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National Accreditation Board for Hospitals and Healthcare Providers

1st EDITION
EFFECTIVE 17TH SEP,2024

NABH Checklist for **Dementia Friendly Hospitals**

QUALITY : SAFETY : WELLNESS

National Accreditation Board For Hospitals and Healthcare Providers (NABH)

NABH-Checklist for Dementia-Friendly Hospitals, 1st Edition Effective 17th Sep, 2024

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FOREWARD

The National Accreditation Board for Hospitals and Healthcare Providers (NABH) is proud to mark its 19th year of fostering an ecosystem of quality in healthcare across India. Over the years, NABH standards have not only redefined how hospitals deliver healthcare services but have also heightened awareness among healthcare workers and patients regarding their rights, responsibilities and the dimensions of safe quality-oriented care.

Dementia, a condition that currently ranks as the seventh leading cause of death globally, is one of the major contributors to disability and dependency among the elderly. With over 55 million people living with dementia worldwide, and more than 60% residing in low- and middle-income countries, the scale of this challenge is immense. Every year, nearly 10 million new cases emerge, yet the absence of an effective cure underscores the urgent need for a comprehensive national action plan to address this growing public health crisis.

This reality compels us to recognize and develop resources that meet the unique needs of patients suffering from dementia with the ultimate aim of enhancing their independence and quality of life. In light of the pressing need to confront this emerging global challenge, NABH has taken a significant step by launching the NABH-Checklist for Dementia-Friendly Hospitals (NABH-DFHs), developed in active collaboration with Dementia India Alliance (DIA).

This checklist is designed to serve as a guide for Dementia-Friendly Hospitals and healthcare professionals specializing in geriatric care. It focuses on critical areas such as early detection, intervention, and the comprehensive care and management of dementia and its associated risk factors. The checklist outlines essential requirements across various domains, including infrastructure, patient assessment, continuity of care, and the necessary skills and knowledge for healthcare providers in dementia care.

Through the dissemination of this checklist, NABH aims to equip healthcare providers with the knowledge and tools required to navigate the complexities of dementia care. This initiative reflects our unwavering commitment to improving the quality of life for those affected by dementia and addressing one of the most urgent public health challenges of our time.

By embracing collective action and informed care, we can pave the way for a more responsive and supportive healthcare system—one that stands ready to meet the needs of patients suffering from dementia with compassion, dignity, empathy, and excellence.

NABH remains committed to its mission of taking Quality, Safety to the last man in the line.

Dr. Atul Mohan Kochhar
CEO, NABH

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to all the dedicated individuals whose commitment and expertise have made the development and release of the NABH-Checklist for Dementia-Friendly Hospitals (NABH-DFHs) possible. This significant achievement is a result of collective efforts, marking an important step forward in our continuous journey towards healthcare excellence.

I am deeply thankful to Shri Jaxay Shah, Chairman Quality Council of India, for his visionary leadership. His mission to instill a culture of quality at every level of society has greatly inspired the creation of this checklist, helping us weave quality into the very fabric of Indian healthcare.

I extend my profound gratitude to Mr. Rizwan Koita, Chairman NABH, for his crucial role in elevating healthcare standards across the country. His guidance and insightful contributions have been essential in shaping the checklist, and his dedication to improving healthcare has been a driving force behind this initiative.

I also wish to convey my sincere thanks to Mr. Chakravarthy T. Kannan, Secretary General Quality Council of India, for his invaluable support and steadfast commitment to advancing excellence in healthcare.

A special acknowledgment goes to the Dementia India Alliance (DIA) and its members, whose significant input and collaborative spirit were vital in bringing this checklist to fruition.

I would also like to thank all the officers at the NABH Secretariat, whose tireless work and dedication ensured the completion of this checklist within the required timeframe. Their efforts have been instrumental in turning this vision into reality.

The NABH-Checklist for Dementia-Friendly Hospitals is a testament to the power of collaboration within the healthcare community. Together, we are advancing towards a future where quality, safety, sustainability, and patient-centred care are at the forefront of healthcare delivery.

Dr. Atul Mohan Kochhar
CEO, NABH

CONTENTS

INTRODUCTION:

What is Dementia

Dementia is characterised by cognitive impairment along with behavioural and psychological symptoms that impair activities of daily living. It is a syndrome that can be caused by a number of diseases, and is usually seen in people above the age of sixty-five years. Neurodegenerative dementias are characterised by progressive loss of neuronal function and cell death, which is irreversible. Alzheimer's disease is the most common form of dementia. When dementia occurs in younger people below the age of sixty-five, it is usually rapidly progressive.

