Enter and View Report | Single Provider

healthwatch North Yorkshire
Improving Health & Social Care Together

Details of visit:

Service address:	Friarage Hospital, Northallerton, North Yorkshire DL6 1JG
Service Provider:	South Tees Hospitals NHS Foundation Trust
Date / Time:	17th November 2014 / 10am – 4pm
Authorised Representatives:	Adrienne Calvert (Visit Lead), Julie Midsummer, Gill Stone, Sue Staincliffe, Julie Janes, David Ita (Supervisor).
Contact details:	Healthwatch North Yorkshire, Blake House, 2A St Martins Lane, York. YO1 6LN

Acknowledgements

Healthwatch North Yorkshire would like to thank the service provider, patients, visitors and staff for their contribution to the Enter and View programme.

Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all patients, relatives or carers and staff, only an account of what was observed and contributed at the time.

What is Enter and View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the service manager, ending the visit.

In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to the CQC where they are protected by legislation if they raise a concern.

Purpose of the visit

- To gather the views of patients, relatives and carers in relation to their experiences of the services being provided.
- Identify examples of good working practice.
- Make observations as care is being provided to patients, and their interactions with staff and the surroundings.

Strategic drivers

- Contribute to our wider programme of work gathering evidence on our three Health and Social Care priorities for 2014/15, which is; Hospital Discharge and post Hospital support arrangements, GP Out of Hours services, and Support for unpaid Carers.
- Looking at the quality of care being provided, and the variation (if any), within the main hospitals serving the citizens and communities of North Yorkshire County.

Methodology

This was an announced Enter and View visit.

Following the formal notification of the visit sent to both the service provider and the clinical commissioning group responsible for commissioning this service, the visit lead arranged a telephone conference with the service providers' nominated person(s) in order to; complete a pre-visit questionnaire, explain the visit process, and answer any questions that the service provider may have about the visit. The visit lead also shared the visit plans with the service provider, including the areas of the service that the visit team planned on visiting, so that relevant staff would be notified in advance, thereby minimising or avoiding disruption to the normal day to day running of the service.

The visit team of six authorised representatives (including the visit lead) split into pre-arranged pairs and visited Accident and Emergency (including Ambulance Services), Romanby Ward, Post-Operative Surgical Day Unit, Gara Ward (Orthopaedic), Rutson Ward (Rehabilitation Unit), Allerton Ward (Surgery), Medical Assessment Unit, Paediatrics (inpatient/outpatient), Maternity Ward (outpatients), Ministry of Defence Health Unit, Ainderby Ward, Surgical Admissions Unit. In total over 30 patients and relatives/carers were spoken to, in addition to the nursing and ancillary staff that provided information and details about 'life on each ward'.

After time limited deliberations at the end of the visit, we communicated the key (headline) findings of our visit to the service providers' nominated person(s). We explained the protocol of "what happens next" following our visit, including timings and expectations contained within the Healthwatch North Yorkshire visit protocol, which was shared with the service provider prior to the visit. This allowed the service provider to respond immediately to some of our findings, as well as ask the visit team any further questions.

Ethical consideration

On entry to Wards we always introduced ourselves to the senior member of staff present and informed them of the reason for our visit. Without exception they were all expecting our visit, so we proceeded to find out if there were any patients we should not approach due to their medical condition, cognitive ability or our possible breach of infection control. This protocol was strictly adhered to by the visit team.

Prior to any conversation being held with a patient we introduced ourselves by name and showed our HW authorisation badge, gave them an explanatory leaflet on Healthwatch "Enter and View" purpose and procedure and then obtained their permission to continue with the conversation. It was also made clear to each patient that whatever they divulged to us in respect of their experience as a patient in the hospital would be anonymised for the purpose of this report.

In addition to our discussion with patients, we spoke to many staff and ancillary workers and family members who were visiting.

Summary of Findings

At the time of our visit, our overall observations show that the hospital was operating to a good standard of care in some areas.

- Staff are very passionate and committed across the entire hospital, and this was reflected in the feedback from patients, which was generally very complimentary.
- Staff are struggling to manage the amount of paperwork involved in the Trusts current policies.
- The application of Dementia policy is not consistent across all parts of the hospital.
- Discharge procedures are largely effective, although some targets are considered unachievable.
- Extra support required to assist at mealtimes.
- Inconsistent use of Patient Status at A Glance (PSAG) boards across each ward.
- Policy changes around paediatric & maternity work succeeding so far.

Results of Visit

The Friarage hospital is part of South Tees Hospitals NHS Foundation Trust which also runs The James Cook University Hospital in Middlesbrough. The Trust provides district general hospital services for the local population, and also offer a range of specialist regional services to 1.5million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria; with a particular expertise in heart

disease, neurosciences, children's services, renal medicine, cancer services and spinal injuries. It is also the major trauma centre for the southern part of the northern region.
The Friarage Hospital provides acute care within Northallerton, North Yorkshire and serves a rural population of 122,000 people. The hospital provides a range of services including an accident and emergency department, intensive care, surgical departments and theatres as well as general medicine wards and outpatient departments.

