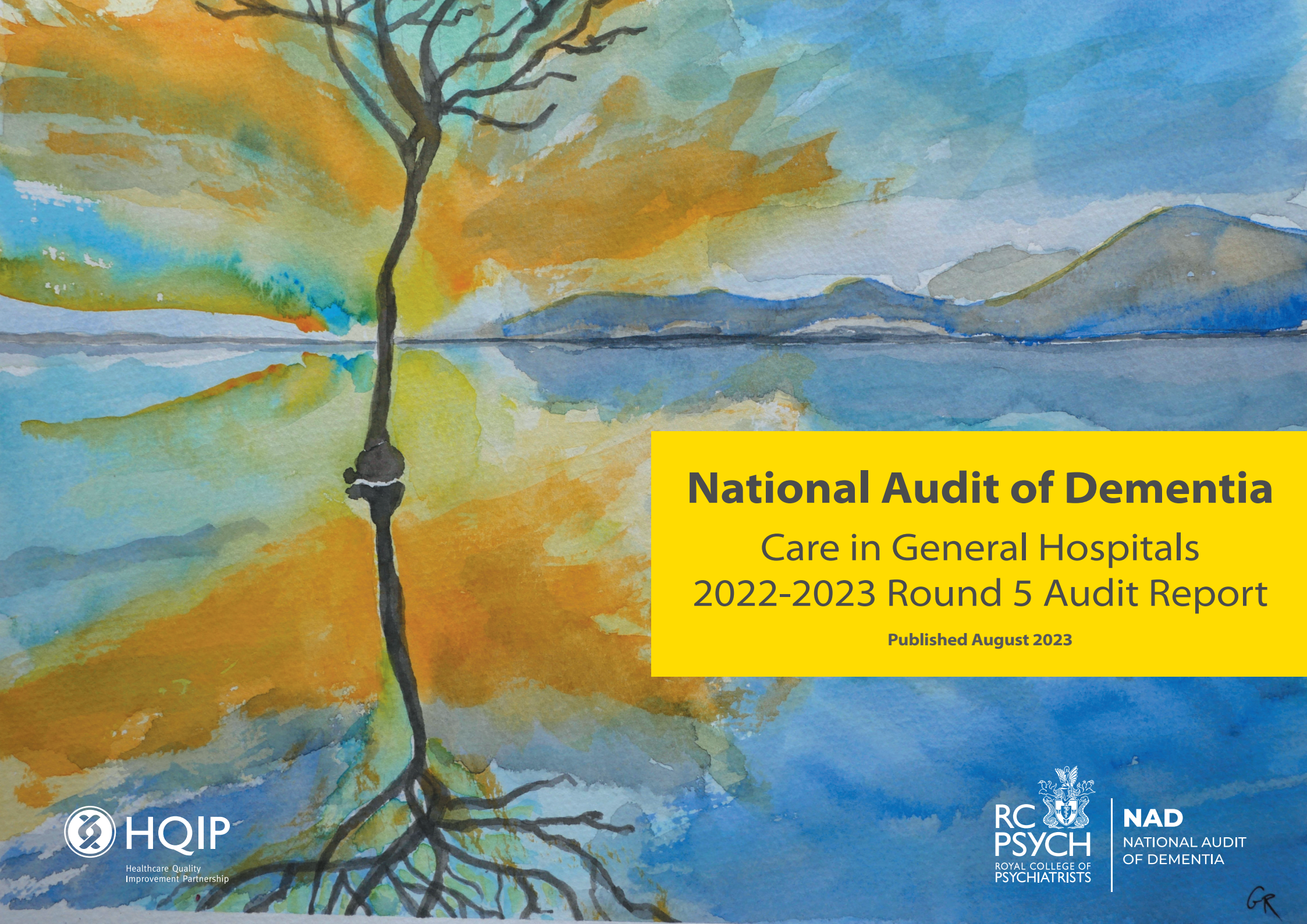

National Audit of Dementia

Care in General Hospitals 2022-2023 Round 5 Audit Report

Published August 2023

HQIP
Healthcare Quality Improvement Partnership

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NAD
NATIONAL AUDIT OF DEMENTIA

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www.hqip.org.uk/national-programmes

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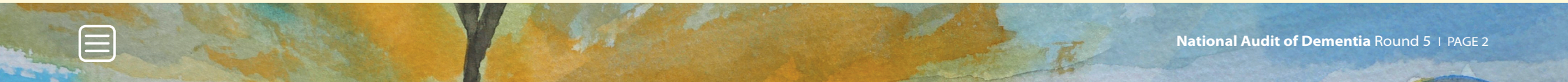


Key Findings

Delirium Screening

87% patients received an initial screen for delirium

Up from 58% in previous round

Pain Assessment and Reassessment

61% patients only had questioning as a pain assessment

92% received any pain assessment

92% received a pain reassessment

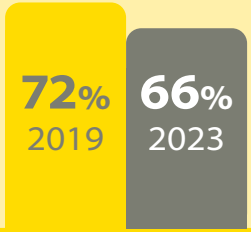
Discharge

39% patients had a discharge plan initiated within 24 hours of admission

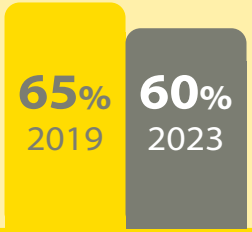
Median length of stay days 10

Feedback from carers

Rating for overall quality of care decreased



Rating for quality of communication decreased



Positive responses **decreased** from previous round for **all questions**

Key Findings

Identifying People with Dementia

Unverifiable figures returned by hospitals for total number of patients with dementia identified per year, ranging from

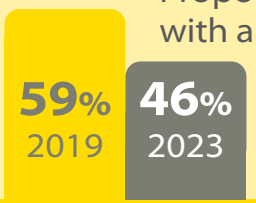
33 – 29,769

with proportion of patients with dementia varying from

0% – 15%

Personal Information Document

Proportion of patients with a personal information document decreased



Staff Expertise

20 hospitals reported having **no lead nurse** for dementia

Staff Training

Large variations of training reported, with

0% – 100%

hospital staff with **tier 1 training**

80% hospitals were able to provide figures for staff with **tier 1 training**

58% hospitals were able to provide figures for staff with **tier 2 training**

Dementia Friendly Environment Review

51% reviews taken place **throughout the hospital/all adult wards**

11% hospital review status' were **unknown or not taken place**

12% environmental review changes were **completed**

Recommendations

Hospital systems which support care monitoring and delivery

1 **The Chief Executive Officer should ensure that the Trust/Health Board has a nominated Board member responsible for dementia in addition to the clinical lead, whose responsibilities will include:**