The Syndrome and Aetiology

The clinical syndrome of dementia, characterised by new functional dependence on the basis of progressive cognitive decline, can be due to a variety of underlying pathophysiological processes. The most common of these is Alzheimer's disease (50-75%) followed by vascular dementia (20%), dementia with Lewy bodies (5%) and frontotemporal lobar dementia (5%). The significant clinical and pathological overlap between these processes mean their relative frequencies are estimates at best. Less common causes (3%) include Huntingdon's disease, Creutzfeldt-Jakob disease, HIV/AIDS and multiple sclerosis.

The Burden of Dementia

In 2012, the World Health Organization (WHO) declared dementia a critical public health priority and introduced the Global Action Plan on the Public Health Response to Dementia (2017–2025). This plan underscores the importance of addressing several crucial areas, including increasing dementia awareness, reducing risk factors, improving diagnosis and treatment, supporting caregivers, and advancing research. With India accounting for over 15% of the global prevalence of dementia—a figure significantly higher than previously estimated—the nation is facing a substantial public health challenge. India is poised to surpass China as the world's most populous country, with life expectancy increasing significantly over recent decades. In 1960, the average life expectancy in India was just 42.9 years. By 2020, this figure had risen to 70.4 years. Projections indicate that by 2050, nearly 20% of India's population will be aged 65 and over, translating to approximately 319 million seniors. Given that aging is the strongest risk factor for Alzheimer's disease and other related disorders, India is facing a potentially dramatic rise in the number of individuals living with dementia.

The burden of dementia in India is not only due to the sheer number of cases but is also exacerbated by the extensive caregiver burden and a lack of sufficient health and social care services. Given the absence of a definitive cure for dementia, there is an urgent need for a comprehensive national action plan to effectively tackle this issue.

The Diagnosis and its Challenges

Cognitive impairments central to the diagnosis of dementia can be categorised into five main domains: memory; executive function; language; visuospatial abilities; personality and behaviour. As dementia, of any cause, progresses, cognitive impairments will broaden, involving more domains, and deepen, causing increased functional impairment. It can thus be difficult to distinguish dementias of different aetiologies in the later stages. Neuropsychiatric symptoms should be sought. Depression can be a cause or effect of cognitive impairments and often features such as hallucinations and delusions will not be volunteered

unless specific enquiries are made. Alzheimer's Disease (AD), the most common cause of dementia, typically presents with short-term memory deficits, manifesting for example as repetitive questioning. Impairment in at least one other cognitive domain is required for a diagnosis of probable dementia due to AD. Atypical presentations of Alzheimer Disease Dementia (ADD) include behavioural or language deficits suggesting frontal variants or prominent early visuospatial problems suggesting posterior cortical atrophy. The most relevant feature of a presentation of Vascular Dementia (VD) is the temporal association of cognitive deficits with stroke and evidence of cerebrovascular disease on examination and imaging. It is relatively common to be presented with clinical scenarios that do not wholly and exclusively fulfil a single diagnostic criterion. Reflecting the concurrent accumulation of pathophysiological processes within the brain, symptoms can represent overlapping disease processes and mixed pictures can be said to occur, this is most commonly the case with ADD and (VaD).

Dementia denotes a group of symptoms associated with impairment of cognitive functions - including memory, language skills, ability to think, plan and reason, problem solving, ability to focus and pay attention, judgement, decision making etc. The person may be disorientated and confused about time and place. Visual perception and self-care may be impaired. People with dementia may have mood changes becoming easily anxious, irritable sad or frightened with difficulty in controlling their emotions. They may undergo changes in their personality and lose interest in things which they were previously keen about. Many patients with dementia have symptoms such as wandering, irritability, aggression, anger, hostility, apathy, depression and psychosis. Sleep problems may be prominent. Activities of daily living get gradually impaired. Over a period of time, dementia progresses from mild to moderate degree - and when severe, the person often is fully dependent on others. The average life expectancy of a person with Alzheimer's disease is around eight to ten years though some people live much longer.

Most symptoms become worse over time, while others might disappear or only occur in the later stages of dementia. As the disease progresses, the need for help with personal care increases. People with dementia may not be able to recognize family members or friends, develop difficulties moving around, lose control over their bladder and bowels, have trouble eating and drinking and experience behaviour changes such as aggression that are distressing to the person with dementia as well as those around them.

