



Report of the Irish National Audit of Dementia Care
in Acute Hospitals 2014

Executive Summary

Report Authorship and Governance

This audit was initiated and led by Dr. Suzanne Timmons and Prof. Des O'Neill, co-chairs of the Audit Steering Committee; Dr Sean Kennelly and Dr Paul Gallagher. For full details of the Steering Committee, Advisory Group members and the Project Team, please see Appendices B & C.

The audit was jointly funded by Atlantic Philanthropies and the Meath Foundation.

Ms. Denise McArdle and Ms. Patricia Gibbons, HSE Quality and Patient Safety Audit Services, performed data collection for the healthcare record audit and the quality assurance of same.

This report was prepared by Ms. Anna de Siún, Ms. Emma O'Shea, Dr. Suzanne Timmons, Ms. Denise McArdle, Ms. Patricia Gibbons, Prof. Des O'Neill, Dr. Sean Kennelly and Dr. Paul Gallagher.

Content was advised and approved by all members of the Steering Committee and Advisory Group.

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Foreword

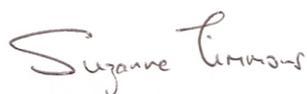
The design and delivery of care in our acute hospitals predates our evolving understanding that older people, and in particular those with dementia and delirium, are proportionately the key groups that they serve. This is reflected in a current focus on acute illness, with relatively little adaptation for cognitive impairment, multiple illness and frailty. The environment is clinical, sometimes sterile, and the systems are designed to promote efficient and cost-effective care. Those not affected by cognitive impairment who are admitted to hospital can adapt to the rigid routines and complex interactions in hospital, where a patient may be bombarded with questions, meet multiple new staff members each day, and be given large amounts of complex new information to take on board, not to mention the possibility of extensive tests, high noise levels, and sometimes, sleep deprivation.

But a person with dementia may not be able to adapt to this environment, particularly when unwell, and may find it frightening and confusing. The person with dementia may become anxious, more confused, and less able to be independent in activities of daily living. Investing in staff training, resources and good design can improve the experience for the person with dementia and their family, and is likely to result in a speedier and more effective transition from the community to hospital and back again. However, it has not been clear to what extent such a vital investment has been made in the Irish hospital system.

Following in the footsteps of other countries such as England, Scotland, Northern Ireland, Norway and Australia, the Irish government has acknowledged the need to make dementia a priority in terms of policy at this time. In recognition of the growing number of people with dementia in Ireland, and the consequent need for guidelines and standards to be put in place around dementia, the Department of Health has committed, under the Programme for Government, to the development of a National Dementia Strategy, which will be published in 2014.

This report contains the findings of the first national audit of dementia care in Ireland's acute hospitals (INAD), performed from April to September 2013, jointly funded by Atlantic Philanthropies and the Meath Foundation. Recommendations from this report have been submitted for inclusion in the National Dementia Strategy.

This audit has found a large number of areas where changes are necessary to improve the quality of dementia care in Irish hospitals. However, some inspiration can be drawn from the fact that the quality of dementia care in acute hospitals in Ireland is generally on par with the quality of care found in the baseline audit of dementia care in acute hospitals in the UK, performed in 2010. The second round UK audit in 2012 found significant improvements as a result of the findings and recommendations of the baseline audit. It is our vision that the findings and recommendations of this audit will make a similar impact on the quality of dementia care in acute hospitals in Ireland.



Dr. Suzanne Timmons



Prof. Desmond O'Neill

Co-chairs of the Steering Group of the Irish National Audit of Dementia

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Executive Summary

Background

National and international research confirms that an admission to an acute hospital can be distressing and disorientating for a person with dementia, and is often associated with a decline in their cognitive ability and levels of functioning around activities of daily living (Cunningham, 2006; Covinsky et al.,2011). In recognition of the need to increase awareness and enhance services for people living with dementia in Ireland, the Department of Health and Children are currently developing the Irish National Dementia Strategy, due to be published in 2014.

In response to the need for more Irish data on dementia care in acute hospitals, the first Irish National Audit of Dementia care in acute hospitals (INAD) was undertaken in 2013 to measure criteria relating to care delivery known to impact on people with dementia admitted to hospital. The results from this audit have fed into the development of the Irish National Dementia Strategy.

The INAD project represents a joint initiative between The Centre for Gerontology and Rehabilitation, University College Cork; The Centre for Ageing, Neuroscience and the Humanities, Trinity College Dublin; and the HSE Quality and Patient Safety Directorate, and is funded by Atlantic Philanthropies and The Meath Foundation. The project is overseen by a multidisciplinary steering committee and advisory group.

