minimum of 5 days, so 5 days +
3. Dates between 01 September 2012 to 31 January 2013. PLEASE NOTE, if 30 HCR cannot be generated from the initial dates please go back to 01 March 2012

These codes indicate a diagnosis of dementia. They may appear in primary coding but are more likely to be a secondary or subsidiary code. Dementia may also appear in current history. All HCRs with any of the codings provided are eligible and should be used to generate a list.

Using the above criteria, please contact your audit liaison person or HIPE administrator to create a patient list of 30 patients discharged with a diagnosis of dementia between 1st September 2012 and 31st January 2013 in your hospital.

NB: The number generated should be completed admissions and not consultant episodes, as there will be many of these per patient.

Insufficient healthcare records

In the event that you find you do not have 30 HCRs of patients discharged during the 5 month period, with any of the codes listed at any level, you will be asked to audit consecutive discharges falling within the period 1st April 2012 – 31st August 2012.

Exclusion

- Length of stay: please exclude patients whose admission was 4 days or less. Use the date of admission and date of discharge to do this (including both dates in the total length of stay).
- Diagnosis or current history of dementia: please exclude patients whose notes have been incorrectly coded.

Choosing your sample

- 1) Obtain your patient list - see "How to select your sample" above and have the HCRs pulled.
- 2) Organise the HCRs so that your sample is in the date order that the patients were discharged from the hospital - with most recent discharges first.
- 3) Allocate each HCR in the list a patient code number from the Healthcare Record Coding List. This is the number you will use when entering "number for patient" in the data collection form. A copy of the Healthcare Record Coding List for your hospital is available from the project coordinator.
- 4) NB. Whenever a set of notes identified is found to be ineligible for this audit, e.g. length of stay less than 5 days or wrongly coded, go on to the next set in the sequence, but do not reallocate the number. E.g. if number 2 is ineligible, go on to number 3, and make up the sample with number 21 on your list, and so on.
- 5) Replace excluded records with the next consecutively discharged patients in the total series, until there is a total return of 20.

Data return

Data collection forms should be returned in the self address envelopes. Envelopes available from the project coordinator.

NB. Healthcare Record Coding Sheets must be returned in a separate envelope. Please return the HCR coding sheets to

Anna de Siún,

58 O'Molloy Street,

Tullamore,

Co. Offaly

Timeline for data collection

All data should be collected and returned within 2 weeks of audit training.

Reporting

Local Reports: Local data will be made available to individual hospitals upon request.

National Report: Key findings from collated anonymised data from the audit and recommendations will be presented in an overall report in Spring 2014.

HIFE codes to be used to identify HCRs for audit

Dementia (F00–F03) is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour or motivation. This syndrome occurs in Alzheimer's disease, in cerebrovascular disease and in other conditions primarily or secondarily affecting the brain.

Use additional code to identify the underlying disease.

F00* Dementia in Alzheimer's disease (G30.-†)

▽ 0528

Alzheimer's disease is a primary degenerative cerebral disease of unknown aetiology with characteristic neuropathological and neuro-chemical features. The disorder is usually insidious in onset and develops slowly but steadily over a period of several years.

- F00.0*** *Dementia in Alzheimer's disease with early onset (G30.0†)*
 Dementia in Alzheimer's disease with onset before the age of 65, with a relatively rapid deteriorating course and with marked multiple disorders of the higher cortical functions.
 Alzheimer's disease, type 2
 Presenile dementia, Alzheimer's type
 Primary degenerative dementia of the Alzheimer's type, presenile onset
- F00.1*** *Dementia in Alzheimer's disease with late onset (G30.1†)*
 Dementia in Alzheimer's disease with onset after the age of 65, usually in the late 70s or thereafter, with a slow progression, and with memory impairment as the principal feature.
 Alzheimer's disease, type 1
 Primary degenerative dementia of the Alzheimer's type, senile onset
 Senile dementia, Alzheimer's type
- F00.2*** *Dementia in Alzheimer's disease, atypical or mixed type (G30.8†)*
 Atypical dementia, Alzheimer's type
- F00.9*** *Dementia in Alzheimer's disease, unspecified (G30.9†)*