The incidence of dementia rises with age making it an increasingly common phenomenon within our aging population. The nature of symptoms mean people with dementia are more dependent and vulnerable, both socially and in terms of physical and mental health, presenting evolving challenges to society and to our healthcare systems. Despite the seemingly simple premise, the clinical diagnosis of dementia can be difficult with de novo functional impairment often obscured by physical frailty, comorbid psychiatric symptoms such as depression and a subtle but steady assuming of household responsibilities by spouses and family. Clinical and pathological criteria for the main dementia-causing diseases overlap significantly. The emergence of symptoms decades into the pathophysiological process hamper targeted disease therapy. A great number of research initiatives are underway to identify potential biomarkers of disease processes earlier. The association of both overt cognitive decline and underlying pathophysiological processes with normal aging complicate the process of identifying disease processes early within the spectrum of normal again.

Diagnosis and differentiation of dementias requires careful history taking and examination. Both patient and collateral histories are needed to establish a new functional dependence and to explore the progressive cognitive impairments as well as neuropsychiatric symptoms. Physical examination is required to examine for focal neurological or extrapyramidal signs. Cognition will be assessed informally

during the course of the consultation but formal testing is required, and facilitates longitudinal monitoring. Age is the main risk factor for dementia. Established modifiable risk factors for dementia include: depression, diabetes, (midlife) hypertension, (midlife) obesity, smoking, alcohol abuse, high cholesterol, coronary heart disease, renal dysfunction, low unsaturated fat intake and inflammation.

The symptoms of dementia differ between individuals and the approach may be different for each one of them. The manifestations may vary depending on the type of dementia, especially in the early stages. Though exact figures are not available, it is estimated that about 50% of the elderly, admitted to hospitals, have some degree of cognitive impairment. There is a high prevalence of medical disorders among patients with dementia - as they are at an increased risk of falls, delirium, infections and physical decline. As a result, they are more likely to have longer hospital stays and readmissions. Hospitalization is never a pleasant and easy experience for anyone. It is harder for people with dementia, as any change in environment can be even more challenging for them. It is difficult, confusing and frightening for them to adjust to new people, places and routines. Communication difficulties can be a big challenge in addressing pain, discomfort, hydration and nutrition. Many patients are not capable of asking for help and may react in a negative way as they do not fully comprehend their surroundings. Memory loss, confusion and difficulty in learning implies that persons with dementia may forget where they and their possessions are and how day-to-day objects around them work.

Once the diagnosis is established, prognostic measures are required, and are still lacking, as disease trajectories between individuals can vary greatly. Globally, governments are recognising these challenges. Investment and research infrastructure are beginning to reflect the scale of the need. Drugs conferring symptomatic benefit are available and memory service structures exist to diagnose dementias and guide management. The personal impact of dementia on patients and families is also being increasingly recognised.

Dementia Friendly Hospitals – The Salient Features

Dementia friendly hospitals are aimed at elderly patients dealing with Dementia. Characteristics of **Dementia-Friendly Hospitals (DFHs)**, based on published literature, include factors such as knowledge and expertise, continuity of care, person centeredness, consideration of phenomena within dementia, environment, valuing relatives etc. These are basic principles of dementia-care and support which need to be ensured in all settings. Care should ensure privacy and dignity, and the approach need to be respectful, gentle and reassuring - avoiding any form of discrimination. The person is to be given importance, along with focus on the diagnosis. The care should be person-centred and family-orientated.

The hospital leadership and the clinical teams should take responsibility for creating and sustaining a culture of person-centred care, specifically tailored to the needs of persons with dementia. The approach should be one of treating patients as unique individuals - each with their own life histories, individuality and preferences - remembering there is a person behind the diagnosis of dementia. Dementia-Friendly Hospital policy should encompass action plans for the proposed standards. They include; the screening process for persons with cognitive impairment, pathways of comprehensive assessment and referrals when cognitive impairment is suspected, availability of and accessibility to specialist staff for diagnosis and interventions for persons with dementia and management of physical problems with templates of person-centred care plans.