- Establishing and implementing hospital systems capable of 1) identifying people with dementia admitted to the hospital and 2) showing the proportion of people with dementia affected by falls, delayed discharges, readmissions, pressure ulcers and incidents of violence/aggression, so that accurate figures may be supplied to NHS England Emergency Dashboard and other national dashboards.
- Monitoring the proportion of ward-based staff who have received Tier 2 level training in dementia, and assessing the impact this has on quality of care, as experienced by patients and carers.
- Scrutinising feedback from patients and carers and reports of the National Audit of Dementia.
- Tabling the Trust/Board Annual Dementia Statement for review.
- Providing regular reports to the Integrated Care Board/Welsh Government relating to the appropriate governance and monitoring of care of people with dementia.
- Developing action plans based on areas identified for improvement in care and patient experience, including ensuring that personal information about their care preferences and needs has been gathered and is available at the bedside; regular review of the environment against "Dementia Friendly" criteria using a standardised tool (e.g. Enhancing the Healing Environment | The King's Fund (kingsfund.org.uk); Patient-Led Assessments of the Care Environment (PLACE) – NHS Digital)

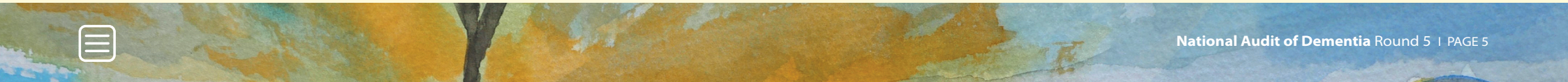
2 **Integrated Care Boards/Welsh Government should seek assurance from Trusts/Health Boards regarding their actions and progress with recommendation one.**

Comprehensive pain assessment

3 **The Medical Director and Chief Nurse should ensure that staff are trained and supported in the use of appropriate tools for comprehensive pain assessment (e.g. e-lfh Pain Management Programme)**

This should include:

- Understanding the need for structured pain assessment.
- How pain interacts with symptoms of dementia, and that people with dementia may not articulate pain.
- The regular use of an appropriate pain tool for assessing people with dementia on the ward.



Change over time

CASENOTE DATA

Audit Year	Round 1 (2010-2011)	Round 2 (2012-2013)	Round 3 (2016-2017)	Round 4 (2018-2019)	Current Round 5 (2022-2023)
Delirium initial screen or assessment				58%	87%
Pain assessment	86%	87%	83%	85%	92%
Discharge Plan initiated within 24 hours of admission	36%	40%	47%	51%	39%

CARER FEEDBACK

Audit Year	Round 1 (2010-2011)	Round 2 (2012-2013)	Round 3 (2016-2017)	Round 4 (2018-2019)	Current Round 5 (2022-2023)
Carer rating of overall care quality			72%	72%	66%
Carer rating of communication			64%	65%	60%

Change over time

ORGANISATIONAL DATA

Audit Year	Round 1 (2010-2011)	Round 2 (2012-2013)	Round 3 (2016-2017)	Round 4 (2018-2019)	Current Round 5 (2022-2023)
Inpatient falls data available/proportion of people with dementia	31%	47%	60%	64%	64%
Delayed discharge data available/proportion of people with dementia	20%	35%	32%	40%	37%
Readmissions data available/proportion of people with dementia	8%	28%	32%	37%	46%
"Dementia Friendly" hospital environment review taken place			43%	53%	36%
Proportion of patients with personal information document (eg This is Me)	43%	45%	49%	59%	46%

Contents

Foreword – Audit Consultants

This report presents the results of the fifth round of the National Audit of Dementia. Improving dementia care remains a key national priority for health services in England and Wales, highlighted in the Prime Ministers Challenge on Dementia 2022 and the Welsh Government Dementia Action Plan.

It is really encouraging that an extremely high proportion (92%) of eligible hospitals participated in this important audit once again.

For the first time the audit has been undertaken prospectively which will enable hospitals to take earlier action to improve patient care and experience. We know this has also created additional work for the audit leads and teams, and we would like to express our sincere thanks to all the staff who took part in this audit.

The prospective identification of patients has demonstrated that many hospitals still have no ready mechanism to identify people with dementia once admitted, particularly those hospitals still using paper-based or mixed patient records (67% hospitals). This might explain why so few hospitals report that they can identify the proportion of patients with dementia when they are affected by falls, develop pressure ulcers, have their discharge delayed or get readmitted, and this is an aspect which needs to improve.

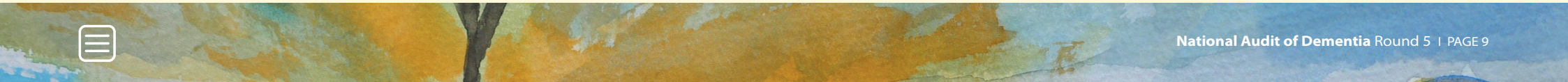
One notable improvement is delirium screening. Dementia is the biggest risk factor for developing delirium and it is vital that delirium is detected early to improve patient outcomes. Screening for delirium has improved from 58% in round 4 to 87% in the current audit and delirium screening tools such as '4AT' are being used far more commonly. A high number of pain assessments are also being undertaken within 24 hours of admission (85%). Although encouraging, the report highlights that 61% assessments were based only on a question about pain. This approach can be unreliable in patients with dementia where a validated dementia pain tool should be used. This is particularly important as the disease progresses and the person with dementia may find it increasingly difficult to understand and respond to questions.

It is encouraging that overall, many staff have received Tier 1 dementia training (median 86%), but we would expect a much higher proportion of ward-based patient facing staff to have received Tier 2 dementia training (median 45%) and it remains worrying that only 58% of hospitals are able to report the proportion of staff who have received training. Any member of staff involved in the direct care of people with dementia should have Tier 2 training and this training should be recorded, to provide assurance to the public and regulators. Feedback provided by carers has also shown a notable reduction in their overall rating of care.

Our health services have experienced an extraordinarily difficult and challenging time for both patients and staff, and despite this, there are areas where progress has been made. This report calls for a strong focus on governance, monitoring and oversight of the care of people with dementia, in order to provide the necessary support to staff and improve the quality of care and experience for people with dementia.

Beth Swanson Consultant Nurse to the Audit

Dr Oliver J Corrado Consultant Physician to the Audit



Foreword – Patient/Carer Adviser

With yet no cure for dementia, a good 'patient experience' is key. As a patient, it is heartening in this round of audit to have the patient voice captured as well as that of carers.