Environment (including Premises)

We found that the hospital layout was inviting. There were comfortable seats along corridors, good signs and attractive art work. Everywhere was light and airy with windows and patio doors where possible, making the place look very clean and tidy. The family room and bereavement room on A&E were well appointed and comfortable. There are planned changes due to the Clinical Decisions Unit as the reception area is not fit for purpose due to the number of patients going through the unit daily.

There was evidence of effective application of infection control measures, like hand gel dispensers at regular points, and toilets with posters showing hand washing guidelines. All toilet brushes had been removed to control the spread of infections, and any patient with an infection was quarantined with appropriate measures taken to improve the situation. There were posters prominently displayed on wards regarding infection control.

Patient Care (Wellbeing, Dignity, Respect and Safety)

All staff we spoke to found the level of paperwork excessive. 'Anything that takes you away from the patients has to be detrimental'. Staff would like to see the paperwork for the whole hospital streamlined.

Vital PAC hand held technology is liked by the staff as they give them the opportunity to stand with the patient while inputting the data. IPads on wards during ward rounds are also popular as these facilitate prompt blood tests, discharge and onward referral.

Where fully implemented, the Patient Status at A Glance (PSAG) board provides excellent information about patient treatment and progress, using a combination of symbols to anonymise patient information from the understanding of visitors and passers-by. The board highlights factors that might be, or is, causing delay. Hold-up points are very clear to see, which allows senior ward staff to take corrective action.

Some nurse's station are now located within the bays so that nurses are able to respond quicker to their patients and also catch up on paper work while there.

Patients who require physiotherapy after a surgery must have their mobility assessed, however the equipment observed for this purpose was said to be inadequate by the physiotherapists spoken to. The equipment appeared to be old and in need of replacement. Patients were being taken to the main physiotherapy department for stair training which was time consuming. Equipment observed was deteriorating due to frequent sanitisation. There was no overhead suspension frame or wall bars.

Paediatric and Maternity services

Both the children's ward and the maternity unit are locked units. The paediatric ward has space for 9 patients and is currently open 10.00am to 10.00pm only. It became a day unit only on 01/10/14. Any admissions should be referred to James Cook Hospital from this date, and this requires effective communication between the Friarage and James Cook Hospitals. However, we have been informed of delays in the availability of ambulances to transfer patients who require admission from the Friarage to James Cook. As a result, staff have often worked beyond 10.00pm purely on a 'good will' basis; although it is fair to say that since the new opening hours are only 7 weeks old the new system is still yet to be fully tested.

The paediatric unit deals with planned admissions and emergencies along with booked surgeries (day cases only). The Maternity Day Unit on the other hand carries out scans, runs anti natal clinics and gynaecological clinics. These changes are still considered to be in its transitional stages, although managing patient expectations during this period of change was difficult and challenging according to staff. The day unit is open 9.00am to 5.00pm Monday to Friday and is closed at weekends, hence outside of these hours patients must attend James Cook.

There are real concerns among patients and staff about the journey to James Cook in an emergency, especially during the heavy traffic of the tourist season in the summer or the bad winter weather, although this situation is yet untested. To date 5 patients have been transferred to James Cook, and there have been 29 births. The unit was previously dealing with 1300 births per annum.

The Maternity Unit became a midwife-led unit from 06/10/14, with staff making the decision as there are no medical staff present. Despite the changes, no leadership or other specialist training has been provided to nurses to assist them manage the units on their own.

Dementia strategy

There are no specific dementia wards, as patients are accommodated according to their medical needs. This means that a frail elderly patient could be sent to any ward that may not necessarily cater properly for their needs as a dementia patient.

The level of specific dementia training on some wards was surprisingly low. Dementia patients are usually accommodated in a bay nearest to a nurse's station and moved to a side room if disruptive. We observed one patient who was very challenging and needed one to one supervision, as he was subject to a Deprivation of Liberty Safeguards (DoLS) decision for the next two months.

We observed no experienced reference point to offer advice for handling challenging dementia patients. The hospital would benefit from a Mental Health Specialist as a reference point/advisor.

Staff in A&E were not aware of how dementia patients were identified. There was no procedure in place for assessing dementia patients. If a patient was suspected of having dementia then staff did their own verbal test for cognitive ability. A&E was not considered to be dementia friendly.

Discharge from Hospital

The Trust target of discharge by lunchtime was generally agreed to be achievable as they have found smarter ways of working. The target of discharge by 10.00am, which we understand was an Executive Board decision, was less popular because meeting this target was considered more challenging.

