The Regulation and Quality Improvement Authority

Reducing Hospital Admissions of People with Dementia from Nursing Homes: Anticipating Care Needs

Phase 1

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 BACKGROUND

Within Northern Ireland the prevalence of dementia is increasing. It is predicted that this could triple from the current estimate of 19,000 to around 60,000 by 2051.[1]

The Worldwide Hospice Palliative Care Alliance[2] recognises the importance of palliative care in the management of dementia, which may continue for many years. However, acute episodes of illness can also occur, resulting in hospital admissions. It is also known that people with a dementia diagnosis tend to have longer stays in hospital than those with a non-dementia diagnosis, admitted for the same procedure.[3,4] Therefore, people with dementia are at risk of adverse health outcomes due to hospitalisation, which also puts financial pressure on the National Health Service.[5]

As acute episodes can happen at end of life, anticipating what people's needs are likely to be can be extremely beneficial.[6] There is evidence that methods of anticipating care needs which can be successful in reducing hospital admissions are:[7,8,9,10]

- ensuring that 'as needed' medication is available and prescribed in the care setting for use when required.
- ensuring that GPs have transferred all relevant information to the out of hours services.
- management and monitoring of common symptoms with appropriate staff training.
- timely advance care planning in conjunction with the person and family regarding their preferences and requests in the event of their health deteriorating, including where they wish to be cared for.

Advance care planning is a voluntary process of discussion with residents, and their families or carers, to make clear their wishes and thoughts for future care. Advance care planning is useful in the context of the person's deterioration where he or she may be unable to make decisions or communicate their wishes to other people.

These aspects of anticipating care needs are also linked to recognised care standards for nursing homes.[11,12]

Reducing hospital admissions from nursing homes has been recognised as a priority area for action by a number of policy documents,[13,14,11] in addition to the emphasis on care in the community within the regional report Transforming Your Care.[14]

Relevant to this audit, Living Matters: Dying Matters,[13] the regional palliative and end of life care strategy in Northern Ireland, has included advance care planning and out of hours care as quality outcomes. In addition, the GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes[11] contain best practice statements focused on anticipating the care needs of residents (advance care planning, anticipatory prescribing and care, out of hours care and staff training in palliative and end of life care). These best practice statements were the focus for this regional audit during the period January 2015-December 2015.

2.0 AIM AND OBJECTIVES

2.1 Aim

The overall aim of this audit is to reduce hospital admissions for people with dementia in nursing homes, through anticipating the care needs of residents. The audit will also assess if recognised strategies to anticipate the care needs of residents, to reduce hospital admissions, are in place within Nursing Homes designated to people with dementia in Northern Ireland. Based on the findings, recommendations will then be made designed to reduce the number of hospital admissions for people with dementia in nursing homes.

2.2 Objectives

The audit objectives, aligned with the GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes[11] (target 100%), were to:

- determine the number of residents with dementia and their place of death.
- assess the number of residents with dementia who died having had their preferred place of care at end of life recorded.

- ascertain if nursing homes had implemented best practice in relation to out of hours care and anticipatory prescribing and care.[11]
- assess the level of implemented best practice in advance care planning in nursing homes inclusive of preferred place of care at end of life.[11]
- determine how palliative and end of life care learning and development needs of nursing home staff were identified.
- assess the number of staff working in nursing homes who attended palliative and end of life care training during the audit period.
- identify challenges and enablers in using strategies to reduce hospital admissions for people with dementia at end of life.
- make recommendations for education, practice and further service development.

The implementation of best practice in the above objectives was determined by adherence to best practice statements with the GAIN Guidelines.[11] These focused on out of hours care, anticipatory prescribing, and care and advanced care planning.

3.0 METHODOLOGY

This is Phase 1 of a dual Phase audit (Phase 2 being funded by RQIA during 2017/2018). The audit sample included all nursing homes designated to people with dementia in Northern Ireland (n=118).

3.1 Data Collection

Data collection for the audit took place between July 2016 and February 2017. Nursing Homes were asked to complete an electronic proforma (Survey Monkey) (Appendix 1). nursing homes designated to people with dementia and nursing home managers were identified using the Regulation and Quality Improvement Authority (RQIA) database, which was accessed by a member of the RQIA audit team who also sat on the project Steering Committee.

The content of the audit proforma was informed by the project objectives, recognised best practice statements within the GAIN Guidelines (2013), (Appendix 2); and through consultation with the Regional Audit Project Team and Steering Group.

The Regional Audit Project Team and Steering Group included representatives from nursing homes participating in the audit and a service user representative. The members of this joint committee assisted in piloting the proforma to ensure clarity and appropriateness of questions and to make any necessary amendments.

To maximise responses from nursing homes, the Dillman[15] method was used as a recognised tool to promote a good response from surveys. This method was applied to the survey as indicated below:

- The original invitation and details about how to take part in the audit were circulated to all nursing homes designated to people with dementia in Northern Ireland.
- The audit proforma was sent on 08 July 2016 with a return date of 05 August 2016.
- A reminder was circulated to all nursing homes one week prior to the initial return date with two further extensions allowed, extending the closing date to 14 October 2016.

Although originally asked to complete the proforma electronically, nursing homes were given the option to both complete and return by post, or to request a telephone interview, with a member of the Project Team using the proforma. A final invitation to participate was sent out to non-responding homes in January 2017. Each Nursing Home received a certificate of participation.

3.2 Data Analysis

The proforma used in the audit consisted of mainly quantitative questions with a small number of qualitative, open-ended questions. Quantitative data were entered into SPSS to obtain descriptive statistics in the form of frequencies and percentages. Qualitative data, obtained from open-ended questions, were analysed into codes and categories.

3.3 Confidentiality & Data Protection

Nursing Home managers were informed in the audit invitation letter that their consent was implied by completion and submission of the proforma.

Data Protection principles were adhered to by:

- anonymising all data.
- electronic data being stored on a password protected pc.
- paper copies of data being stored securely in a locked filing cabinet in a locked room in the School of Nursing & Midwifery, Queens University, Belfast.

4.0 FINDINGS

All nursing homes designated to people with dementia in Northern Ireland (n=118) were invited to take part in this regional audit which generated a response rate of 33% (n=39). Three homes only completed the first eleven questions on the proforma. A description outline of the participating nursing homes can be seen in Appendix 3.

Although only a small sample of nursing homes took part in the audit, there was geographical spread across the five Health and Social Care Trust (HSCT) regions (Appendix 3). Of the participating nursing homes, nine were single homes and the remainder were owned by nursing home companies. The number of beds designated to people with dementia in responding nursing homes varied from four to fifty-six.

4.1 Demographic Information

A total number of 1,388 nursing home residents had a documented dementia diagnosis recorded during the audit period. Across nursing homes there was wide variation in numbers of people with a dementia diagnosis, which reflected the differences in bed numbers within these care settings. The number of residents varied from 8-87.

Individual nursing homes provided information in relation to numbers of full-time and part-time Registered Nurses and Health Care Assistants employed at time of audit (Table 1 & Table 2).

Table 1: Number of Full and Part-time Registered Nurses*

(N=39 Homes)	11-20		1-10		None		Not provided	
	n	%	n	%	n	%	n	%
Full-time Register Nurses	10	26%	22	26%	3	8%	4	10%
Part-time Register Nurses	3	8%	20	51%	8	20.5%	8	20.5%

*Nursing Homes will ensure that Registered Nursing staff are available 24/7 and when required bank staff (Registered Nurses) will be in place to provide the required cover.

Table 2: Number of Full and Part-time Health Care Assistants (HCAs)

(N=39 Homes)	41-50		31-40		21-30		11-20		1-10		None		Not provided	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Full-time HCs	2	5%	7	18%	7	18%	12	31%	5	13%	2	5%	4	10%
Part-time HCs	-	-	-	-	3	8%	4	10%	21	54%	5	13%	6	15%

Nursing homes reported that during the audit period a total of 24% (333 of 1,388) of residents with dementia diagnosis recorded had died. Table 3 shows the place of death and number of residents to which this related.

Table 3: Place of Death and Number of Residents to which this Relates:

Place of Death	Percentage	Number of Residents (n=333)
Nursing Home	80%	268
Hospital	20%	65

Table 3 shows that 80% (268 of 333) of residents died in nursing homes with 20% (65 of 333) dying in hospital. It was noted that eleven nursing homes reported that no residents had died in hospital and two had no deaths during the audit period.

4.2 Preferred Place of Care at End of Life

Nursing homes were asked to indicate if residents with a dementia diagnosis who died during the audit period had recorded a preferred place of care at end of life (Table 4).

Table 4: Number of Residents who had Preferred Place of Care Recorded

Preferred Place of Care	Percentage	Number of Residents (n=333)
Nursing Homes	77%	257
Hospital	5%	17
'Other'*	<1%	1
Not Recorded	17%	58

*'Other' recorded by one nursing home was specified as an instance where a resident had just been admitted to the nursing home and had to go back to the hospital so no discussion on preferred place of care at end of life had taken place. Data was not collected relating to actual place of death for each resident. It was envisaged that this would be collected in Phase 2 as part of a regional chart review in nursing homes.

4.3 Hospital Transfers of Residents with Dementia

Based on their own experience (not related to the audit period) staff were asked what, in general were the most common reasons for a resident with a dementia diagnosis to be transferred to hospital. The most common reason highlighted was a General Practitioner (GP) decision (82%, (32 of 39). Some nursing homes highlighted other contributory factors, which could still require the GP to act, such as hospital transfers taking place at the request of the family (54%, 21 of 39) or due to emergency situations such as injuries due to a fall (49%, 19 of 39).