A lot of difficult situations can be avoided through a better understanding of how to communicate with a patient with dementia. Dementia patients are no different to non-dementia patients in wanting care and treatment to be done 'with' them and not 'to' them. For this reason the low level of tier 2 training reported is disappointing. I would encourage tier 2 training for all staff working with patients with dementia. This not only benefits the patient but will make life easier for staff as they learn how best to engage with patients with dementia.

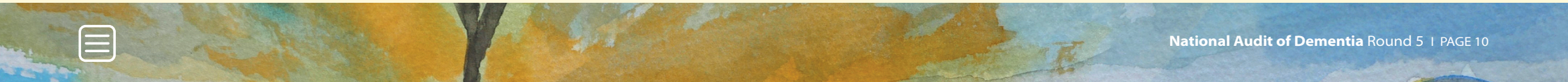
Whilst it is pleasing there are some areas showing improvements compared to previous audit, overall the results show there is plenty of opportunity to improve the patient experience. At present only 36% of hospitals are seeking regular feedback from people with dementia so there is not a full breakdown in this report. I hope that as more questionnaires are returned, analysis will show there is a strong correlation between patient and carer satisfaction with higher rates of tier 2 training.

Questionnaires returned may not reflect the experience of those in the later stages of the disease. This has to be a concern with the later stages being harder to manage and communication more difficult. How this affects the patient experience is therefore unknown. Carer responses may give an indication, but conclusions cannot be drawn. Hospitals with high satisfaction scores should be mindful of the often overlooked patients in the later stages and satisfy themselves this group are treated with dignity.

I would encourage all hospitals to actively seek patient feedback and to include patients and carers as valued members of their dementia strategy groups.

I wish to thank hospital staff and the NAD team for their excellent work, enabling this insight into dementia care and treatment without which key opportunities to improve the patient experience would be missed.

Hilary Doxford Patient/Carer Adviser



Overview

The National Audit of Dementia (NAD) measures the performance of general hospitals in England and Wales against standards relating to care delivery which are known to impact people with dementia while in hospital.

Standards are derived from national and professional guidance, including NICE Quality Standards and guidance[1], the Dementia Friendly Hospitals Charter[2], and reports from the Alzheimer's Society, Age Concern and Royal Colleges. Standards are updated for every round of audit.

Dementia in general hospitals

There are between 850,000-900,000 people living with dementia in the UK, according to current estimates.[3, 4]

"Dementia" is the term used to describe a range of symptoms that can include memory loss, difficulties with thinking, problem solving or language and changes in mood and behaviour. It is caused when the brain is damaged by diseases, such as Alzheimer's disease, or a series of strokes. People with dementia are known to experience adverse effects resulting from hospital admission, including increased confusion, long lengths of stay and delayed discharge.[5]

Improving dementia care remains a key national priority for health services in England and Wales. NHS England is committed to supporting improvements to hospital care as set out in the Dementia 2020 Implementation Plan. [6] The Welsh Government Dementia Action Plan for Wales promotes a whole system integrated care approach and a rights-based approach to improved hospital care, with quarterly reports on implementation led by Improvement Cymru.[7]

Sampling and data collection in Round 5

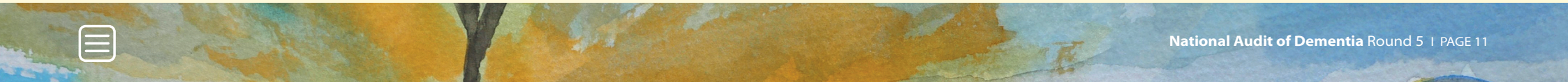
For all previous rounds of audit, identification of the records of patients for inclusion was carried out using ICD10 coding. This is applied retrospectively when a patient is discharged from hospital, and often with a significant time lag affecting when records could be accessed for data collection. This methodology produced a gap of 12-15 months between the dates when patients were discharged and audit reporting.

The cause of admission or primary diagnosis for an admission to a general hospital is very rarely dementia itself. The coding was therefore applied as secondary or lower-level coding, and not always consistently applied.

For the current and future rounds of audit, a main aim is to move towards prospective, cohort based national and annual reporting based on a focussed dataset. More frequent and timely feedback to hospitals is required to support focus on quality improvement to the experience and outcomes of care for patients with dementia.

Samples of patients' records for audit was carried out as patients were admitted (or during admission) for this round of audit, using any local system in place.

This round of audit also aimed to reduce the number of items audited, continue the focus on overall governance and monitoring of care, include ratings and feedback from carers of people with dementia, and roll out a newly developed short survey for people with dementia admitted to hospital.



Method

Casenote audit - Identification
Hospitals identified all patients with dementia as they were admitted

Casenote audit - Key Metrics
Hospitals selected the first 80* patients and submitted key metric information

*The optional Spring Flex period allowed hospitals to split their sample, with a minimum of 40 across two data points.

Casenote audit - Discharge Information
Hospitals submitted information about discharge

Annual Dementia Statement
One statement including organisational information per hospital

Carer Questionnaire and Patient Feedback
Hospitals distributed questionnaires in paper or online form, returned directly to NAD team

In the Casenote Audit

there were **178** participating hospitals that identified **14,888** patients within the audit period, and selected a total of **10,642** patients.

Casenote Audit Eligibility:

- patients with a dementia diagnosis or with concerns about cognition
- admitted to hospital for 24 hours or longer
- admitted around September – October

In the Annual Dementia Statement

there were **168** hospitals that submitted information for their statement.

In the Carer Questionnaire

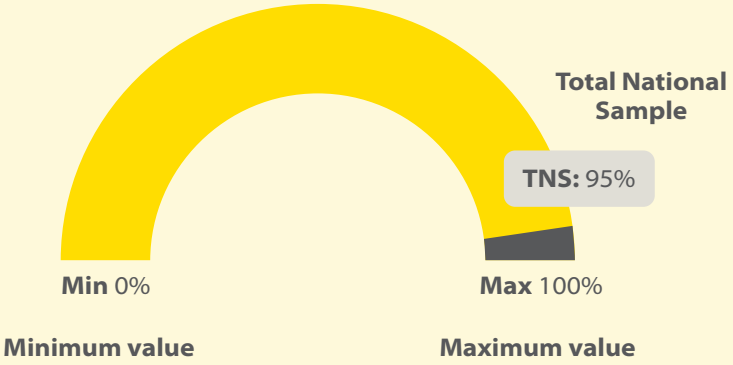
160 hospitals received responses from **2,223** carers.

How to read this report

Percentages in this report may not add up to 100% as they have been rounded (0.5 has been rounded up).

