DEMENTIA NATIONAL AUDIT OF DEMENTIA

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

National Audit of Dementia Care in General Hospitals 2012-13

Second Round Audit Report and Update

Executive Summary and Recommendations

HQIP Healthcare Quality Improvement Partnership

Royal College of Physicians

Royal College of Nursing The voice of nursing in the UK

RCGP Royal College of General Practitioners

Alzheimer's Society Leading the fight against dementia

British Geriatrics Society

Audit governance

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

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

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

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

If citing this report, please reference it as:
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Painting on front cover:
Among the Hills by Mildred Doyle, 2009.
Alzheimer's Association of Colorado Memories in the Making® Art Program.

The report is published by HQIP and produced by the Royal College of Psychiatrists' Centre for Quality Improvement.

Audit background

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

The first round of the National Audit of Dementia was carried out in 2010/11. The national report[39] concluded that hospitals needed to design and implement an integrated approach to the care of people with dementia and highlighted improvements to be made at all levels.

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

- **a hospital organisational checklist** to audit the service structures, policies, key staff and care processes that impact on service planning and provision for the care of people with dementia within a general hospital.

- **a retrospective case note audit** of the records of a minimum of 40 patients with a diagnosis or current history of dementia, audited against a checklist of standards that relate to their admission, assessment, care planning/delivery, and discharge. Audit was of a single admission, and eligible admissions were of 5 days or longer between the period of September 2011 to February 2012.

Participation

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

Data received

- Organisational checklists – 210 checklists received (1 from each participating hospital).

- Case note audit – 7987 case note submissions received (from 206 of the participating hospitals).

Summary of results by theme

1. Governance

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

- 81% of hospitals have a senior clinician responsible for the implementation of the care pathway, which is either in place or in development. Just over a third of hospitals had a care pathway in place for people with dementia at the time of audit, and around half of hospitals had a care pathway in development.

- Executive Boards are not regularly involved in reviewing key information related to the care of people with dementia. Readmissions, delayed discharges and in-hospital falls are reviewed by less than 50% of Executive Boards.

- 82% of hospitals have a champion for dementia at directorate level and around three quarters of hospitals have a champion for dementia at ward level.

2. Assessments

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

- All hospital assessment procedures included assessment of nutritional status, and 89% of case notes had a record that this assessment had been carried out.

- Over 90% of case notes recorded that an assessment of mobility and a pressure sore risk assessment had been carried out. Over 85% of case notes recorded that the patient had been asked about any continence needs and the presence of any pain.

- Approximately half of hospitals had a policy or guideline in place to ensure that patients with dementia or cognitive impairment are assessed for the presence of delirium at presentation. A further 41% of hospitals had a policy in development. 62% of case notes had no record that an initial assessment for indicators of delirium had been carried out.

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

3. Antipsychotic prescription: protocol and practice

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

- 61% of hospitals have a protocol in place governing the use of interventions for patients displaying violent or challenging behaviour, aggression and extreme agitation, which considers the needs of patients who present behavioural and psychological symptoms of dementia. A further 30% of hospitals are developing such a protocol. In the first round of audit, only around a third of hospitals had this in place.

- 19% of case notes recorded that the patient was prescribed antipsychotics during their admission to hospital (existing and new prescriptions). 8% of these contained prescriptions made during the admission. This is a drop of 10% overall since the first round of audit, and a drop of 4% for in-hospital prescription.

- The proportion of patients admitted from care home settings with an existing prescription of antipsychotics is still higher than the proportion of patients admitted from elsewhere, such as their own home, with a prescription, although overall prescription has fallen in both groups in the sample.

- 8% of patients in the total sample left hospital with a prescription for antipsychotics in place.

4. Liaison psychiatry services

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

- Nearly all hospitals report access to a liaison psychiatry service. Most of these had a Consultant Psychiatrist lead.

- Nearly all hospitals reported their liaison service provides routine mental health care to older people. In around two thirds of cases, this was combined with working age adult services.

- 96% of the hospitals reported having access to a liaison psychiatry service provided by a specialist mental health team. Only one third of hospitals had access to an older people's service both during the day, and out-of-hours during evenings and weekends.

- Out-of-hours availability is higher when onsite services are available and this particularly affects weekends.

- 16% of case notes contained a referral to liaison psychiatry. Only 42% of all referrals were seen within two days.

5. Hospital discharge and transfers

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

- 46% of hospitals do not have a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia.

