

Fix Dementia Care

Fern Howard

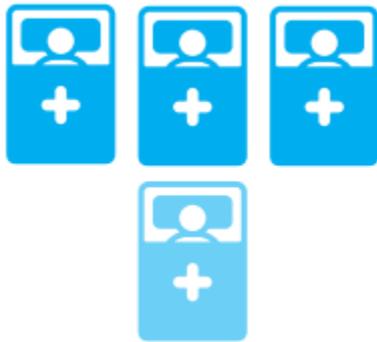
Stakeholder Relations Manager, Alzheimer's Society

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Introduction to Fix Dementia Care

- Over the course of 2016 the Fix Dementia Care campaign will investigate the experiences of people affected by dementia in hospitals, care homes and homecare
- Launching in January 2016 with a report on the state of dementia care in hospitals, where we have uncovered a shocking variety of dementia care across England
- Our report calls for better oversight of dementia care from NHS England, the Care Quality Commission and Monitor, the health regulators.

Key findings

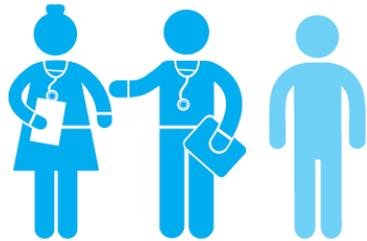


At least **25% of hospital beds** are occupied by people with dementia.



In 2013/14, **£264.2m** was **wasted on poor** dementia care in hospitals.

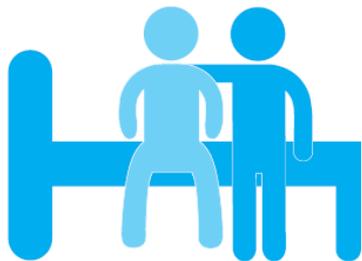
Key findings



Almost 60% of carers felt the person with dementia they care for **wasn't treated with dignity or understanding** while in hospital.



92% of carers said hospital environments are **frightening** for the person with dementia they care for.



90% of carers said the person with dementia they care for becomes **more confused** while in hospital.

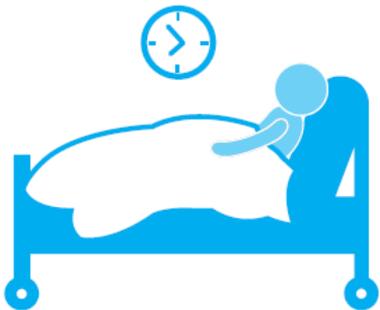
Key findings



There were **5,500** incidents of people with dementia **falling in hospital** last year.



In the three worst performing hospital trusts **25%** of people aged over 65 were **discharged late at night**.



On average people with dementia stay in hospital **twice as long** as other patients aged over 65.



88% of carers said either **no hospital staff, or only some**, understood the needs of people with dementia.

Case studies

David's Story: when care is not personalised

David's story is one of inadequate staff training at hospital and how staff struggles with challenging behaviour, poor quality care.

Iris' story: a fatal fall

Iris fell whilst in hospital causing significant harm. The fall directly contributed to a quick deterioration of her dementia.



Case studies

Joyce's story: admissions, hours of A&E agony

Joyce experienced unnecessary distress while waiting in A&E, unfriendly environment, staff not recognising needs; highlights the need of fast-tracking admission for people with dementia.

Geoff's story: dangerous discharge

Hospital failing to co-ordinate a discharge. Several attempts of discharge, no care plan in place, person with dementia left alone for an hour with all the medication in a bag. The person took part of the medication at once; it could have caused a fatal overdose.



What is Alzheimer's Society calling for?

Recommendation 1	Hospitals	All hospitals to publish an annual statement of dementia care that includes: satisfaction levels, number of falls, discharges at night, emergency readmissions within 30 days, levels of staff and board dementia awareness and training, prescriptions of anti-psychotics and examples of how care is being personalised.
Recommendation 2	Monitor	Monitor to use the annual dementia statement as part of their Risk Assessment Framework to identify and take action in hospitals where dementia care is inadequate.
Recommendation 3	CQC	Care Quality Commission (CQC) to appoint a specialist dementia adviser and include dementia care indicators as part of their Intelligent Monitoring work to improve regulation of dementia services in hospital.

Putting it right

- **Fast-tracking admission**
- **Personalised care**
- **Dementia support workers**
- **Preventing falls**
- **A dementia-friendly workforce**
- **Dementia-friendly environments**
- **Discharge co-ordination**
- **A dementia strategy**



Thank you

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