Nursing homes were then asked in relation to the audit period, what they considered were the three most common reasons for residents with a dementia diagnosis to be transferred to hospital. Table 5 describes the three most common and related reasons for hospital transfer, during the audit period, as cited by nursing homes which were:

decision of the GP (74%, 29/39), injuries due to a fall (51%, 20/39) and at request of the family (51%, 20/39). Some nursing homes listed other reasons for hospital transfer, which may still have required a GP decision, or a 999 call, such as residents having Pneumonia or Influenza or unexplained deterioration in health.

Table 5: Three Most Common Reasons for Hospital Transfer

*Reasons for hospital transfer	Percentage	Number of responses (n=69)
Decision of the GP	74%	29
Injuries due to a fall	51%	20
Request of the family	51%	20

***This question generated more than one response from each nursing home and thus the total percentage is not 100%

Nursing homes reported the number of hospital transfers involving a resident with a dementia diagnosis during the audit period. These can be seen in Appendix 3, for each of the individual thirty-nine homes, with the number of beds designated to people with dementia also listed. As Phase 1 was not a chart review these hospital transfers were not mapped to a reason for the hospital transfer.

As can be seen from Appendix 3, there was a wide range of hospital transfers during the audit period, which ranged from 1-5 to over 30. It was noted that Nursing Home 21 had no hospital transfers during the audit period and had 26 beds. The bed numbers in Nursing Homes which had 1-5 hospital transfers ranged from 4 beds to 56 beds; those which had 6-10 hospital transfers had a range of 4 to 52 beds; homes with 11-15 hospital transfers had 10 to 56 beds and homes with 16-20 hospital transfers had a range of 24-45 beds. Nursing Home 11 which was the only home with 21-25 transfers had 32 beds and Nursing Home 30 which was the only home with 26-30 transfers had 33 beds. Finally, the four homes with over 30 hospital transfers had a range of 22 to 52 beds.

4.4 Advance Care Planning

The audit contained a number of questions relating to advance care planning, a voluntary process of discussion with residents, and their families or carers, to make clear their wishes and thoughts for future care. This planning is useful in the context of any future deterioration in the person's condition where he or she may be unable to make decisions or communicate their wishes to other people.

Within the 39 participating nursing homes in relation to assessment of capacity:

- 46% (18 of 39) homes reported that all residents with a documented dementia diagnosis were assessed for their capacity to engage in advance care planning discussions, within the first three months of admission.
- Eighteen homes (46%) reported that residents had not been assessed for their capacity and for the remaining three homes (8%) information was not returned.

4.4.1 Engagement in relation to Advance Care Planning/Best Interest Discussions

Responses were received relating to residents with a dementia diagnosis having the opportunity to actively engage in advance care planning, or their families/carers having the opportunity to engage in best interest discussions, within the first three months of admission. As Table 6 shows, whilst only a small number of residents with dementia were able to, or wished to engage in advance care planning, a large number of family/carers were consulted with and engaged in this discussion within the majority of homes.

Table 6: Advance Care Planning/Best Interest Discussions within Three Months

Participation in Discussions	Number of Residents	Number of Homes
Yes - resident able to engage and given opportunity within 3 months of admission	40	4
Yes - resident able to engage, but did not wish to engage	45	4
Yes - however resident unable to engage with discussion and had no family carer to consult	22	8
Yes - resident unable to engage, but family/ carers were consulted and engaged	467	34
Advance care preferences had been recorded within the first 3 months of admission	217	8
Yes - however, resident unable to engage and family/carer did not wish to engage	112	14
No - resident not given opportunity within 3 months of admission	187	9
No - resident has not completed 3 months admission during audit period	67	8

Table 6a shows the number of Nursing Homes who were asked to indicate if advance care planning discussions were held after the first three months of admission.

Table 6a: Advance care planning/Best Interest Discussions after Three Months

Participation in Discussions	Number of Residents	Number of Homes
Yes - resident able to engage and given opportunity after 3 months of admission	8	1
Yes - resident able to engage, but did not wish to engage	0	32
Yes - however resident unable to engage with discussion and had no family carer to consult	0	28
Yes - resident unable to engage, but family/ carers were consulted and engaged	164	14
Yes - however, resident unable to engage and family/carer did not wish to engage	24	7
No - resident not given opportunity after 3 months of admission	33	3
No - resident had not completed 3 months admission during audit period	66	5

4.4.2 Challenges to Discussion of Advance Care Preferences

A number of challenges were cited by Nursing Home managers relating to discussing advance care preferences within three months of admission, with four categories of data emerging. These categories were:

a) reluctance of the family
b) resident lacking capacity
c) availability of the GP
d) lack of staff confidence

(a) Reluctance of the Family

This appeared to be the main challenge for nineteen nursing homes. Families felt anxious about discussing the subject and felt that it was too soon to have difficult conversations about end of life care. Families also felt that they needed some time to accustom themselves to the transition of their family member to the nursing home and they needed a settling in period, rather than thinking about end of life care. One nursing home manager commented:

'Families are still very traumatised by making the initial decision to put their relative into care-many are not willing to accept that it will be their final stage of life' (Manager 13).

Another manager commented that the three month period was too soon for residents to think about advance care planning and that feelings of guilt were often present for family members:

'*Residents want time to settle in to a new environment. Don't want to discuss advanced care preferences so soon. Same for the family- also a lot of guilt about the placement' (Manager 17).*

(b) Resident Lacking Capacity

Four homes highlighted that many of their residents were unable to make decisions, or to take part in advance care planning discussions during the first three months of

admission. This created difficulties especially if the family also chose not to engage with these conversations.

'Due to the stage of dementia on admission some residents are unable to discuss their wishes and some family members are reluctant or anxious to engage in advance care planning' (Manager 28).

'For the most part patients are unable to engage and only one family has made an appointment with their GP to discuss their relatives end of life care' (Manager 37).

(c) Availability of the GP

This was seen as a challenge to the advance care planning process by five nursing homes. Lack of time for GP input was seen as a barrier to being able to discuss advance care plans and also to complete the relevant documentation. This was a relevant issue given the role of GPs in nursing homes and in facilitating these sensitive discussions around end of life care preferences.

'*If discussing end of life wishes for resuscitation it can be difficult for the GP to have allocated time to discuss/sign documents' (Manager 19).*

'GPs would appear to be busy at times- to complete same (advance care planning). It depends on practices' (Manager 2).

(d) Lack of Staff Confidence

Three nursing homes reported that staff found it difficult to start conversations about death and dying with residents and families. This reflected a need for staff training to develop the necessary knowledge and skills to be able to initiate these difficult discussions.

'Difficult subject to discuss with families, families not being keen to make advance care decisions' (Manager 26).

'*Staff find it difficult to initiate conversation, GPs not willing to undertake same.' (Manager 38)*

'Staff not confident to have this discussion and often this only occurs when they (residents) become ill-not newly admitted to the nursing home' (Manager 9).

4.5 Guidelines for Palliative Care and Advance Care Planning

During the audit period:

- Twenty-five nursing homes (of 39, 64%) reported that they had a system/policy/guideline in place for palliative care, to document that advance care planning was discussed with the resident with a diagnosis of dementia and or their family/carer(s).
- Twenty one of these 25 nursing homes (84%) reported that the resident with a diagnosis of dementia and or their family/carer(s) did not wish to engage in discussions at that stage.
- Twenty-five nursing homes (of 39, 64%) reported that they had provided residents with a dementia diagnosis and or their family or carers with information explaining their right to engage in advance care planning/best interest discussions.
- Five nursing homes submitted electronic copies of their palliative care policies with their completed proformas.

The proforma asked Nursing Homes to identify within their documentation if key components of advance care planning were included (Table 7).

Table 7: Components of Advance Care Planning within Documentation

Component	Yes	No
Discussing and recording advance care preferences within 3 months of admission	62% (24 of 39)	38% (15 of 39)
Information for staff on making decisions in the person's best interests	69% (27 of 39)	31% (12 of 39)
Information for staff on including the family in the decision making process	69% (27 of 39)	31% (12 of 39)
Information for staff on advance care planning relating to decisions to refuse treatment (including Advance Directive/ Do not attempt Resuscitation Status)	69% (27 of 39)	31% (12 of 39)

4.5.1 Palliative Care Register (PCR)

The presence of a Palliative Care Register (PCR) prompts the GP, staff and key worker to consider the need for an advance care planning discussion, if this has not already taken place. Information about the use of the PCR within nursing homes was captured by the audit. Table 8 shows that several homes used a PCR in relation to caring for people with dementia at end of life.

Table 8: Palliative Care Register

Palliative Care Register	Yes	No
Palliative Care Register in place in which Residents with Dementia included	23% (9 of 39)	77% (30 of 39)
Systems in place to update register	100% (9 of 9)	-
Systems in place to update staff in a timely manner	100% (9 of 9)	-
Key worker identified for Residents with Dementia placed on Palliative Care Register	100% (9 of 9)	-

Nine Nursing Homes (23%) had recorded having a key worker in the documentation of residents with a dementia diagnosis.
NB: One home recorded key worker on residents' documentation and in PCR.

4.5.2 Out of Hours Care

Out of Hours Care Services provide health care for urgent medical problems outside normal surgery hours. In the United Kingdom this is normally 6.30pm-8am on weekdays and all day weekends and Bank Holidays. Twenty-nine nursing homes (74%) had a system/policy/guideline for palliative care in place that included planning for out of hours care.

4.6 Staff Training

Table 9 shows responses in relation to how nursing homes identified the palliative and end of life care learning and development needs of registered nurses and health care assistants, caring for residents with a dementia diagnosis.