The mechanisms to ensure compliance with Mental Healthcare Act, 2017 should be highlighted. There should be a section on the details of caregiver support measures which the hospital provides. Timely and

accurate clinical documentation, seamless continuity of care and safe dementia friendly environment are other standards suggested to be included in the policy. Details of the training of staff on care of patients with dementia need to be incorporated in the policy, as also details on the processes to monitor the dementia friendliness of the hospital. There needs to be transparency in measures for support of staff caring for persons with dementia. DFH policy has to incorporate the role of leadership and governance mechanisms to ensure the dementia friendliness of the hospital. The proposed standards are intended to make the hospital environment more dementia friendly by focusing on the systems, processes and design to enhance the quality of care provided to persons with dementia

Conclusion

In conclusion, the launch of NABH Dementia-Friendly Hospitals represents a critical step forward in addressing the multifaceted challenges of dementia. By focusing on the systems, processes, and design of healthcare facilities, DFHs aim to provide high-quality, person-centred care that honours the dignity, individuality, and needs of individuals living with dementia. This initiative is not only a response to the rising tide of dementia cases but also a commitment to fostering an inclusive, supportive, empathetic and compassionate healthcare environment.

NABH-CHECKLIST FOR DEMENTIA-FRIENDLY HOSPITALS

To support healthcare organizations aspiring to adapt their services to the specific needs of individuals with dementia, National Accreditation Board for Hospitals & Healthcare Providers (NABH), in collaboration with the Dementia India Alliance (DIA), has developed a comprehensive self-assessment checklist. This tool is designed to enable organizations to assess their current capabilities and formulate a structured action plan towards becoming Dementia-Friendly Hospitals (DFHs). Each element within the checklist can be systematically evaluated, and compliance documented, facilitating a clear pathway for continuous improvement. The checklist is organized into the following key parameters:

1. Infrastructural Requirements
2. Initial Assessment of Dementia Patients
3. Care of Dementia Patients
4. Continuity of Care of Dementia Patients
5. Dementia Specific Knowledge, Skills and Competencies
6. Vulnerability
7. Aspects Related to Care Giver and Family Members
8. Social Aspects
9. Quality of Life

Each parameter includes specific elements that are scored on a scale from 0 to 10, reflecting the degree of compliance:

I. Non-compliant '0' – Non-compliance to the requirement
II. Partial complaint '5'- Partial compliance to the requirement
III. Fully compliant '10' – Compliance to the requirement
IV. NA - Not Applicable

S.No.	PARAMETERS	Scoring (0/5/10)) Non-compliant - 0 Partial Compliant – 5 Fully Compliant - 10
	INFRASTRUCTURAL REQUIREMENTS	
1.	Ensure Hospital entrances and reception areas are bright, well-lit, and maximize natural light.	
2.	Keep corridors bright and evenly lit, following lighting guidelines that recommend double the normal levels.	
3.	Ensure Main entrance doors in hospitals are wide enough (minimum 800mm) for all users and fitted with suitable ironmongery, including control gear for disabled access.	
4.	Provide good levels of both natural and artificial lighting in all hospital areas, supplemented by localized lighting.	
5.	Ensure bright, even, and natural lighting in all hospital areas to minimize glare, shadows, and reflections, reducing the risk of falls.	
6.	Utilize open-plan layouts in hospitals to enhance visibility, such as from the reception area to the entrance and waiting area.	
7.	Install easy-to-reach and operate light switches in hospital rooms and corridors.	
8.	Integrate display spaces for personal belongings in rooms to help stimulate memory and identity.	
9.	Minimize overstimulation in hospital environments, such as excessive noise and too many visitors.	
10.	Use slip-resistant ramp surfaces in hospitals that still accommodate a shuffling gait.	
11.	Provide access to quiet rooms or spaces for patients and caregivers who need them.	
12.	Design hospital reception areas with good visibility of the entrance and waiting areas.	
13.	Remove tripping hazards, such as rugs or mats, from hospital floors to minimize fall risks.	
14.	Avoid sharp edges on hospital furniture, fittings, and equipment.	
15.	Use clear, easily visible, and legible labels and signage in all hospital areas.	
16.	Place signage at eye level, using large, bold fonts and contrasting colours, with images wherever possible.	
17.	Incorporate landmark objects, such as memorabilia and artwork, to aid hospital wayfinding.	