Feedback from patients with dementia and carers are taken from the qualitative responses of the NAD Patient Feedback and Carer Questionnaire respectively (see **Appendix I** for further information).

The **local ranges** in this report refer to hospital-level data and demonstrate variation between hospitals. Each diagram shows the minimum and maximum local value with the **total national sample (TNS)** average in a box. See the example below. For a full breakdown of the hospital-level data, please refer to **Appendix XI.**



NB *As the sampling methodology has changed from previous reports, please treat comparisons with caution.*

Data sources in the sections of this report:

Section	Data Source
Information about Patients	Identification part of Casenote audit
Identification of People with Dementia	Identification part of Casenote audit and Annual Dementia Statement
Governance and Monitoring Care of People with Dementia	Annual Dementia Statement
Delirium Screening and Assessment	Casenote audit selected sample
Pain Assessment and Reassessment	Casenote audit selected sample
Discharge Planning	Casenote audit selected sample
Discharge Information	Casenote audit selected sample
Nutrition and Environment	Annual Dementia Statement
Feedback from Carers	Carer Questionnaire
Appendix XI: Hospital-Level Results – Key Metrics & Carer Questionnaire	Casenote audit selected sample and Carer Questionnaire

Information about Patients

Age

Average age

84 (no change from 2019)

with a range of **30-106**

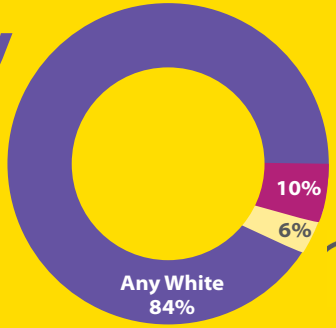
Gender

8% unknown/ not documented

2023 Female - 52%	Male - 40%

2019 Female - 59%	Male - 41%

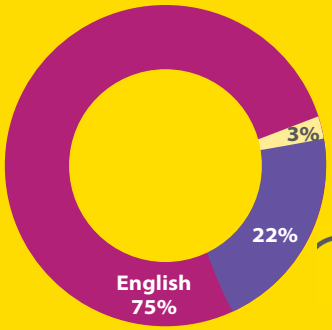
Ethnicity



Unknown/not documented

Any Other Background

First Language



Any Other Language

Unknown/ not documented

Dementia Status

25%	Known Dementia - 75%

Patients with suspected dementia or concerns about cognition

Place of Residence & Care

Own Home or Short Term Care - 71%	Long Term Care - 29%

There were no significant differences in level of care between demographic groups and audit key metrics. See Appendix VIII

Identifying People with Dementia

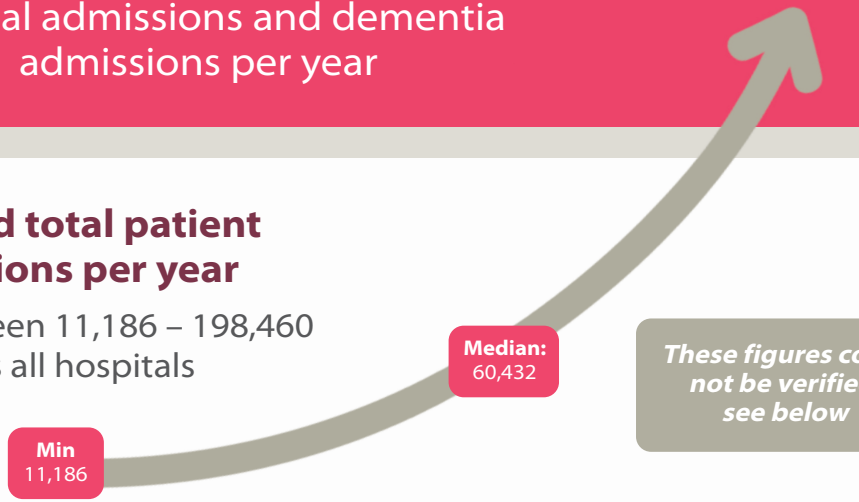
155

hospitals submitted information on total admissions and dementia admissions per year

> ***No use of the butterflies [identification] system... as a family we felt we had to be there as much as possible.***
>
> *CARER*

Reported total patient admissions per year

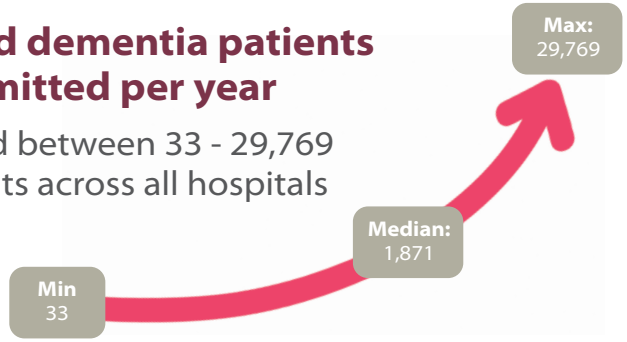
ranged between 11,186 – 198,460 across all hospitals



These figures could not be verified, see below

Reported dementia patients admitted per year

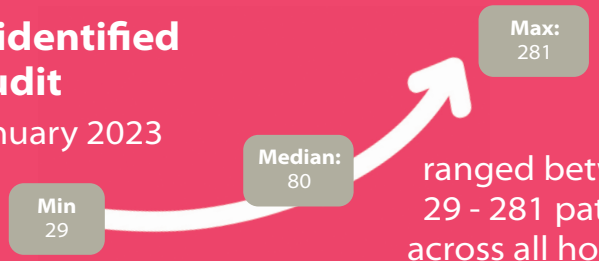
ranged between 33 - 29,769 patients across all hospitals



Refer to Recommendations

Dementia patients identified within this audit

September 2022 - January 2023



ranged between 29 - 281 patients across all hospitals

Why identifying patients with dementia matters

See full breakdown of Casenote data in **Appendix III**, Annual Dementia Statement data in **Appendix VI**, and Hospital Level Results in **Appendix XI**.

Dementia itself is very rarely the primary diagnosis or cause of admission to a general hospital, but has a significant effect on experience and outcomes. As NICE[1] has summarised:

People with dementia often experience longer hospital stays, delays in leaving hospital and reduced independent living.

Being able to identify someone who has or may have a dementia condition as they are admitted allows the multidisciplinary team to plan and provide the right inputs, care and discharge planning during their admission. Without such knowledge, the hospital also lacks information needed for planning care provision and resource allocation (**See Governance**).

