

Quality and Excellence in Specialist Dementia Care (QESDC): baseline one-off self-assessment tool and reporting arrangements

A summary of activity from self-assessments in NHS boards across Scotland

November 2015

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Introduction

The context for longer-term hospital care for people with progressed-stage dementia is complex. In line with current policy, continuing care for people with dementia is provided in local communities as close to home as possible. With the growth in demand for services as the incidence of dementia rises, much of the care will be delivered in care homes. While hospital units and wards should be considered primarily as providers of short-term care, some deliver longer-term services to people who will live out the last days of their lives in these settings.

With the introduction of post-diagnostic support and Alzheimer Scotland's Five- and Eight-pillars Models, dementia care in Scotland is being transformed. People being diagnosed today are likely to have a different future to those presently at a more advanced stage, but it will take time for the benefits to be fully realised. In the meantime, NHS mental health services for people with dementia must strive to meet the standards that have been set.

Commitment 11 of the National Dementia Strategy

Commitment 11 of *Scotland's National Dementia Strategy 2013–2016*¹ relates to extending the work in improving care for people with dementia in acute hospitals to other hospital settings. This includes mental health and community hospitals to which people are admitted for short periods of assessment and treatment not necessarily related to dementia, but whose needs are complex as a result of co-morbidity.

Commitment 11 also includes specialist mental health dementia care settings, and these services have been identified as the first priority. People with progressed-stage dementia commonly have complex physical and psychological needs. As such, they require highly skilled interventions from staff who have undertaken special training and whose specialist role is recognised, supported and nurtured.

Mental Welfare Commission report

The Mental Welfare Commission (MWC) report of care in these wards, *Dignity and Respect: dementia continuing care visits*,² published in June 2014, shows that the level and quality of care and support provided is in many cases falling short of the expected standards.

The MWC carried out a series of visits to 52 units in 12 NHS boards in Scotland³ during 2013. While examples of good practice were found, concerns were raised in relation to elements considered essential in specialist dementia care, such as application of the Adults with Incapacity (Scotland) Act 2000 and the management of stressed and distressed behaviours.

¹ Access at: <http://www.gov.scot/Topics/Health/Services/Mental-Health/Dementia/DementiaStrategy1316>

² Access at: http://www.mwscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf

³ Excluding Orkney and Shetland.

Summarising, the report states:

While we found that many people were receiving good quality care in a suitable environment, we also found units where the care and/or the environment were poor, and where the rights and dignity of people with dementia were not adequately respected. We were disappointed that too many people with dementia were not receiving care which met acceptable standards.

It is clear that people with dementia have the right to receive person-centred, safe and effective high-quality care at all stages of their illness and in all care settings – including, of course, the settings described in the MWC report. The *Standards of Care for Dementia in Scotland*,⁴ published in 2011, prescribes that everyone has a human right to this level and quality of care.

The self-assessment and reporting process

A process was developed to support NHS boards to undertake a one-off baseline self-assessment of current practices in all specialist dementia care settings to meet the needs of Commitment 11 and address the issues raised in the MWC report. To minimise duplication, a composite self-assessment form based on the Healthcare Improvement Scotland Older People Acute Hospital (OPAH) inspection self-assessment method was used, with some additions to reflect specific issues in the MWC report.

The self-assessment was carried out between September 2014 and March 2015. It aimed to identify current good practice but also enable NHS boards to identify where improvements could be made. Eleven main areas, or outcomes, were covered:

1. Legal matters and safeguards
2. Person-centred care
3. End-of-life care
4. Medication, non-pharmacological support and managing stressed and distressed behaviours
5. Care environment
6. Safe and effective care – food, fluid and nutrition
7. Safe and effective care – pressure area care/continence care
8. Safe and effective care – falls care
9. Workforce planning and development
10. Leadership
11. Carer involvement.

Each board was expected to develop an improvement action plan based on the priorities highlighted by their self-assessment. The collated self-assessments are being used by the Scottish Government and others to identify national priorities for improvement that will be taken forward under the auspices of the Quality and Excellence in Specialist Dementia Care (QESDC) programme.