S.No.	PARAMETERS	Scoring (0/5/10)) Non-compliant - 0 Partial Compliant – 5 Fully Compliant - 10
18.	Ensure a contrast in colour between hospital signage and the background mount.	
19.	Make Hospital toilets easily accessible, well-lit, and equipped with adaptations like grab bars for physical limitations.	
20.	Ensure en-suites and toilet areas in hospitals have good lighting levels, with manual and automatic controls.	
21.	Ensure shared hospital areas have immediate and full access to toilets, easily identifiable from multiple viewpoints.	
22.	Install traditional-style taps in hospital bathrooms that are easy to operate, with clear "hot" and "cold" indicators.	
23.	Ensure Grab rails in hospital bathrooms are comfortable to grip and contrast with the surrounding tiles and walls.	
24.	Ensure bathroom controls in hospitals are easy to see and operate for independent use by patients.	
25.	Design Fire doors to blend seamlessly into the hospital environment or use unobtrusive systems to conceal restricted areas for safety reasons.	
26.	Ensure Hospital windows have low sill levels to allow views from sitting positions, including wheelchair accessibility.	
27.	Avoid Highly reflective finishes or mirrors in hospital elevators.	
28.	Attach signs to the doors they refer to rather than adjacent walls in hospital settings.	
29.	Avoid complex designs and representations of real-life objects in hospital wall, floor, and curtain finishes.	
30.	Install Handrails at hospital steps and ramps and door handles in hospitals that are easy to use, comfortable, and contrasting in colour with walls, with clear safety indicators.	
31.	Ensure Wheelchair-accessible paths in hospital gardens that return users to the starting point.	
32.	Provide resting areas in hospital gardens with protection from direct sunlight and wind.	
33.	Use Exterior fencing in hospitals that is difficult to climb over but still allows views of the outside world.	
34.	Ensure Outdoor areas accessible to patients are easily visible to hospital staff from inside the building.	
35.	Ensure good access for individuals with physical or mobility issues, including wheelchair users, throughout the hospital.	

S.No.	PARAMETERS	Scoring (0/5/10)) Non-compliant - 0 Partial Compliant – 5 Fully Compliant - 10
36.	Use glass in hospital designs to show what is behind doors and walls, balancing visibility with privacy and dignity.	
37.	Provide seating areas at frequent intervals in hospitals to offer opportunities for rest.	
38.	Equip Hospital windows with restrictors to limit opening, except for cleaning and maintenance on higher levels.	
39.	Provide facilities for general recreational activities in hospitals, including wireless access for recreational technology.	
40.	Position Hospital mirrors thoughtfully, making them removable or easy to cover if needed.	
41.	Provide Discrete storage spaces in hospitals for bulk items like incontinence pads.	
42.	Conceal or Blend hospital exits and manhole covers into the colour scheme, with hidden handles and latches where possible.	
43.	Conceal Hospital equipment that may pose a risk to unsupervised patients when not in use.	
	INITIAL ASSESSMENT	
44.	Consent for Care needs to be addressed	
45.	Provide Comprehensive Cognitive Impairment screening for all individuals aged 65 and older (and others as appropriate) in outpatient and inpatient settings across all departments.	
46.	A Holistic approach to assessment should be used. Where appropriate, assessments should be conducted in conjunction with family members, friends, and informal and formal carers (including domiciliary support).	
47.	Establish a Clear assessment pathway for individuals when cognitive impairment is suspected.	
48.	Administer quick Dementia screening tests (e.g., Verbal Fluency test, Mini-Cog) for patients with suspected dementia to determine if further evaluation is necessary.	
49.	Conduct Comprehensive Dementia assessments when indicated, using standardized tools (e.g., MMSE, MoCA, AD8) to evaluate cognitive function, behavioural/psychosocial symptoms, and daily living activities.	

S.No.	PARAMETERS	Scoring (0/5/10)) Non-compliant - 0 Partial Compliant – 5 Fully Compliant - 10
50.	Involvement of a specialist using multi-disciplinary approach (i.e. Psychiatrist, Neurologist, Geriatrician, or Dementia-focused physician) to request necessary investigations and confirm or rule out a dementia diagnosis.	
51.	Perform formal cognitive testing for patients who show abnormal results on initial Dementia screening.	
52.	Conduct Physical health assessments (e.g., CBC, CMP, Thyroid-Stimulating Hormone, Vitamin B12, Folate, Calcium levels) for patients suspected of having Dementia.	
53.	Order additional Diagnostic tests (e.g., Neuroimaging, CSF analysis, HIV testing, Lyme titre, RPR) for patients with suspected dementia who have specific risk factors or symptoms.	
	CARE OF DEMENTIA PATIENTS	
54.	Ensure Person-centred care planning for individuals with dementia, with shared decision-making involving caregivers and family members.	
55.	Schedule an appointment to initiate Anticipatory care planning discussions and obtain consent to add data to the Key Information Summary.	
56.	Arrange Annual (or more frequent) appointments with a consistent GP to review medication and assess physical and cognitive changes.	
57.	Ensure a specialist is available to prescribe and monitor dementia medications within the organization.	
58.	Collaboratively develop a list of Dementia-appropriate medications and therapies with input from a multi-disciplinary team.	
59.	Provide Psychosocial and Non-Pharmacological interventions as needed, especially for managing Behavioural and Psychological Symptoms of dementia (BPSD).	
60.	Ensure access to non-pharmacological management protocols for individuals with dementia within the organization.	
61.	Offer appropriate nutrition and self-care guidance to both the patient and caregivers.	
62.	Ensure the hospital operates in compliance with the Mental Healthcare Act, 2017 and provides care accordingly.	

