National Audit of Dementia 2026

Guidance: Annual Census Day data collection

What is Annual Census Day?

NAD Annual Census Day (ACD) is a new data collection initiative aimed at collecting vital information relating to care provision for people living with dementia admitted to the hospital, which is not otherwise readily available. ACD enables the timely collection of data about the patient's experience and care during their admission to hospital.

By participating, your hospital will gain valuable national and local insights, including:

- **The proportion of acute hospital beds occupied by people living with dementia and/or other cognitive impairment**, based on a whole-hospital, ward-by-ward census
- **The proportion of people living with dementia admitted to hospital who have a personal information document**, such as *This is Me* or *All About Me*, based on a sample across three representative wards
- **The proportion of people living with dementia admitted to hospital who are appropriately "sat out" of bed** to help prevent deconditioning, also based on a sample across three representative wards

When will this take place?

Hospitals are asked to select a weekday within Carers Week **(8 - 12 June).** Annual Census Day presents an opportunity to focus on dementia, raise awareness across the hospital, and align with wider Carers Week activities and resources.

The short timeframe is intended to support greater consistency and comparability of information across different hospitals.

Is Annual Census Day mandatory for all hospitals in 2026?

In 2026, Annual Census Day will be offered as a **voluntary trial** for all general hospitals that wish to participate. Findings from the trial will inform our evaluation, and – if recommended – the Annual Census Day will become a part of the core audit requirement for all hospitals from 2027 onwards.

What will be involved?

There are three separate activities for participating hospitals (you are asked to trial all of them, but can still participate even with one or two):

1) Whole-hospital census
2) Mini spot audit of personal information document
3) Mini spot audit of patients who are "sat out" of bed

Outline guidance is below.

The **deadline** for submitting this information to NAD will be **31 July 2026.**

1. Whole hospital census

This audit is of admitted patients, and it includes all inpatient wards (including admissions units) which admit adults (any mental health, rehabilitation or intermediate care wards should be excluded). For **each ward** in the hospital, a Champion (nominated by the Dementia Lead or Strategy Group) should return information on:

a) the number of beds occupied
b) the number of beds occupied by a patient with known dementia
c) (if possible) the number of beds occupied by a patient with known delirium or other cognitive impairment, which is not dementia

To do this, the ward Champion can draw upon the following sources (where available):

- **Electronic patient records**
- **Information from the *Butterfly Scheme*, *Forget Me Not* or other dementia-support schemes** used to assist people living with dementia during hospital admission
- **Admission lists** sent to dementia/ delirium leads or teams
- Information gathered during patient clerking or ward rounds, or held by the ward manager or ward dementia champion

The output will provide both a national and local illustration of how many people living with dementia are hospital inpatients at one time, supporting effective planning, training and resource allocation, and ultimately enabling better care.

Who needs to be informed?

- Heads of Nursing, Clinical Directors and Leads and Patient/ Public Engagement
- Ward Managers and Dementia Champions

Who needs to be involved?

- Dementia/ Delirium Leads and Teams
- Dementia Strategy Committee members
- Ward Managers and administrative staff
- Dementia Champions
- Hospital audit teams

How long will it take?

Dementia leads will need to allocate approximately 1 hour to meet with Heads or Directors in order to secure approval and support.

The Dementia Strategy Team will need an estimated 1-hour project planning and regular brief update meetings to:

- Agree the date on which the data will be collected
- Determine how the numbers will be obtained within their hospital (e.g. via EPR, the Butterfly Scheme, Forget Me Not, or similar)
- Plan how this information will be disseminated across the hospital
- Confirm the nominated Dementia Champion for each ward
- Identify the central contact responsible for collating and returning the figures at hospital level

Once these points have been agreed, it should not take longer than one hour for each Ward Champion to record and return the number of occupied beds, along with the number occupied by a person with dementia or other cognitive impairment, to the designated central contact for data return.

The aim is for all qualifying wards to be included.

2. Mini spot audit of personal information document

For this part of the audit, you will need to select **three wards** of different types. We suggest one general **medical**, one **surgical,** and one **geriatric medicine/older people's** ward. They should have a high proportion of admissions of people with dementia. You could identify these wards by:

a) **Comparing admissions over a single month** (e.g. April 2026) to determine which wards receive the highest number of patients with dementia;
b) **Discussing with MDTs** to gather feedback on which wards typically care for patients with the highest dependency related to cognitive impairment; or
c) **Using a combination of the above methods**

Conducting the mini audit

Once you have selected your wards, follow the steps below for each ward:

- **Identify eligible patients** (see inclusion/exclusion criteria below).
- **Arrange list in alphabetically by surname**.
- **Review the first 10 patients** per ward and check whether each has a personal information document or equivalent scheme in place.

What counts as "Personal Information Document in place"?

A personal information document should include **meaningful personal and care-related information.** For example, documents where only the patient's name is completed should not be counted as "in place".