Single Point is an excellent, time saving system for tracking availability of beds in the community hospital. It improves staff relations and facilitates purposeful conversations.

The intensive monitoring of patient progress assists discharge to go smoothly as seen in Rutson ward (Rehabilitation unit). Case conferences to discuss and plan for each patient's needs and checks that the ward meets NICE guidelines of specific goals for each patient all assist a smooth discharge. The use of the PSAG board is an excellent driver to discharge as seen on Gara ward (Orthopaedic).

Nursing and Ancillary Staff

On Rutson ward (Rehabilitation unit) four patients in a six bed bay were highly dependent needing help to eat, drink, toilet and dress. Another patient in another bay was also as highly dependent. There was only one staff member to assist these patients with eating and drinking. Meals had to be kept in a hot oven until patients could receive assistance. One patient told us that his breakfast was regularly so late that by the time he was up and dressed he had missed his physiotherapy appointment.

Staffing on Romanby ward was considered inadequate to meet the needs of patients who required more hands on care because of dementia.

Additional Findings

- 'Time to Care' an approach to release time for nurses to care by increasing efficiency has worked exceedingly well on Gara ward. The before and after pictures are very revealing and having a designated member of staff for each area works well.
- In two wards the sister had arranged a separate work area for Doctors, as this keeps the nurse's station clear and more welcoming to patients and relatives.
- There is no central hospital discharge lounge. Some wards have a waiting or discharge room and others do not. Patients can wait some time before departing the premises and can feel that no one is responsible for their care or welfare.
- Patients on the Clinical Assessment Unit seem to be moved more often than is necessary, primarily due to lack of bed space.
- We were informed that the North East Ambulance service had been diverted to the Friarage without warning two days ago. Since the changes, there are still patients being taken to the Friarage by the Ambulance service when they should be taken to James Cook instead. For example; patients with conditions like Stroke, Paediatrics, Gynaecology and Trauma.
- Ambulances can be diverted from North Tees and James Cook on Saturdays to the Friarage and also Sundays 3.15pm to 7.15pm.
- The Friarage is a 'stocking centre' for drugs to be replenished on ambulances.

- Patients who are about to be discharged are able to purchase nutritionally balanced meals through the hospital Café in order to take home, which means patients don't have to worry about having to cook as they continue their recovery at home.
- Although not unique to Friarage Hospital, there is currently no process for identifying patients who are also unpaid carers, either on admissions or at discharge. This process could help alleviate the anxiety of unpaid carers about the person they are caring for, who may have been left at home without support.

Recommendations

- The paperwork for each process should be looked at with a view to streamlining, with more effective use of technology platforms like the IPads.
- Dementia policy to be seen to be applied across all service areas, and staff training brought up to speed.
- Discharge policy to be refined with a view to speeding up the discharge process.
- More volunteers to be recruited, as well as family and friends encouraged to assist staff at mealtimes.
- Consider introducing a Mental Health Specialist on site as a reference point to advice and support nursing staff with challenging dementia patients.
- Stroke Rehabilitation equipment to be reviewed.
- Yorkshire Ambulance Service to be requested to provide an exception report to cover any patient delivered to the Friarage who should not be there according to the current policy.
- Paediatric & Maternity services to continue to be monitored.
- Consider asking all patients on admission and discharge whether they currently look after anyone (family, friend, neighbour etc.), and use this information to identify appropriate support within the community for the cared for person.

Service Provider response

Thank you for your report following the Health Watch NY enter and view visit which took place at the Friarage Hospital Northallerton on Monday 17 November. Your report was widely circulated both to staff and the managers for those areas visited by you and your team. We have considered the detail provided in the report and I am now in a position to respond.

Page 4: Physiotherapy

The physiotherapist for the Rutson Unit feel that they have good equipment, however the outer coating of the parallel bars has deteriorated due to frequent wiping. This is not an infection control

risk and they do not need replacing at present but they will continue to be monitored. The Bobath plinths do have rips in their covering and have been measured and replacement tops ordered.

Page 5: Paediatric and Maternity Unit

The activity within the ante natal clinic and Gynaecology out patients remains unchanged and therefore there is no transition for these services. The Maternity Day Unit activity has been reduced although early pregnancy services managed within this area also remain unchanged. Information for women and families regarding the services offered in the Maternity Day Unit and when women needed to attend the James Cook University Hospital was very clear, although some women were unhappy with the consequences of reconfiguration.

The maternity unit is midwifery led with no medical staff present with midwives risk assessing all women prior to admission. The community midwives also ensure that continuous risk assessment of all women is undertaken at all ante natal visits to define the suitability for the Midwife Led Unit and continuous discussions regarding her choice of place of birth are undertaken. Midwives have always undertaken these risk assessments and discussion regarding choices of birthplace so there was no need for any additional training in this area of practice.

