National Audit of Dementia (care in general hospitals)  
Round 3

Progress Report

Summer 2016
Progress Report

Summary

This progress report presents an account of the work carried out during the pilot year of the third round of the National Audit of Dementia and in the run up to the main audit.

In 2015-2016 the NAD Project Team:

- Revised and developed tools, guidance and reporting through a pilot with 10 acute hospitals
- Carried out a feasibility study with 5 community hospital sites
- Began work on content for a module on psychotropic medication prescription
- Held a joint feedback event with the Dementia Action Alliance
- Recruited 97% of hospitals in England and Wales to participate in the main audit
- Revised tools for a wider pilot in 20 community hospitals

Current activity

Round 3 of audit is underway in 200 acute hospitals in England, Wales and the Isle of Man.

Revised versions of the audit tools are undergoing pilot in 20 community hospitals.
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**Background**

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

Two full rounds of audit were carried out, reporting in 2011 and 2013. The report for the second round concluded that despite significant positive change, many best practice standards remained unmet. The report recommended that further audit should provide a focus on meaningful change in organisational practice (rather than policy) and include measures which reflect the experiences of carers for people with dementia and the staff providing care.

Criteria measured across both rounds included comprehensive assessment, the use of personal information to plan and improve care and communication, and planning to support discharge (including communication with carers and family). You can see full and summary reports from previous rounds [here](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/dementia/nationalauditofdementia/reportsandauditmaterials.aspx).

**Summary of key findings Round 1 and Round 2**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>At Round 2 there had been overall improvement in physical health assessments, although further improvement was still possible. Assessments for mental health and delirium remained low.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of personal information documents (e.g. patient passport, This is Me)</td>
<td>A minority of the patient records audited on both rounds showed these documents in use. However hospitals reported that the document was often in the care of the person with dementia or carer, so could not be audited. Records with the information showed that it was often incomplete. Round 3 of audit contains a new requirement to audit the use of this information whilst the patient is in hospital.</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>At Round 2 there was a significant increase in discussions about discharge with the person with dementia, as well as the carer. Provision of copies of the discharge care plan to people with dementia and carers/ family had also increased significantly. There was a decrease in the percentage of carers or family receiving 24 hours’ notice of discharge or more. Notice was not documented in nearly a quarter of cases.</td>
</tr>
</tbody>
</table>

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1. [http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/dementia/nationalauditofdementia/reportsandauditmaterials.aspx](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/dementia/nationalauditofdementia/reportsandauditmaterials.aspx)
Round 3 of audit

Round 3 was commissioned by the Healthcare Quality Improvement Partnership on behalf of the Department of Health and Welsh Government in 2014.

The Royal College of Psychiatrists was awarded a three year contract to manage a further round of audit beginning in 2015.

The audit is managed by a project team based at the Royal College of Psychiatrists’ Centre for Quality Improvement and supported by advice and guidance from an expert Steering Group and consultants with expertise in dementia care in acute healthcare settings, quality improvement and person-centred care. The third round of audit is commissioned by Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government and supported by:

- 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
- Age UK
- Dementia Action Alliance

Summary content required for Round 3:

- An organisational checklist
- A casenote audit comparing care provided by hospitals to patients with a clinical diagnosis of dementia of any severity
- The collection and reporting of carer-reported experience measures
- A feasibility study for the extension of the audit to community hospital settings
- A survey of staff regarding the training and support they receive
- A spotlight audit on prescription of psychotropic medication to people with dementia

Other specifications

Other specifications for this round of audit were:

- Operates synergistically with the National Dementia CQUIN\(^2\) in England, yet is also designed appropriately for Wales

  \(This\) \(was\) \(specified\) \(so\) \(that\) \(data\) \(already\) \(being\) \(collected\) \(by\) \(hospitals\) \(would\) \(be\) \(used\) \(in\) \(the\) \(audit.\)

- Provides comparative data

\(^2\) Commissioning for Quality and Innovation payment framework
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Previous rounds have compared hospital results with the national data set but have not compared results between hospitals. Changes in design were required to make this possible.