Methodology

As there are no dementia specific standards in place in Ireland for dementia care in acute hospitals, the audit measured current practice against international best practice guidelines. The audit tool was adapted from the first National Audit of Dementia Care in general hospitals in the UK, with the kind permission of the Healthcare Quality Improvement Partnership (Royal College of Psychiatrists, 2011).

All 35 acute public hospitals that admit adults with known or suspected dementia were included in the audit (Appendix A). In order to capture a comprehensive picture of dementia care policies and practices, four audits were conducted in each hospital.

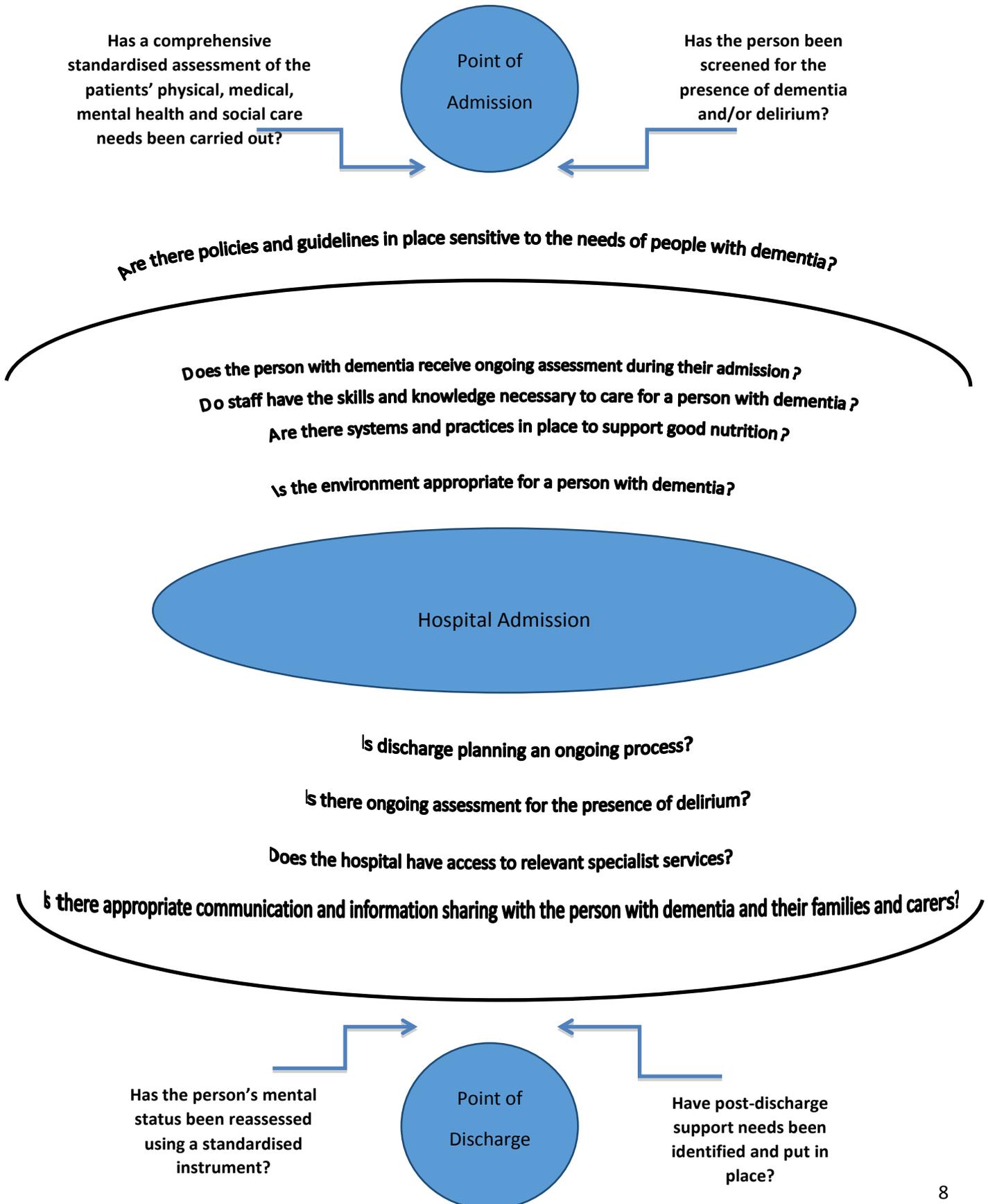
- I. The Organisational Audit collected data on dementia-related policies, protocols, structures, processes and key staff that impact on service delivery for people with dementia. Data was

collected through interviews with Hospital Managers/Chief Executive Officers, Directors of Nursing and/or Geriatricians.