F01 *Vascular dementia*

- Vascular dementia is the result of infarction of the brain due to vascular disease, including hypertensive cerebrovascular disease. The infarcts are usually small but cumulative in their effect. Onset is usually in later life.
Includes: arteriosclerotic dementia
- F01.0** *Vascular dementia of acute onset*
 Usually develops rapidly after a succession of strokes from cerebrovascular thrombosis, embolism or haemorrhage. In rare cases, a single large infarction may be the cause.
- F01.1** *Multi-infarct dementia*
 Gradual in onset, following a number of transient ischaemic episodes which produce an accumulation of infarcts in the cerebral parenchyma.
 Predominantly cortical dementia
- F01.2** *Subcortical vascular dementia*
 Includes cases with a history of hypertension and foci of ischaemic destruction in the deep white matter of the cerebral hemispheres. The cerebral cortex is usually preserved and this contrasts with the clinical picture which may closely resemble that of dementia in Alzheimer's disease.
- F01.3** *Mixed cortical and subcortical vascular dementia*
- F01.8** *Other vascular dementia*
- F01.9** *Vascular dementia, unspecified*

F02* *Dementia in other diseases classified elsewhere*

- Cases of dementia due, or presumed to be due, to causes other than Alzheimer's disease or cerebrovascular disease. Onset may be at any time in life, though rarely in old age.
- F02.0*** *Dementia in Pick's disease (G31.0†)*

A progressive dementia, commencing in middle age, characterised by early, slowly progressing changes of character and social deterioration, followed by impairment of intellect, memory, and language functions, with apathy, euphoria and, occasionally, extrapyramidal phenomena.

F02.1* *Dementia in Creutzfeldt-Jakob disease (A81.0†)*

A progressive dementia with extensive neurological signs, due to specific neuropathological changes that are presumed to be caused by a transmissible agent. Onset is usually in middle or later life, but may be at any adult age. The course is subacute, leading to death within one to two years.

F02.2* *Dementia in Huntington's disease (G10†)*

A dementia occurring as part of a widespread degeneration of the brain. The disorder is transmitted by a single autosomal dominant gene. Symptoms typically emerge in the third and fourth decade. Progression is slow, leading to death usually within 10 to 15 years.

Dementia in Huntington's chorea

F02.3* *Dementia in Parkinson's disease (G20†)* **GMC**

A dementia developing in the course of established Parkinson's disease. No particular distinguishing clinical features have yet been demonstrated.

Dementia in:

- paralysis agitans
- parkinsonism

F02.4* *Dementia in human immunodeficiency virus [HIV] disease (B22†)*

Dementia developing in the course of HIV disease, in the absence of a concurrent illness or condition other than HIV infection that could explain the clinical features.

F02.8* *Dementia in other specified diseases classified elsewhere*

Dementia (in):

- cerebral lipidosis (E75.-†)
- epilepsy (G40.-†)
- hepatolenticular degeneration (E83.0†)
- hypercalcaemia (E83.5†)
- hypothyroidism, acquired (E01.-†, E03.-†)
- intoxications (T36–T65†)
- Lewy body disease (G31.3†)
- multiple sclerosis (G35†)
- neurosyphilis (A52.1†)
- niacin deficiency [pellagra] (E52†)
- polyarteritis nodosa (M30.0†)
- systemic lupus erythematosus (M32.-†)
- trypanosomiasis (B56.-†, B57.-†)
- uraemia (N18.5†)
- vitamin B₁₂ deficiency (E53.8†)

F03 Unspecified dementia

Presenile:

- dementia NOS
- psychosis NOS

Primary degenerative dementia NOS

Senile:

- dementia:
 - depressed or paranoid type
 - NOS
- psychosis NOS

Excludes: senile dementia with delirium or acute confusional state (F05.1)
senility NOS (R54)¹

ALZHEIMER'S DISEASE

When only 'Alzheimer's disease' is documented, rather than 'Alzheimer's dementia', the dementia component can be assumed and thus two codes should always be assigned, G30.- *Alzheimer's disease* and F00.-* *Dementia in Alzheimer's disease*.

F05 Delirium, not induced by alcohol and other psychoactive substances

An aetiologically nonspecific organic cerebral syndrome characterised by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion, and the sleep-wake schedule. The duration is variable and the degree of severity ranges from mild to very severe.

Includes: acute or subacute:

- brain syndrome
- confusional state (nonalcoholic)
- infective psychosis
- organic reaction
- psycho-organic syndrome

Excludes: delirium tremens, alcohol-induced or unspecified (F10.4)

F05.0 Delirium not superimposed on dementia, so described

F05.1 Delirium superimposed on dementia

Conditions meeting the above criteria but developing in the course of a dementia (F00–F03).¹

¹ Extracted from NCCH eBook, July 2008, Mental and Behavioural disorders.