A midwifery manager is in post in the Maternity Led Unit who was a also a manager at the Friarage Hospital prior to the reconfiguration. She has undertaken the relevant management and leadership training and does not work in isolation but is supported by the Head of Midwifery and the Clinical Matron who both work across site and attend the Maternity Led Unit on a regular basis.

There are no nurses in post in the maternity unit, only midwives supported by health care assistants.

Page 5: Dementia Strategy

The A&E department staff rotate between the James Cook University Hospital (JCUH) site and the Friarage (FHN) site. Several staff at the JCUH A&E department have completed the relevant city and guilds training and the champions training although as yet this may not have had such an impact on the FHN site.

A new dedicated dementia educator funded by Hambleton, Richmondshire and Whitby CCG started in December 2014. However, as soon as the enter and view report was circulated, the dementia educators were asked to prioritise the Friarage site and in particular the A&E department. The educators were requested to put together a training plan for the new educator to undertake after induction.

Page 6: Nursing and Ancillary Staff

The report refers to "Staffing on Romanby ward (Cardiology Outpatients) was considered inadequate to meet the needs of patients who required more hands on care because of dementia".

The Trust undertakes a quarterly review of staffing levels in every ward using the nationally approved Safer Nursing Care Tool. The review monitors staffing levels and patient acuity for each shift over a 7 day period (including weekends). The last review showed that levels of staffing in the Rutson Unit were within the recommended ratio given the acuity of the patients on the ward at the time although patient dependency can vary significantly from day to day so we do ask our ward managers to

escalate staffing pressures and use staff flexibly where possible.

On the day of the visit staffing numbers on Romanby ward were above national guidance for qualified nurses. This guidance suggests 1 registered nurse to 8 patients. There are 26 beds on Romanby and there were 4 registered nurses and 3 health care assistants on duty with a ward assistant and a ward clerk. The ward does take a significantly higher number of patients with challenging behaviour and this is reflected in the staffing numbers. The ward does use volunteers for help at mealtimes and has therapeutic volunteers.

We have passed your comments regarding dementia patients to our dementia team and asked them to discuss with the ward managers whether further support and training for staff would be useful and if any further adjustments can be made for dementia patients in this area.

Page 6 & 7: **Additional Findings**

Bullet 4: "Patients on the Clinical Assessment Unit seem to be moved more often than is necessary, primarily due to lack of bed space"

The Friarage Hospital Clinical Decisions Unit (CDU) is specifically designed for patients suffering from medical conditions. Tests and investigations are started to determine the correct course of treatment and whether admission to hospital is required. If a hospital admission is deemed essential then the patient will be transferred to one of the inpatient wards to continue any necessary investigations and / or treatment. There are times when bed moves are made within the unit and this is primarily for privacy and dignity reasons to ensure that all patients are cared for within a same sex environment.

Bullet 5: "We were informed that the North East Ambulance service had been diverted to the Friarage without warning two days ago. Since the changes, there are still patients being taken to the Friarage by the Ambulance service when they should be taken to James Cook instead. For example; patients with conditions like Stroke, Paediatrics, Gynaecology and Trauma"

This statement is incorrect. The managing Director on call Saturday 15 November states the divert was arranged with mutual aid agreed with the Friarage site manager prior to the divert being put in place with North East Ambulance Service (NEAS). The Friarage site had more available beds than the James Cook University Hospital site and mutual aid was sought first from County Durham and Darlington FT and North Tees Hospitals FT to no avail. Mutual aid was requested from the Friarage site and was agreed before being put in place with NEAS. All further extensions were subsequently requested via mutual aid policy to the Friarage and mutually agreed and then put in place with NEAS. We would not expect all staff to have a full understanding of the divert process as this is always arranged by the managing director on call and the respective site manager.

Bullet 6: "Ambulances can be diverted from North Tees and James Cook on Saturdays to the Friarage and also Sundays 3.15pm to 7.15pm".

Any diverts can only be agreed with mutual consent via the mutual aid policy. Therefore if ambulances are diverted at any time it would only be if the receiving hospital has been able to offer mutual aid and then once this is agreed the ambulance service are contacted to facilitate the divert process. Ambulance diverts are not put in place without mutual aid being agreed first. If an

ambulance divert is agreed within our own Trust sites this is always communicated and is never "without warning".

Page 7: **Recommendations**

Bullet 1: "The paperwork for each process should be looked at with a view to streamlining, with more effective use of technology platforms like the IPads".

A rapid process improvement workshop was held in November to review the paperwork used on admission, and is currently being implemented and reviewed. The review looked to standardise and streamline the paperwork used across the organisation. The trust has implemented the electronic recording of physiological observations across the James Cook University Hospital and Friarage Hospital sites. In addition to this the trust is currently exploring the option of introducing clinical noting.