Table 9: Identifying Palliative & End of Life Care Learning and Development Needs

Method of Identifying	Registered Nurses	Health Care Assistants
Annual Staff Appraisal	64% (*25)	59% (*23)
Individual Registered Nurse/ Health Care Assistant	82% (*32)	82% (*32)
Nursing Home Manager	77% (*30)	82% (*32)
Regional and National Competencies and Standards	44% (*17)	44% (*17)
Other	3% (*1)	3% (*1)

This question generated more than one response from Nursing Homes and thus the total percentage is not 100%
*N = number of Nursing Homes participating in the audit and not the number of staff members

Table 9 shows that learning and development needs in nursing homes were mainly identified by individual registered nurses or health care assistants (82%). However, 30 homes (77%) reported that learning and development needs were identified by the nursing home manager and although a separate category of response this may also have been through annual staff appraisal. Other, was specified as E-Learning, but no further information was given in relation to how this was used as a method of identifying learning and development needs in palliative and end of life care.

4.6.1 Completed Staff Training

Appendices 5 and 6 illustrate the data collected concerning types of training completed by registered nurses and health care assistants involved in the care of people with dementia, during the three-year period January 2013 to December 2015. This is inclusive of the audit period, but data collected reflect training during the three-year period and indicate if this training was mandatory or non-mandatory, yearly, three yearly or neither. The audit focused on specific training relevant to the objectives of the project in reducing unscheduled hospital admissions for people with dementia from Nursing Homes: These training topics were identified as best practice within the GAIN Guidelines for Palliative and End of Life Care in Nursing Homes.[11] The training topics were:

- Holistic Assessment
- Advance Care Planning
- Communication Skills
- Diagnosing Dying
- Assessment and Management of Symptoms
- Care of the Syringe Driver
- Out of Hours Care
- Feeding and Hydration

As can be seen from the tables in Appendices 5 and 6 there was wide variation across nursing homes and nursing home companies concerning what was viewed as mandatory or non-mandatory training and how frequently this was accessed by staff.

In relation to registered nurses, three homes had missing data and two homes did not report the number of registered nurses they employed. It was apparent that overall, nine homes provided a high level of training with all or almost all registered nurses employed completing training relevant to reducing hospital admissions for people with dementia. The number of beds, designated to people with dementia, in these nine homes ranged from 14-50 beds.

All homes had provided training on assessment and management of symptoms for some of their registered nurses. However, key deficits in training were also noted. Two

homes, who had the largest number of registered nurses (Nursing Home 8, n=20 and Nursing Home 32, n=35) reported that there had been no training provided on care and management of a syringe driver. Nursing Home 8 had 28 beds, designated to people with dementia, and there were 14 beds, designated to people with dementia, in Nursing Home 32. In addition, it was reported that registered nurses in seven homes had not undertaken advance care planning training and those in four homes had not received communication skills training.

There were missing data in relation to training for health care assistants (HCAs). Six homes did not report the number of HCAs employed and three of these homes did not provide data in relation to training of HCAs. Health care assistants in most homes had not had training in out of hours care or care and management of a syringe driver, perhaps as these are not considered key aspects of their role. However, seven homes appeared to have a high level of training with one home providing training, relevant to reducing hospital admissions of people with dementia from Nursing Homes, to all twenty HCAs employed by them. It was noted that HCAs in five homes had not received communication skills training and in five homes, a deficit was noted in training for HCAs in relation to feeding and hydration.

Appendices 5 and 6 also provide individual staff training information by nursing home.

4.7 Access to the Local Specialist Palliative Care Team for support and advice

Thirty five (of 39, 90%) of nursing homes indicated that they had access to their local Specialist Palliative Care Team or Hospice for support and advice in assessment and care planning for residents with a dementia diagnosis.

4.8 Challenges to Anticipating Care Needs

a) Advance care planning discussions are only one aspect of trying to anticipate and prepare for all the needs of patients who may deteriorate during their time in the nursing home and eventually reach the stage of requiring palliative care. Nursing home managers made reference to the need for specialist equipment and prescribing of medication especially during the out of hours' period.

4.8.1 Out of Hours Care

A number of homes highlighted the challenges around having access to equipment as well as necessary medication to avoid unscheduled hospital admissions.

'Availability of syringe driver and needed equipment during out of hours- some difficulty getting medication prescribed in a timely manner' (Manager 27).

Key to out of hours care was having the co-operation of GPs to anticipatory prescribe. This meant anticipating what medication might be needed to ensure this was prescribed and readily available in the Nursing Home, if required. There was a recognised need for support from Out of Hours Services in keeping residents in their home rather than transferring to hospital and this often meant a visit from the Out of Hours Service to prevent a transfer to hospital. The provision of continuous subcutaneous infusion equipment by District Nursing Services was also referenced by Nursing Home managers, as this equipment was difficult to access when needed.

4.9 Enablers to Anticipating Care Needs

Nursing Home managers also identified those factors that they considered acted as enablers to anticipating patients' care needs. These were identified as:

a) Relationships with Primary Care Team and local Hospice/Palliative Care Team
b) Enhancing Knowledge and Skills
c) Identifying Deterioration.

(a) Relationships with Primary Care Team and Local Hospice/Palliative Care Team.

These were viewed as positively influencing anticipation of care needs in Nursing Homes. Examples of good cooperation included support provided in a number of ways such as supply of necessary equipment by primary care teams and specialist advice provided by palliative care teams. Good relationships and communication with local hospices were also seen as enablers to anticipating care needs.

'*Medication is readily prescribed and equipment supplied by District Nurses as required. Good support from District Nurses and palliative care team. Care Home Support Team has been excellent support to care homes'*
(Manager 38).

'Good rapport with local GPs and rapid response team who will ensure that all equipment required is available for the nursing home' (Manager 1).

(b) Enhancing Knowledge and Skills

This was also recognised by homes as being an enabler to anticipating care needs. Nursing Homes highlighted the need for more staff training within the private sector. Some Nursing Home staff accessed training through links with their local Health and Social Care Trust.

'We have e-learning modules and workbooks to help us train our staff with access to (Trust) training sessions' (Manager 17).

The Palliative Care Link Nurse scheme was thought to have had a beneficial input in relation to on-going training for staff. Reflective practice as a team helped with the identification of learning and being able to anticipate care needs. Family and carer education was also recognised as necessary to help families see the benefits of advance care planning and the need to encourage staff to have early conversations about end of life/care preferences in the event of acute episodes of illness:

'*Encourage staff to discuss at time of admission with next of kin and resident, if possible' (Manager 29).*

'Staff training, confidence building and timeframe for Advance Care Planning to be drawn up' (Manager 30).

(c) Identifying Deterioration was a trigger for anticipating care needs and identifying the need to have end of life care discussions with families.

'There is one thing I have identified…with our residents and that is when they become ill, a decline in their general condition. I as home manager arrange to speak with the next of kin and document the resident's wishes in a care plan. If they are not able to discuss their wishes then the next of kin can tell me what their preferences would have been prior to their dementia' (Manager 5).

The importance of an individualised approach to end of life care was recognised in the nursing home setting:

'Different approach is required for each resident and their family dynamic-one size does not fit all' (Manager 13).

5.0 DISCUSSION

Whilst there was a smaller than anticipated response rate (33%, 39/118) of all private nursing homes designated to people with dementia, a regional geographical representation was achieved. The variation of bed size within nursing homes was reflected, as some were part of a large nursing home company whilst others were smaller single homes. The number of dementia beds in responding nursing homes ranged from four (single home) to fifty-six (company home).

5.1 Demographic Information and Preferred Place of Care

Findings showed that 1,388 nursing home residents had a documented dementia diagnosis. Whilst it was recognised that not all Nursing Home residents with dementia have a documented diagnosis it was important in meeting the audit objectives that the data collected was centred on those residents with a definitive documented diagnosis of this condition. The wide range of numbers of residents with dementia (8 - 87) in participating Nursing Homes reflected the variation in bed numbers within the sample.

The majority of the 333 (of 1,388) residents who died during the audit period recorded the nursing home as their preferred place of care (77%, n=257). It was noted that 268 (of 333) died in the nursing home and thus a large number of residents had been enabled to achieve their chosen place of care, which was the nursing home in which they resided. This finding is an example of good practice.

5.2 Hospital Transfers for Residents with Dementia

The main reasons for unscheduled hospital admissions for residents with dementia from Nursing Homes centred on:

- decisions of the GP
- request of the family, or
- the nursing home resident having had a fall.

Limited information was provided in relation to GP decisions to transfer a resident with dementia from the nursing home to hospital. These decisions should be further

explored to identify any areas that could be addressed though forward planning and which would assist in anticipating care needs.[9]

During the audit period, there was a wide range of numbers of hospital transfers, which ranged from 1-5 to over 30. One home reported that they had no hospital transfers during this period. As this was not a chart review, it was not possible for homes to report the reason for each hospital transfer. Nursing homes were asked to report the number of hospital admissions using a range of numbers. Some homes with a large number of beds for people with dementia (56 beds) reported hospital transfers in the lower ranges of numbers (1-5) and other homes, with 52 beds for people with dementia, reported 6-10 hospital transfers. The four homes with the most hospital transfers during the audit period (over 30) had a range of 22-52 beds for people with dementia.

5.3 Advance Care Planning

Almost half of nursing homes which responded to the audit (46%, 18/39) reported that they had assessed all residents with a documented diagnosis, for their capacity to engage in advance care planning discussions, within the first three months of admission. The audit did not seek to determine how nursing homes assessed capacity and so this information is not available. However, examples of good practice have been highlighted within nursing homes during the audit period. One important example of good practice is that whilst only a small number of residents with dementia were able to, or wished to engage with advance care planning, a large number of family/carers were consulted and engaged with best interest discussions, in the majority of homes. Data collected shows that 467 family carers were consulted and engaged in best interest discussions within three months of the resident's admission and 164 family carers participated in this discussion after three months of admission.