⁴ Access at: <http://www.scotland.gov.uk/Publications/2011/05/31085414>

All NHS boards will be required to undertake regular reporting based on the national and local priorities. The reporting will be monitored through the Commitment 11 Implementation and Monitoring Group, Scottish Government NHS board performance reports, NHS board local delivery plan reporting and annual NHS board reviews. Regular summaries and an annual report will be provided to the Cabinet Secretary for Health, Wellbeing and Sport and the Minister for Sport, Health Improvement and Mental Health.

This report

The aim of this report is to summarise the self-assessment returns from NHS boards to identify common areas of practice.

The focus is less on what distinguishes the boards one from another, although examples of practice from named boards are cited throughout, and more on what unites them.

The self-assessments confirm a wide range of initiatives across the identified topic areas that all or most boards seem to have in place – practices like protected mealtimes, actions around Do Not Attempt Cardiopulmonary Resuscitation orders, developing life-story and “Getting to Know Me” documents, promoting carer support and involvement, providing appropriate training for staff, and tailoring ward designs through appropriate signage and access to outdoor spaces. It is these kinds of initiatives and practices that the report seeks to highlight.

Outcome 1. Legal matters and safeguards

Promote a culture that ensures that staff language and behaviours are respectful, enhance dignity and promote zero tolerance of derogatory and discriminatory language and behaviours. Promote a culture that all staff understand and apply principles, practices and values of human-rights-based care and treatment in line with the Charter of Rights, including issues of consent and capacity.

The NHS boards demonstrate a strong understanding of their legal responsibilities, with evidence across boards of activity to align and comply with legal safeguards. Several describe measures taken in relation to the certificate of incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000. NHS Grampian, for instance, carried out an audit at the Royal Cornhill Hospital in May 2014 which indicated that 98% of patients had valid Section 47 Certificates. The audit highlighted, however, that while 95% had accompanying treatment plans, only 54% of the plans covered all prescribed treatments. An improvement plan was consequently developed and a second audit planned for 2015.

All patients in NHS Lothian have a Section 47 in place with an appropriate treatment plan, a finding that was commented on by the Mental Welfare Commission. The Mental Welfare Commission also commented on the high Section 47 compliance with appropriate treatment plans in place for patients being cared for in the elderly mental health service in NHS Ayrshire & Arran.

NHS Lanarkshire carried out mock inspections in 2014 that evidenced good compliance with Section 47 and Part 5 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Treatment plans were completed where appropriate and family members were included in the process of care-planning.

Advocacy is a recurrent theme in the survey returns, with boards taking measures to ensure patients and relatives have information about local services available to them. In NHS Western Isles, a generic advocacy service is available locally and the ward information leaflet is being updated to reflect the availability of this service, while staff in NHS Forth Valley can access independent advocacy services for patients in their care, downloading patient-information leaflets from the board intranet. Independent advocates have visited wards in NHS Lothian to keep staff informed about their services.

NHS Lanarkshire has developed and implemented a training programme for adult support and protection and the Mental Health (Care and Treatment) (Scotland) Act 2003 across services, involving both face-to-face and LearnPro activity. Staff in NHS Lothian have opportunities to access LearnPro modules on issues such as public protection, capacity and consent, and adult support and protection. Training sessions on the Adults with Incapacity (Scotland) Act 2000 were available for staff in NHS Forth Valley during 2014; the need for further training has been identified as a priority, particularly in relation to medical staff induction programmes and nursing staff updates.

The pattern regarding locked-door policies appears mixed. Locked-door procedures are in place for all wards in NHS Fife and in NHS Grampian, for example, with information displayed clearly on ward doors where necessary, but NHS Dumfries & Galloway has no locked-door policy.

Outcome 2. Person-centred care

Ensure that all care is person-centred and that care is developed with the involvement of the person with dementia, their family and their carer, if appropriate.

The “Getting to Know Me” documentation and wider approaches to life-story work are being used commonly across boards. All specialist dementia wards in NHS Forth Valley, for instance, use person-centred assessment and care planning processes that include the use of “Getting to Know Me” documentation, which encourages family and carer participation in completing the documents with patients and ensures patients’ views and wishes are at the heart of care-planning. More in-depth processes for life-story work are currently being considered for patients in specialist dementia wards.