Bullet 2: "Dementia policy to be seen to be applied across all service areas, and staff training brought up to speed".

Please see previous comments in terms of the dementia strategy and attached action plan.

FHN A&E department.doc

Attached as Appendix 1

Bullet 3: "Discharge policy to be refined with a view to speeding up the discharge process".

The discharge policy is currently under review by the Clinical Lead for the Case Management Team.

Bullet 4: "More volunteers to be recruited, as well as family and friends encouraged to assist staff at mealtimes".

Bay nursing has helped to alleviate some problems associated with feeding patients however the Friarage manager has contacted Head of Fundraising and Volunteering to explore if additional support can be provided at meal times.

Bullet 6: "Consider introducing a Mental Health Specialist on site as a reference point to advice and support nursing staff with challenging dementia patients".

In relation to employing Registered Mental Health Nurses on the wards at the Friarage Hospital, this has been considered, although it is felt that it would be difficult to attract staff and difficult to recruit. However, the ward staff are able to access the Hospital Mental Health Liaison Team from 8am – 8pm seven days per week, who offer support and advice to staff when nursing patients with an existing diagnosis of dementia or a newly diagnosed dementia. A referral system is used, however should emergency situations arise ward staff are able to bleep members of the team to attend the ward environment immediately. As alluded to above, the Trust is committed to continue educating all staff and increase their knowledge about dementia to ensure our patients receive high standards of safe care.

Bullet 7: "Stroke Rehabilitation equipment to be reviewed".

Please see previous comments on page 1.

Bullet 8: "Yorkshire Ambulance Service to be requested to provide an exception report to cover any patient delivered to the Friarage who should not be there according to the current policy"

It is expected practice for the A&E staff to complete an incident form for any patient who is transported by ambulance to the Friargae A&E department who should be taken elsewhere according to the current policy. This will be investigated and the outcome shared by the A&E manager with the YAS and CCG colleagues at the monthly SDIP meeting.

Bullet 9: "Paediatric & Maternity services to continue to be monitored"

The changes to the paediatric and maternity services were monitored by the Friarage A&E department, the maternity unit, the paediatric unit and the Yorkshire ambulance service. If any issues did occur these were investigated and the outcomes discussed at a weekly teleconference. Key personnel representing these areas participated in a weekly teleconference where if any specific issues did occur these were investigated, discussed and necessary actions taken to prevent any reoccurrences. There were very few issues raised therefore the teleconference was dissolved and these services are monitored and discussed monthly with the CCG.

Bullet 9: "Consider asking all patients on admission and discharge whether they currently look after anyone (family, friend, neighbour etc.), and use this information to identify appropriate support within the community for the cared for person".

All nursing staff are encouraged to establish if the patient is a carer on admission and if this is identified the appropriate services would be contacted.

Appendix 1

South Tees Hospitals NHS
NHS Foundation Trust

We will become a dementia friendly organisation with environments and processes that cause no harm to patients with dementia.

together we do the amazing

Elizabeth Swanson April 2013
Adapted from National Audit of Dementia Care - Royal College of Psychiatrists and D-KIT DAA & NHS Institute of Innovation and Improvement

Strategic Aim 2
We will become a dementia friendly organisation with environments and processes that cause no avoidable harm to patients with dementia.

Objectives:

- By year 5 - All our care environments used by those with dementia will be fully compliant with best practice recommendations contained within the supporting documentation.
- By year 5 - All service and environmental improvements will consider impact of change on patients with dementia

Location: FHN A&E **Date: 11/3/2014** **Present: Gina Warren**

Section 1 Self Assessment

Markers of best practice from the National Dementia Audit-Royal College of Psychiatrists	RAG Year 1	Evidence	Actions /Areas for improvement
People with dementia are cared for in an environment that is adaptable to their needs and preferences			
Orientation			
Does the approach to the ward/department look and feel welcoming. Is there an obvious reception desk? Are views of nature maximised.		The waiting areas are not in full view of staff, but some of the bays are. There are	Suggest use of bays in view of desk for patients with Dementia. Ideally an improved reception area

Markers of best practice from the National Dementia Audit-Royal College of Psychiatrists	RAG Year 1	Evidence	Actions /Areas for improvement
		lots of pictures of natural scenes on the walls and indoor plants promoting a welcoming atmosphere. The lack of an obvious reception detracts from this slightly.	required with a clear view of reception staff, this may not be possible in current space.
Patients with dementia and/or who are being assessed for cognitive impairment are situated on the ward where they are visible to staff and staff are visible to them, so that they can be observed unobtrusively.		Yes; when placed in a bed near the nursing desk or in the Mental health assessment room.	
Are patients cared for in the least restrictive environment possible while maintaining the appropriate level of security? Is the bedrail policy being adhered to?		No locked door, but all patients have rails up on the trolley beds. If someone is considered a risk they are accompanied at all times.	Further clarification required regarding application of bedrail policy in relation to the trolley beds when stationary.
Colour schemes are used to help patients with dementia to find their way around the ward *e.g. doors and bays are painted in a different colour*		Some toilet doors are a contrasting colour, but others are similar to wall colour. There is no distinction between bays.	Short term; Clear signage to be installed Long term; Doors to be painted in a contrasting colour except those that are leading to non-patient areas.
Signs and maps use large and clear (easy to read) fonts and colours		No. Some signs are small or lost	Clear signage needed, LED display needs to be set to a slower speed.