- II. The Healthcare Record Audit examined 20 healthcare records (HCRs) in each hospital. The audit collected data on assessments carried out on or during admission, discharge planning and coordination, and referral to specialist services. The majority of hospitals (76%) were audited by independent auditors, while 24% self-audited their HCRs.
- III. The Ward Organisational Audit collected information on staffing, services available and systems/structures to support the person with dementia. Two to three medical, surgical or orthopaedic wards were selected in each hospital for audit. Data was collected through interviewing the ward managers on selected wards.
- IV. The Environmental Audit collected information on aspects of the wards' physical environment which are known to impact on people with dementia. Ward environmental audits were carried out by the INAD Project Coordinator and INAD Research Assistant.

All data was collected between April and September 2013. Data from all four audits were combined and are reported under ten headings below; Governance, Assessment, Mental Health and Liaison Psychiatry, Nutrition, Information and Communication, Staff Training, Staffing and Staff Support, Physical Ward Environment, Discharge Planning and Discharge, and Palliative Care. In all cases valid percentages are presented, i.e. missing data is excluded from the calculation. Unless otherwise specified, all variation in denominator values are due to missing data.

Audit Summary



Key Recommendations

The findings from the audit resulted in 47 detailed recommendations to ensure policies and practices in the acute care setting are appropriate for the care of a person with dementia. These recommendations are listed by theme on pages 22-26 of the Executive Summary. Below are six key recommendations;

1. Each acute hospital has responsibility for developing a training and knowledge strategy to ensure that all staff are provided with basic training in dementia awareness, and a locally agreed specified proportion of ward staff receive higher level training (including dementia champions).
2. Liaison Psychiatry, Liaison Psychiatry of Old Age, and Geriatric Medicine services should be in place in all acute hospitals to provide access for the treatment and referral of people with dementia. These services should have a named consultant providing the liaison service who has dedicated time in his/her job plan for the provision of same. Response times to referral should be a key performance indicator for these services.
3. Based on evidence from best practice, each hospital should develop and implement policies and systems for the prevention, identification and treatment of delirium.
4. An assessment of mental status should be an integral part of the acute admission of people with dementia, utilising standardised assessment tools and collateral history. All staff responsible for the assessment of older people need to have training in the assessment of mental status using standardised measures.
5. A period of treatment in hospital should be highlighted as an appropriate point for review by an appropriate expert of any use of antipsychotic medication. Guidelines currently being developed by The College of Psychiatrists of Ireland will provide guidance on the use of antipsychotics and the circumstances in which prescription of antipsychotics is appropriate.
6. National guidelines on dementia friendly ward designs should be developed, to be incorporated as standard into all refurbishments and new builds. At ward level managers and dementia champions should ensure that simple and effective improvements to the environment are made to all wards admitting adults, including appropriate signage and visual aids to support orientation and continence and adequate space and resources to support activity and stimulation.

Summary of Results by Theme

Governance

The theme of governance relates to whether the policies, guidelines and systems in place in a hospital take into account and are sensitive to the needs of people with dementia. The organisational audit collected data on hospital policies, guidelines and resources available to support high quality person-centred dementia care. The healthcare record (HCR) audit identified trends in demographics and length of stay.

- 94% of hospitals (33/35) have no dementia care pathway in place.
- 6% of hospitals (2/34) could identify people with dementia when reviewing readmissions and 38% (13/34) could identify people with dementia when reviewing delayed discharges/transfers.
- The majority of wards can provide access at least five days a week to specialist services such as Liaison Psychiatry, Geriatric Medicine, Occupational Therapy, Physiotherapy, Specialist Infection Control and Specialist Palliative Care. There is more limited access to Psychiatry of Old Age, Specialist Continence Services, Psychology and Social Work Services.
- 35% (128/363) of people with dementia who were admitted from home were discharged to long-term residential care while 45% (164/363) of people with dementia who were admitted from home were discharged home.
- There was variation in the average length of stay depending on place of admission and place of discharge:
 - The average length of stay for a person with dementia admitted from and discharged to their home was 22 days
 - The average length of stay for a person admitted from home and discharged to a nursing home was 59 days
 - The average length of stay for a person admitted from and discharged to a nursing home was 17 days.

The findings indicate that current reporting and review structures could be used more effectively to monitor appropriateness of hospital policies and systems for people with dementia. In order to ensure the needs and voice of patients with dementia are heard and taken into consideration, hospital management teams need to develop dementia specific pathways of care and appoint appropriate personnel to lead dementia care in the acute hospital. Findings also indicate a need for more supports, resources and integrated care planning with community agencies and services.