In NHS Borders, life histories are well underway in one of its two facilities for people with dementia. These are completed by the patient’s named nurse with input from carers and significant others, which can prove challenging at times: skilled interventions are required to support carers in what can be an emotional experience. Person-centred care plans continue to be developed in both wards areas, with “This is Me” documentation being completed for each patient in the second unit.

All units in NHS Grampian aim to have life-story work initiated within the first week of admission, using the “Getting to Know Me” booklet as a starting point. The Mental Welfare Commission commented in September 2014 that: “Life stories were completed for all patients on the wards. Some of these documents contained a large amount of information which could be used to guide care and management of patients. This reflected the efforts of staff to develop knowledge about the patients in their care.”

Examples of the wide range of person-centred approaches being adopted in boards include:

- all patients in units in NHS Grampian having a therapeutic activity care plan with information derived from the patient (where possible), family/carers and life-story work
- two dedicated activities nurses in the ward in NHS Western Isles to ensure that appropriate activities are provided for each patient
- the use of nursing assessments in NHS Ayrshire & Arran undertaken in partnership with the patient and family/carers (if appropriate and possible) to provide a systematic and consistent approach to ensuring safe and effective multidisciplinary care-planning from initial assessment to discharge
- the establishment of a multidisciplinary steering group in NHS Lanarkshire with representation from social work and voluntary agencies that links into the board’s wider commitments under the Scottish Government’s Person-centred Health and Care Programme
- a review of nursing care plans in NHS Forth Valley to ensure they incorporate person-centred care principles

- continuous review of the quality of person-centred care in NHS Lanarkshire through methods such as the Scottish Recovery Indicator 2 and ongoing action plans, ward-based clinical governance groups, record-keeping audits and dementia care-mapping.

Training also plays a big part in boards' approaches to promoting person-centred care. In NHS Lanarkshire, for instance, all staff working in the board's admission wards for patients with dementia and associated care homes are in the process of taking training to ensure they are working at the Enhanced Dementia Practice or Expertise in Dementia Practice Level of the Promoting Excellence Framework,⁵ regardless of profession or banding. A focus on a person-centred approach to care is considered fundamental to current and future training. And NHS Greater Glasgow & Clyde has undertaken awareness-raising education and training as appropriate on key policy, standards, guidance and recommendations on dementia.

The importance of spiritual, cultural and religious preferences and people's individual value systems in providing significant information for the development of person-centred care planning seems to be recognised. Person-centred care plans in NHS Lothian demonstrate that staff are fully aware of people's spiritual and religious needs and that the views and wishes of people with dementia are taken into account in care-planning. In NHS Forth Valley, values-based care planning is being rolled out across the board area. The principles of person-centred care using the five "must-dos" are being implemented in older people's services, with a strong focus on "who matters to me", "what matters to me" and engaging with carers and families.

NHS Forth Valley is also the first Scottish board to take part in the Macmillan Values-based Standard Programme, which defines eight moments that patients and staff say matter most to them. The moments are grounded in dignity and respect and embrace behaviours that encourage patients' involvement in decisions on their own care. While primarily developed for people with cancer, the board is currently piloting the programme in specific areas, including a community hospital ward that provides care for patients with dementia.

⁵ Access at: <http://www.gov.scot/resource/doc/350174/0117211.pdf>

Outcome 3. End-of-life care

People with dementia are involved in the planning and decisions about their end-of-life care and receive the care that respects their wishes and meets their individual needs. Prognostic indicators are used to prompt timely and appropriate discussions with people with dementia and their carers or families, including issues such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

Boards recognise the importance of patients and carers being involved as much as possible in decisions around end-of-life care and present evidence of complying with national guidelines, including the *Interim Guidance: caring for people in the last days and hours of life*⁶ and the *Living and Dying Well* action plan.⁷

They are also aware of the advantages of anticipatory care planning and advanced directives, and present examples of use. NHS Greater Glasgow & Clyde, for instance, uses anticipatory care plans to establish patients' preferred place of death and define the care to be given, including accessing the board's rapid discharge algorithm if appropriate. Hospital staff in NHS Lanarkshire are using anticipatory care plans to facilitate discussions with patients and carers that focus on their wishes and beliefs.