- Organisational checklist should focus on activity rather than policy

Data from previous rounds showed that having a policy in place, for example on comprehensive assessment, did not predict better practice – hospitals with the policy were not carrying out more assessments than hospitals without. After Round 2 we recommended that the organisational part of the audit should look at actions carried out and not organisational documentation.

Summary programme of work 2015-2017

<table>
<thead>
<tr>
<th>2015</th>
<th>Acute general hospitals</th>
<th>Community hospitals</th>
<th>Development and Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revise standards.</td>
<td></td>
<td>Work with up to 5 sites to test and comment on tools and data collection.</td>
<td>Develop staff questionnaire and carer questionnaire.</td>
</tr>
<tr>
<td>Revise and curtail casenote audit and organisational checklist, ensuring comparative data.</td>
<td></td>
<td>Revise tools and prepare for wider pilot.</td>
<td>Develop new scoring system and apply to pilot data.</td>
</tr>
<tr>
<td>Work with 10 pilot sites to test new sampling methods and pilot revised tools and new staff and carer questionnaire.</td>
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<td>Implement new online data collection system.</td>
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<tr>
<td>2016</td>
<td>Roll out audit to at least 90% of hospitals in England and Wales.</td>
<td>Work with up to 20 sites to pilot and comment on data collection.</td>
<td>Develop content and sampling for module on psychotropic medication people with dementia</td>
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<tr>
<td>Made recommendations on future audit in community hospitals.</td>
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<td>Event for community hospitals.</td>
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<tr>
<td>2017</td>
<td>Roll out module on psychotropic medication.</td>
<td></td>
<td>Run topic based quality improvement workshops.</td>
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<tr>
<td>Optional casenote audit data collection Local and national reporting.</td>
<td></td>
<td>National event for acute general hospitals.</td>
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</table>

Main audit Pilot participation

Over 60 expressions of interest were received for the 10 places available for acute general sites to pilot revised and new tools in 2015.

The pilot was generously supported by 10 hospitals in England and Wales. Audit leads and their colleagues contributed time, feedback and guidance throughout data collection.
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and evaluation (see acknowledgements for details of hospitals and leads). Hospitals were based in urban and rural locations and ranged in size from 150 to 1200 beds. Sites were selected based on location, setting and size.

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Pilot content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>• Revised organisational checklist with activity focus</td>
</tr>
<tr>
<td>Kingston Hospital</td>
<td>• Casenote audit with new sampling technique</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital, Gateshead</td>
<td>• Carer questionnaire with 3 methods of distribution</td>
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<tr>
<td>Royal United Hospital, Bath</td>
<td>• Staff questionnaire online to randomly selected staff</td>
</tr>
<tr>
<td>Southport and Formby District General Hospital</td>
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<tr>
<td>Sunderland Royal Hospital</td>
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<tr>
<td>Tunbridge Wells Hospital</td>
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<tr>
<td>University College Hospital</td>
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<td>Wrexham Maelor Hospital</td>
<td></td>
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<tr>
<td>Ysbyty Ystrad Fawr</td>
<td></td>
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</tbody>
</table>

Map

Revisions to the audit tools prior to pilot

Organisational checklist
As previously, this module looked at the structures, key staff and care processes that impact on service planning and provision for the care of people with dementia within a general hospital. Each participating hospital was expected to submit one checklist.

Changes to the organisational checklist: Previous rounds of audit had shown that having a policy on an area of good practice (e.g. use of personal information) did not lead to better results when evidence was looked for in casenotes. To look more closely at what the organisation did in practice, policy based items were removed. New questions on training provision, review of the environment, carer engagement and staffing level review were included for pilot.

Casenote audit
The eight hospitals in England tested a new sampling method (way of identifying casenotes for audit). This was based on the CQUIN, used in English hospitals, which is a check used when a person is admitted to hospital showing whether they have or may have dementia. This was to test whether this means of identification would prove more satisfactory and consistent than identification through ICD10 coding, used previously. Hospitals in Wales used ICD10 coding as in previous audits. Casenotes were audited against a checklist of standards relating to assessment, information and communication, and discharge.

