Results of the Irish National Audit of Dementia (INAD) Care in Acute Hospitals

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Audit Summary

Has a comprehensive assessment of physical, medical, mental health and social care needs been carried out?

Has the person been assessed for the presence of dementia and/or delirium?

Are there policies and guidelines in place sensitive to the needs of people with dementia?

Does the hospital have access to relevant specialist services?

Do staff have the skills and knowledge necessary to care for a person with dementia?

Are there systems and practices in place to support good nutrition?

Is the environment appropriate for a person with dementia?

Is there appropriate communication and information sharing with the person with dementia and their families/carers?

Have post-discharge support needs been identified, recorded and put in place?

Has a discharge plan, which includes all relevant information on the person's mental health status and support needs been recorded in the healthcare record.

Point of Admission

Hospital Admission

Point of Discharge
Improving Quality of Care for People with Dementia in Acute Hospitals
Governance

• 94% of hospitals (33/35) have no dementia care pathway in place.
• 97% of wards (75/77) reported some level of access to specialist palliative care services.
• Few hospitals utilised existing reporting structures to identify people with dementia (e.g. reviewing readmissions, delayed discharges/ transfers).
• 5% of wards (4/77) reported being able to provide access to relevant faith-specific support from someone with experience of supporting vulnerable adults.
Assessment

• Reasonably high levels of medical assessments being carried out.
• Good deal of variation in the implementation and documentation of physical assessments e.g. functional assessments and recording of weight/BMI.
• Poor collateral history regarding dementia.
• 43% of patients (283/658) had a standardised mental status test carried out.
• 23% of HCRs (151/658) showed that the person had not been asked about the presence of any pain.
• 70% of patients (463/659) had no assessment for delirium.
• 86% (564/658) had no assessment for recent changes in mood.
Mental Health

• 25% of patients who died (13/51) had an existing prescription for antipsychotic medication.

• 27% of patients who died (14/51) had a new prescription for antipsychotic medication via PRN in place.

• 14% of patients who died (7/51) had a new regular prescription for antipsychotic medication put in place before their death.

• ‘Agitation’ was the reason recorded for 43% of new prescriptions (6/14), while ‘end of life’ was the reason recorded for 14% of new prescriptions (2/14).
Information and Communication

• Few hospitals have policies or guidelines in place around information sharing and how to involve families/carers.

• One hospital has a formal system in place for collecting information about the person with dementia.

• Few wards assign a single named nurse who is accountable for an individual patient’s care.
Staff Training

• Lack of commitment to dementia training at an organisational level.

Knowledge and training...

- 21% Included in staff induction
- 0% Mandatory

• Very little dementia specific training given in hospitals.

• 38% of wards (29/77) have arrangement in place to allow staff to attend training relating to the care of people with dementia.
Staffing and Staff Support

• 35% of wards (27/77) reported unfilled registered nursing staff vacancies.

• 76% of wards (54/71) meet their agreed minimum staffing levels.

• Poor staff support.

• 32% of hospitals (11/34) reported having a dementia champion in place, though only 16% of wards (12/77) reported having access to guidance and support from a dementia champion.
Physical Ward Environment

• Majority of wards did not have environmental cues to help the person orientate themselves.

• Few wards used colour schemes or had appropriate signage to assist wayfinding.

• 46% of wards (35/77) had a patient lounge or day room.

• A number of areas for improving the environment were identified.
Discharge Planning and Discharge

- 72% of HCRs (387/536) had no evidence documented of discharge planning being initiated within 24 hours of admission.
- 32% of HCRs (174/535) had support needs identified during admission included in the discharge plan or summary.
- Person with whom place of discharge discussed:
  - With person with dementia: 21%
  - With carer/relative: 50%
  - Consultant: 35%
  - Multidisciplinary team: 48%
Palliative Care

- 8% of patients (51/660) died whilst in hospital.
- 6% of patients (37/629) were receiving end of life care or on 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.
- A decision to attempt resuscitation was documented in 32.5% of HCRs.
- One referral for family/carer bereavement support was recorded.
Where to next?