

**Dementia Care Bundle**

**Patient Name:**

**CSN:**

**Ward:**

Element	Requirement	Yes/ No/NA	Comments/ additional information	Sign, Print Name and Date
1. Staff have information about the patient within 24 hrs	“This Is Me” given to carer/ relative for completion or contact made with the Nursing/ Residential Home. <i>If patient has no carers or relatives please indicate</i>	Yes/ No/NA		
	“This Is Me” completed and signed by the carer	Yes/ No/NA		
	Dementia guidelines followed	Yes/ No/NA		
2. Communication takes place with the patient/ relative/ carer frequently, skilfully and compassionately	Patient focused rounding	Yes/ No/NA		
	Be-friending volunteer	Yes/ No/NA		
	Diversional activity/ reminiscence	Yes/ No/NA		
	Communication with relative/ carer documented	Yes/ No/NA		
	Carers/ relatives take part in carers audit <i>to be completed by audit nurse</i>	Yes/ No/NA		
	Memory Café utilised	Yes/ No/NA		
3. Nutrition and hydration are adequate for the individual patient	MUST assessment	Yes/ No/NA		
	Braden assessment	Yes/ No/NA		
	Red tray/beaker	Yes/ No/NA		
	Forget me not on patient's locker	Yes/ No/NA		
	Flexible visiting	Yes/ No/NA		

<b>Element</b>	<b>Requirement</b>	<b>Yes/ No/NA</b>	<b>Comments/ additional information</b>	<b>Sign, Print Name and Date</b>
4. A safe environment	Falls risk assessment	Yes/ No/NA		
	Bed rails assessment	Yes/ No/NA		
	Pain assessment completed	Yes/ No/NA		
	MCA completed	Yes/ No/NA		
	De-cluttered area	Yes/ No/NA		
	Signage to toilet etc	Yes/ No/NA		
	Calendar/ clock visible for the patient	Yes/ No/NA		
5. Discharge planning	Named co-ordinator on tear off discharge sheet e.g. GP, Community Nurse	Yes/ No/NA		
6. End of life care	Pain assessments completed	Yes/ No/NA		
	Medication reviewed	Yes/ No/NA		
	Palliative care referral made	Yes/ No/NA		
	Communication with relatives	Yes/ No/NA		