Assessment

A comprehensive assessment of physical, mental health and social care needs is essential to ensure best outcomes for the person with dementia. While many hospitals have guidelines in place for comprehensive assessment procedures, the healthcare record (HCR) audit indicated that many assessments are not routinely carried out.

- 76% of patients (496/656) had a problem list recorded in their HCR, 87% (570/657) had current medication recorded and 96% (633/658) had comorbid conditions recorded.
- 62% of hospitals (21/34) reported that a standardised assessment of functioning was carried out on all patients, though only 36% of patients (236/653) had a standardised assessment of functioning recorded in their HCR.
- 63% of hospitals (22/35) reported that the multidisciplinary assessment includes a routine assessment of mental status, though only 43% of patients (283/658) had a standardised mental status test recorded in their HCR.
- 30% of patients (196/659) had an assessment for recent changes or fluctuations in behaviour that may indicate the presence of delirium.
- 14% of patients (64/468) had their level of cognitive impairment summarised and recorded at discharge, 24% (47/194) had symptoms of delirium (where present) summarised for discharge, and 27% (37/139) had persistent behavioural and psychological symptoms of dementia (where present) summarised and recorded at discharge.
- Many hospitals reported no access, or inadequate access, to social workers.

The results suggest that while there are reasonably high levels of medical and functional assessments being carried out, more consistent assessments ought to be performed and recorded to ensure patients are appropriately monitored and the most positive outcomes possible are identified and achieved. There is evidence of a lack of comprehensive assessment of mental status to detect depression, delirium and worsening in dementia status. The importance of including relevant mental health information at discharge needs to be highlighted to all staff involved with discharge, given the higher risk for accelerated cognitive decline with a pre-existing dementia, and the risk of recurrence for those who develop delirium.

Mental Health and Liaison Psychiatry

People with dementia have particular mental health needs and during an acute admission may require access to specialist mental health services. Routine assessment, monitoring and review are necessary to ensure mental health needs are appropriately responded to and managed.

- All hospitals reported having access to liaison psychiatric services, while 71% of hospitals (25/35) reported they can provide access to a liaison psychiatry of old age service.
- There is variation between hospitals in how these services are structured and delivered.
- In many hospitals, psychiatry of old age services are being delivered by community-based services, who are not formally commissioned to deliver a liaison service to the acute hospital.
- 32% of hospitals (11/34) have a protocol in place governing the use of interventions for patients displaying violent or challenging behaviour, aggression and extreme agitation, which is suitable for use in patients who present behavioural and psychological symptoms of dementia.
- 41% of patients (271/656) had an antipsychotic medication administered at some point during their admission.
- 46% of patients (100/216) admitted from a nursing home and 19% of patients admitted from home were already prescribed antipsychotic medication.
- 16% of patients (109/657) were given a new regular prescription for antipsychotic medication.

The results indicate the need for more consistent provision of liaison psychiatry of old age services nationally as many hospitals have inadequate access to specialist mental health services for older people. There is also a need for guidelines to be developed and implemented on the use of restraint and promoting restraint-free environments in acute hospitals. The relatively high use of antipsychotics indicates a need for improved review and monitoring of the use of antipsychotics in the acute setting.

Nutrition

Good nutrition and hydration are essential for wellbeing and for recovery from illness, surgery or accident. People with dementia often face particular challenges in maintaining adequate nutrition and hydration. It is therefore essential that adequate systems for monitoring and promoting good nutrition practices are in place in the acute setting.

- 76% of patients (496/651) had a nutritional assessment recorded in their HCR, though only 39% (259/658) had their weight or BMI recorded.
- 50% of hospitals (17/34) have protected mealtimes on all wards that admit adults with known or suspected dementia. Wards' adherence to protected mealtimes is reviewed and monitored in 27% of hospitals (9/33).
- 35% of wards (27/77) have a system in place to signal the need for increased assistance with eating.
- 92% of wards (71/77) can provide food to patients between mealtimes.
- 20% of wards (15/77) have opportunities for patients to socially interact at mealtimes.
- 94% of hospitals (33/35) reported having access to specialist assessment and advice on helping patients with dementia in their swallowing and eating.

The findings indicate that there is good awareness of the importance of nutrition at ward level, though there is a need to improve monitoring and recording of weight/BMI. Protected mealtimes have been introduced in half of hospitals, though many hospitals reported facing a number of challenges in the implementation of this system. There is an opportunity for hospitals to capitalise on the nutrition initiatives being implemented across the country by sharing best practice and learning. The lack of standardised instruments to measure dependency, combined with reduced staffing levels, may impact on the ability of staff to ensure all patients are given the support they need to eat at mealtimes. Hospitals reported good access to specialist services.