Markers of best practice from the National Dementia Audit-Royal College of Psychiatrists	RAG Year 1	Evidence	Actions /Areas for improvement
		amongst cluttered walls/noticeboards and the LED display is moving too fast to follow easily.	
Information (words and pictures) on signs is in clear contrast to the background		Pictures are not used in signage.	Adding signage in pictures as well as words.
Key areas are clearly marked *e.g. the nursing station, the bathrooms/toilets, any side rooms or waiting areas*		Some areas are not clearly signed. (Initial reception window)	Improved signage needed in the waiting area.
All patients with dementia are able to see a clock from their bed		Not in the assessment bays.	Calendar clocks required.
All patients with dementia are able to see a calendar (or orientation board) from their bed		Not in the assessment bays.	As above.
Signs to locate the toilet are visible from the patient's bed		Yes.	
For patients with dementia, messages from relatives and personal objects including self care items are situated where the patient can see them at all times		N/A	
A room/area is available for patients to use for a break from the ward environment *e.g. a patient lounge, "quiet" room, seating area*		Yes. Appropriately furnished with contrasting	

Markers of best practice from the National Dementia Audit-Royal College of Psychiatrists	RAG Year 1	Evidence	Actions /Areas for improvement
		comfortable furniture and facilities.	
Are spaces and walls clutter free?		No.	Some of the signage visibility is compromised by the amount of information on the walls and noticeboards.
Are doors to exits clearly marked, but staff only areas disguised by painting doors and door handles the same colour as the walls?		Yes.	
Toilet and bathroom doors carry signs utilising a picture and words that are a different colour to the walls		All signage present but not of a distinctive colour in waiting area.	Toilets need improved signage in waiting area, utilising pictures and words in a distinctive contrasting colour.
Activities of Daily Living			
Items such as the soap dispenser, the bin, the hand dryer are clearly labelled with pictures as well as words so that the patient can identify them		No.	Improved signage.
There are call/alarm buttons visible in the toilet/bathroom		Yes, but only in the ward toilet.	Alarm required in the waiting area toilet area.

Markers of best practice from the National Dementia Audit-Royal College of Psychiatrists	RAG Year 1	Evidence	Actions /Areas for improvement
There are hand rails, large handles and a raised toilet seat to support the patients		Yes, but only in the ward toilet.	There is clear signage directing towards the toilet with disability equipment in place.
Door handles are a different colour to the wall so that they stand out		No.	
Toilet paper is a different colour to the wall so that it stands out		No.	
The toilets are big enough for assisted toileting		Yes.	There is clear signage directing towards the toilet with disability equipment in place and appropriate space.
The bathroom is big enough for assisted bathing		N/A	
Single sex toilet/washing facilities are provided for patient use		Yes.	
Facilities are available so that patients have choices about bathing or assisted bathing, *e.g. at the sink, overhead showering, hand held shower head, full bath*		N/A	
There is space for restless patients with dementia to walk up and down where they are visible to staff.		Yes.	

Markers of best practice from the National Dementia Audit-Royal College of Psychiatrists	RAG Year 1	Evidence	Actions /Areas for improvement
Obvious social area with chairs arranged in small groups to encourage conversation	?	There is a quiet room which could be utilised as a time limited social area, but signage to this is limited and it is generally used for sensitive discussions so may not be available. The waiting room is not laid out in a social manner.	One option would be improved seating arrangement in the waiting area; this may be hampered by limited space.
Are activities encouraged other than passively watching TV?		Small selection of magazines.	Improved selection of magazines, provision of a welcome folder.
Do patients have control/choice over the sounds they hear? (Radio, TV, Music)		Yes, only in waiting area.	
The ward is adapted to assist people with mobility difficulties, *e.g. large handles, hand rails.*		Yes, but corridor rails are not clearly identified due to unusual shape and may be difficult to grasp by some patients.	Improved rails in corridor, replacement with a distinctive rail that is able to be fully grasped.
Is there somewhere to eat other than beside the bed? Is there space for patients /or carers and patients to eat together socially?		Waiting area and cafe. Food is presented on green crockery.	