- Only 19% of case notes showed that the person's level of cognitive impairment was included in summary discharge information. Only 9% of people with dementia who lived in a care home when they were admitted to hospital had this included.

- Less than half of the patients who had had symptoms of delirium, or of behavioural or psychological symptoms of dementia (such as agitation, distress or aggression) during admission had this in their discharge summary.

- 80% of case notes contained evidence that discussions had taken place with the person's carer about appropriate place of discharge and support needs. 57% of case notes contained evidence that these discussions had taken place with the person with dementia, when this was possible.

- In half of the case notes, there was no record that information about support on discharge had been given to the person with dementia or the carer.

- In a quarter of case notes, there was no record that notice of discharge from hospital had been given to carers or family.

6. Information and communication

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

- Approximately three quarters of hospitals had a formal system in place for gathering information pertinent to caring for a person with dementia. When this information is recorded in the notes, less than half contained information about details which aid communication with the person; support or actions that can calm the person if they become agitated; and recurring factors that may cause or exacerbate distress.

- Approximately half of hospitals do not have a system in place to ensure that all staff in the ward or care area are aware of the person's dementia or condition and how it affects them. 59% of hospitals have no system in place to ensure that staff are aware of the person's dementia or condition whenever the person accesses other treatment areas.

7. Staff training

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

- Over three quarters of hospitals had a training and knowledge framework or strategy that identifies necessary skill development in working with and caring for people with dementia. In the first round of audit, under a quarter of hospitals had this in place.

- 41% hospitals do not include dementia awareness training in their staff induction programmes.

- When looking at dementia awareness training hospitals provided in the 12 months prior to audit:
  - Under a quarter of hospitals did not provide dementia awareness training to doctors or other allied healthcare professionals;
  - 11% of hospitals did not provide dementia awareness training to nurses and 10% did not provide dementia awareness training to healthcare assistants;
  - 40% of hospitals did not provide dementia awareness training to support staff in the hospital.

Commissioners/Health Boards

- Commissioners/Health Boards should ensure that contracts, incentives and outcome measures support hospitals in providing high quality care for people with dementia, taking account of specific guidance on resources for care and dementia specialist roles such as that published by the Royal College of Nursing[4].

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

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

- The Trust Board/Council of Governors/Board of the Health Board should ensure they are presented with information on the review of key policies and procedures to include the needs and perspective of people with dementia and their carers, including the following as evidence that action is taken:
  - Evidence relating to Trust performance against Dementia CQUIN targets on identification, assessments and referral for people with suspected cognitive impairment and of identification and management of delirium.
  - Clinical information on admission rates, falls, intra-hospital ward transfers, treatment and discharges, in which people with dementia can be identified.
  - Evidence that person centred care is practiced throughout the Trust, for example using "This is Me"[1] or a similar personal information document.
  - Evidence that a training programme is underway addressing competencies and skill development for staff working with people with dementia, and that this is suitable for a range of competency levels and roles.
  - Evidence from local audit of in-hospital prescription of antipsychotics that their prescription is in line with guidance.
  - Trust Board members should undertake training to become a dementia friend.

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

- The Trust Board/Council of Governors/Board of the Health Board should be made aware of any incidents of discharge taking place after midnight or when carers/family receive less than 24 hours notice of discharge. This should be a routinely reported statistic, and these occurrences should be reviewed and investigated.

Recommendations

Chief Executive Officer

- The Chief Executive Officer should ensure that the Trust/Health Board identifies a senior clinician in each hospital to oversee high quality care for people with dementia and specifically to take charge of developing, implementing and monitoring the care pathway for dementia. This should be implemented by June 2014.

- The Chief Executive Officer should ensure that dignity leads and dementia champions are employed in all hospitals, and dementia specialist nurses are employed in line with Royal College of Nursing guidance[4].

- The Chief Executive Officer should ensure routine audit of in-hospital prescription of antipsychotics is carried out, which allows for comparison between wards and different departments.

- The Chief Executive Officer should ensure that their hospital is committed to being dementia friendly[3].

Medical and Nursing Directors, and Heads of Therapy Directorates

- The Director of Nursing should ensure through regular and frequent review that protected mealtimes are fully implemented and ensure that this does not exclude support for people with dementia at mealtimes from their carers and families.