Information and Communication

Good information sharing and communication with the person with dementia, families and carers is a key aspect of person-centred dementia care. The organisational audit looked at procedures and guidelines in place for collecting appropriate information, while the HCR audit examined what information was collected and recorded. Information and communication systems at ward level were also identified.

- 30% of hospitals (10/33) have guidelines asking the carer about their wishes and ability to provide care and support to the person with dementia post discharge.
- 6% of hospitals (2/34) have clear guidelines on making sure the carer knows what information will be shared with them and why, while 27% of wards (21/77) reported they discussed with carers and the person with dementia when personal and healthcare information would be shared with carers.

- One hospital (1/35) has a form dedicated to collecting information about the person with dementia from a carer or relative.
- 99% of wards (76/77) identified handover as the system used for communicating appropriate personal information and any behavioural or communication needs specific to the person with dementia.
- 79% of wards (61/77) provide information about ward routines such as mealtimes and visiting hours, while 15% of wards (12/77) provide information on the hospital complaints procedure.

There is a need for more structured guidelines on communicating with families and carers to ensure this group can access appropriate information about a patient's current medical condition, and their anticipated care and support needs on discharge. There is clearly a lack of formal structures to collect and communicate pertinent information about the person with dementia necessary for the delivery of person-centred care. Current systems of communication need to be formalised to ensure relevant information is routinely given to people with dementia and their carers on admission.

Staff Training

Dementia specific training and education is vital to ensure that front-line staff have the skills, knowledge and awareness to respond appropriately to, and care holistically for, a person with dementia. The organisational audit looked at whether dementia training had been available in the hospital, either formally or informally. Whether there were arrangements in place to allow staff to attend training was explored through the ward audits.

- 21% of hospitals (7/33) have a knowledge and training framework that identifies necessary skill development in working with and caring for people with dementia.
- 6% of hospitals (2/33) include dementia awareness in their staff induction programmes and no hospital has mandatory dementia awareness education for staff.
- Just over half of hospitals had provided dementia awareness training to doctors (54%, 18/33) and nurses (52%, 16/31) in the last 12 months. Far fewer hospitals had provided training to healthcare assistants (29%, 9/31), allied healthcare professionals (16%, 5/31) or support staff (10%, 3/31).
- Just under half of hospitals had provided training to doctors on approaches to behaviours that challenge (48%, 16/33), while nearly two-thirds had provided this training to nurses

(65%, 20/31). 55% of hospitals (17/31) reported providing this training to healthcare assistants (HCAs).

- There was little training in the area of communication with less than 10% of hospitals providing training in hearing/visual impairments to nurses, doctors or HCA's. 6% of hospitals (2/33) had provided training to doctors in communication skills specific to people with dementia, 26% (8/31) had provided this training to nurses, while 13% (4/31) had provided this training to HCAs.
- 41% of hospitals (13/33) had provided training to doctors in assessment of capacity, 22% (7/32) had provided this training to nurses, while 3% (1/32) had provided training in assessment of capacity to HCAs.
- 27% of hospitals (9/33) had provided training to doctors in assessing risk before the use of restraint or sedation, 42% (13/31) had provided this training to nurses, and 29% (9/31) had provided this training to HCAs.
- At ward level, 38% of wards (29/77) had arrangements in place to allow staff to attend training relating to the care of people with dementia.

There is clearly a need for more dementia specific education and training across a range of competencies for all staff. Even where training has been made available in the last 12 months, it is often delivered informally and is not accessible to all staff in the hospital. The development of policies and guidelines for high quality dementia care must be accompanied by increased awareness amongst frontline staff of how to recognise, respond to, and meet the unique needs a person with dementia may have.

Staffing and Staff Support

Adequate staffing levels and staff support are necessary elements to providing essential care to patients in an acute setting. The ward organisational audit looked at staffing levels, systems for measuring dependency levels and skills mix, and what supports are available to staff on the ward.

- 69% of wards (53/76) have at least one vacancy in their permanent nursing staff. Vacancies are filled using either hospital pool (31%, 27/77) or agency staff (52%, 40/77).
- 35% of wards (27/77) reported having unfilled registered nursing staff vacancies.
- 17% of wards (13/77) have a system to ensure that all factors that affect nursing staff numbers and skill mix are taken into consideration and staffing levels are reviewed on a daily basis.

