DAA Dementia Action Alliance

NHS Institute for Innovation and Improvement

Partnership working with carers

Section 1

Self assessment statements from National Audit-Royal College of Psychiatrists	Measures used (see examples section 3)	RAG	Evidence	Areas for improvement
Discharge policy: People with dementia are supported by a discharge planning process that takes account of individual needs and the impact of the condition				
There is a named person who has responsibility in their job role to advise carers/relatives on a range of matters, such as: problems getting to and from hospital; benefits; residential and nursing care; help at home; difficulties for carers/ relatives such as illness, disability, stress or other commitments that may affect their ability to visit or to continue to care.				
Carers or relatives are asked about the extent to which they prefer to be involved in the care of the person with dementia while on the ward, e.g. help with personal care or at mealtimes, looking after clothing, spectacles or hearing aids, enjoyable				

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pastimes.				
There are clear guidelines regarding involvement of carers and what information is to be shared with them and this is communicated to carers.				
The person with dementia is involved in decisions alongside the carer wherever possible.				
Carers views are sought throughout the assessment and treatment process.				
Carers are involved in best interest decisions when the person with dementia lacks capacity.				
Carers are regularly updated and involved in care plans and treatment.				
Information about carers assessment is available on wards.				
There is a system in place to ensure that carers are advised about obtaining carers assessment and support e.g. wards can provide information about who to approach				

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in the hospital for further information and assistance.				
Information about discharge and support is made available to patients and their relatives on admission and this is recorded e.g. a leaflet summarising information, in plain English or other appropriate language.				
There is a section or prompt in the general hospital discharge summary for mental health diagnosis and management This includes the following : • the patient's level of cognitive ability • the cause of cognitive impairment • whether there are or have been symptoms of delirium • the presence of persistent behavioural and psychiatric symptoms of dementia to a degree which requires specialist dementia care or needs to be addressed • antipsychotics or other medication prescribed for mental health needs.				
The discharge co-ordinator/ person planning discharge discusses (or receives information about) the appropriate place of				

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discharge and support needs with: • the person with dementia • the person's carer or relative • the medical consultant responsible for the patients care • other members of the MDT.				
In advance of discharge, carers are offered an assessment of their current needs.				
In advance of discharge, patient information is complied into a single, up-to-date, discharge plan.				
The discharge plan contains the following: • up to date physical and mental health assessment information • details of onward referrals and support needs • details of changes in social circumstances.				
A copy of the discharge plan is provided to the patient and/ or carer and this is recorded.				
Carers or family receive advance notice of discharge (at least 24 hours) and this is				

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documented.				

Section 2

Relevant NICE standards

- NICE QS10: Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.
- NICE QS 4: People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care coordinator and addresses their individual needs.
- Counting the cost recommendation 7: Involve people with dementia, carers, family and friends in the care of people with dementia to improve person-centred care.
- NICE QS6: Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.
- Government quality outcome 6: Those around me and looking after me are well supported.
- Counting the cost 7.3 Carers and people with dementia where possible, must be involved in day-to-day care and treatment decisions.

Section 3

Example measures and indicators
Evidence of - audit and surveys; - action plans; - reports to hospital governance committee and Board.
Evidence of delivery of training and attainment.
Commissioning specification; contract monitoring requirements.
Targeted case reviews. Audit of medical records, including care plans. Audit of referrals to mental health liaison service.
Audit of medical records. Feedback from named carer/relative/friend.
Audit of pre-admission clinics' use of 'This is me'; audit of medical records. Audit of acute admissions' use of 'This is me'; audit of medical records. Audit of care plans.
Audit of evidence of transfer of information regarding patients to community memory services. Audit of discharge summaries.

Example measures and indicators
Evidence of hospital guidelines and protocol on information sharing and involvement of carers/families. Audit number of carers offered referral for assessment, expressed as a percentage of total numbers of carers of patients with dementia. Number of carers referred for assessment of needs. Feedback from staff, carers and families.
Audit of compliance with system. Observation.
Audit of medical records and discharge plans. Review of delayed transfers of care. Review of intermediate care pathways.

Section 4

Resources to help you All the resources below can also be found at www.dementiaaction.org.uk/DKITresources
DH Hospital to Home Care pack – Department of Health http://housinglin.org.uk/hospital2home%5Fpack/
Carers UK guide to involving and consulting carers - Carers UK PDF http://www.carersuk.org/media/k2/attachments/Involving_and_consulting_carers___a_good_practice_guide_May_2007.pdf
Carers UK guide to coming out of hospital - Carers UK http://www.carersuk.org/help-and-advice/practical-help/coming-out-of-hospital
Carer's assessment – Carers UK http://www.carersuk.org/help-and-advice/practical-help/care-and-support/carers-assessment
Dementia: workers and carers together – Dementia UK PDF http://www.skillsforcare.org.uk/developing_skills/dementia/supporting_people_with_dementia.aspx
Dementia and carers: workers' resource – Dementia UK PDF http://www.skillsforcare.org.uk/developing_skills/dementia/supporting_people_with_dementia.aspx
RCN Dementia resources: Learning Resources http://www.rcn.org.uk/development/practice/dementia/learning_resources
RCN Commitment to care How to Guide: (pages 13 - 15) – RCN http://www.rcn.org.uk/__data/assets/pdf_file/0011/480269/004235.pdf
The South West Dementia Partnership Compendium (Standard 2 & 3 page 12 - 25) – SWDP http://www.dementiapartnerships.org.uk/wp-content/uploads/dementia-care-in-hospital-positive-practice-compendium.pdf
Carers Resource – www.carersresource.org

Resources to help you
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GP Dementia risk notification form – Bradford Teaching Trust PDF
http://www.dementiaactionalliance.org.uk/assets/0000/0792/BTH_GP_dementia_risk_notification.pdf

Core Care Plans - discharge pathway with MDT involvement – Bradford Teaching Trust PDF
http://www.dementiaactionalliance.org.uk/assets/0000/0793/BTH_MDT_Core_Care_Plan_-_Discharge_Pathway_v2.pdf

Involving and consulting carers: a guide to giving carers and effective voice – Carers Northern Ireland
http://www.dementiaactionalliance.org.uk/assets/0000/0794/Involving_and_Consulting_Carers_-_A_guide_to_giving_carers_an_effective_voice_-_May_2007.pdf

This is me - Alzheimer's Society
http://www.dementiaactionalliance.org.uk/assets/0000/0795/This_is_Me.pdf