S.No.	PARAMETERS	Scoring (0/5/10)) Non-compliant - 0 Partial Compliant – 5 Fully Compliant - 10
	CONTINUITY OF CARE	
63.	Ensure that hospital staff are easily accessible and responsive when needed.	
64.	Ensure Healthcare providers report performance aligned with care pathways, with defined timelines and milestones.	
65.	Involve Dementia patients and their caregivers in care plan development and ongoing management.	
66.	Ensure consistent collaboration to meet the psychological and emotional needs of patients.	
67.	Recognize the importance of cultural background and lived experience of the person living with dementia when developing a plan of care	
68.	Clearly communicate all treatment interventions and prescriptions among caregivers to avoid gaps or overlaps.	
69.	Implement and maintain Electronic Health records for tracking and managing patient data.	
70.	Promote the use of assistive technologies and home adaptations for dementia patients.	
71.	Standardize Handover procedures and minimize care staff changes to reduce behavioural challenges during transitions.	
72.	Record missed appointments and schedule regular reviews with the same GP for monitoring.	
	DEMENTIA SPECIFIC KNOWLEDGE, SKILLS AND COMPETENCIES	
73.	Ensure the governing body or leadership integrates the specific needs of dementia patients into the hospital's Vision, Mission, and Strategic Goals.	
74.	Enhance training and educational programs for providers on Dementia-specific knowledge, skills, and competency. Minimum Basic qualifications of staff to be addressed.	
75.	Maintain staff competency through ongoing education, training, and performance evaluations.	
76.	Implement a pre-assessment, training, post-assessment, and re-training format to objectively assess knowledge and skills acquisition.	

S.No.	PARAMETERS	Scoring (0/5/10)) Non-compliant - 0 Partial Compliant – 5 Fully Compliant - 10
77.	Identify both Cognitive and Non-Cognitive symptoms of Dementia in patients.	
78.	Establish a DFH policy covering screening, assessment pathways, care plan formulation, clinical documentation, environmental safety, training details, and staff support.	
79.	Encourage participation in support groups for professionals and family carers, focusing on patient and caregiver experiences within hospital committees.	
80.	Utilize assessment tools like Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) to monitor care quality and drive continuous improvements.	
81.	Identify and implement strategies to promote personal safety when working with individuals living with dementia.	
VULNERABILITY		
82.	Identification and Management of Vulnerable patients should be carried out	
83.	Process of Informed consent in case where patient is incapable of making independent decision should be defined and implemented.	
84.	Identification and Management of patients who are at risk of fall/ developing or worsening of Pressure ulcers/ Deep Vein Thrombosis shall be carried out using validated assessment tools and written guidance	
85.	Policy for Physical and Chemical Restraints should be defined including details about who can authorize the use and validity of restraint orders and frequency of monitoring these patients.	
ASPECTS RELATED TO CARE GIVER AND FAMILY MEMBERS		
86.	Care givers and family members should be involved in the process of developing Care Plan.	
87.	Care givers and family members are made aware of the Pricing policy in different care settings.	
88.	Psycho Social support in form of counselling etc should be made available for the care givers and family members.	
89.	Care giver and Family members rights including personal dignity, privacy, confidentiality, refusal of treatment, right to seek additional opinion.	

S.No.	PARAMETERS	Scoring (0/5/10)) Non-compliant - 0 Partial Compliant – 5 Fully Compliant - 10
90.	Care givers and Family members are educated about food drug interactions, potential side effects of medication, diet and nutrition, pain management techniques, processes for dementia care, complication and prevention strategies, infection prevention.	
91.	Care givers and family members are informed about right to complain and how to voice complaint.	
92.	Special Educational needs of care givers and family members should be identified and addressed.	
93.	Feedback regarding care is obtained from care givers and family members, review and analysis should be carried out within defined timeframe for proper preventive and corrective actions.	
	SOCIAL ASPECTS	
94.	Awareness program about Dementia should be conducted. e.g. Poster, IEC etc.	
95.	Provision of Dementia meet ups which can provide an opportunity to meet other people, talk about living with dementia and take part in group activities.	
96.	Carers can help by supporting existing relationships and encouraging the person with dementia to join social groups, community activities.	
	QUALITY OF LIFE	
97.	Ensure the persons with dementia do the activities at their own pace and interest level	
98.	Utilization of Reminiscing Therapy	
99.	Ensure patients with Dementia provided with proper nutritional requirements, hydration and support for activates of daily life i.e. Bathing, cleaning etc.	
100.	Facilities for the Board Games /Memory Games /Playing Cares /Indoor Games etc.	