- Clinical supervision was available to nurses on 38% of wards (29/77), and to HCAs on 26% of wards (20/77).
- Few wards had appraisal and mentorship programmes for nurses (20%, 15/77), or HCAs (8%, 6/77).
- Very few ward staff had access to peer support groups (12%, 9/77) or reflective practice groups (5%, 4/77).
- While 32% of hospitals (11/34) reported having a dementia champion in place at ward level, only 16% of wards (12/77) reported having access to guidance and support from a dementia champion for nursing staff, and 5% of wards (4/77) had access for HCAs.
- 96% of wards (74/77) have access to administrative staff during the week.

The ability of the hospital to provide essential care to people with dementia may be negatively impacted by the high number of vacancies in permanent staff, leading to the common use of hospital pool and agency staff, combined with unfilled vacancies on over one third of wards. In addition, very few wards have the tools to measure their dependency levels and skills mix on a daily basis. There is also a need for more consistent systems for supporting staff development.

Physical Ward Environment

The ward environment is designed to manage acute conditions, focused on surveillance, security and infection control. The resulting environment, which often has many competing stimuli, can be very distressing for the person with dementia. However, there is growing recognition of the range of adaptations that can be made at ward level to make the immediate environment more suitable for people with dementia. The ward environmental audit examined aspects of the physical ward environment known to impact on people with dementia.

- The majority of wards did not have environmental cues to help the person with dementia orientate themselves; 56% of wards (43/77) had no clocks visible, 93% of wards (72/77) had no calendar visible, while 84% of wards (65/77) had no personal objects visible.
- 74% of wards (57/77) did not have signs to locate the toilets visible from the patient's bed or door of their room.
- 43% of wards (33/77) had no signs on their toilet doors while 33% of wards (25/77) had no signs on their bathroom doors.

- 74% of wards (57/77) provided gender-specific toilets and bathrooms for patient use, and 61% (47/77) provided facilities so that patient have a choice about bathing or assisted bathing.
- No wards labelled items such as soap dispensers, bins or hand dryers.
- All toilets and bathrooms had alarm bells. These were visible and in reach on 62% of wards (48/77).
- 46% of wards (35/77) had a day room or patients' lounge.
- The flooring in the majority of wards was appropriate, with floors on 92% of wards (72/77) being plain/subtly patterned, 82% of wards (63/77) had floors that were subtly polished rather than high gloss, and 88% of wards (68/77) had floors that had a non-slip surface.

A number of areas were identified where changes could be made to make the ward environment more suitable for a person with dementia, many of which have minimal resource implications and some which would need to be carried out on a larger scale and have more substantial resource implications. Changes to the ward environment will need to be made in conjunction with increased awareness amongst staff of the needs of people with dementia, and of the benefits of providing a suitable and supportive environment.

Discharge Planning and Discharge

Adequate and appropriate discharge planning is vital, as inadequate discharge practices are linked to adverse outcomes and an increased risk of readmission. The organisational audit collected information on discharge policies and systems within the hospital while the HCR audit examined how discharge practices were recorded.

- 94% of hospitals (33/35) have a discharge policy in place.
- 94% of hospitals (29/31) reported that their discharge policy states that discharge should be an actively managed process which begins within 24 hours of admission. However, 72% of HCRs (387/536) had no evidence documented of discharge planning being initiated within 24 hours of admission.
- 86% of hospitals (30/35) reported having a named person who takes overall responsibility for complex needs discharge, and this includes people with dementia.
- 37% of HCRs (198/532) had documentation to show that a named person coordinated the discharge plan.

- 32% of HCRs (174/535) had support needs, identified during admission, included in the discharge plan or summary.
- 21% of HCRs (110/527) had evidence that place of discharge was discussed with the person with dementia.
- 87% of hospitals (27/31) reported that their discharge policy states that relatives and carers should be informed and updated about the prospective discharge date, while 41% of HCRs (221/535) had evidence that families/carers received 24 hours or more notice of discharge.

Though there are no dementia specific standards in place in Ireland at the moment, the HSE Code of Practice for Integrated Discharge Planning (IDP) is relevant to this audit. While the majority of hospital policies are compliant with the standards laid out in the code of practice for IDP, the audit found a gap between policy and practice in many areas. The discharge planning processes and the recording of same need to be improved, to ensure that the person with dementia is being discharged to a setting that has the appropriate resources and supports to care for them. In addition, the person with dementia and their families/carers need to be involved in the discharge process.

Palliative Care

The HCR audit looked at referral to palliative care services and whether a person was on an “end of life” care pathway. As nearly half of deaths in Ireland each year (48%) occur in the acute hospital, there is a need for hospitals to provide appropriate palliative care and end of life care.