Data collected suggested that some confusion appeared to exist around the purpose and content of advance care planning discussions, given that this can focus on when residents could have episodes of deterioration and not just on the end of life phase. Narrative data from open questions in the audit focused on the difficulties that families and staff had in having end of life conversations. These difficulties were identified by

nursing homes as one of the main challenges in relation to discussing advance care preferences within three months of admission.

Reluctance of the family to engage in end of life care discussions, and staff's lack of confidence in initiating such conversations, highlight the need for professional and family/carer education to allow these issues to be addressed. There is evidence that health care professionals who are able to demonstrate knowledge and expertise, can more effectively initiate discussions with family/carers of people with dementia and facilitate decision making in relation to best interest decisions.[16]

Livingstone et al[17] noted that family/carers need a whole family approach to consultation and will require some reassurance following a best interest decision. Some nursing homes felt that the three month timeframe for taking part in advance care planning/best interest decisions was too soon for families as they were still adjusting to their loved one being in care. Many of the residents admitted to nursing homes had lost capacity to take part in advance care planning meaning that discussions should perhaps be offered at an earlier stage of the disease, possibly by the Primary Health Care Team. An early discussion within the nursing home should also be focused on building trust with families. Nursing home staff should demonstrate a willingness to listen to and hear the views of residents and families, in order to build an on-going relationship prior to the need for further more sensitive conversations. Sixty-four per cent (25 of 39) of Nursing Homes identified system/policy/guideline for palliative care in place to document that advance care planning was discussed. Of these nursing homes 84% (21 of 25) identified that the resident and or family did not wish to engage in discussions at that stage. It is noteworthy that 64% (25 of 39) of nursing homes demonstrated an example of good practice through providing information on advance care planning for residents with dementia and information for families on best interest decision making. This example of good practice should be shared with other nursing homes.

5.4 Palliative Care Register and Out of Hours Care

A Palliative Care Register (PCR) within nursing homes was an initiative promoted within the GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Care Homes,[11] as a means of identifying and recognising residents

requiring end of life care. PCRs were originally initiated within GP Practices as advocated by the National Gold Standards Framework for End of Life Care, but in line with the GAIN guidelines[11] the audit focused on a PCR within the nursing homes.

Nursing homes taking part in the audit were asked if they held a PCR in which residents with a documented dementia diagnosis would have been included. Nine Nursing Homes (23%) reported that they held a PCR in which residents with dementia were included. These nine homes also reported that they had identified a key worker for residents with dementia placed on the PCR. The importance of dementia being recognised as a condition requiring palliative and end of life care has been demonstrated at a European level.[18] In this context, out of hours care is important in relation to reducing unscheduled hospital admissions. It was noted that 74% (29/39) of Nursing homes had out of hours Care included in their system/policy /guidelines for palliative care.

5.5 Staff Training

Data collected from participating Nursing Homes in relation to training for registered nurses and health care assistants focused on key aspects of palliative and end of life care evidenced to reduce hospital admissions. These aspects are listed as:

- Holistic Assessment
- Advance Care Planning
- Communication Skills
- Diagnosing dying
- Assessment and Management of Symptoms
- Care of the Syringe Driver
- Out of Hours Care
- Feeding and Hydration.

This was not a full training needs analysis; however, it sought to collect data from the previous three years in relation to the training undertaken in these key aspects of palliative care. There was wide variation across nursing homes and nursing home companies relating to what was considered to be mandatory or non-mandatory training

and how much and how frequently training on these aspects of palliative and end of life care were accessed by staff. Whilst a high level of training was apparent in nine homes, deficits in training were apparent in other homes, such as where two homes with the largest number of registered nurses had provided no training on care and management of a syringe driver, which is an important end of life care clinical skill to maintain. Findings from the audit suggest a need for regional standardisation of palliative and end of life care education and training for nursing homes, to coincide with the already existing accessible modes of education.

Ninety per cent of Nursing Homes (35 of 39) reported being able to access their local specialist palliative care team or hospice for support and advice. It is recognised that this partnership and joint working also promotes learning and development in clinical practice.

5.6 Challenges and Enablers to Anticipating Care Needs

The final two questions of the audit proforma focused on the perceived challenges and enablers to anticipating care needs as experienced by nursing homes. Although there was potential for this term to be seen solely as advance care planning, responses mainly indicated that Nursing Homes appeared to see this term as anticipating care needs of those approaching end of life, with advance care planning as a key part of this. Challenges to caring for residents at home, included ensuring the availability of needed equipment such as the continuous subcutaneous infusion equipment (syringe driver), sometimes obtained from the District Nursing Service, and the co-operation of GPs in relation to timely anticipatory prescribing.

One of the key enablers of anticipating care needs was highlighted as Nursing Homes having a strong relationship with the Primary Care Team and the Specialist Palliative Care Team/local Hospice, which were considered to be positive influences and a source of support. Central to this was the building of good relationships and ensuring good communication across services.

Enhancing the knowledge and skills of staff were also seen as an enabler for anticipation of care needs and in addressing the issue of training for Nursing Homes in the private sector. Some Nursing Homes participated in accessible modes of training

delivered through e-learning by their local HSCT. Others had experience of using the Palliative Care Link Nurse Programme and team reflective practice sessions, which were both valued in relation to learning and development. Clarification around the process of advance care planning, and its role as a tool for relationship and trust building, may help boost staff confidence. If staff have an understanding of the process in helping individuals and families prepare for the challenges of living with growing frailty, rather than simply prepare for end of life, they may feel more empowered to engage in these important discussions.

Education for family/carers about palliative and end of life care and the benefits of having sensitive conversations about increasing frailty, death and dying were also recognised by nursing homes as enablers to anticipating needs and advance care planning. Family/carer education has the potential to diffuse some of the anxiety and fear which family/carers experience about having conversations about end of life and could help their readiness to take part in best interest decisions.[19, 20]

6.0 KEY MESSAGES

There were a total of 1,388 residents who had a documented dementia diagnosis with wide variation in numbers across nursing homes. Findings relating to the audit period highlight some examples of good practice but also a number of areas for development:

6.1 Good Practice

- The majority of residents who died (257 of 333) had their preferred place of care at end of life recorded as the Nursing Home in which they were residing.

- Of the 333 residents' deaths recorded with a dementia diagnosis, eighty per cent (268 of 333) took place in Nursing Homes with 65 (20%) occurring in hospital.

- The majority of Nursing Homes engaged with family/carers in discussions around advance care planning/best interest discussions within three months of admission.

6.2 Areas for Development

- There is a wide range of variation in palliative and end of life care training across Nursing Homes suggesting a need for regional standardisation and accessibility of training.

- Some confusion appears to exist amongst nursing home staff about the role of palliative care and advance care planning in living well with dementia. Perceptions are that these processes focus simply on end of life care, which indicates a need for further staff training.

- A need for more family/carer education to promote readiness for best interest discussions at end of life.

- Challenges and enablers to anticipating care needs in nursing homes caring for people with a dementia diagnosis have been identified.

7.0 CONCLUSIONS

This audit project aimed to reduce hospital admissions of people with dementia in nursing homes through anticipating the care needs of residents. A retrospective regional audit of nursing homes (118) designated to people with dementia in Northern Ireland (audit period: January 2015-December 2015) was undertaken to assess if recognised evidenced based strategies to anticipate the care needs of residents were in place. Although there was a low response rate 33% (39/118) regional geographical representation was achieved and the findings provide insights relevant to the aim and objectives of this project. Findings indicate that during this audit period, the majority of residents died in the nursing home and that the majority of residents had the nursing home recorded as their preferred place of care at end of life. Although hospital transfers of residents with dementia occurred, reasons for this have been suggested, as have challenges and enablers to anticipating the care needs of residents with dementia in nursing homes. Although some examples of good practice are present, the findings also highlight areas for development. Central to this is training for both staff and family carers.

8.0 RECOMMENDATIONS

Based on the audit findings three recommendations were made:

- Training for staff working in nursing homes should be standardised and made more accessible. It should include the role of palliative care and advance care planning in living well with dementia throughout the disease trajectory.

- Family/carer education to prepare family carers to participate in best interest discussions should be developed and evaluated.

- A regional chart review of homes designated to people with dementia in Northern Ireland, to assess how strategies to reduce hospital admissions of people with dementia have been implemented in practice should be undertaken.

Project Team

Name	Designation	Organisation
Dr Dorry McLaughlin (Project Lead)	Lecturer in Palliative Care & Chronic Illness	School of Nursing & Midwifery, Queen's University, Belfast
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Linda Graham	Nursing Home Manager	Four Seasons Health Care
Rema Borland	Oncology and Palliative Care Facilitator for Nursing Homes	Belfast Heath and Social Care Trust
Lesley Nelson	Community Specialist Palliative Care Physiotherapist	South Eastern Health and Social Care Trust

Regional Advisory/Steering Team

Name	Designation	Organisation
Lorraine Kirkpatrick	Regional Manager	Four Seasons Health Care
John Rafferty	Northern Ireland Operational Director	Runwood Homes Ltd;
Chris Walsh	Business Support Manager	Larchwood Care Homes and Care Circle Homes
Oonagh Grant	Nursing Home Manager	Glencarron Private Nursing Home
Lesley Rutherford	Nurse Consultant in Palliative Care	Marie Curie Hospice, Belfast, Belfast Health & Social Care Trust and Queen's University, Belfast
Joanne Ballentine	Project Lead for Hospice Enabled Dementia Partnerships Project	Northern Ireland Hospice
Gordon Kennedy	Family Carer and Service User	Not Applicable
Siobhan Crilly	Regional Clinical Audit Facilitator	Regulation and Quality Improvement Authority

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APPENDIX 1: Audit Proforma

Reducing Hospital Admissions of People with Dementia from Nursing Homes: The Role of Anticipatory Care Planning Audit.
Audit Period for this proforma - January 2015 - December 2015**

Dear Participant,

Thank you for participating in Phase 1 of project entitled:

'Reducing Hospital Admissions of People with Dementia in Nursing Homes - The Role of Anticipatory Care Planning'

The Audit period for this project relates to January 2015 to December 2015**.