Challenges in identifying patients with dementia

Identifying patients with dementia presents challenges for many hospitals, and systems may not be set up to record information about dementia as a secondary condition or co-morbidity and convey this to staff.

In many hospitals, records are not fully electronic and this also makes it challenging to identify these patients. Paper based or mixed records were in use in **67%** (125/187) of hospitals. This means that no one method is in use across hospitals, or sometimes within hospitals.

Smaller hospitals in particular found that the given identification period was not long enough to find an absolute minimum of patients requested for audit, and had to extend the "finding" period (41 hospitals extended beyond the given period of 19 September-14 October. 59 admission dates fell between 1 November and 17 January). This meant that the **proportion** of identified patient records audited also had a wide range from **18% to 100%** (median 84%).

Reliability of patient admissions data

We asked hospitals to submit their yearly annual totals for all admissions/admissions of people with dementia. These have a very large variation and these proportions do not seem to reflect Hospital Episodes Admissions data, or some early data supplied by the NHS England Emergency Admissions Data Dashboard for the National Dementia Programme.

We cannot say that the yearly totals shown here reliably report the number/proportion of people with dementia admitted to general hospitals. Therefore, we do not present a comparison of these totals with the totals found during identification for the casenote audit.

In piloting the audit, we found that prospective identification seemed to identify more patients than the coding applied after discharge on which this audit based its sampling in previous rounds. However, until systems are in place which consistently identify people with dementia, true proportions cannot be established.

Governance and Monitoring Care of People with Dementia

168 hospitals submitted governance information

Refer to Recommendations

Proportion of patients with a Personal Information Document

2023: 46%

2019: 59%

Decrease from previous round

% hospitals with information systems that can identify people with dementia experiencing:

Falls	Readmissions	Delayed Discharge	Pressure Ulcers	Violent Incidents
64%	**46%**	**37%**	**49%**	**58%**

Staff Training

Out of **168** hospitals

33 hospitals were unable to provide figures for staff with **Tier 1 training**

Tier 1 training

ranged between 0% - 100% across all hospitals

Out of **168** hospitals

71 hospitals were unable to provide figures for staff with **Tier 2 training**

Why Governance Matters

See full breakdown of Annual Dementia Statement data tables in **Appendix VI.**

Monitoring and oversight of care

The Dementia-Friendly Hospital Charter[2] highlights governance and governance structures as key to the care of people with dementia, recommending that:

> ***'Systems are in place to support continuous improvement of quality of care for people with dementia and their carers whilst in hospital, including resources and governance structures that support staff to deliver care that is dementia-friendly.'***

35.7% (60/168) hospitals reported collecting feedback from people with dementia.

Most hospitals (**82.1%**, 138/168) have a dementia strategy group) and **88.4%** (122/138) meet once a quarter or more frequently. **44.9%** (62/138) of strategy groups involve patient and public representatives, and **35.5%** (49/138) involve people with dementia and carers.

We asked hospitals whether the monitoring systems they have in place (such as DATIX or CAMIS) recording events such as falls and delayed discharge could identify the proportion of patients with dementia.

Such systems help hospitals to evaluate the care experience of people with dementia when reviewing strategic reports that come before the Trust/ Health Board.

> ***Unfortunately the ward in question didn't seem to have a clear understanding of dementia. [RELATIVE] was basically left to self care 24/7.***
>
> *CARER*

Personal information document/patient passport

The Dementia-Friendly Hospital Charter[2] promotes the use of personal profiles or patient passports, which contain information about the person with dementia's preferences as well as care needs, and support staff in providing person centred care.

Hospitals were asked to carry out a spot check on a randomly selected 10 patients with dementia across 3 wards to see whether their personal information documents was at the bedside visible to staff providing care.

> ***A 'This is Me' booklet was [a] very helpful way to get down on paper my [RELATIVE] 's needs especially because he has a number of difficulties including hearing loss. This was provided by the ward which was helpful.***
>
> *CARER*

Why Governance Matters

Staff training

Understanding and awareness of dementia and how patients living with dementia are affected is fundamental to the provision of good quality care. NICE guideline (2018)[1] recommends that care and support providers should provide all staff with training in person-centred and outcome-focused care for people living with dementia and additional face-to-face training and mentoring to staff who deliver care and support to people living with dementia.

The Dementia Friendly Hospital Charter (2018)[2] recommends all hospitals should publish reports which monitor dementia training among staff.

In previous rounds of this audit, we have tried to ascertain the proportion of staff in each hospital provided with Tier 1 (Awareness) and Tier 2 (Knowledge, skills and attitudes for roles that have regular contact with people living with dementia) training. [8]

This is not recorded centrally in all hospitals, and in this round it remains the case that many sites cannot provide a figure for the proportion of staff trained, either at hospital or at Trust/Health Board level (**See Appendix VI**).

> ***The clinical ability of the nurses and doctors is beyond reproach. They only lack Dementia training. They struggled to deal with patients who have dementia because they don't understand how to deal with the issues dementia present. This is made worse when the clinicians work under such pressure.***
>
> *CARER*

More Information on in-hospital falls:

- **National Audit of Inpatient Falls Annual report 2022**[9] highlights that injurious falls can occur on any ward and quality improvement (QI) for falls prevention should avoid focusing only on those for older people.
- **NICE Guideline CG161 for assessing falls risk and prevention.** [10]
- **Preventing Falls in Hospital: Fallsafe/Carefall 12**[11] – is a 2 module e-learning programme for clinical staff by e-learning for healthcare.

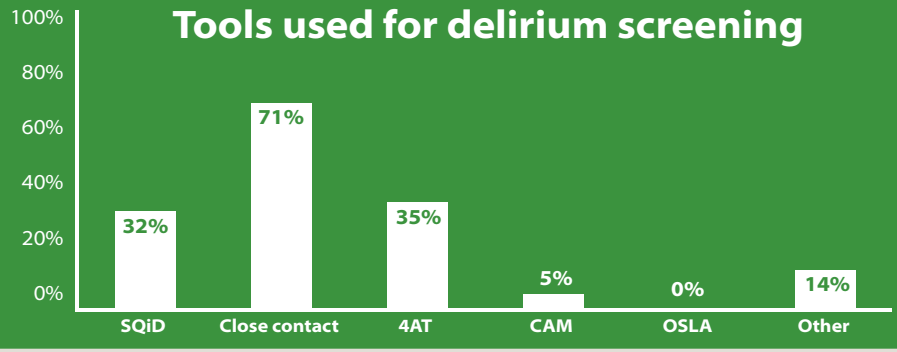
Delirium Screening & Assessment

An Improvement...