This is not the case in all boards, however. One of the wards surveyed in NHS Lothian, for example, was unable to present evidence of advance planning per se, but staff nevertheless work with carers to ensure that people's choices are met as fully as possible, and this is routinely included in end-of-life care plans. While anticipatory care planning is used in most areas in NHS Tayside to guide staff on patients' wishes, the board feels that the culture of anticipatory planning needs to become more embedded in specific wards. Local training is in place to address this issue.

As is the case across the country, NHS Ayrshire & Arran follows the advice detailed in the *NHSScotland Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy*,⁸ which aims to prevent inappropriate or unwanted attempts at cardiopulmonary resuscitation (CPR). DNACPR certificates are always completed with the involvement of family/next of kin if the decision not to attempt resuscitation has been reached. DNACPR is included in medical and nursing induction training throughout the organisation.

The National DNACPR policy has also been introduced in NHS Lothian and NHS Western Isles, with information resources (virtual and paper-based) and awareness-raising training being made available to staff. All patients who have a DNACPR certificate in NHS Lothian have documented evidence explaining why the certificate was issued, with carers involved in multidisciplinary discussions and reviews. Evidence was found during the survey process in NHS Lothian that the DNACPR forms had recently been audited by the senior charge nurse.

⁶ Access at:

http://www.2010palliativecareguidelines.scot.nhs.uk/documents/SG_InterimGuidanceDec2013.pdf

⁷ Access at: <http://www.gov.scot/Publications/2008/10/01091608/0>

⁸ Access at: <http://www.gov.scot/Publications/2010/05/24095633/0>

An audit to ensure DNACPR certificates were in place was also undertaken in the elderly mental health wards of NHS Ayrshire & Arran, with positive results. These audits will be repeated at regular intervals. Audits in NHS Forth Valley showed that a DNACPR form had been completed for 99% (n=82) of patients in the Forth Valley Royal Hospital who had an expected death. The process will now be replicated in community hospital wards. In NHS Borders, auditors on one of the board's two units for people with dementia noted that DNACPR forms were completed and visible in 95% of patient notes.

Other relevant initiatives taken forward by boards include the following.

- Patients living with dementia may have difficulty vocalising pain due to cognitive impairment. Assessment tools for patients who may be unable to communicate pain, such as the Abbey Pain Scale and DisDat scale, are being used in inpatient areas and NHS contracted beds in NHS Lanarkshire to improve recognition of pain and ensure better relief. NHS Lothian is also using the Abbey Pain Scale with appropriate patients.
- NHS Grampian has developed an integrated palliative care plan derived from the *Living and Dying Well* national action plan which recommends that all patients are assessed on admission using the Palliative Performance Scale. The plan also covers areas such as skin care, food, fluid and nutrition, continence care, oral care, assessing and monitoring symptoms and anticipatory/palliative medication prescribing. Some areas in the board have access to a palliative link nurse who has completed the European Certificate in Palliative Care.
- The Emergency Department and Hospital Specialist Palliative Care Team in NHS Forth Valley has implemented a supportive and palliative care tool that has been introduced to one area with a view to being extended to other wards. It is recognised that predicting prognosis accurately is highly complex, but using such a tool can be helpful in supporting teams in planning care.

Training initiatives are widespread throughout the boards. NHS Lanarkshire has introduced a two-day palliative care training programme developed by Alzheimer Scotland and NHS Education for Scotland and funded through the Reshaping Care for Older People (RCOP) initiative. The training is delivered by old-age psychiatry nurses and has included staff from all inpatient wards for patients with dementia, including NHS contracted beds. Palliative and end-of-life care training linked to Commitment 11 of the Dementia Strategy has also been developed in NHS Lothian.

Several boards, including NHS Forth Valley and NHS Fife, are supporting staff through training on the SAGE & THYME® model, which is designed to enable all grades of staff to listen and respond to patients and carers who are distressed or concerned.

Outcome 4. Medication, non-pharmacological support and managing stressed and distressed behaviours

People with dementia experience care that is tailored to meet their individual needs and promotes their mental wellbeing. Care for people with dementia meets the Scottish Government Standards of Care for Dementia in Scotland, and guidelines on use of medication for the behavioural and psychological symptoms of people with dementia are available to all staff.