Changes to the casenote audit: Changes were made to reduce the resources and time needed casenote audit by shortening the tool. Questions retained were selected because responses could make it possible for results of hospitals to be compared.
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Questions removed: Many routed questions (sub questions) were removed, as it was not possible to compare their results. Sections on referral to liaison psychiatry and prescription of antipsychotics were removed as they had affected a small number of patients. Development of a separate module on the prescription of psychotropic medication was included in the tender. A separate study is underway to determine which characteristics of liaison services tend to result in better care and treatment which will inform future rounds of audit (LP-MAESTRO)3.

New questions in the casenote audit: The casenote audit contained new questions on whether capacity had been established in the case of a patient changing residence after discharge, and whether the discharge had been forwarded to the GP or primary care team. Additional response options were included for assessment of functioning to capture how this is carried out and recorded. The section on information asked specifically about food and drink preferences.

Carer questionnaire
This questionnaire was newly developed for audit by the Patient Experience Research Centre at Imperial College London. It consisted of 8 questions identified by carers as top priority items relating to the care of people with dementia that all carers/ family members visiting would find relevant and be able to answer. The Friends and Family Test question was also included for validation. The questionnaire also included a free text comment box for any additional feedback. The questionnaire was distributed by staff to carers visiting, and also sent to carers identified through a search of patient records. Questionnaires were anonymous and returned directly to the Project Team in freepost envelopes.

Staff questionnaire
This was newly developed for audit via a process of consultation with staff based at each of the pilot sites. Workshops identified key items for inclusion and the preferred format for questions. The questionnaire was distributed to a randomised sample of staff via email and also handed out to staff on wards working with people with dementia. Questionnaires were anonymous and paper copies (where used) returned directly to the Project Team in freepost envelopes.

Learning from the pilot - Data return and evaluation

Organisational checklist
Questions were included on staffing level escalation (provision of extra staff when patients with higher needs are admitted to hospital), the proportion of staff who had received awareness and other training, environmental review using the Kings Fund or other tools, access to finger foods and food outside mealtimes, and carer engagement.

The question on staffing escalation was very variously interpreted. As a clear definition has not been arrived at, it has not been included in the main audit tool.

3 https://medhealth.leeds.ac.uk/info/615/research/1541/liaison_psychiatry_measurement_and_evaluation_of_service_types_referral_patterns_and_outcomes_lp-maestro/2
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Questions on the number and percentage of staff trained were returned as unknown or broad estimates. The ability of sites to return this data was affected by staff turnover and differing methods used in maintaining training records for different staff groups. Pilot site audit leads rated information about progress made with training as very useful. After consulting with audit advisors and HEE England, a simplified question has been included in the main audit tool.

Other new questions were retained in the main audit.

Casenote audit
For the pilot, each site was asked to audit 20 casenotes, which was achieved by all but one site which audited 14.

Sampling for the casenote audit
When a person with dementia is admitted to hospital, this is usually not because of dementia but for a physical health reason, such as fracture, pneumonia or heart problems. Reasons for admission are known as primary or admitting conditions. To deliver good care and treatment the hospital also needs to know about other healthcare conditions, e.g. diabetes, dementia, arthritis. These are known as secondary conditions.

In both previous rounds of audit the records to be audited were identified using ICD10 coding (International Statistical classification of Diseases and Related Health problems). Hospitals reported that often the coding for secondary conditions was missing or incorrect. A CQUIN target based on identifying patients with dementia on admission was introduced in 2012 (England only) and it was decided that it should be tested whether this way of identifying casenotes would give more consistent results with less need for searching through records.

Hospitals participating in the pilot in England compared lists of patients with dementia discharged over three months, using first the CQUIN and then ICD10 coding to identify records.

It was discovered that there was very little overlap between the lists. An important factor in this is the ability of the CQUIN test to identify patients on admission with temporary cognitive impairment which may subsequently resolve.

Audit leads returning casenote data based on CQUIN identification reported that in many of the cases, the person did not have dementia on discharge. For one hospital, this affected their total casenote sample, so all the data returned was for people who did not have dementia. One hospital double searched to ensure that the notes they were auditing were those of people with dementia, and only found 14 they could audit.