Important information to be aware of when completing the proforma:

- Proforma should be accessed through one pc/laptop/device only.
- If for any reason you cannot complete the proforma in one sitting please remember when returning to the link to use the same pc/laptop or device you originally used to open it.
- You can save your responses as you progress through the proforma, but REMEMBER only fully completed pages i.e. pages where you have clicked 'Next' will be saved. Do not stop midway through a page or the information will not be saved.
- Once you have completed the proforma click on 'Done' and it will automatically be forwarded to the Project Team.
- You will not be able to revisit the proforma once it has been submitted.

By clicking "Next" and completing the proforma you are giving your consent for the information provided to be included in this project.

Please click "Next" to complete the proforma.

Reducing Hospital Admissions of People with Dementia from Nursing Homes: The Role of Anticipatory Care Planning Audit.
Audit Period for this proforma - January 2015 - December 2015**

Demographic Information

* 1. Please provide the name and address and geographical HSC Trust Area the nursing home is located in e.g. SEHSCT
(Please note: On receipt of the completed proforma each nursing home will be assigned a unique ID by the QUB project team).

Name:	
Address:	
Located within which geographical HSC Trust Area e.g. SEHSCT:	

* 2. Please provide your designation within the nursing home:
Designation/ Role:

* 3. Please provide your name and email:
(Please note QUB Project Team will only contact you if clarification of information is required)

Name:

Email:

Reducing Hospital Admissions of People with Dementia from Nursing Homes: The Role of Anticipatory Care Planning Audit.
Audit Period for this proforma - January 2015 - December 2015**

* 4. During the audit period** how many residents with a documented dementia diagnosis recorded were resident in your nursing home? Please provide the number below:

* 5. During the audit period** how many of these residents with a documented dementia diagnosis died? Please provide the number below: (If none please indicate below)

* 6. During the audit period** please indicate the actual place of death and thenumber of residents with a diagnosis of dementia to which this relates? Please complete the table below:

N/A - No deaths recorded during the audit period	
Number who died within Nursing Home	
Number who died within Hospital	
Number who died within Hospice	
Number who died within Own/ Family Home	
Not recorded (specify number)	
Other (specify other and the number this relates to)	

* 7. During the audit period** of those residents with a diagnosis of dementiathat died we would like to know the number who had their preferred place of care at the end of life recorded Please indicate in the appropriate boxes below the preferred place of care at end of life which residents had chosen. If not recorded please also tell us the number of residents to which this relates in the "not recorded" box below:

N/A - No deaths recorded during the audit period	
Number preferred place: Nursing Home	
Number preferred place: Hospital	
Number preferred place: Hospice	
Number preferred place: Own/ Family Home	
Not recorded (specify number)	
Other (specify other and number this relates to)	

* 8. In general (not related to the audit period) what would you say are the main reasons for a resident with a dementia diagnosis to be transferred to hospital? Please tick all boxes below that apply:

- [ ] Required medication either not available or not prescribed
- [ ] Necessary equipment not available e.g. syringe driver
- [ ] Lack of staff training in palliative and end of life care
- [ ] Lack of staff training in other aspects of care
- [ ] Pneumonia, influenza or other infection/ viral illness
- [ ] Injuries due to a fall
- [ ] Insufficient staff to monitor unwell patient in a satisfactory way
- [ ] Unexplained deterioration in health
- [ ] Request of the family
- [ ] Decision of GP
- [ ] Other (please specify)

* 9. During the audit period** what would you say were the 3 most common reasons for residents with a dementia diagnosis to be transferred to hospital? Please select only 3 by ticking the appropriate boxes below:

- [ ] Required medication either not available or not prescribed
- [ ] Necessary equipment not available e.g. syringe driver
- [ ] Lack of staff training in palliative and end of life care
- [ ] Lack of staff training in other aspects of care
- [ ] Pneumonia, influenza or other infection/ viral illness
- [ ] Injuries due to a fall
- [ ] Insufficient staff to monitor unwell patient in a satisfactory way
- [ ] Unexplained deterioration in health
- [ ] Request of the family
- [ ] Decision of GP
- [ ] Other (please specify)

* 10. In Q8 or Q9, if you selected 'lack of staff training in other aspects of care' please specify which aspects of care to which you are referring: If not applicable to you enter N/A in box below

* 11. During the audit period** please indicate the number of hospital transfers from your nursing home that involved residents with a dementia diagnosis.

- ( ) None
- ( ) 1-5
- ( ) 6-10
- ( ) 11-15
- ( ) 16-20
- ( ) 21-25
- ( ) 26-30
- ( ) More than 30

Advance Care Planning

(Advance Care Planning: the voluntary process of discussion with residents and or families/carers

to make clear their wishes and thoughts for the future).

* 12. During the audit period** were all residents with a documented dementia diagnosis assessed for their capacity to engage in advance care planning discussions within the first 3 months of admission?

- ◯ Yes
- ◯ No

* 13. During the audit period** were all residents with a documented dementia diagnosis given the opportunity to engage in advance care planning/ or their families/carers given the opportunity to engage in best interest discussions within the first 3 months of admission? Please indicate the number in the appropriate box below:

Yes - resident was able to engage were given the opportunity within 3 months of admission	
Yes - resident was able to engage in discussion however did not wish to engage	
Yes - however resident unable to engage with discussion and had no family/carer(s) to consult	
Yes - resident unable to engage, but family/carer(s) were consulted and engaged	
Yes - however, resident unable to engage and family/carer(s) did not wish to engage	
No - resident not given opportunity within 3 months of admission	
No - resident had not completed 3 months admission during audit period	

* 14. During the audit period** if advance care planning discussions werenot held within first 3 months of admission were they later held for residents with a documented dementia diagnosis? Please indicate number in appropriate box below:

Yes - resident was able to engage and given the opportunity after 3 months of admission	
Yes - resident was able to engage however did not wish to engage	
Yes - resident unable to engage and had no family/carer(s) to consult	
Yes - resident unable to engage, but family/carer(s) consulted and engaged	
Yes - resident unable to engage and family/carer(s) did not wish to engage	
No - resident not given opportunity after 3 months of admission	
No - resident had not completed 3 months admission during audit period	
Advance care preferences had been recorded within first 3 months of admissior	

* 15. Please tell us in the box below what challenges your nursing home faces when discussing advance care preferences within 3 months from admission?

* 16. During the audit period** did your nursing home have a system/policy/guideline for palliative care in place to document that advance care planning was discussed with the resident or family/carer(s) of a resident with a documented diagnosis of dementia? Please tick the appropriate box below:

- ◯ Yes
- ◯ No

* 17. During the audit period** did your nursing home have a system/policy/guideline for palliative care in place to document that advance care planning was discussed, but the resident with a dementia diagnosis or the family/carer(s) did not wish to engage in discussion at that stage. Please tick the appropriate box below:

- ◯ Yes
- ◯ No

If YES to Q16 and Q17 please provide Dorry McLaughlin with a copy of this policy/guideline. Contact details can be found at the end of this proforma or on the accompanying letter sent with the link to the proforma.

* 18. During the audit period** did your nursing home provide those residents with a dementia diagnosis and or/ their families/carer(s) with information explaining their right to engage in advance care planning/best interests discussions?

- ◯ Yes - resident and/or family/carer(s) were provided with information
- ◯ No - residents and/or family/carer(s) were not provided with information

* 19. During the audit period** did your nursing home system /policy/ guideline include the following aspects relating to advance care planning? Please tick the appropriate box below for each of these aspects of advance care planning:

The need to discuss and record advance care preferences within 3 months of resident's admission (e.g. record of wishes, preferred place of care at end of life)?	
Information for staff on making decisions in the person's best interests, i.e. residents previously known wishes, where it is not possible to include the person in decisions regarding their care (e.g. where they are unable to communicate)?	
Information for staff on including the family in the decision making process?	
Information for staff on advance care planning relating to decisions to refuse treatment (including - Advance Directive/ Do not attempt Resuscitation status)?	