Markers of best practice from the National Dementia Audit-Royal College of Psychiatrists	RAG Year 1	Evidence	Actions /Areas for improvement
The ward is able to provide adapted utensils to encourage patients to assist themselves with their meals and eat independently.	**?**		
The ward can readily provide equipment to assist mobility, *e.g. walking frames, wheelchairs.*	?		
The ward can readily provide hearing aids such as amplifiers/communicators/hearing loops/batteries for personal aids or other assistive devices.	?		
Vision and Mobility			
Floor Level changes and contrasts (gentle slopes and steps) are clearly marked		None present.	
Floors are plain or subtly patterned, not “busy” *e.g. without bold or high contrast design or pattern which could affect orientation*		Yes.	

Markers of best practice from the National Dementia Audit-Royal College of Psychiatrists	RAG Year 1	Evidence	Actions /Areas for improvement
Floor surfaces are subtly polished rather than high gloss		Yes.	
Floor surfaces are non slip		No.	
Have strong patterns been avoided in wall coverings, curtains, furnishings and screens?		Two sets of curtains used. The inner set is patterned but the outer privacy set is plain blue. Walls do not contrast with the floor, but do have a black skirting to identify where they change. The ward toilet area does have a contrasting floor covering.	All curtains and wall coverings need to be a plain solid colour that contrasts with floor.
Is the level of light comfortable and appropriate for what the patients want to do in the space? Is lighting even (without shadows or patterns forming on the floor)?		No. Light in the corridor is too low, the brighter light from the rooms along the corridor throw stripes of shadow across the hallway floor.	Brighter lighting in the corridor would resolve these issues.
Is it possible to adjust lighting according to time of day and care needs? Is lighting designed to support normal sleep and wake patterns?		N/A	

Markers of best practice from the National Dementia Audit-Royal College of Psychiatrists	RAG Year 1	Evidence	Actions /Areas for improvement
Planning			
All life cycle refurbishment and re-decoration plans should consider the needs of older people and those with dementia.			
Is there inclusion of markers of dementia friendliness within all environmental audits and assessments for areas used by patients with dementia and/or older people.			

The RAG rating for individual performance measures is determined as:

- Green, if on or better than target
- Amber if worse than target, but within an acceptable tolerance level
- Red, if worse than target, and below an acceptable tolerance level

Section 2
Relevant National standards

Section 2
Relevant standards

NICE CG 103: Delirium. Priority ii. Give a tailored multi-component intervention package to prevent delirium

Elements of Person Centred Care (Brooker 2007)

V- A value base that asserts the absolute value of all human lives regardless of age or cognitive ability.
I - An individualised approach, recognising uniqueness.
P- Understanding the world from the perspective of the service user.
S- Providing a social environment that supports psychological needs.

Section 3

Resources to help you **All the resources below can also be found at www.dementiaaction.org.uk/DKITresources**
Kings Fund EHE Assessment tool http://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia
RCN Commitment to care: How to Guide (pages 26- 28) http://www.rcn.org.uk/__data/assets/pdf_file/0011/480269/004235.pdf
SCIE Dementia Gateway http://www.scie.org.uk/publications/dementia/environment/index.asp
The South – West Dementia Partnership Competency Framework: (Standard 4 page 26 - 44) http://www.dementiapartnerships.org.uk/wp-content/uploads/dementia-care-in-hospital-positive-practice-compendium.pdf
Stirling University – Dementia Design Audit Tool http://dementia.stir.ac.uk/node/1918
The wander some patient – case study http://www.dementiaaction.org.uk/assets/0000/0804/BTH_The_Wander_Some_Patient_-_Case_Study.pdf
Yorkshire Outdoors (RCN PowerPoint presentations) www.dementiaaction.org.uk/assets/0000/0805/BTH_Yorkshire_Outdoors_-_RCN_Presentation.pdf

References

Allen D (2009) Designed for a better life. *Nursing Older People* 21(3) pp. 28-29.
Looks at the value of audit tool for in designing improved care environments used by people with dementia.

Andrews J (2012) How acute care managers can support patients with dementia. *Nursing Management (UK)* 19(2) pp. 18-20.
Guidance for nurse managers including some discussion on redesigning the care environment.

Benham L (2008) A sensory stairwell. *Journal of Dementia Care* 16(5) pp. 16-17.
A stairwell was decorated in a day hospital in Weymouth, Dorset to provide increased mental stimulation.

Burns A (2011) Help patients see more clearly. *Health Service Journal* 121(6282) pp. 26-27.
Suggests ways to make hospital wards easier for patients with dementia to use.

Cook G (2011) Dementia care: sensory environments. *Nursing & Residential Care* 13(5) pp. 240-243.
Includes discussion on finding a balance between over-stimulating and under-stimulating environments.

Cosh J (2007) Lost in space. *Mental Health Today* pp. 18-19.
Use of colours and other factors to provide a dementia-friendly environment.