Due to these problems the casenote audit has reverted to using ICD10 coding in order to identify casenotes for audit in Round 3.

The new questions included in pilot were retained for the main audit.

Carer questionnaire
Identifying carers of people with dementia from the person’s casenotes was unsuccessful as a method, returning very little data. Distributing questionnaires face to face with a
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verbal explanation was much more successful, and although a small number were given out, response rates were good (where it was possible to calculate these).

Analysis of the pilot data carried out independently by the Patient Experience Research Centre of Imperial College indicates that the questionnaire was acceptable to carers, with very little missing data. Positivity in answering individual questions was found to correlate with the positivity of response to the overall rating of care.

Due to these findings, we have some confidence that when distributed more widely within hospitals over a longer period, meaningful results can be obtained which will be of use to hospitals in improving care.

The questionnaire was very slightly amended for main audit with inclusion of an additional question asking carers to rate support from the hospital to help them in their role as carer.

Distribution of the questionnaire in the main audit is taking place over June-September. An online version of the questionnaire is also available.

Staff questionnaire
Random distribution of the staff questionnaire online resulted in a poor return rate. Much better returns were obtained distributing paper copies for a very limited period towards the end of data collection. No data was obtained from support staff (housekeeping, domestic and other services). There was a low number of responses for some staff groups, and it was found that questions on nutrition, patient moves and mealtimes received responses only from nursing staff.

Analysis of the data found that the questionnaire was acceptable to staff, and staff agreed that it would help to create an accurate picture of care (through evaluation questions).

The pilot demonstrated that the themes of the questionnaire were well received by staff. However, analysis showed that a section of questions could be answered by all clinical and ward based administrative staff, some only by nurses, doctors and allied healthcare professionals, but for some questions, only nursing staff consistently had the information needed to respond.

The final version of the questionnaire was therefore divided and routed to appropriate staff groups. Questions maintained after pilot address the agreed broad themes of support, training, flexibility to respond to needs and preferences, nutrition, and communication:

For all staff responding: Support, training, ability to respond to individual needs and preferences.

For doctors, nursing staff and AHPs: Team discussion of dementia, carer visiting and generally meeting nutritional needs.

For nursing staff (registered and unregistered): Responding to individual care needs on the ward, availability of additional staffing support, details of communicating and meeting nutritional needs and avoiding bed moves.
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Distribution of the questionnaire in the main audit is a) online to all staff working in wards which admit older adults, with the exception of support staff and b) to staff in a sample of 3 wards where the highest numbers of people with dementia are admitted. This will allow for comparison between staff most likely to have experience of dementia and of training and staff in the hospital as a whole.

Data collection in Round 3

Per hospital:
- One organisational checklist
- 50 – 100 casenotes of people with dementia, discharged during April or April and May
- 45-60 staff questionnaires, distributed on paper, from 3 key wards, selected as having a high admission rate of people with dementia
- 50-75 staff questionnaires online from other clinical staff in the hospital working with people with dementia
- 30-50 carer questionnaires, distributed throughout the hospital

Local reporting

For the third round of audit it is required that reporting allows comparison between hospitals. This allows hospitals a better sense of their areas of achievement and where they need to take action. Because of the number of criteria measured in this audit, comparison will be on the basis of composite scores derived from each audit tool, and associated with key themes of the audit (see below).

Reporting will also allow comparison of hospitals with the national data set and with results from the previous round where possible.

Composite scores based on key themes

This is a new feature of audit reporting. Composite scores have been created from items in individual audit tools. They have been chosen from items which are identified priorities in good care provision for people with dementia, and for which we have reason to believe that data quality will be good, based on reliability analysis and participant comment from previous rounds, or on testing of psychometric properties in new tools. The scores can be presented together (see example infographic) and at the beginning of each theme in the report. Scores are intended as an overview of key areas of care provision and it is recommended that the responses to individual questions in the tools are also studied to give a clear picture of achievement and areas for action.

Scores for all hospitals participating will be presented in tables for the national report resulting from the full audit in 2016, giving participants an easy basis for comparison between hospitals and clear areas of focus.