Reducing Hospital Admissions of People with Dementia from Nursing Homes: The Role of Anticipatory Care Planning Audit.
Audit Period for this proforma - January 2015 - December 2015**

Palliative Care Register (PCR) and Out of Hours Care

* 20. During the audit period** did your nursing home hold a palliative care register (PCR) in which residents with a documented dementia diagnosis would have been included? Please tick the appropriate box below:

- ◯ Yes
- ◯ No

* 21. If yes, were there systems in place to ensure that the palliative care register (PCR) was updated as and when required? Please tick the appropriate box below:

- ◯ Yes
- ◯ No
- ◯ N/A as no PCR available

22. If yes, were there systems in place to ensure that the updated information in the palliative care register (PCR) was communicated to staff in a timely manner? Please tick the appropriate box below:

- ◯ Yes
- ◯ No
- ◯ N/A as no PCR available

* 23. During the audit period** was a 'key worker' identified for residents with a documented dementia diagnosis who were placed on the palliative care register(PCR)? Please tick the appropriate box below:

- ◯ Yes
- ◯ No
- ◯ N/A as no PCR available

* 24. During the audit period** did your nursing home record 'key worker' on the documentation of a resident with a dementia diagnosis and/or on palliative care register (PCR)? Please tick the appropriate box below:

- [ ] Yes recorded on residents documentation
- [ ] Yes recorded on residents PCR
- [ ] No not recorded on residents documentation
- [ ] Not recorded on residents PCR
- [ ] N/A as no PCR available for resident

* 25. During the audit period** did your nursing home have a system/policy/guideline for palliative care in place to ensure planning for out of hours care? Please tick the appropriate box below:

- ( ) Yes
- ( ) No

Training relating to staff involved in the care of residents with a documented dementia diagnosis

* 26. How does your nursing home identify the palliative and end of life care learning and development needs of registered nurses who care for residents with a dementia diagnosis? Please tickall of the appropriate box(es) below:

- [ ] Annual staff appraisal
- [ ] Learning needs identified by the individual registered nurse
- [ ] Learning needs identified by the nursing home manager
- [ ] Learning needs assessed taking account of regionally and nationally agreed competencies or standards
- [ ] Not identified
- [ ] Other (please specify)

* 27. How does your nursing home identify the palliative and end of life care learning and development needs of healthcare assistants who care for residents with a dementia diagnosis? Please tickall of the appropriate box(es) below:

- [ ] Annual staff appraisal
- [ ] Learning needs identified by the individual health care assistants
- [ ] Learning needs identified by the nursing home manager
- [ ] Learning needs assessed taking account regionally and nationally agreed competencies or standards
- [ ] Not identified
- [ ] Other (please specify)

* 28. Please indicate the number of registered nurses (RN), involved in the care of residents with dementia, who have completed training during the three year period (January 2013 – December 2015), on the following palliative and end of life care topics as appropriate to their role and scope of practice:

Principles of holistic assessment - please indicate the number of RN this applies to

Advance Care Planning - please indicate the number of RN this applies to

Communication Skills - please indicate the number of RN this applies to

Identifying and diagnosing the deteriorating and dying person - please indicate the number of RN this applies to

Assessing and managing common symptoms at end of life - please indicate the number of RN this applies to

Care and management of a syringe driver - please indicate the number of RN this applies to

Out of Hours Care - please indicate the number of RN this applies to

Feeding and hydration - please indicate the number of RN this applies to

Other (please specify other and the number of RN this relates to)

* 29. With regards to the identified training completed byregistered nurses during the three year period (January 2013 – December 2015), click on the drop down boxes below to indicate if the training was mandatory or non-mandatory, and if it was yearly, three yearly or neither:

	Was this training: mandatory/non- mandatory/neither/N/A	Was this training: yearly/three yearly/neither/N/A
Principles of holistic assessment		
Advance Care Planning		
Communication Skills		
Identifying and diagnosing the deteriorating and dying person		
Assessing and managing common symptoms at end of life		
Care and management of a syringe driver		
Out of Hours Care		
Feeding and hydration		
Other (as specified in Q28)		

* 30. Please indicate the number of healthcare assistants (HCA), involved in the care of residents with dementia, who have completed training during the three year period (January 2013 – December 2015), on the following palliative and end of life care topics as appropriate to their role and scope of practice:

Principles of holistic assessment - please indicate the number of HCA this relates to

Advance Care Planning - please indicate the number of HCA this relates to

Communication Skills - please indicate the number of HCA this relates to

Identifying and diagnosing the deteriorating and dying person - please indicate the number of HCA this relates to

Assessing and managing common symptoms at end of life - please indicate the number of HCA this relates to

Care and management of a syringe driver - please indicate the number of HCA this relates to

Out of Hours Care - please indicate the number of HCA this relates to

Feeding and hydration - please indicate the number of HCA this relates to

Other (please specify other and number of HCA this relates to)

* 31. With regards to the identified training completed by healthcare assistants during the three year period (January 2013 – December 2015), click on the drop down boxes below to indicate if the training was mandatory or non-mandatory, and if it was yearly, three yearly or neither:

	Was this training: mandatory/non-mandatory/neither/N/A	Was this training: yearly/three yearly/neither/N/A
Principles of holistic assessment		
Advance Care Planning		
Communication Skills		
Identifying and diagnosing the deteriorating and dying person		
Assessing and managing common symptoms at end of life		
Care and management of a syringe driver		
Out of Hours Care		
Feeding and hydration		
Other (as specified in Q30)		

* 32. Please indicate, in categories below, the number of staff who were employed during the audit period** in the care of residents with dementia diagnosis? Please enter number(s) only in response

Full time Registered Nurses	
Part time Registered Nurses	
Full time healthcare assistants	
Part time healthcare assistants	

* 33. During the audit period** did staff in your nursing home, and other members of the multi-disciplinary team, have access to the 'local specialist palliative care team' for support and advice in their assessment and care planning for residents with a dementia diagnosis? Please tick the appropriate box below:

- ◯ Yes
- ◯ No

* 34. Have you identified any challenges in implementing anticipatory care planning for residents with dementia in the nursing home setting (e.g. training for staff, advance care planning within 3 month period of admission, out of hours care, ensuring as needed medication is prescribed and equipment available etc)? Please identify these below:

* 35. Have you identified anything which enables anticipatory care planning to be implemented for residents with dementia in the nursing home setting (e.g. training for staff, advance care planning within 3 month period of admission, out of hours care, ensuring as needed medication is prescribed and equipment available etc.)? Please identify these below:

<u>If you responded "yes" to Q16 and Q17</u> Please forward by email a copy of the advance care plan to: d.mclaughlin@qub.ac.uk
Dorry McLaughlin contacts details can also be found on the letter containing the link to this online proforma.

THANK YOU

Thank you for your participation in Phase 1 of this project:

'Reducing Hospital Admissions of People with Dementia from Nursing Homes: The Role of Anticipatory Care Planning Audit'.

Please click "Done" button below and your completed proforma will be automatically forwarded.

APPENDIX 2: Best Practice Statements Mapped to Proforma from GAIN Guidelines for Palliative and End of Life Care in Nursing Homes (2013) Best Practice Statements Mapped to Audit Proforma

STANDARDS **MAPPED TO PHASE 1 PROFORMA**

If criteria refer to detail given in other standards (e.g. local protocols/guidelines), please attach a copy of these standards or provide a website reference

	Criteria	Target (%)	Exceptions	Evidence	Instructions for where to find data
1	• The home holds a palliative care register and has a system in place to ensure that this is updated regularly and communicated to staff in a timely manner • Inclusion on the palliative care register prompts the GP, staff in the home and the key worker to consider the need for an advance care planning discussion, if this has not already taken place.	100%		*(Mapped to Q.20, 21, 22, 23 & 24)* p.16 Best Practice 1 p.16 Best Practice 9	Guidelines and Audit Implementation Network (2013) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes
2	• Every resident is given the opportunity to develop an advance care plan within three months of admission. • This includes the opportunity to discuss their wishes including their preferred place of care at the end of life.	100%	Resident has advanced dementia and is unable to participate in advance care planning	*(Mapped to Q12, 13, 14, 15, 16, 17, 18, 19)* p.16 Best Practice 9 p.25 Best Practice 4	Guidelines and Audit Implementation Network (2013) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes

Criteria		Target (%)	Exceptions	Evidence	Instructions for where to find data
3	• Where it is not possible to include the person in decisions regarding their care (e.g. were they are unable to communicate), decisions will be made in their best interests and their previously known wishes will be taken into consideration. • The family will be included in the decision making process.	100%	Resident has no family members nor significant others	*(Mapped to Q12, 13, 14, 15, 16, 17, 18, 19)* p.17 Best Practice 3	Guidelines and Audit Implementation Network (2013) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes
4	• Where the person is considered to be definitely in the last months or weeks of life, staff in the home will liaise with the GP to ensure there is written information available within the home regarding the person's Do Not Attempt Resuscitation Status. • Out of Hours handover form is completed. • Unnecessary medication is discontinued and alternative anticipatory medication prescribed and available when appropriate.	100%		*(Mapped to Q19, 25, 34, 35)* p.17 Best Practice 10 p.34 Best Practice 4	Guidelines and Audit Implementation Network (2013) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes

Criteria		Target (%)	Exceptions	Evidence	Instructions for where to find data
5	• The GP completes a handover form to advise out of hours and ambulance services which includes decisions from the advance care plan and any advance decision to refuse treatment/do not attempt cardiopulmonary resuscitation status.	100%		*(Mapped to Q19, 25, 34, 35)* p.26 Best Practice 8	Guidelines and Audit Implementation Network (2013) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes
6	• Staff in the home, the GP and other members of the multidisciplinary and specialist palliative care teams work together as appropriate to plan care. • The person (if appropriate) and/or their family are involved in the decision making processes. The plan of care includes: – All unnecessary medications are discontinued – Anticipatory prescribing- subcutaneous medications necessary to manage common end of life symptoms are prescribed on a PRN basis	100%		*(Mapped to Q33, 34, 35)* p.34 Best Practice 4	Guidelines and Audit Implementation Network (2013) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes

	Criteria	Target (%)	Exceptions	Evidence	Instructions for where to find data
7	• Based on the Palliative and End of Life Competency Assessment Tool (HSC, 2012) palliative and end of life care education should include: – Principles of holistic assessment – Communication Skills – Advance Care Planning – Identifying and diagnosing the deteriorating and dying person – Managing common symptoms at end of life – Management of a syringe driver • Staff know who on the team has the knowledge, skills and competence to sensitively and appropriately initiate an advance care plan discussion with residents and their families	100%		*(Mapped to Q26, 27, 28, 29, 30, 31, 32)* p.42 Section 7.2 Bullet points p.25 Best practice 3	Guidelines and Audit Implementation Network (2013) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes

