DEMENTIA
NATIONAL AUDIT OF DEMENTIA

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Results of the Feasibility Study for the Inclusion of Community Hospitals in the National Audit of Dementia

February 2016

Contents

Introduction

What is the National Audit of Dementia?

The National Audit of Dementia (NAD) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government to measure criteria relating to care delivery which are known to impact on people with dementia admitted to hospital.

Criteria include policies and governance in the hospital that recognise and support the needs of people with dementia, elements of comprehensive assessment, involvement of carers, discharge planning, and identified changes to support needs during admission.

The first round of audit took place in 2010. Nearly all (99%) acute Trusts/Health Boards in England and Wales registered one or more sites to participate.

The second round of audit took place in 2012. All acute Trusts/Health Boards in England and Wales registered one or more sites to participate.

The third round of audit (2015 - 2017)

Round three of the audit has been preceded by a pilot which included two new surveys; one for staff and one for carers.

The full dataset includes:

- 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.

Feasibility study

So far, only acute hospitals have participated in NAD. Several community hospitals have expressed interest in becoming involved, but the tools and sampling methodologies were untested within a community hospital setting.

Before inviting a larger number of community hospitals to pilot completion of the NAD dataset in Round 3, a feasibility study was undertaken with five community hospitals in order to establish whether adjustments to the audit tools and methods developed for acute hospitals would be necessary. This involved the hospitals completing the full NAD Round 3 pilot dataset, and providing feedback to the NAD project team about which aspects of the process required adaptation for a community hospital context.

Participation

Expressions of interest to participate in the study were invited from all community hospitals in England and Wales. Twenty six hospitals volunteered to take part, and five were selected based on their size and location so that the sample included both English and Welsh hospitals of varying size:

Hospital	Trust/Health board	N beds	N adult wards
St Helens Hospital	St Helens and Knowsley NHS Trust	28	3
Liskeard Community Hospital	Peninsular Community Health	52	2
East Cleveland Primary Care Hospital	South Tees Hospitals NHS Foundation Trust	30	1
Teddington Memorial Hospital	Hounslow & Richmond Community Healthcare NHS Trust	50	2
Ystradgynlais Community Hospital	Powys Teaching Health Board	20	1

Audit process

Prior to the data collection period, information was sought from each hospital including bed numbers, proportion of patients with dementia being treated on the wards at any time, possible methods for identifying casenotes eligible for audit, and number of staff in patient-facing roles. This information was used to inform sample size targets, and guidance for collecting the data set.

Participating wards were sent guidance on assembling their list of eligible casenotes for audit six weeks prior to the start of data collection, and full guidance for collecting the data set was sent four weeks prior to this date.

The audit toolkit comprised the following tools:

- Organisational Checklist
- Casenote Audit
- Staff Questionnaire
- Carer Questionnaire

The organisational checklist and casenote audit data were submitted online. The carer questionnaire was distributed by each hospital either by post to carers associated with the patients whose casenotes were audited, or handed directly to visitors. These were returned to the NAD project team within postage-paid pre-addressed envelopes. Staff questionnaires could be completed online or on paper, and returned as per the carer questionnaire. All data was returned between **10th August – 9th November 2015.**

Tools

The toolkit used for the feasibility study matched that developed for the pilot of the third round of audit in acute hospitals.

Organisational Checklist

The organisational checklist was developed for previous rounds of audit and shortened prior to the pilot by removing most of the routed questions, in order to facilitate comparison between hospitals on this measure. It was used to collect data on hospital-level support for the provision of good quality care to patients with dementia. Comment boxes were added throughout the tool allowing participants to state if the question was not applicable/measurable in a community hospital setting.

Sample: One was to be completed by each hospital.

Outcomes:

1) All but one site completed an organisational checklist.
2) No items were identified as inappropriate for a community hospital.
3) Any questions that were highlighted as difficult to answer were also highlighted as such by acute hospitals. They will be amended before use in the main audit.

Casenote audit tool

This tool was developed for previous rounds of audit, but was shortened prior to its use in the third round pilot and feasibility study to reduce audit burden and increase comparability of results.

Eligibility criteria were consistent between the feasibility study and pilot audit and stated that the patients should:

- have been discharged between 1st March – 31st May 2015;
- have a diagnosis of dementia or been referred for assessment of dementia (eligible ICD10 codes were provided);
- have been admitted to hospital for 72 or more hours.

Sample:

Feedback from sites suggested that a maximum of ten eligible casenotes could be identified by each site.

Outcomes:

1) Eligible casenotes were identified in different ways by participants. Examples include:

   - "The list provided for patients with Dementia is found out through the referrals form that comes with the patient, with this information detailed." (Teddington)
   - "Discharge summaries for all patients discharged within the required time period were reviewed." (Duffy suite).