An explanation of scoring for each theme can be found here.
Comments made by carers and by staff

Carer and staff questionnaires included free text comment boxes. Carers were able to add any comments about the quality of care received by the person with dementia. Staff were asked to put forward any suggestions they had about improving care quality. Comments will be analysed by theme and presented in the front of each local report. This will give valuable context to the detailed results.

Presentation of the dataset by theme

Findings from all four tools will be presented together, to encourage comparison between the results from the different perspectives derived from patients’ notes, organisational level feedback, and the experiences of staff and carers for people with dementia.

Comparison of local and national findings

Hospitals will also receive the results from each of the tools individually. The Round 3 national data sample will be shown with the interquartile range percentage and the national median percentage. This will allow hospitals to compare local casenote data with the national dataset and Round 3 results, taking into consideration site variation and the small size of the curtailed samples requested for pilot.
The infographic shows your hospital scores for each theme compared with R3 average.
Audit in acute hospitals 2016

200 hospitals are participating in the audit in 2016, including 97% of eligible hospitals across England and Wales. A full list of participating sites can be found [here](#). Audit tools and guidance are available [here](#).

Audit timeline

<table>
<thead>
<tr>
<th></th>
<th>Organisational checklist</th>
<th>Casenote audit</th>
<th>Carer questionnaire</th>
<th>Staff questionnaire</th>
<th>Online staff questionnaire (see below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>Guidance issued</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April</td>
<td></td>
<td>18 April Data Collection opens</td>
<td>Guidance issued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
<td></td>
<td>Guidance issued</td>
<td>Guidance issued</td>
<td>Guidance issued</td>
</tr>
<tr>
<td>June</td>
<td>17 June deadline</td>
<td>1 June Data collection opens</td>
<td>1 June Data collection opens</td>
<td>1 June Paper distribution on 3 wards</td>
<td></td>
</tr>
<tr>
<td>July</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 July Data collection opens</td>
</tr>
<tr>
<td>August</td>
<td></td>
<td></td>
<td></td>
<td>31 August distribution end date</td>
<td></td>
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<tr>
<td>September</td>
<td></td>
<td>30 September deadline</td>
<td>30 September deadline</td>
<td></td>
<td></td>
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<tr>
<td>October</td>
<td></td>
<td></td>
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<td></td>
<td>28 October deadline</td>
</tr>
</tbody>
</table>
Community hospitals – feasibility study and pilot

This is a summary of a longer report on the study which can be viewed on the website.

Background

In previous rounds of the National Audit of Dementia (care in general hospitals), community hospitals had expressed an interest in being included. The second National report recommended exploring the possibility of their inclusion.

During the pilot year in 2015, a smaller feasibility study of 5 community hospitals ran alongside the pilot taking place in the general hospitals. The community sites were to use the same versions of the tools which the acute hospitals were testing in the pilot, with additional comment facility. This would produce an understanding as to how the tools functioned in a community hospital setting and allow the participating community hospitals to provide feedback on where changes would be necessary in order for the tools to fit the difference in setting.

Expressions of interest were solicited via acute hospital trusts/health boards which had previously taken part in the acute part of the audit and general contacts list.

Study Participation and the tools

The five community sites who volunteered to be included in the feasibility study were:

- East Cleveland Primary Care Hospital, North Yorkshire
- Ystradgynlais Community Hospital, Wales
- Teddington Memorial Hospital, Middlesex
- St Helens Hospital, Merseyside
- Liskeard Community Hospital, Cornwall

As with the pilot in general hospitals, the sites tested four tools:

- A survey of carer experience of quality of care
- A casenote audit of people with dementia, focusing on key elements of assessment, monitoring, referral and discharge
- An organisational checklist and analysis of routine data collected on delayed discharge, complaints and staff training
- A staff questionnaire examining support available to staff and the effectiveness of training and learning opportunities

The tools differed from the acute tools only in that they had more comment boxes which allowed the participating hospitals to comment on every question. This encouraged them to comment wherever any part of a question did not suit the setting.