Medication should be used as a last resort in the management of people with dementia who exhibit stressed and distressed behaviours. “Start low, go slow” is the edict used to guide prescribing for people with dementia in NHS Dumfries & Galloway, where the use of discretionary medication is monitored to assess requirements for anti-psychotic medication and carers are involved in reviews.

Boards have review processes in place to ensure medication prescriptions are appropriate to patients’ needs. All patient medications in NHS Grampian, for example, are reviewed on admission to hospital. A multidisciplinary review is then carried out on a weekly basis, with progress reports and future plans documented in medical and nursing notes. Weekly multidisciplinary ward rounds are conducted in NHS Highland with a view to reducing polypharmacy for patients. Polypharmacy has also been investigated in four ward areas in NHS Borders, three of which were under the Mental Health for Older Adults service. A complete review was undertaken of each patient’s medication regime, with significant changes made to address interactions and multiple prescribing.

Patient medication reviews form an integral part of multidisciplinary meetings and case reviews in NHS Forth Valley, and an audit of six sets of patient notes in a 20-bedded male dementia assessment unit in NHS Lothian revealed that medication had been reviewed weekly by the multidisciplinary team and attempts had been made to reduce the use of anti-psychotic drugs.

NHS Lanarkshire has been instituting psychological and other non-pharmacological approaches in its inpatient sites for several years: these are now established as core elements of care. Community and inpatient staff are trained to assess and respond to distress using methods based on the “Newcastle Model”. The training comprises a two-day workshop developed by NHS Education for Scotland that has been delivered (using a “train-the-trainers” approach) to senior clinical staff working at Enhanced/Expertise levels of the Promoting Excellence Framework. The content provides staff with a formal structure from which to coordinate holistic multidisciplinary assessments and develop highly personalised formulation-led care plans.

Stress and distress training has been rolled out extensively across local inpatient, community and nursing home teams in the board area and work is ongoing to establish Stress and Distress Champions from existing nursing staff to support wards. Carers and families are also encouraged to be involved. All this means a non-pharmacological approach is now expected to be the first option.

At present, people with dementia in NHS Forth Valley who are stressed or distressed are assessed and supported with treatment plans agreed by the clinical team in their ward. The availability of specialist support from clinical psychology services is very limited, however, and while several staff trainers for NHS Education for Scotland's "Responding to Stress and Distress in Dementia" course are in place, the roll-out plan for this training is under review. Assessment of distress is the first-line approach adopted in NHS Lothian, with patients referred to Edinburgh Behaviour Support Services if necessary.

Cognitive Stimulation Therapy (CST), a brief treatment for people with mild-to-moderate dementia, has been introduced by some boards, including NHS Ayrshire & Arran. In addition, practically all qualified nursing staff in the elderly mental health service in NHS Ayrshire & Arran have undertaken Promoting Excellence training to Expertise Level. This, the board believes, will enable the achievement of a reduction in the number of incidents involving violence and aggression by implementing ABC charts⁹ as part of a needs-assessment and formulation process. A reduction in the use of "when required" medication is also anticipated.

The board has also introduced a delirium pathway for use in general hospitals and elderly mental health wards, backed by a proactive training programme primarily focused on the acute hospital setting and delivered in conjunction with elderly mental health medical and nursing staff.

Some of the boards have established a range of other non-pharmacological interventions in which people can take part, such as use of outdoor space and dementia-friendly gardens, reminiscence therapy, aromatherapy and music therapy. NHS Lothian is among the boards who use "Memory boxes" as part of a range of meaningful activities for patients.

⁹ The ABC approach is a way of characterising events and resultant behaviours. A behaviour in response to an activating event generates a consequence. If the consequence is inappropriately managed, the situation may escalate and in turn become another activating event (Source: http://www.dementiamanagementstrategy.com/Pages/ABC_of_behaviour_management.aspx).

Outcome 5. Care environment

People with dementia are cared for in a safe and supportive, dementia-friendly environment that enables them to be as independent as possible while retaining links with the external environment.

The boards demonstrate wide understanding of the importance of positive, stimulating and safe environments to support people with dementia and their carers, and many innovative initiatives are underway.