Patients who received an initial delirium screen, up from

58% in 2019 to **87%** in 2023

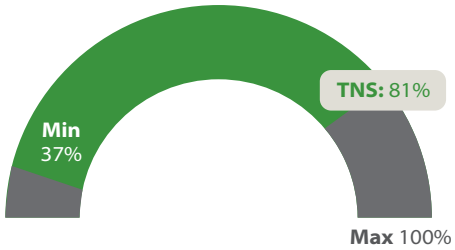
Tools used for delirium screening



87% patients received an initial delirium screen

No initial delirium screen

81% patients received a delirium screen within 24 hours of admission



Delirium screen within 24 hours

ranged between 37% - 100% across all hospitals

Delirium Diagnosis

72% patients were diagnosed with delirium

15%

13%

No further investigations took place

No delirium confirmed

93% patients received a delirium medical management plan

50% patients received a delirium nursing care plan

Why Delirium Screening and Assessments Matter

See full breakdown of Delirium data tables in **Appendix IV** and Hospital Level Results in **Appendix XI**.

People with dementia have a five-fold risk of developing delirium during a hospital admission, and the risk increases with the progression of dementia.[12]

Delirium is associated with greater risks of longer admission, hospital acquired infections, admission to long term care, and death.[13]

Delirium is defined by the National Institute for Health and Care Excellence (NICE) as:

> ***'a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course'.***

NICE recommends that people at risk are assessed at presentation for any changes or fluctuations that may indicate delirium. If delirium is indicated, a full assessment should be carried out by a clinician. [14]

> ***Being on a busy ward with little rest from noise and artificial light has confused night and day and he is now distressed with delirium/sundowning.***
>
> *CARER*

More information about delirium:

- The British Geriatrics Society has collated resources relating to delirium awareness and training at

  Delirium Hub: Education and training | British Geriatrics Society (bgs.org.uk), [15] including resources from Health Education England.

Pain Assessment

Pain assessments

ranged between 3% – 100% across all hospitals

> ***[RELATIVE] given a bell to press if he was in pain, but having dementia meant he mostly forgot what it was for and I often visited the hospital to find him in pain.***
>
> *CARER*

92% patients received any pain assessment

Patients who did not receive a pain assessment

85% patients received a pain assessment within 24 hours of admission

Refer to Recommendations

61% patients received only questioning as a pain assessment

> ***All of the ward staff, doctors and nurses were very professional and caring towards my [RELATIVE]. Ensuring he was kept pain free and comfortable at all times.***
>
> *CARER*

Pain Reassessment

60% patients received only questioning as a pain reassessment

Patients who did not receive a pain reassessment

92% patients received any pain reassessment

83% patients received a pain reassessment within 24 hours of the first assessment

Why Pain Assessments and Reassessments Matter

See full breakdown of Pain Assessment data tables in **Appendix IV** and hospital-level data in **Appendix XI**.

People with more severe symptoms of dementia may be unable to describe pain although may display behavioural symptoms relating to untreated pain, and also may not respond appropriately to questions about pain.

> ***…sometimes [RELATIVE] will not ask, with her dementia she will not say she is in pain….***
>
> *CARER*

Pain should be routinely and repeatedly assessed and treated appropriately for its underlying cause. NICE[1] recommends considering assessment using a structured observational pain assessment tool:

- ***alongside self-reported pain and standard clinical assessment for people living with moderate to severe dementia***
- ***repeatedly alongside standard clinical assessment for people living with dementia who are unable to self-report pain.***

There has been an improvement in terms of any pain assessment received, from 85% in the previous audit round to **91.6%** this round. However, a large proportion of reported assessments (**61%**) are based on asking the patient a question about pain.

More information about pain assessment:

e-PAIN[16] is an online learning resource designed for NHS staff by Health Education England. It is a multidisciplinary programme for healthcare professionals learning about pain management.

Discharge Planning

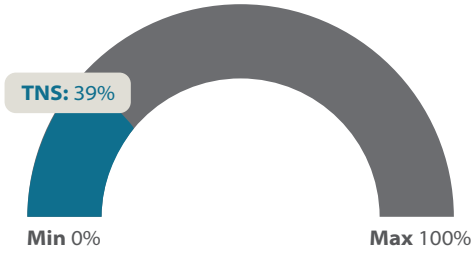
> *The hospital put in place things to make sure my friend was discharged safely and with a package of care in place. They were fantastic really*
>
> CARER

72% patients had named staff coordinate their discharge

64% patients had an expected date of discharge

86% patients received a discharge plan

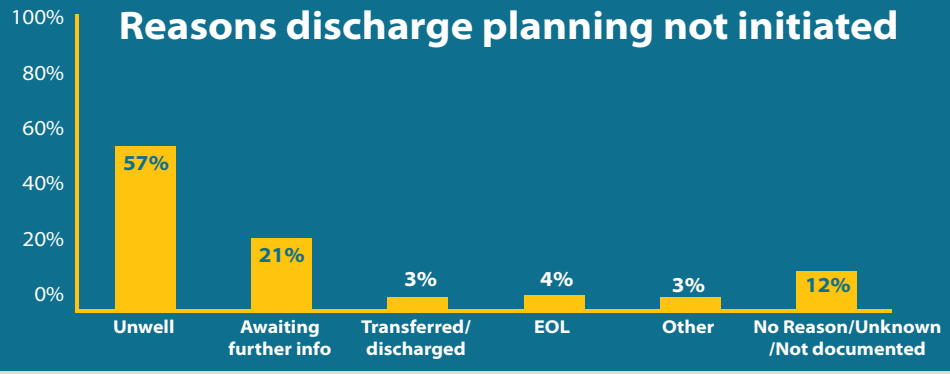
39% patients received a discharge plan within 24 hours of admission



discharge planning within 24 hours

ranged between 0% - 100% across all hospitals

Reasons discharge planning not initiated



> *I was contacted out of the blue and told my [AGE] [RELATIVE] would be discharged to a Travelodge... The discharge team did not take into account her night time needs and I was distraught*
>
> CARER

Why Discharge Planning Matters

See full breakdown of Discharge Planning data tables in **Appendix IV** and hospital-level data in **Appendix XI**.

Hospital admission can trigger distress, confusion and delirium for someone with dementia. This can contribute to a decline in functioning and a reduced ability to return home to independent living. [5]

Planning for discharge from the beginning of admission helps to ensure that all factors are considered for safe and effective discharge.

NHS England Principles for Reducing length of stay[17] highlight the importance of early discharge planning.