2) One site was unable to identify ten eligible casenotes within the given timeframe so were advised to identify and include additional patients discharged a month either side of these three months to enable them to reach their target of ten.
3) Casenotes returned by each hospital:

	Casenotes audited	Comments
Community hospital 1	9	Only 9 eligible patients were found despite searching a month either side of the three months in which patients should have been discharged.
Community hospital 2	0	This hospital only returned staff questionnaires and cited staffing shortages as the reason for failure to complete the rest of the dataset.
Community hospital 3	10	
Community hospital 4	12	
Community hospital 5	10	

Staff Q

The staff questionnaire was developed for the third round of audit. Workshops took place involving staff members from the acute pilot sites of various disciplines and seniority at which the questions were created and refined.

The tool was disseminated to each hospital via a weblink within a template email to send to their staff sample, which explained why they were being asked to complete the questionnaire.

Sample:

Community hospitals were instructed to disseminate the questionnaire to staff in patient-facing roles who may interact with a patient with dementia, i.e. all clinical staff (qualified and unqualified, excluding those in maternity or paediatric services), porters, receptionists, housekeepers and ward clerks, and to remove all staff employed by the hospital for less than six months.

Outcomes:

1) Participants returned the following numbers of staff questionnaires:

Pilot/Feasibility	Online entries received	Paper copies received	Total returns (includes online and hard copies)
Community hospital 1	0	29	**29**
Community hospital 2	6	14	**20**
Community hospital 3	31	8	**39**
Community hospital 4	0	65	**65**
Community hospital 5	17	25	**42**

2) Many cases were deleted from hospital 4 at the point of data cleaning as it was apparent that the questionnaire had also been distributed to staff working exclusively with outpatients.
3) A higher return rate was achieved through paper distribution of the questionnaire. This was also the case at acute hospitals.
4) Total number of eligible staff at each site are not known, so the overall return rates have not been calculated.

Carer Questionnaire

The carer questionnaire was commissioned from the Patient Experience Research Centre at Imperial College, who developed it independently for the third round of audit. It collected feedback from carers on their perceptions of the care received by the patient, communication, and overall ratings of care.

Sample:

The questionnaire was designed for family carers or key worker carers who visited the person with memory problems during their admission to hospital.

These were targeted in three ways:

Sample 1- Carers associated with patients whose notes were audited.

Sample 2- Carers associated with patients whose notes were eligible for audit, but were not amongst the first ten eligible cases (and consequently were not audited).

Sample 3- Carers visiting patients with memory problems during one month within the data collection period.

Outcomes:

1) Participants returned the following numbers of carer questionnaires:

	Sample 1 returns	Sample 2 returns	Sample 3 returns	Sample 3 response rate	Total return
Community hospital 1	1	0	0	**0**	**1**
Community hospital 2	0	0	2	6.67	**2**
Community hospital 3	4	0	11	73.33	**15**
Community hospital 4	1	1	2	23.33	**4**
Community hospital 5	3	0	0	0	**3**

2) Returns were generally low, in part due to the small number of patients with memory problems on the wards at any one time.
3) It is impossible to make assumptions about the response rate based on such a small sample. Being given a clear explanation by staff of the aims of the questionnaire (as well as the accompanying information sheet) was found to encourage carers to complete it.

Feedback from Participants

Audit leads from all hospitals participating in the feasibility study were invited to a feedback event at the Royal College of Psychiatrists on the 15th December 2015. All but one of the hospitals sent at least one delegate. Feedback was gathered around the following themes:

Sampling

- All participants were surprised by how few eligible patients they had been able to identify, as many of the patients they expected to be eligible did not have a formal diagnosis, had resolving delirium or were receiving end of life care.
- Participants employed a range of different approaches to identifying their sample, and agreed that doing so would need to remain a local solution - there is no one method applicable to all community hospitals.

Casenote audit

- No questions were deemed to be inappropriate for a community hospital.
- It was reported to take a long time to complete – but "so do all national audits".
- Filing systems were a hindrance – different parts of notes are stored in different places and with little consistency.
- It was suggested we should make clear at all points that this tool of for audit of the community hospital admission only.

Organisational Checklist

- No questions were deemed to be inappropriate for a community hospital, although it was suggested that guidance should be tweaked to clarify that questions should be answered on behalf of the hospital or trust.
- It was suggested that it would be useful to add a question about access to specialists e.g. SALTs, dieticians – to show how community hospitals compare to acute hospitals (as in R1 acute audit), and that we should ask about waiting times to access these services. These questions had featured in the organisational checklist in previous rounds, but were removed due to almost universal compliance in acute hospitals.

Staff questionnaire

- Paper copies were far more popular and quicker to get staff to complete – many nursing staff do not regularly look at emails.
- Ward manager backing helped to get people to complete.
- Participants felt that staff feedback gathered by the staff questionnaire would be helpful.