Appendix 3: Number of Hospital Transfers of Residents with Dementia

Audit ID of Nursing Home	Number of Hospital Transfers	Number of Dementia Beds
NH 1	1-5	16
NH 2	6-10	42
NH 3	16-20	28
NH 4	1-5	20
NH 5	6-10	52
NH 6	6-10	21
NH 7	>30	38
NH 8	1-5	28
NH 9	11-15	10
NH 10	11-15	14
NH 11	21-25	32
NH 12	6-10	32
NH 13	16-20	39
NH 14	6-10	22
NH 15	1-5	14
NH 16	6-10	22
NH 17	16-20	45
NH 18	11-15	39
NH 19	1-5	20
NH 20	16-20	24
NH 21	0	26
NH22	6-10	29
NH 23	1-5	56
NH 24	16-20	30
NH 25	>30	35
NH 26	11-15	56
NH 27	1-5	4
NH 28	1-5	20
NH 29	>30	52

NH 30	26-30	33
NH 31	1-5	50
NH 32	1-5	14
NH 33	16-20	43
NH 34	16-20	30
NH 35	1-5	31
NH 36	6-10	14
NH 37	6-10	4
NH 38	1-5	8
NH 39	>30	22

APPENDIX 4:

Descriptive Outline of Nursing Homes (n=39) Who Responded to the Regional Audit

Number of Nursing Home	Geographical Region	Number of Beds (Number of dementia beds)	Company or Single Home
Nursing Home 1	WHSCT Region	44 (16 –Dementia)	Company
Nursing Home 2	NHSCT Region	72 (42 - Dementia)	Company
Nursing Home 3	BHSCT Region	43 (28 –Dementia)	Company
Nursing Home 4	SHSCT Region	40 (20 –Dementia)	Company
Nursing Home 5	SEHSCT Region	52 (52 - Dementia)	Company
Nursing Home 6	WHSCT Region	55 (21 –Dementia)	Company
Nursing Home 7	SEHSCT Region	75 (38 –Dementia)	Company
Nursing Home 8	BHSCT Region	60 (28 –Dementia)	Company
Nursing Home 9	SEHSCT Region	56 (10- Dementia)	Company
Nursing Home 10	SHSCT Region	63 (14- Dementia)	Company
Nursing Home 11	WHSCT Region	66 (32- Dementia)	Company
Nursing Home 12	SHSCT Region	63 (32- Dementia)	Company
Nursing Home 13	SHSCT Region	60 (39- Dementia)	Company
Nursing Home 14	SEHSCT Region	22 (22- Dementia)	Company
Nursing Home 15	BHSCT Region	27 (14- Dementia)	Company
Nursing Home 16	WHSCT Region	58 (22- Dementia)	Company
Nursing Home 17	BHSCT Region	45 (45- Dementia)	Company
Nursing Home 18	WHSCT Region	81 (39- Dementia)	Company
Nursing Home 19	NHSCT Region	44 (20- Dementia)	Single Home
Nursing Home 20	SHSCT Region	53 (24- Dementia)	Company
Nursing Home 21	WHSCT Region	52 (26- Dementia)	Single Home
Nursing Home 22	NHSCT Region	43 (29- Dementia)	Single Home
Nursing Home 23	BHSCT Region	76 (56- Dementia)	Company
Nursing Home 24	BHSCT Region	30 (30- Dementia)	Single Home
Nursing Home 25	SEHSCT Region	35 (35- Dementia)	Single Home
Nursing Home 26	WHSCT Region	64 (56- Dementia)	Company
Nursing Home 27	NHSCT Region	52 (4- Dementia)	Single Home
Nursing Home 28	SHSCT Region	48 (20- Dementia)	Single Home
Nursing Home 29	NHSCT Region	64 (52- Dementia)	Company
Nursing Home 30	SHSCT Region	71 (33- Dementia)	Company
Nursing Home 31	WHSCT Region	81 (50- Dementia)	Company
Nursing Home 32	NHSCT Region	67 (14- Dementia)	Company
Nursing Home 33	WHSCT Region	43 (43- Dementia)	Company
Nursing Home 34	NHSCT Region	83 (30- Dementia)	Single Home
Nursing Home 35	NHSCT Region	62 (31- Dementia)	Company
Nursing Home 36	SHSCT Region	41 (14- Dementia)	Company
Nursing Home 37	SHSCT Region	44 (4- Dementia)	Single Home
Nursing Home 38	SHSCT Region	26 (8- Dementia)	Company
Nursing Home 39	NHSCT Region	66 (22- Dementia)	Company

Source: Regulation & Quality Improvement Authority

Regional Representation of Nursing Homes who Responded to Phase 1

Geographical Region	Number of Homes who Responded to Phase 1
NHSCT Region	9
SEHSCT Region	5
BHSCT Region	6
SHSCT Region	10
WHSCT Region	9

APPENDIX 5: Training for Registered Nurses During 3 Year Period: January 2013- December 2015

No. of NH	No of RNs*	Holistic Assessment	Advance Care Planning	Communication Skills	Diagnosing Dying	Assessment/ Management of Symptoms	Care of Syringe Driver	Out of Hours Care	Feeding & Hydration	Other
NH 1	5	8 (NM/3Y)	6 (NM/3Y)	8 (NM/3Y)	0 NM/NA)	8 (NM/3Y)	8 NM/NA)	0 (NA)	8 (M/Y)	0
NH 2	14	0 (NA)	0 (NA)	0 (NA)	2 (NA)	2 (N)	2 (N)	0 (N)	0 (M/N)	0
NH 3	8	8 (M/3Y)	8 (M/Y)	8 (M/Y)	8 (M/Y)	8 (M/Y)	8 (M/Y)	8 (M/Y)	8 (M/Y)	0
NH 4	10	0 (NA/Y)	0 (NM/Y)	10 (NA/3Y)	10(NM/Y)	10 (NM/Y)	10 (NM/Y)	10(NM/Y)	10(M/Y)	0
NH 5	9	3 (NM/N)	2 (NM/N)	3 (NM/N)	9 (M/N)	9 (NM/N)	3 (NM/N)	9 (NM/N)	9 (M/Y)	0
NH 6	8	8 (M/N)	8 (M/N)	8 (M/N)	8 (M/N)	8 (M/N)	8 (M/N)	8 (M/N)	8 (M/N)	0
NH 7	6	5 (M/Y)	0 (NM/Y)	5 (NM/Y)	5 (M/Y)	5 (M/Y)	1 (NM/Y)	0 (NM/Y)	2 (M/Y)	0
NH 8	20	6 (M/Y)	6 (M/Y)	6 (M/Y)	6 (M/Y)	6 (M/Y)	0 (NM/Y)	6 (NM/Y)	6 (M/Y)	0
NH 9	8	2 (NM/N)	2 (NM/N)	4 (NM/N)	2 (NM/N)	2 (NM/N)	5 (NM/N)	0 (NA)	0 (NA)	0
NH 10	4	0 (NA)	5 (NM/Y)	0 (NA)	5 (M/Y)	5 (M/Y)	2 (N)	5 (M/N)	4 (NM/N)	0
NH 11	8	7 (NA)	0 (NM/N)	0 (NA)	7 (NM/N)	7 (M/Y)	4 (NM/N)	0 (NA)	7 (M/Y)	0
NH 12	6	5 (NM/N)	5 (NM/N)	5 (NM/N)	5 (NM/N)	6 (NM/N)	2 (NM/N)	0 (NA)	5 (NM/N)	0
NH 13	7	3 (M/N)	0 (NA)	0 (NA)	3 (M/N)	3 (M/N)	4 (NM/Y)	0 (NA)	0 (NA)	0
NH 14	Missing	12 (M)	12 (NM)	12(NM)	12(NM)	12(NM)	12(NM)	12(NM)	12(NM)	0
NH 15	4	0 (NM/N)	3 (NM/Y)	3 (NM/Y)	4 (NM/Y)	4 (NM/Y)	4 (NM/Y)	2 (NM/Y)	4 (NM/Y)	0
NH 16	9	2 (NM/3Y)	2 (NM/Y)	10(M/N)	2 (NM/N)	2 (NM/N)	9 (NM/N)	9 (NM/N)	10(M/N)	0
NH 17	12	11 (M/Y)	11(M/Y)	11(M/Y)	11(M/Y)	11(M/Y)	2 (NM/N)	0 (NM/N)	11(M/Y)	0
NH 18	14	12 (NM/3Y)	0 (NM/3Y)	12(NM/Y)	12(NM/Y)	12(NM/Y)	12(M/Y)	12(M/Y)	12(M/Y)	0
NH 19	1	6 (NM/NA)	6 (NM/NA)	6 (NM/NA)	6 NM/NA)	6 (NM/NA)	6 NM/NA)	6 (NM/NA)	6 (NM/NA)	6*(NM/NA)
NH 20	17	17 (M/3Y)	17(M/3Y)	17(M/3Y)	17(M/3Y)	17(M/3Y)	17(M/3Y)	17(M/3Y)	17(M/3Y)	0
NH 21	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing
NH 22	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing
NH 23	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing
NH 24	11	1 (NM/N)	1(NM/N)	1(NM/N)	1 (NM/N)	1 (NM/N)	8 (NM/Y)	1 (NM/N)	1 (NM/N)	0
NH 25	13	9 (M/Y)	10(M/Y)	10(M/Y)	10(M/Y)	10(M/Y)	5 (M/Y)	10(M/Y)	10(M/Y)	0
NH 26	18	10 (NM/3Y)	13(NM/3Y)	18(NM/3Y)	10(NM/N)	13(NM/N)	13(M/3Y)	0 (NA)	20(M/Y)	0
NH 27	10	5 (NM/N)	5 (NM/N)	5 (NM/N)	5 (NM/N)	5 (NM/N)	5 NM/3Y)	5 (NM/N)	5 (NM/N)	0
NH 28	11	3 (NM/N)	3 (NM/N)	9 (M/Y)	9 (NM/N)	9 (NM/N)	4 (M/Y)	0 (NA)	9 (NM/N)	0
NH 29	13	7 (NM/Y)	7 (NM/3Y)	7 (NM/3Y)	7(NM/3Y)	7 (NM/3Y)	4 (NM/3Y)	7 (NM/3Y)	7 (NM/3Y)	0
NH 30	Missing	1 (NM/N)	1 (NM/N)	1 (NM/N)	1 (NM/N)	1 (NM/N)	3 (NM/N)	0	0	0