All 5 of the sites were able to distribute both the staff and carer questionnaires (though response rates varied) and 4 of the sites returned an organisational checklist and at least 9 casenotes in the casenote audit.
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Feasibility Study Evaluation and Feedback
All comments the hospitals made when completing the tools, were taken into account when interpreting the data and also formulated an agenda for a feedback workshop which 4 of the sites were able to attend. From this workshop, it became apparent that changes would need to be made to two of the tools (the casenote audit and the organisational checklist) in order to suit the community hospital setting. Participants had no problem with the content of the staff and carer questionnaire but agreed response rates would improve if the questionnaires were distributed over a longer period of time.

Changes to the casenote audit
As community hospitals are generally much smaller than acute hospitals, it was not expected that the hospitals in the feasibility study would be able to identify as large a sample for audit. Participants expressed some surprise at how few casenotes of people with dementia they were able to find in the 3 months chosen for the study. It was clear community hospitals would need a longer time period if they would be able to gain a sample of more than 10.

The feasibility study highlighted that hospitals would need to use different methods to identify casenotes. Some hospitals used ICD10 coding, while others identified patients by looking through discharge summaries or admissions books. This depended on local circumstances. There was no single way the project team could expect community hospitals to use to identify eligible casenotes. It was clear from the feasibility study that this would need to be explored further in the pilot.

The main change recommended to the content of the casenote audit related to the section on assessment. Participants recommended that the casenote audit questions should be amended to take into account the fact that assessments asked about may not have been done in the community hospital itself because these may have been carried out just prior to transfer, in the acute hospital. Additional response options were added to deal with this.

Changes to the organisational checklist
It became apparent during the feedback workshop that some of the hospitals had answered questions according to the hospital site and some had answered them with a view to the whole trust/health board. It was suggested that questions would need clarifying as to whether they related to the hospital or were being asked at trust or health board level.

It was also noted in the workshop that the hospitals saw an advantage to adding questions to the organisational checklist relating to access to specialist services such as speech and language therapists, dieticians and liaison psychiatry to highlight areas of little coverage in community settings.

Community Hospital Pilot Overview
For the wider pilot study in community hospitals which is taking place in 2016 (including 20 hospitals), all community sites in England were identified by running an online search. The criteria (for the project’s purposes) for hospitals to be classed as a community hospital included:
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- Provide medical care but not a general hospital
- Do not provide emergency care
- Have inpatient beds

The search identified over three hundred of these hospitals in England. The project team made contact at Trust level to see if any of the hospitals would have an interest in taking part in the pilot. Welsh community hospitals were also contacted to see if they would like to take part via a mail out to Health Boards.

Pilot Participation

The project team received 30 expressions of interest and from these, 20 hospitals confirmed that they wished to take part in the pilot.

The 20 hospitals who have confirmed participation are:

- **Amersham Hospital**, Buckinghamshire Healthcare NHS Trust
- **Bluebird Lodge Community Hospital**, Ipswich Hospital NHS Trust
- **Blyth Community Hospital ward 3**, Northumbria Healthcare NHS Foundation Trust
- **Bridgnorth Community Hospital**, Shropshire Community Health NHS Trust
- **Castleberg Hospital**, Airedale NHS Foundation Trust
- **Chippenham Community Hospital (Cedar Ward)**, Great Western Hospitals NHS Foundation Trust
- **Crawley Hospital**, Sussex Community NHS Foundation Trust
- **Dartmouth and Kingswear Community Hospital**, Torbay and South Devon NHS Foundation Trust
- **Dawlish Community Hospital**, Torbay and South Devon NHS Foundation Trust
- **East Riding Community Hospital**, Humber NHS Foundation Trust
- **Ilkeston Community Hospital (Hopewell and Heanor Ward)**, Derbyshire Community Health Services NHS Foundation Trust
- **Lings Bar Hospital**, Nottinghamshire Healthcare NHS Foundation Trust
- **Macmillan Wolds/GP Unit at Bridlington and District Hospital**, Humber NHS Foundation Trust
- **Savernake Hospital (Ailesbury Ward)**, Great Western Hospitals NHS Foundation Trust
- **Hemel Hempstead Hospital (St Peter’s Ward)**, Hertfordshire Community NHS Trust
- **Uckfield Community Hospital**, Sussex Community NHS Trust
- **Warminster Hospital (Longleat Ward)**, Great Western Hospitals NHS Foundation Trust
- **Withernsea Community Hospital**, Humber NHS Foundation Trust
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- **Whitchurch Community Hospital**, Shropshire Community Health NHS Trust
- **Zachary Merton Hospital**, Sussex Community NHS Trust