REFERENCES AND RESOURCE MATERIALS:

1. Abbott RA, Rogers M, Lourida I, Green C, Ball S, Hemsley A, Cheeseman D, Clare L, Moore D, Hussey C, Coxon G, Llewellyn DJ, Naldrett T, Thompson Coon J. New horizons for caring for people with dementia in hospital: the DEMENTIA CARE pointers for service change. Age Ageing. 2022 Sep 2;51(9):afac190. doi: 10.1093/ageing/afac190. PMID: 36057987; PMCID: PMC9441201.
2. Alladi, S., Rajagopalan, J., Hurzuk, S., Pattabiraman, M., Narendhar, R., Thomas, P.T., Gurjal, V.R., Ballal, D., Gupta, I., Mohapatra, A. and Kalkonde, Y., 2022. The dementia care landscape in India: Context, systems, policies and services. STRiDE desk review.
3. Allegri N, Rosi A, Del Signore F, Cremascoli R, Cappa S, Tassorelli C, Govoni S. Dementia-friendly intervention for hospitalized older adults with cognitive impairments: results of the Italian Dementia-Friendly Hospital Trial (IDENTITA). Aging Ment Health. 2022;26(4):716–24.
4. Burgstaller M, Mayer H, Schiess C, Saxer S. Experiences and needs of relatives of people with dementia in acute hospitals-A meta-synthesis of qualitative studies. J Clin Nurs. 2018;27(3–4):502–15.
5. Das, P.C., Kumar, P.R.A.K.A.S.H., Amara, A. and Dey, A.B., 2014. Dementia care in India: Issues & prospects. Int J Med Pharm Sci, 4(1), pp.29-36.
6. Dewing J, Dijk S. What is the current state of care for older people with dementia in general hospitals? A literature review Dementia. 2016;15(1):106–24.
7. Digby R, Bloomer MJ. People with dementia and the hospital environment: the view of patients and family carers. Int J Older People Nurs. 2014;9(1):34–43.
8. Digby R, Lee S, Williams A. The experience of people with dementia and nurses in hospital: an integrative review. J Clin Nurs. 2017;26(9–10):1152–71.
9. Digby R, Lee S, Williams A. The liminality of the patient with dementia in hospital. J Clin Nurs. 2018;27(1–2): e70–9.
10. Emery-Tiburcio EE, Mack L, Zonsius MC, Carbonell E, Newman M. The 4Ms of an age-friendly health system. Am J Nurs. 2021;121(11):44–9.
11. Dewing J, Dijk S. What is the current state of care for older people with dementia in general hospitals? A literature review. Dementia. 2016;15(1):106–24.
12. Fogg C, Griffiths P, Meredith P, Bridges J. Hospital outcomes of older people with

cognitive impairment: an integrative review. Int J Geriatr Psychiatry 2018; 33: 1177–97.

13. Hansen TEA, Praestegaard J, Tjornhoj-Thomsen T, Andresen M, Norgaard B. Dementia-Friendliness in Danish and international contexts: a critical discourse analysis. Gerontologist. 2022;62(1):130–41.

14. Hebert CA, Scales K. Dementia friendly initiatives: a state of the science review. Dementia (London). 2019;18(5):1858–95.

15. Hospital wards get a dementia-friendly makeover https://www.guysandstthomas.nhs.uk/news/hospital-wards-get-dementia-friendly-makeover#:~:text=Older%20patients%20on%20wards%20at,environment%20for%20people%20with%20dementia'.

16. https://www.nursingtimes.net/roles/older-people-nurses-roles/a-guide-to-creating-a-dementia-friendly-ward-21-02-2013/

17. Hung L, Phinney A, Chaudhury H, Rodney P, Tabamo J, Bohl D."Little things matter!" Exploring the perspectives of patients with dementia about the hospital environment. Int J Older People Nurs. 2017;12(3):e12153.