No. of NH	No of RNs*	Holistic Assessment	Advance Care Planning	Communication Skills	Diagnosing Dying	Assessment/ Management of Symptoms	Care of Syringe Driver	Out of Hours Care	Feeding & Hydration	Other
NH 31	18	18(M/3Y)	18(M/3Y)	18(M/3Y)	18(M/3Y)	18(M/3Y)	13(M/Y)	18(M/3Y)	18(M/3Y)	0
NH 32	35	20(M/Y)	0 (N/NA)	20(M/Y)	20(M/Y)	20(M/Y)	0(N/Y)	20(M/Y)	20(M/Y)	0
NH 33	12	4 (M/Y)	10((NA)	10(M/Y)	10(NM/N)	10(NM/N)	6(NM/N)	10(NM/N)	10(NM/N)	0
NH 34	30	25(M/Y)	25(M/Y)	25(M/Y)	25(M/Y)	25(M/Y)	25(M/Y)	25(M/Y)	25(M/Y)	0
NH 35	0	16(M/N)	16(M/N)	16(M/N)	16(M/N)	16(M/N)	5 (M/N)	16(M/N)	14(NM/N)	0
NH 36	14	14(M/3Y)	1 (N/N)	14(M/3Y)	14(M/3Y)	14(M/3Y)	1 (NM/Y)	0 (N/N)	14(M/3Y)	0
NH 37	18	13(NM/N)	0 (NA)	13(NM/N)	14(NM/N)	14(NM/3Y)	13(M/3Y)	14(NM/NA)	14(NM/N)	14
NH 38	13	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	10(NM/N)	0 (NA)	0 (NA)	7
NH 39	11	10(NM/N)	10(NM/N)	10(NM/N)	10(NM/N)	10(NM/N)	10(NM/N)	10(NM/N)	10(NM/NA)	0

*Number of Registered Nurses Employed During the Audit Period

*Other indicated training in Spirituality in End of Life Care (Home No.19), Supporting Families (Home No. 37) and Palliative Awareness Training (Home No.38)

M = Mandatory

NM = Non-Mandatory

Y = Yearly

3Y = 3 Yearly

N = Neither

NA = Not Applicable

APPENDIX 6: TRAINING FOR HEALTH CARE ASSISTANTS DURING 3 YEAR PERIOD- JAN 2013- DEC 2015

No of NH	No of HCAs*	Holistic Assessment	Advance Care Planning	Communication Skills	Diagnosing Dying	Assessment/ Management of Symptoms	Care of Syringe Driver	Out of Hours Care	Feeding & Hydration	Other
NH 1	15	0 (NA)	0 (NA)	15 (NM/3Y)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	15 (M/Y)	0
NH 2	50	0 (N/N)	0 (N/N)	0 (N/N)	0 (N/N)	0 (N/N)	0 (N/N)	0 (N/N)	0 (N/N)	0
NH 3	20	20 (M/Y)	20 (M/Y)	20 (M/Y)	20 (M/Y)	20 (M/Y)	20(M/Y)	20(M/Y)	20 (M/Y)	0
NH 4	20	20 (NM/NA)	0	20 (NM/NA)	20 (NM/NA)	0 (NM/NA)	0	0	20 (M/Y)	0
NH 5	34	4 (N/N)	4 (N/N)	4 (N/N)	4 (N/N)	4 (N/N)	0 (N/N)	0 (N/N)	30 (N/N)	0
NH 6	43	40 (M/Y)	0	40 (M/Y)	40 (M/Y)	40 (M/Y)	40 (M/Y)	0 (NA)	40 (M/Y)	0
NH 7	27	22 (M/Y)	0 (NM/NA)	0 (NM/NA)	22 (M/Y)	22 (M/Y)	0 (NM/NA)	0 (NM/NA)	22 (NM/Y)	0
NH 8	55	15 (MY)	15 (M/Y)	15 (M/Y)	15 (M/Y)	15 (M/Y)	0 (NA)	0 (NA)	0 (NA)	0
NH 9	23	0 (NA)	0 (NA)	20 (NM/N)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	20 (NM/N)	0
NH 10	5	0 (NM/Y)	0 (NM/Y)	0 (NM/N)	0 (NM/Y)	6 (NM/Y)	0 (NM/N)	0 (M/N)	6 (M/Y)	0*
NH 11	50	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	40 (M/Y)	0
NH 12	20	5 (NM/N)	5 (NM/N)	5 (NM/N)	5 (NM/N)	15 (NM/N)	0 (NM/N)	0 (NM/N)	15 (NM/N)	0
NH 13	27	0 (NA)	0 (NA)	0 (NA)	0 (NA)	6 (M/N)	0 (NA)	0 (NA)	0 (NA)	0
NH 14	Missing	0	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing
NH 15	7	0 (NM/Y)	0 (NA)	4 (NM/Y)	4 (NM/Y)	4 (NM/Y)	0 (NA)	0 (NM/3Y)	4 (NM/Y)	0
NH 16	16	16 (M/N)	0 (N/N)	16 (M/N)	0 (NM/N)	0 (N/N)	0 (NA)	0 (NA)	16 (M/N)	0
NH 17	18	15 (M/Y)	15 (M/Y)	15 (M/Y)	15 (M/Y)	15 (M/Y)	15(NA)	0(NA)	15 (M/Y)	0
NH 18	40	33 (NM/Y)	0 (NA)	33 (NM/3Y)	0 (NA)	0 (NA)	0 (NA)	0(NA)	33 (NM/3Y)	0
NH 19	4	9 (NM/NA)	9 (NM/NA)	9 (NM/NA)	9 (NM/NA)	9 (NM/NA)	0 (NA)	0(NA)	9 (NM/NA)	0
NH 20	42	0	0	76 (M/Y)	0	76 (M/3Y)	0	0	76(M/Y)	0
NH 21	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing
NH 22	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing
NH 23	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing
NH 24	20	1 (NM/N)	1 (NM/N)	1 (NM/NA)	1 (NM/N)	1 (NM/N)	0 (NA)	1 (NM/N)	1 (NM/N)	0
NH 25	18	12 (M/Y)	3 (NM/Y)	12 (M/Y)	12 (M/Y)	12 (M/Y)	0 (NA)	0 (NA)	12(M/Y)	0
NH 26	51	5 (NM/N)	0 (NA)	20+(NM/N)	5 (NM/N)	5 (NA)	0 (NA)	0 (NA)	30+(M/Y)	0
NH 27	41	4 (NM/N)	3 (NM/N)	3 (NM/N)	3 (NM/N)	3 (NM/N)	0 (N/N)	3 (NM/N)	3 (NM/N)	0
NH 28	30	2 (NM/N)	0 (NA)	30 (M/Y)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0
NH 29	36	11 (NM/Y)	11 (NM/3Y)	11 (NM/3Y)	11(NM/3Y)	11 (NM/3Y)	0 (NM/3Y)	11(NM/3Y)	11(NM/3Y)	0
NH 30	Missing	3 (NM)	0 (NA)	3 (NM)	0 (NA)	0 (NA)	0 (NA)	0	0	0
NH 31	Missing	20 (NM)	0	20 (NM)	0	20 (NM)	0	0	20(NM)	0

No of NH	No of HCAs*	Holistic Assessment	Advance Care Planning	Communication Skills	Diagnosing Dying	Assessment/ Management of Symptoms	Care of Syringe Driver	Out of Hours Care	Feeding & Hydration	Other
NH 32	43	43 (M/Y)	0 (M/Y)	43 (M/Y)	43 (N/Y)	43 (M/Y)	0 (NA)	0 (NA)	43 (M/Y)	0
NH 33	60	6 (N/N)	0 (N/N)	6 (M/Y)	0 (NM/N)	0 (NM/N)	0 (NA)	0 (NA)	6 (M/Y)	0
NH 34	71	71 (M/Y)	71(NA)	71 (M/Y)	71(NA)	71 (NA)	0 (NA)	0 (NA)	71 (M/Y)	0
NH 35	11	2 (NM/N)	2 (NM/N)	8 (M/N)	2 (NM/N)	2 (M/N)	0 (NA)	2 (N/N)	2 (NA)	0
NH 36	28	28(M/3Y)	0 (N/N)	28 (M/3Y)	28(M/3Y)	28 (M/3Y)	0 (NM/Y)	0 (N/N)	28 (M/3Y)	0
NH 37	35	9 (NM/N)	0 (NA)	9 (NM/N)	9 (M/N)	9 (NM/N)	0 (NA)	0 (NA)	9 (NM/N)	9*
NH 38	20	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	5*
NH 39	13	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0

*Number of Health Care Assistants Employed During the Audit Period

*Other indicated 'Staff can complete additional training at their own discretion' (Home No. 10), 'Spirituality at End of Life' (Home No.19), 'Supporting Families' (Home No. 37) and Palliative Care Awareness Training (Home No. 38)

M = Mandatory

NM = Non-Mandatory

Y = Yearly

3Y = 3 Yearly

N = Neither

NA = Not Applicable

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