- 8% of patients (51/660) died whilst in hospital.
- 6% of patients (37/629) were receiving end of life care, or were being managed according to an end of life care pathway.
- 9% of patients (44/466) were referred to specialist palliative care services, over half of whom (26/44) died whilst in hospital.
- One referral for family/carers bereavement support was recorded.

The findings indicate that approximately 1 in 12 patients admitted to acute hospital with dementia will die during that admission, highlighting the need for a co-ordinated palliative care approach. Early assessment and documentation of a person with dementia's End of Life Care needs and preferences in the acute setting is needed in the form of Advance Care Planning.

Recommendations by Theme

Governance

1. A dementia care pathway, moulded to existing acute, rehabilitation, care of older people, stroke, mental health, palliative care and end of life care pathways, should be developed and implemented at a local level in each acute hospital. A senior clinician to be appointed to lead the development, implementation and monitoring of the dementia care pathway.
2. Hospital management team should regularly review hospital policies and procedures, including discharge policies, as they relate to people with dementia.
3. In order to inform the ongoing review of hospital policies and procedures, management teams need to identify the cohort of people with dementia in their reviews of readmissions, delayed discharges, in-patient hospital falls, treatments and discharges.
4. Hospital management, with guidance from the senior clinician, should identify dementia champions across the hospital who have appropriate knowledge, skills and awareness of dementia.
5. The role of and access to patient advocacy services needs to be clarified and communicated at a local level through the hospital management team and senior clinician.
6. Research is needed to help determine the impact that a lack of resources and inequitable availability of services has on the quality of care for people with dementia. Further research is also needed to explore the reasons for the trends identified regarding discharge destination.
7. All hospitals should be re-audited after three years to evaluate the development of hospital policies and practices as they relate to the care of people with dementia.

Assessment

8. All acute hospitals should have access to a geriatric service a minimum of five days per week (Geriatrician and appropriate multi-disciplinary support), for the referral and treatment of people with dementia. These services should have a named consultant geriatrician providing the liaison service who has dedicated time in his/her job plan for the provision of same. Response times to referral should be a key performance indicator for these services.
9. Adherence to multidisciplinary assessment procedures should be clarified and reinforced. Standardised assessments of functional ability to be carried out to identify potential for rehabilitation: the forthcoming national implementation of the interRAI (Single Assessment Tool) system will provide a national template for such assessments (McDermott-Scales et al., 2014).

10. An assessment of mental status should be an integral part of the acute admission of people with dementia, utilising standardised assessment tools and collateral history.
 - In addition, routine cognitive screening should be performed with standardised instruments, for all people 65 and older on admission to an acute hospital in order to identify patients with here-to-fore undiagnosed dementia and/or delirium.
 - All staff responsible for the assessment of older people need to have specific training in the assessment of mental status using standardised measures.
11. Based on evidence from best practice, it is imperative to develop and implement policies and systems in each acute hospital for the prevention, identification and treatment of delirium.
12. Guidelines to ensure appropriate and timely referral for social and environmental assessment ought to be developed.
13. A number of hospitals identified difficulties related to having no social work support. Exploration of the impact of this lack of service on the availability and quality of social and environmental assessments, and the resulting impact on the person with dementia is needed as a priority.
14. Guidelines for the assessment of carer needs should be developed: the carer section of the national interRAI (SAT) programme may be helpful in this regard (McDermott-Scales et al., 2014).

Mental Health and Liaison Psychiatry

15. Liaison Psychiatry and particularly Liaison Psychiatry of Old Age services should be in place in all acute hospitals to provide daily access for the treatment and referral of people with dementia. These services should have a named consultant psychiatrist/psychiatrist of old age providing the liaison service who has dedicated time in his/her job plan for the provision of same. Response times to referral should be a key performance indicator for these services.
16. A separate process for auditing the use and prescription of antipsychotic medication in the acute setting should be developed.
17. A restraint policy for the acute services needs to be developed on a national level, taking into account the recommendations of the 2011 Department of Health Policy 'Towards a Restraint Free Environment in Nursing Homes' and the findings of the 2011 audit of the HSE 'Policy on Use of Physical Restraints in Designated Residential Care Unit for Older People'. Individual hospitals should appoint a clinical lead with responsibility for implementation and monitoring of the policy/standards.