18. Kirchen Peters S, Krupp E. Dementia sensitivity in acute care hospitals : why the implementation is so difficult, and how it can nevertheless succeed. Z Gerontol Geriatr. 2019;52(Suppl 4):291–6.

19. Kumar CS, Varghese M, Duddu V, et al., Indian Psychiatric Society multicentre study: Diagnostic patterns, comorbidity and prescription practices for patients with Dementia. Indian J Psychiatry. 2023 Jan;65(1):52-60. doi: 10.4103/indianjpsychiatry.indianjpsychiatry_736_21. Epub 2023 Jan 13.Digby R, Lee S, Williams A. The experience of people with dementia and nurses in hospital: an integrative review. J Clin Nurs. 2017;26(9–10):1152–71.

20. Kumar CTS, Shaji KS, Varghese M, Nair MKC (Eds) Dementia in India 2020. Cochin: Alzheimer's and Related Disorders Society of India (ARDSI), Cochin Chapter, 2019

21. Kumar CTS., George, S. and Kallivayalil, R.A., 2019. Towards a Dementia-Friendly India. Indian Journal of Psychological Medicine, 41(5), pp.476-481.

22. Lee, Jinkook, Erik Meijer, Kenneth M. Langa, Mary Ganguli, Mathew Varghese, Joyita Banerjee, Pranali Khobragade et al. "Prevalence of dementia in India: National and state estimates from a nationwide study." Alzheimer's & Dementia 19, no. 7 (2023): 2898-2912.

23. Manietta, Christina & Purwins, Daniel & Reinhard, Anneke & Knecht, Christiane & Roes, Martina. (2022). Characteristics of dementia-friendly hospitals: an integrative review. BMC Geriatrics. 22. 10.1186/s12877-022-03103-6.

24. National Dementia Action Alliance, N . Dementia-Friendly Hospital Charter. London: Dementia Action Alliance, 2018

25. National Dementia Action Alliance. Dementia-Friendly Hospital Charter. Revised 2020: COVID-19 Recommendations. 2021.

26. Nichols, Emma, Jaimie D. Steinmetz, Stein Emil Vollset, Kai Fukutaki, Julian Chalek, Foad Abd-Allah, Amir Abdoli et al. "Estimation of the global prevalence of dementia in 2019 and forecasted prevalence in 2050: an analysis for the Global Burden of Disease Study 2019." The Lancet Public Health 7, no. 2 (2022): e105-e125.

27. Petry H, Ernst J, Steinbruchel-Boesch C, Altherr J, Naef R. The acute care experience of older persons with cognitive impairment and their families: a qualitative study. Int J Nurs Stud. 2019;96:44–52.

28. Pinkert C, Faul E, Saxer S, Burgstaller M, Kamleitner D, Mayer H. Experiences of nurses with the care of patients with dementia in acute hospitals: a secondary analysis. J Clin Nurs. 2018;27(1–2):162–72.

29. Reilly JC, Houghton C. The experiences and perceptions of care in acute settings for patients living with dementia: a qualitative evidence synthesis. Int J Nurs Stud. 2019;96:82–90.

30. Rosvik J, Rokstad AMM. What are the needs of people with dementia in acute hospital settings, and what interventions are made to meet these needs? A systematic integrative review of the literature. BMC Health Serv Res. 2020;20(1):723.

31. Royal College of Nursing. Dementia. Commitment to the care of people with dementia in hospital settings. London: RCN; 2012.

32. Toubol A, Moestrup L, Ryg J, Thomsen K, Nielsen DS. Stakeholder perspectives of the dementia-friendly hospital: A qualitative descriptive focus group study. Dementia (London). 2021;20(5):1501-17

33. United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects 2022: Summary of Results. UN DESA/POP/2022/TR/NO.3. New York: United Nations, New York; 2022. Accessed September 3, 2020. https://www.un.org/development/desa/pd/content/World-Population-Prospects-2022

34. Van der Flier WM, Scheltens P. Epidemiology and risk factors of dementia. J Neurol Neurosurg Psychiatry. 2005; 76(5): v2. doi:10.1136/jnnp.2005.082867

35. World Health Organization. Global action plan on the public health response to dementia 2017 - 2025. 2017.

36. Improve the quality of life of persons with dementia https://dementiacarenotes.in/caregivers/quality-of-life/

37. Improving the quality of life for patients with dementia and their caregivers https://www.apa.org/monitor/2023/04/continuing-education-patients-dementia-caregivers

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