**Pilot Tools**

Participating hospitals have been asked to collect the following data:

- One organisational checklist (amended as above)
- 20 casenotes
- 50% eligible staff or at least 10 staff questionnaires
- At least 10 carer questionnaires

**Possible Outcomes of the Pilot**

From the feasibility study and initial discussion with the pilot sites, it is evident that community hospitals will not be able to take part in a joint audit with acute hospitals as it is impossible to achieve a comparable number of casenotes.

From the discussions with hospitals taking part in the pilot, it is also now clear that it would take hospitals varying and extensive amounts of time to be able to gain the generally accepted casenote sample number for national clinical audits (a minimum of 40 is recommended). The pilot will show how many casenotes hospitals of varying size will be able to return from a retrospective audit over 6 months. In most cases only 15-20 are expected.

This points to two options for any future community hospital audit:

a) Hospitals taking part in a longer cycle of audit in order to gain the required audit sample to allow comparison between hospitals. This would require an ongoing commitment of resources. It would mean hospitals which were slightly larger (and could gain a sample in a few months) may be compared to a sample of potentially a few years (for a smaller hospital).

b) Allow community hospitals to return smaller number of casenotes which would contribute to a sizable national dataset of at least 3000 casenotes. Hospitals could compare their local results with the dataset and national averages to provide them with understanding of their progress in meeting best practice in caring for people with dementia. Smaller sample sizes would mean that benchmarking between hospitals would not be realistic.
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Pilot Timeline

Below is the data collection and reporting timeline. In December 2016, pilot sites will meet at the Royal College of Psychiatrists to share feedback on the pilot.

<table>
<thead>
<tr>
<th>Organisational checklist</th>
<th>Casenote audit</th>
<th>Carer questionnaire</th>
<th>Staff questionnaire</th>
</tr>
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<tbody>
<tr>
<td>April</td>
<td></td>
<td><strong>Initial introductory telephone calls</strong></td>
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<td></td>
<td></td>
<td>Guidance issued</td>
<td></td>
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<tr>
<td>May</td>
<td></td>
<td><strong>16 May</strong> Data Collection opens</td>
<td>Guidance issued</td>
</tr>
<tr>
<td>June</td>
<td></td>
<td><strong>6 June</strong> Data collection opens</td>
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<td>July</td>
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<td><strong>4 July</strong> Data collection opens</td>
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<td><strong>4 July</strong> Data collection opens</td>
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<td><strong>2 December</strong> Feedback event</td>
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Events and quality improvement activities

Joint event with Dementia Action Alliance

In February, we held a joint event at the Royal College of Psychiatrists with the Dementia Action Alliance on the theme of the Dementia Friendly Hospital. We presented and discussed the learning from the pilot in acute hospitals. Three of the audit key themes were chosen as event topics. Presentations and workshops were given by local dementia leads. You can see presentations from the event [here](#).

Planned events

Events in 2017
Events for audit participants will take place in 2017. The aim is to bring audit leads together to discuss audit findings, action planning and next steps.

Summer 2017 – a total of five topic based quality improvement workshops based on areas for review emerging from the data will be held in different locations in England and Wales.

December 2017 – a full day national event will take place at the Royal College of Psychiatrists.

Other work

Local re-audit
The casenote audit will re-open in April 2017 for hospitals wishing to submit data to compare with the data submitted in 2016.

Case studies
Working with the Dementia Action Alliance we will invite hospitals to submit case studies selected from their ongoing quality improvement work. This builds on the focus on action planning coming out of previous rounds of audit. Following the second round, hospitals were invited to submit updates on their work which were presented in two bulletins, available on the website. The information will be provided in a standard format identifying learning points, evaluation and resources required. The studies will be available via the DAA website for reference on an ongoing basis.