Reasons indicated for later initiation of discharge included awaiting results or surgical outcomes, and the acuity of the patient's condition. When these are taken into account, discharge planning within 24 hours rises to **83.5%** (4084/4891).

Early Discharge Planning and Length of Stay

Comparison of the proportion of patients with and without discharge initiation within 24 hours shows that those patients with planning initiated were more likely to be discharged within one week. This could reflect the complexity of admissions where it was not possible to immediately start the discharge plan.

More information about discharge planning:

NHS England - Improving hospital discharge resources[18]

This collates advice, good practice, guidance and support available on improving hospital discharges.

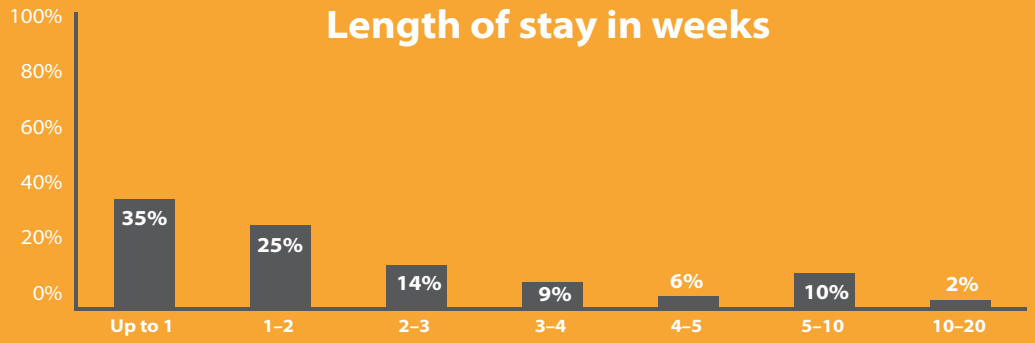
Discharge Information

86%
patients were discharged by the end of audit period

92%
patients were on the right ward for their consultant specialty at point of discharge

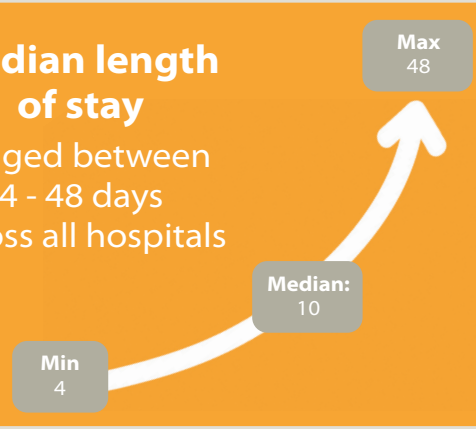
81%
patients who died received an end of life care plan

Length of stay in weeks



10
Median days length of stay

Median length of stay
ranged between 4 - 48 days across all hospitals



Change of Place of Residence/Care

13% patients had a change in care location after discharge from **own home/short term to long term care** compared to **8%** in 2019

60%
patients were discharged to their own home or short term care

Why Discharge Information Matters

See full breakdown of Discharge data tables in **Appendix V** and hospital-level data in **Appendix XI**.

Length of stay

Prolonged stays in hospital are bad for patients, especially for those who are frail or elderly.

Spending a long time in hospital can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning. [19]

As patients whose records were audited were identified prospectively (from the point of admission), 213 had not been discharged at the close of data collection. The median length of stay presented is therefore of those patients who had been discharged (or died in hospital) at that point, and a comparison with previous rounds of audit is not shown. **40%** (4127/10347) of patients had not been discharged 2 weeks after admission.

Ward patient is on at point of discharge (outliers)

Studies have shown that admissions can be longer when the patient is "outlying" – i.e. moved from the ward they were admitted to for care and treatment of their admitting condition(s), to another ward for reasons of bed management. [20, 21.]

Change of place of residence/care after discharge

Auditing change of place of residence/care after discharge helps us understand whether patients have experienced downturn in wellbeing over the admission.

> ***Her discharge was a near disaster. Staff called a cab to take her home instead of calling me - her main carer. They would have sent her off with no clothes, shoes or key to get into her home. This a dementia patient.***
>
> *CARER*

Nutrition and Environment

Wards with finger foods available

ranged between
0% - 100%
across all hospitals

Wards with snack foods available

ranged between
0% - 100%
across all hospitals

'Dementia Friendly' Environment Review

36% reviews taken place **throughout the hospital**

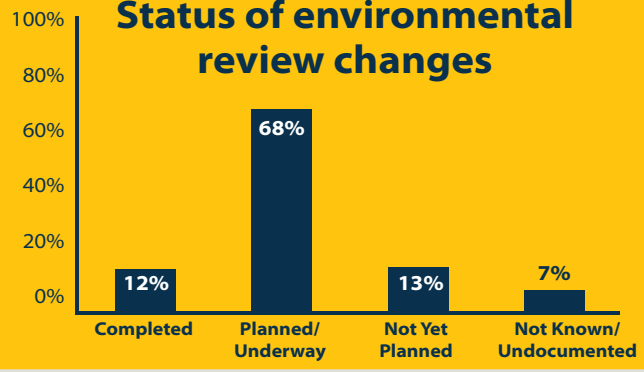
15% reviews taken place on **all adult wards**

39% reviews taken place **some wards**

11% hospital review status' were **unknown or not taken place**

Refer to Recommendations

Status of environmental review changes



> *I think there could be more assistance with feeding and drinking. The food and drink is just out on the table and left. Elderly people and those with dementia do not always understand how to eat.*
>
> CARER

> *The dementia team always helped me at meal times*
>
> PATIENT

Why Nutrition and Environment Matter

See full breakdown of nutrition and environment data in **Appendix VI**.

Providing easy to eat meal alternatives

Weight loss is a common problem in people with dementia[22], who can experience problems with eating and drinking especially when unwell.

Helping to increase intake by providing finger foods which are easy to eat, and making snacks available so that people can eat little and often, can help to prevent decline in weight and support recovery.

Providing a dementia friendly environment

Relatively simple, cost-effective changes to the physical environment of care have positive effects on people with dementia receiving care and those working in the hospitals. These include reducing agitation and distress and raising staff morale.[23]

The Charter promotes the use of the Enhancing the Healing Environment resources[24], created to support the development of physical environments for people with dementia.

As shown above, a review of at least part of the hospital environment had taken place in most participating hospitals, but a relatively small proportion of post-review changes were completed.