They generally have in place standard facilities that help to improve care environments, with appropriate signage, contrasting colours on walls and furniture to help define space, access to safe garden spaces, quiet areas in wards where patients can relax, and single, personalised en-suite bedrooms being common features. Chaplaincy and access to church services are also available across boards.

The NHS Grampian Older Adults Mental Health Environmental Group meets on a monthly basis and is in the process of developing six-monthly environmental audits that will cover estates work, appropriate escalation procedures and promotion of dementia-friendly environments. The work will be supported by NHS Grampian's four dementia design auditors.

Dementia design auditors are also in place in other boards. In NHS Ayrshire & Arran, for instance, three members of the Elderly Mental Health Management Team have trained at the Dementia Services Development Centre at Stirling University. They provide advice, assistance and expertise on creating dementia-friendly environments within existing environmental constraints. They also advise on how telecare can be used to promote independence for people with dementia while in hospital. Similarly, NHS Forth Valley is one of several boards that use the Dementia Services Development Centre environmental audit tools to assess clinical areas. An auditing programme is being implemented and a number of areas have developed action plans, with many environmental improvements being precipitated by the audits.

More generally, the Dementia Services Development Centre has been involved in staff training and the structuring of many wards, including the Prosen Unit, a custom-built dementia facility in NHS Tayside. The board has trained 22 staff in elderly mental health units and community hospitals on dementia care-mapping, which is now featuring across most of the board's mental health wards for older people. Staff members in NHS Lanarkshire have influenced the board's Facilities and Estates Department to consider and incorporate dementia design into its planned maintenance programme, and together they have designed and developed a dementia ward specification.

Other audit tools have also been used. A ward in NHS Lothian, for instance, carried out a self-audit using the King's Fund Enhancing the Healing Environment (EHE) environmental audit tool. The EHE ethos is that small and inexpensive changes can have significant impacts. As a consequence of the audit, the ward took steps to improve the height of signage, provide more signage to help patients identify their

bedrooms, and give more consideration to the presentation of patients' food and drinks.

Safety is a priority across all boards, but there is also a recognition of the need to adopt risk-enablement approaches to enhance patients' independence and freedom. In NHS Greater Glasgow & Clyde, for example, community time out of the ward is regularly planned as part of ward activity schedules and is included in individual care plans (following risk assessment and, where appropriate, discussions with patients and carers). This approach is enabling patients to take part in previously enjoyed community activities, such as visiting a local chip shop for a fish tea, or just enjoying walks in well-known places. Patients in NHS Grampian's wards are encouraged to be as independent as possible while physical safety is maintained through use of appropriate equipment, such as hip protectors, walking aids, protective mats and bed sensors to promote freedom and minimise risk. The units use environmental observations to allow freedom of movement while maintaining safety.

Occupational therapists and activity coordinators provide structured meaningful activity in wards in many boards, with some, including those in NHS Greater Glasgow & Clyde, also actively involving third-sector and voluntary organisations to provide support and assistance to patients and carers. Many boards use life-story or "Getting to Know Me" documents to help staff identify how they can support people to maintain their meaningful community activities and relationships. NHS Highland has been participating in a pilot scheme using the Elderflowers programme, which has a specific focus on engaging with older people with dementia.

Innovative work in relation to developing musical playlists for patients on iPod or similar devices is being taken forward by boards such as NHS Ayrshire & Arran and NHS Fife, supported in some instances by equipment donated by carers. One patient in NHS Lothian had been supported to use an iPad to communicate with staff.

Outcome 6. Safe and effective care – food, fluid and nutrition

The status of people with dementia is maintained or improved and appropriate food, fluid and nutrition is provided in a way that meets their individual needs. Ensuring the care for all people meets the NHS Quality Improvement Scotland Clinical Standards for Food, Fluid and Nutritional Care in Hospitals.

Boards are using a range of tools to assess patients' nutritional levels and needs, including the Malnutrition Universal Screening Tool (MUST), LanQIP audits for food and nutrition, and the Food, Fluid & Nutrition Clinical Quality Indicators. Fluid and nutrition charts are used as appropriate and patients' weights are regularly recorded. Dietician and speech and language therapy services are widely available, and mealtimes are monitored and protected – indeed, NHS Lanarkshire has been involved in the national Making Meals Matter programme.