- The Medical and Nursing Directors, and Heads of Therapy Directorate, should ensure that:
  - People with dementia admitted to hospital receive a standardised or structured assessment of functioning based on activities of daily living, and that this is recorded.
  - People with dementia receive a pain assessment, suitable to the individual's cognitive functioning and ability to respond, leading to a full pain assessment in line with good practice guidance produced by the Royal College of Physicians, British Geriatrics Society and the British Pain Society[5].
  - All staff responsible for the assessment of older people have had training in the assessment of mental state using standardised measures.

- The Medical and Nursing Directors, and Heads of Therapy Directorate, should ensure that all staff (including support staff roles such as porters, housekeepers, administrators) are provided with basic training in dementia awareness and a locally agreed and specified proportion of ward staff receive higher level training. This should be implemented by June 2014.

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

Senior Clinical Lead for Dementia

- The Senior Clinical Lead for Dementia should ensure that the hospital has a care pathway in place that takes account of the needs of people with dementia at each stage of admission. This should be implemented by June 2014.

- The Senior Clinical Lead for Dementia should liaise with the Directors of Nursing and of Therapy, and the Medical Director to identify dementia champions and to support their role on wards.

- The Senior Clinical Lead for Dementia should ensure that a personal information document (e.g. "This is Me"[1]) is in use throughout the hospital, and is recorded and accessible in the patient's notes.

- The Senior Clinical Lead for Dementia should implement systems to ensure that all staff can easily identify people with dementia on the ward or when transferred to different departments, and provide an appropriate response to care and treatment needs (e.g. "Butterfly Scheme").

- The Senior Clinical Lead for Dementia should ensure that clinical teams can ascertain the involvement of patients' carers in treatment decisions, and all staff involved in the patient's care are aware of this. This should take into consideration mental capacity, stated wishes and best interests decisions (as defined under the Mental Capacity Act).

- The Senior Clinical Lead for Dementia should regularly review discharge policies with particular reference to the needs of people with dementia/their carers to ensure that they describe the task of discharge coordination and the importance of carer assessments.

Ward Managers and Multidisciplinary Teams

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

- Ward Managers should ensure that the care of the person is informed by their capacity, expressed wishes and their best interests. Taking this into account at all times, carers' views, knowledge and expertise should be sought and used to inform care planning and provision. Carers should be regularly updated and involved in discussions on care, treatment and discharge planning and receive adequate notice of discharge.

- Ward Managers should ensure that staff summarise and record pertinent information related to the person's dementia and/or delirium in the discharge documentation.

- Clinicians and Multidisciplinary Teams in the hospital should ensure, in line with their duty of care, that people with dementia receive a full assessment based on the British Geriatrics Society's guidance on comprehensive assessment of the frail older patient[2].

- Clinicians and Multidisciplinary Teams in the hospital should carefully consider whether or not a prescription for antipsychotic medication is appropriate for someone with dementia and review the prescription on discharge from hospital to transfer to another setting.

Regulatory and Professional Bodies

- The General Medical Council and the Nursing and Midwifery Council should work with higher education institutions to deliver appropriate curricula for enhanced and specialist skills in dementia care, including requirements in undergraduate and postgraduate medical and nursing curricula.

- The Royal College of Psychiatrists, Royal College of Nursing, and Royal College of Physicians, with the British Geriatrics Society, should provide guidance on any circumstances in which PRN (as required) prescription of antipsychotics is appropriate.

- Future audit should include a module looking at whether people with dementia who are prescribed antipsychotics are receiving care and treatment in hospital according to guidance, whether prescription is appropriately reviewed, and take into account inappropriate prescription of other drugs used for sedation.

References

1. Alzheimer's Society and Royal College of Nursing (2010). *This is Me*. London: Alzheimer's Society.

2. British Geriatrics Society (2010). *Comprehensive assessment of the frail older patient*. Accessed at: http://www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/195-gpgcgassessment

3. Dementia Action Alliance (2012). *National dementia declaration for England*. Accessed at: http://www.dementiaaction.org.uk/assets/0000/1157/National_Dementia_Declaration_for_England.pdf

4. Royal College of Nursing (2013). *Scoping the role of the dementia nurse specialist in acute care. Findings from a report prepared by the University of Southampton on behalf of the Royal College of Nursing*. London: Royal College of Nursing.

5. Royal College of Physicians, British Geriatrics Society and British Pain Society (2007). *The assessment of pain in older people: National guidelines. Concise guidance to good practice series, No 8*. London: Royal College of Physicians.

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