> ***Hospitals are NOT GOOD PLACES TO GET WELL. Noisy too may bright lights, loud noises, loud voices etc.***
>
> *CARER*

> ***I appreciated the safe comfortable calm environment my [RELATIVE] was an inpatient. A lot of this was due to the hardworking efforts of all the wards staff.***
>
> *CARER*

More information about Environment:

Patient-Led Assessments of the Care Environment (PLACE), 2022 - England - NDRS (digital.nhs.uk) [25]

PLACE assesses a number of non-clinical aspects of the healthcare premises identified as important by patients and the public, known as domains, including: Dementia: how well the needs of patients with dementia are met.

Feedback from Carers

Participation
2,223
responses across
160 hospitals

Carer Rating of Overall Care Quality

66%
compared to **72%** in 2019

Positive responses
decreased
from previous round for
all questions

Refer to Recommendations

Carer Rating of Communication

60%
compared to **65%** in 2019

> ***Very happy with the consistent empathy & patience shown by everyone from the cleaner to the Dr, nurses, physicians...***
>
> *CARER*

> ***I constantly reminded both staff and doctors to phone anytime to ask anything. No one ever phoned and we were rarely spoken to on the ward***
>
> *CARER*

Why Carer Feedback Matters

See full breakdown of carer questionnaire data in **Appendix VII**, methodology in **Appendix I** & hospital-level data in **Appendix XI**.

The Dementia Friendly Hospital Charter*[2] *and NICE Guideline1 highlight the importance of involving and supporting carers and people with dementia, recognising them as partners in care. John's Campaign*[26] *works for the right of people with dementia to be supported by their family carers in all care settings.

87.5% 147/168 hospitals in this audit are signatories to John's Campaign.

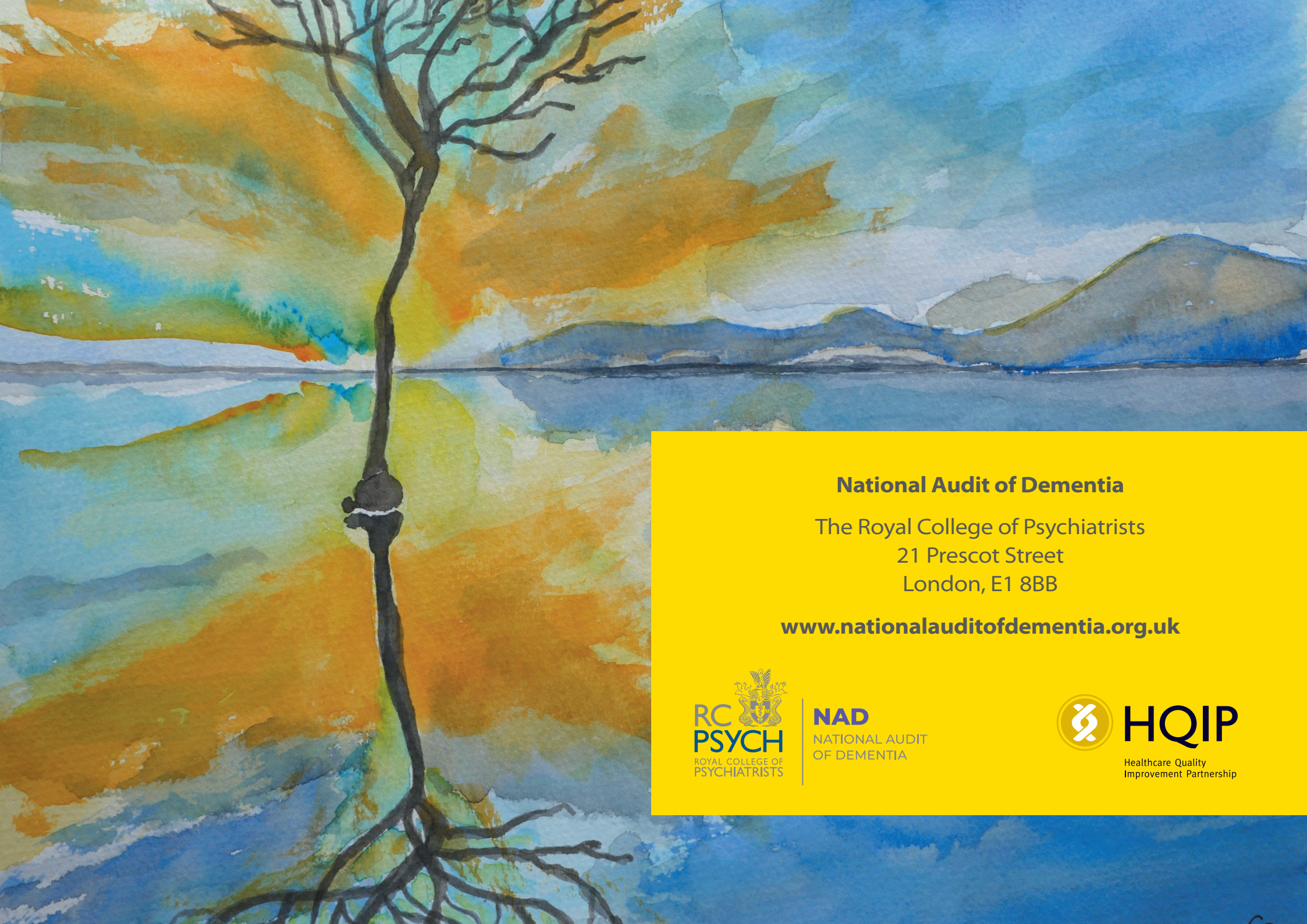
> ***To attempt to reduce any deterioration in my [RELATIVE]'s Alzheimer's whilst in hospital, members of the family were allowed to visit for prolonged periods outside normal visiting hours. We were also present at mealtimes in order to encourage and assist her to eat. The staff were very accommodating in allowing us to do this, and we were grateful for it.***
>
> *CARER*

NAD Carer Questionnaire

The carer questionnaire[27] was used in two previous rounds of audit (2017, 2019). It collects feedback about the care of people with dementia, communication with hospital staff and support for the carer.

The previous page shows the national breakdown of carer questionnaire responses, and the decrease in positive responses from Round 4 of audit. The carer questionnaire also produces 2 scores: the rating of overall care quality, and the rating for information and communication. The average score for each has also decreased, reflecting reduced satisfaction with care.

> ***I was able to visit my [RELATIVE] and help with mealtimes on most occasions. However one time I was asked to leave by a nurse even though I was feeding my [RELATIVE] so I had to speak with the senior nurse who allowed me to stay.***
>
> *CARER*



National Audit of Dementia

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www.nationalauditofdementia.org.uk

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | NAD NATIONAL AUDIT OF DEMENTIA

HQIP Healthcare Quality Improvement Partnership