Cowdell F (2010) The care of older people with dementia in acute hospitals. *International Journal of Older People Nursing* 5(2) pp. 83-92.
Looks at some research done on the experiences of nurses and patients on care received in acute hospitals including the ward environment.

Cunningham C (2009) Auditing design for dementia. *Journal of Dementia Care* 17(3) pp. 31-32.
Describes development of an audit tool for evaluating design in dementia care environments by Stirling University's Dementia Services Development Centre.

Cunningham C (2006) Understanding challenging behaviour in patients with dementia. *Nursing Standard* 20(47) pp. 42-45. **FT**
Includes examples of how the environment might contribute to the development of challenging behaviour.

Daykin N et al (2008) The impact of art, design and environment in mental healthcare: a systematic review of the literature. *Journal of Royal Society for the Promotion of Health* 128(2) pp. 85-94. **FT**
Systematic review on the impact of the arts, design and the environment in mental health care settings.

Dewing J (2009) Caring for people with dementia: noise and light. *Nursing Older People* 21(5) pp. 34-38. **FT**
This literature review looks at causes of sensory overload or underload in relation to improvements to the environment.

Duffin C (2008) Designing care homes for people with dementia. *Nursing Older People* 20(4) pp. 22-24. **FT**
Use of colour and materials in fitting out care homes to create a restful environment.

Hughes J and Harris D (2004) The environment and dementia: shaping ourselves. *Nursing & Residential Care* 6(8) pp. 394-398.
Effects of social and physical environment on people with dementia in a care home.

Hunt L (2011) Environments designed to heal. *Nursing Older People* 23(1) pp. 14-17. **FT**
Looks at a number of Enhancing the Healing Environment (EHE) projects including creation of a palliative care suite.

Hunt L (2010) A change of scenery. *Nursing Standard* 24(52) pp. 18-20. **FT**
This also explores the importance of the environment in palliative care using a project at Bodmin Hospital Cornwall as an example.

James J and Hoddenett C (2009) Taking the anxiety out of dementia. *Emergency Nurse* 16(9) pp. 10-13. **FT**
Improving the design of A&E environment and services at a London NHS trust including designated cubicles for patients with dementia.

Johnson R (2009) Signing up. *Journal of Dementia Care* 17(5) pp. 20-21.
Use of individualised bedroom door signs for dementia patients on a hospital ward.

Marshall M Delaney J (2012) Dementia-friendly design guidance for hospital wards. *Journal of Dementia Care* 20(4) pp. 26-28.
Looks at the guidelines and audit tool developed for general hospitals and emergency departments by the Dementia Services Development Centre (DSDC) at the University of Stirling.

Mason M (2011) Environmental health. *Nursing Standard* 26(13) pp. 23-25. **FT**
Work done by the dementia nurse specialist-led project to improve the physical environment of the King's College Hospital dementia unit.

Peace S and Reynolds J (2004) Managing different experiences of place and space, part 2. *Nursing & Residential Care* 6(9) pp. 452-454.
Looks at some of the issues around space and territory.

Phair L and Heath (2001) Environments and older people with dementia. *Mental Health Practice* 4(9) pp. 32-38.
Continuing professional development article on promoting a positive care environment with special reference to non-specialist care homes.

Pollock R (2008) Shedding new light on design for dementia. *Journal of Dementia Care* 16(6) pp. 22-23.
Advice on improving lighting in care homes and what needs to be taken into account when designing new facilities.

Price L and Grout G (2009) Environments that help, not hinder. *Journal of Dementia Care* 17(3) p. 21.
Describes project to improve the environment in a continuing care ward for dementia patients.

Richardson S and Richards V (2007) Nurses leading on activities in hospital. *Journal of Dementia Care* 15(5) pp. 16-17.
Development of a nurse-led therapeutic activities centre in a Swansea hospital.

Swann J (2006) Helping residents reminiscence: the role of the environment. *Nursing & Residential Care* 8(10) pp. 459-462.
Explains how a care home's environment helped to promote memory in residents.

Turner L (2012) A legacy of inspiration. *Journal of Dementia Care* 20(4) pp. 29-34.
Describes the transformation of a hospital ward into a dementia friendly environment through participation in the King's Fund Enhancing the Healing Environment (EHE) programme.

Walker W (2004) Promoting a safe environment for confused older people at risk from falling in hospital. *Journal of Orthopaedic Nursing* 8(2) pp. 72-76.
Suggests strategies for risk assessment and provision of a safe environment in hospitals.

Waller S (2012) Redesigning wards to support people with dementia in hospital. *Nursing Older People* 24(2) pp. 16-21. **FT**
Overview of the nurse-led initiative Enhancing the Healing Environment programme which encouraged staff and dementia patients to work together to create more therapeutic environments.