Sample size

10 patients per ward. You may include more than 10 patients per ward (i.e. more than 30 patients in total. If you do not have 10 patients, you may include up to 3 extra wards.

Inclusion and Exclusion criteria

For this mini-audit, only include patients with a diagnosed or known dementia (e.g., recorded diagnosis in current notes or previous record or current history from family or primary care)..

Do not include:

- Patients for whom dementia is only recently suspected and not yet known to family or carers
- Newly admitted patients whose stay had been too short for information to be collected from family or carers
- Patients whose personal information document has been given to a family member or carer for completion but **has not yet been returned**.

Who can complete this part of the audit?

To identify the eligible sample of patients, the **Dementia Lead or a member of the dementia team** should first liaise with the ward managers.

Once the sample of 30 eligible patients is confirmed, the audit can be completed by **any staff member (nursing, medical or AHP) who has appropriate authority and permissions** to check whether the personal information document is in place and accessible to staff providing care. This person should be nominated by the Dementia Lead or Strategy Group. The audit could be completed by more than one person.

What will be reported?

The information to be reported will be:

- **Number of patients checked**
- **Number with a personal information document in place**

How long will it take?

Once you have identified your wards, allow up to **90 minutes** to complete this part of the audit (30 minutes per ward).

Quality Improvement Learning activity:

The information that can be included in a personal information document will naturally vary from person to person. However, to serve as a high-quality source of information that benefits the patient, it should ideally include:

- **Personal details and preferences** (e.g. preferred name, significant personal items)
- **Support needs for personal care**, including hearing aids, glasses, dentures, mobility aids)
- **Factors that may cause distress** (e.g. noise, bright/dark lighting, unfamiliar environment, recurring worries or fears)
- **Actions or approaches that can help when the person is distressed**
- **Information that is meaningful or brings joy** (such as names of grandchildren, photos of pets..)
- **Any additional information that supports communication**, such as cues, meaningful topics, or preferred ways of interacting
- **Food and drink preferences**, including hot or cold drinks choices or dietary considerations

Not all of the above will be relevant for every patient, but together they form the basis of a patient-centred care record that supports staff to provide safe, compassionate, and individualised care.

Some Dementia Leads intend to use the Annual Census Day mini-audit as a **learning opportunity** for ward staff - demonstrating what a well-completed personal information document should contain and explaining how meaningful information directly supports staff in delivering care aligned with patients' needs and preferences.

3. Mini-audit of people with dementia who were appropriately “sat-out” of bed:

For this part of the audit, you will need to select **three wards** in the same way as previous. We suggest one general medical, one surgical, and one geriatric medicine/care of older people elderly ward. They should have a high proportion of admissions involving people with dementia. You can identify these wards by:

a) **Comparing admissions over a single month** (e.g. April 2026) to determine which wards receive the highest number of patients with dementia;
b) **Discussing with multi-disciplinary teams** to gather feedback on which wards typically care for patients with the highest dependency related to cognitive impairment; or
c) **Using a combination of the above methods**

They can be **the same three wards as those covered in part 2** mini-audit of the personal information document**, or different wards**.

Conducting the mini-audit

Once you have selected your wards, carry out the mini-audit:

- **Choose an appropriate time of the day** when patients are typically out of bed. For example, late morning (around 11:00)
- **Identify eligible patients** across the three wards. For this activity, you can include anyone with a *suspected* as well as a *confirmed* dementia diagnosis.
- **Order the patient list by date of admission** - your sample will be **the first 10 patients on each ward**.
- **At the chosen time**, observe whether the patients in your sample are
    - Out of bed
    - Washed (or have had appropriate presentational care done)
    - Dressed in their own clothes

You may report each part of this information separately. Information relating to patients in the sample being washed and dressed are optional to report.

If including these elements, please consider whether you will need to allow extra time to confer with nursing staff on the ward.

Sample size

10 patients per ward. You may include more than 10 patients per ward (i.e. more than 30 patients in total. If you do not have 10 patients, you may include up to 3 extra wards.

Who can complete this part of the audit?

To find the sample of eligible patients, the **Dementia Lead or a member of the dementia team** should first liaise with the ward managers.

Once the sample is confirmed, the audit can be completed by **any staff member who has appropriate authority and permissions to visit the ward**. nominated by the Dementia Lead or Strategy Group.

What will be reported?

The information to be reported will be:

- **Number of patients checked**
- **Number of people with dementia who were sat out of bed**

How long will it take?

Once you have identified your wards, allow up to **90 minutes** to complete this part of the audit (30 minutes per ward).

Quality Improvement Learning activity:

Some Dementia Leads intend to use the Annual Census Day mini-audit as a learning opportunity for ward staff. For example, if a patient is declining personal care, is this a sign of unfamiliarity with environment or has the person developed a delirium? If the former are there alternative ways of offering personal care (e.g. hygienic wipes they can use themselves) which they would find more acceptable? If the latter are staff aware of the signs of delirium?