18. The role of psychology services in the care of the person with dementia needs to be highlighted, and appropriate services should be developed to further support and promote good mental health and holistic care for the person with dementia.
19. Systems need to be developed to ensure that appropriate information on cognitive impairment and delirium are included in the hospital discharge summary, including information/training for staff on the significance of the identification of cognitive impairment and its causes.
20. A period of treatment in hospital should be highlighted as an appropriate point for review by an appropriate expert of any use of antipsychotic medication. Guidelines on dementia care currently being developed by The College of Psychiatrists of Ireland will provide guidance on the use of antipsychotics and the circumstances in which prescription of antipsychotics is appropriate.

Nutrition

21. Dementia specific education and training should be provided to all staff to support the routine use of a standardised nutritional assessment tool (e.g. MUST or MNA), including the routine monitoring and recording of weight/BMI, and the development of standardised approaches to supporting patients who require assistance with eating.
22. Ward managers should be provided with appropriate instruments to assess the staffing levels required to support mealtimes, including assessment of the additional support needs of people with dementia.
23. The Director of Nursing should ensure ward managers are given responsibility and support to promote mealtimes as a social activity and provide appropriate equipment and an engaging environment.
24. Protected mealtimes to be established in all wards. Best practice and learning from hospitals with established protected mealtimes should be shared.

Information and Communication

25. Guidelines for the involvement of patients, families and carers should be developed and implemented.
26. A single named healthcare professional should be appointed as a point of contact for each person with dementia and their families. This person would then have responsibility for ensuring the family or carer is involved in the care plan and decisions about discharge.

27. The feasibility of introducing a personal information document (e.g. patient passport) to articulate the normal everyday needs of the person, and to assist staff in delivering person-centred care should be explored.
28. Explore the appropriateness of implementing systems to ensure that people with dementia can be identified by staff both on the ward, and staff from outside the ward when accessing other treatment areas.
29. Information on advocacy services, complaints procedures and discharge processes should be routinely given to people with dementia and their families/carers.
30. Systems for appropriately communicating all pertinent information to support the delivery of person-centred care by all staff on the ward and throughout the hospital need to be developed.

Staff Training

31. Given the high number of adults with known or suspected dementia admitted to acute hospitals, basic dementia specific training should be mandatory for all staff that care for or come into contact with adults in the acute hospital setting.
32. Each acute hospital has responsibility for developing a training and knowledge strategy to ensure that all staff are provided with basic training in dementia awareness, and a locally agreed and specified proportion of ward staff receive higher level training.
33. Arrangements must be put in place at ward level to allow staff to attend training relating to the care of people with dementia. Appropriate education programmes currently available should be provided to and promoted amongst all staff in the acute settings, e.g. The National Dementia Education Programme.
34. Dementia awareness training should be included in all staff induction programmes.

Staffing and Staff Support

35. Care of those with dementia requires appropriate levels of suitably trained staff, avoiding both vacant posts and temporary staff to the greatest extent possible.
36. Guidance is needed on how staffing levels should be determined, including consideration of measures of acuity and dependency sensitive to the care of people with dementia.
37. Staff working with people with dementia should have access to staff support systems such as formal appraisal and mentorship programmes, clinical supervision, peer support groups and reflective practice groups.

38. The CEO/Hospital Manager of each site should ensure that key leadership roles and support from specialist staff are in place to ensure delivery of dignified, skilled and compassionate care, for example Dignity Leads or Dementia Champions.

Physical Ward Environment

39. National guidelines on dementia friendly ward designs should be developed, to be incorporated as standard into all refurbishments and new builds, including safe walking spaces and the use of colour, lighting, signage, orientation cues and space to promote social interaction.
40. Ward managers and Dementia Champions should ensure that simple and effective improvements to the environment are promoted in all wards admitting adults, including appropriate signage and visual aids to support orientation and continence, personalising bed areas, and adequate space and resources to support activity and stimulation.

Discharge Planning and Discharge

41. All hospitals should have a systematic discharge and transfer policy in place.
42. Through a formal reporting process, identify factors contributing to delayed discharges, with particular reference to people admitted from home and discharged to a nursing home/residential care setting.
43. There is a need for increased awareness of, and adherence to, the processes and documentation required for appropriate discharge planning.
44. Mental health status, symptoms and behaviours relevant to the person's dementia noted during admission, and any on-going mental health needs, to be summarised and recorded at discharge.

Palliative Care

45. Guidelines should be developed for the recording and communication of assessments of the person's wishes and preferences regarding end of life care.
46. Acute hospitals need to be aware of the work of the Irish Hospice Foundation and the Alzheimer's Society of Ireland as it relates to improving end of life and palliative care for people with dementia and implement best practice guidelines as they become available.
47. Guidelines on dementia-appropriate advance care planning should be developed.