Carer Questionnaire

- Obtaining addresses (for the casenote linked sample) was very difficult. Next of Kin are usually identified– not "carers". It was not known if the NOK had visited.
- Some patients whose notes were audited had since died. Both the Project Team and participants felt strongly that it would not be appropriate to send those carers questionnaires by posts. There was work involved in checking with GPs.
- Handing out questionnaires during a census period was preferred, although this will result in a small sample due to low numbers of admissions of eligible patients.

Overall

- Carer satisfaction followed by staff training figures were considered to be the most important things to highlight when reporting.
- The timeline was acceptable for collection of the dataset.
- Support from the NAD project team was good.
- Participants suggested that whilst the achievable sample over three months (about 10 patients) may be too small for NAD to draw conclusions from, the results would still be useful to them at a local level.
- Given that participation in audit can support local quality improvement, participants felt that allowances should be made for their small possible samples.
- Some sites could identify more patients, even over 3 months, but not using coding alone.
- It was suggested that the audit could be reframed as an audit of people with cognitive impairment to cover delirium in order to increase the potential sample. However, this would result in many questions becoming not applicable and potentially two different samples.

Conclusions

With appropriate amendments identified by the study the tools developed for National Audit of Dementia in Acute Hospitals are suitable for use in a community setting. However, the small numbers of admissions to community hospitals of patients eligible for inclusion under the current criteria would prevent community hospitals from participating in the audit process developed for acute hospitals on the same basis.

Community hospitals remain keen to participate in future audit as a means of focussing attention on improving dementia care locally, and national–level comparisons between community and acute hospitals' performance could identify strengths and disparities in care provision in these settings.

Next steps

Sample sizes could be increased through:

i) Increasing the data collection period. This would mean a separate audit for community hospitals.
ii) Widening the sampling eligibility criteria. This would have implications for the applicability of elements of the current toolkit, especially the casenote audit and organisational checklist. Data would also not be comparable with that collected through the main audit.

Alternatively, community hospitals could pilot participation in a national audit for community hospitals, despite their smaller sample sizes, as long as scoring of results is not applied, performance is not ranked, and only local results are reported back to participants. This would still generate a good sized and robust total national sample from which conclusions could be drawn about the relative performance of community and acute hospitals' dementia care, or performance of community hospitals of different sizes.

2016 pilot

This year, a wider pilot of 20 hospitals is taking place. Sites are participating on the understanding that the pilot will not lead to participation of community hospitals in the same audit as acute hospitals, due to the reasons discussed above. Participants believe that local results will be very valuable, and any future opportunity for benchmarking against a national dataset would be welcomed. Amendments have been made to the data collection period and tools as suggested by participants in the 2015 study. Hospitals are collecting data between June and end of September. As in the acute sites audit, the community pilot will feature four audit tools:

- A survey of carer experience of quality of care. The carer questionnaire will be distributed to carers visiting people with dementia during July, August and September.
- A casenote audit of people with dementia, focusing on key elements of assessment, monitoring, referral and discharge. Data will be collected retrospectively over a 6 month period September 2015-February 2016, with a target of 20 casenotes per site.
- 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 staff questionnaire will be given to all staff in a clinical role working with adult inpatients.

A feedback event will be held in December 2016 for pilot sites to discuss their results and recommendations for future audit.

Tools and guidance for the pilot and a list of the participating hospitals can be found here.

The Project Team will report to HQIP with recommendations for next steps at the end of the year.

The National Audit of Dementia project team

Chloë Hood, Programme Manager

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)

Contact the team

Email: NAD@rcpsych.ac.uk

Telephone: 020 3701 2697/2681/2688

Address: Royal College of Psychiatrists' Centre for Quality Improvement, 21 Prescot Street, London, E1 8BB

Website: www.nationalauditofdementia.org.uk

Acknowledgements

Huge thanks to staff at all the feasibility study sites for their part in testing tools, collecting data and commenting on the process and necessary amendments. Especial thanks to audit leads:

Beth Swanson, East Cleveland Primary Care Hospital, South Tees Hospitals NHS Foundation Trust

Sharon Savigar, Liskeard Community Hospital, Peninsular Community Health

Jacqui Bussin, St Helens Hospital, St Helens and Knowsley NHS Trust

Nina Jalota and Teresa Keegal, Teddington Memorial Hospital, Hounslow & Richmond Community Healthcare NHS Trust

Anya Pinhorn, Ystradgynlais Community Hospital, Powys Teaching Health Board

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, for his encouragement, wisdom and patience.

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

Royal College of Psychiatrists' Centre for Quality Improvement

21 Prescot Street • London E1 8BB

www.nationalauditofdementia.org.uk

NAD@rcpsych.ac.uk