Input from people living with dementia
We will be working with the Alzheimer’s Society and patient experience panels to seek feedback from people living with dementia on initial results of the carer questionnaire. This feedback will be incorporated into national reporting.

Psychotropic medication module
The casenote audit in previous rounds contained a section of questions on any antipsychotic medications that had been administered to the person with dementia during their admission. Although results were locally useful and informative at a national level, the section was not satisfactory for inclusion in the main casenote audit, as the questions could not produce results which were comparable between sites, as they were
not applicable to the majority of patients whose notes were audited. The project team proposed a separate module to look specifically at patients with dementia who had been prescribed psychotropic medication of any kind during their admission. The main aims of the module will be:

- To identify a cohort of patients with dementia who have had any psychotropic medication
- To identify the circumstances surrounding the prescription and whether these were consistent with NICE guidance
- To look at whether appropriate assessment, including of pain and analgesia, has taken place
- To identify whether other medications are being prescribed in place of antipsychotics

The audit will ask about documented assessment/management of pain in notes and care plan.

**Proposed content for the module**

From the drug chart, prescription of:

- 4 most prevalent antipsychotics (Risperidone, Quetiapine, Olanzapine, Haloperidol) plus Other
- Analgesics
- Antidepressants (SSRI and other)
- Cholinesterase inhibitors
- Memantine
- Other memory enhancing drug
- Lorazepam
- Benzodiazepines
- Z-hypnotics
- Any other **psychiatric** drug

(Based on prevalence data from audit of medications prescribed for people with dementia in MH Setting, POMH-UK 2013). This will include oral or IM and PRN prescription, dosage daily mg.

**Context for prescription**

The audit will ask for:

- Reason for prescription
- Whether potential underlying causes (e.g. pain, depression, anxiety, physical such as constipation, UTI) have been considered
- Any evidence recorded of non-pharmacological interventions (e.g. changes to staff approach, environmental changes, animal therapy, massage etc
- Evidence of medication review and risk/benefit analysis

The greatest challenge from the outset of development has been to find a means of identifying the cohort of patients whose notes are to be audited, by diagnosis and prescription. This will be possible in Trusts which have electronic prescribing but may be problematic for other Trusts.

Further information about the module and registration will be circulated in the autumn.
The National Audit of Dementia project team

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Chloë Snowdon, Deputy Programme Manager
Josephine Francis, Project Worker
Sarah Keane, Project Worker
Rahena Khatun, (Project Administrator to June 2016)
Holly Robinson, (Deputy Programme Manager to March 2016)
Simone Jayakumar, (Project Worker to December 2015)
Alan Quirk, Senior Programme Manager
Mike Crawford, Director of the College’s Centre for Quality Improvement (CCQI)

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Acknowledgements

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<table>
<thead>
<tr>
<th>Community sites</th>
<th>Acute sites</th>
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<tbody>
<tr>
<td>Beth Swanson, East Cleveland Primary Care Hospital</td>
<td>Peter McCann, Chorley and South Ribble Hospital</td>
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<tr>
<td>Sharon Savigar, Liskeard Community Hospital</td>
<td>Chooi Lee, Kingston Hospital</td>
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<tr>
<td>Jacqui Bussin, St Helens Hospital</td>
<td>Andrew Fletcher and Judith Gibson, Queen Elizabeth</td>
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<tr>
<td>Nina Jalota and Teresa Keegal, Teddington Memorial Hospital</td>
<td>Hospital Tyne and Wear</td>
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<tr>
<td>Anya Pinhorn, Ystradgynlais Community Hospital</td>
<td>Chris Dyer, Royal United Hospital Bath</td>
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<td>Lesley Young, Sunderland Royal Hospital</td>
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<td>Carla Howgate and Sue Johnson, Southport and Formby</td>
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<td>Liz Champion, Tunbridge Wells Hospital</td>
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<td>Vicki Leah, University College Hospital London</td>
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<td>Sue Yorwerth and Anthony White, Wrexham Maelor Hospital</td>
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<td>Inderpal Singh, Ysbyty Ystrad Fawr</td>
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We would also like to thank all consultants and members of the Steering Group, Bethan Davies and Sarah Beardon of Imperial College, London and our Chair, Peter Crome.