An example of a comprehensive nutritional assessment process is found in NHS Grampian. All patients are assessed on admission using the MUST tool and a three-day total intake chart is commenced, allowing staff to identify appetite, food preferences and any swallowing difficulties that can be referred for speech and language therapy assessment. A food preference sheet is completed on admission, including specific dietary requirements and specialised equipment necessary to support nutritional intake. Carers may be involved in this process to ensure a comprehensive assessment is achieved, and the occupational therapist is included if any appropriate needs are identified. Personalised assessments and interventions are recorded in the nursing notes and individualised care plans are created.

MUST scores are reviewed weekly and appropriate actions taken. Patients with a high score are referred to the dietetics service and a further three-day total intake chart is commenced. Medication and general physical health is reviewed by the multidisciplinary team and care planned accordingly.

Food has always featured highly on the agenda of NHS Borders. The units in the board have a long history of supplementing foods of choice for patients: if patients do not wish food they had previously ordered, other choices, including finger-foods, are always available. As is the case across the boards, carers are encouraged to work with ward staff to maintain how patients prefer to dine, and nutrition champions or nutrition link nurses are in place. In NHS Lothian and NHS Tayside, nursing and care intentional rounding has a focus on food and fluids.

NHS Dumfries & Galloway and NHS Lothian are among the boards that provide special crockery and cutlery to aid patients and present picture menus to enhance choice. Most boards make provision for wards to be able to provide a range of food and fluids outwith mealtimes.

Each clinical area in NHS Ayrshire & Arran has been provided with a standardised nutrition folder consisting of food and fluid charts and information on required supplements and snacks, diet and fluid consistency, and type of diet required. The aim is to create an “at-a-glance” nutritional information guide for the multidisciplinary

team to ensure appropriate delivery of individualised nutritional care. This is supported by information-sharing sessions with the Dementia Nurse Consultant that enable the cascade of research data and lessons learned from research projects in relation to nutritional intake for patients in the later stages of dementia. A food hygiene module is also available on LearnPro, which is completed by all inpatient staff as part of their personal development plans.

NHS Lanarkshire has taken forward work focusing on hydration, with guidance on completing fluid balance charts developed and distributed to all wards. Fluid balance charts were reviewed and updated in line with the national Hydration Framework. Flow charts that indicate the need for fluid balance monitoring have been introduced and a mental health version agreed. Visual prompts have been introduced to highlight patients on fluid balance monitoring and posters have been developed to provide information to staff on the volume of the various drinking vessels used in ward areas.

A multidisciplinary group with representation across care groups has been evaluating dysphagia management in NHS Forth Valley. The group has developed a clinical care standard, reviewed current practice and developed or updated resources, and is developing a LearnPro module plan for dysphagia management.

Overall strategic approaches to food, fluid and nutrition emerge at high levels in boards. In NHS Greater Glasgow & Clyde, for instance, the Partnership Food, Fluid and Nutrition Operational Group is chaired by the Nurse Director Partnerships. The work plan is operationalised by the Mental Health Services Food, Fluid and Nutrition Group, which is co-chaired by a senior nurse and the Lead Dietician. The other boards, including NHS Lanarkshire and NHS Forth Valley, have food, fluid and nutritional care steering groups or equivalent bodies in place, backed up by clear local policies and standards.

Outcome 7. Safe and effective care – pressure area care/continence care

Where avoidable, people with dementia do not acquire a pressure ulcer during their stay in hospital. If they are admitted with a pressure ulcer, their care is tailored to their needs – ensuring the care is delivered in line with the NHS Quality Improvement Scotland Best Practice Statement for the Prevention and Management of Pressure Ulcers, so those at risk of a pressure ulcer are identified and receive care to minimise the risk, including access to a local wound care formulary. People with dementia have their continence care needs assessed, planned, implemented and evaluated in a person-centred way.

A range of scales and assessment tools is in use across boards, including the Waterlow tool, Braden scale, Pressure Ulcer Risk Assessment (PURA) tool, NHS Quality Improvement Scotland Best Practice Statement on Prevention and Management of Pressure Ulcers, the Clinical Quality Indicators and the SSKIN bundle.

The National Association for Tissue Viability Nurses in Scotland assessment chart for wound management is used in the hospital in NHS Western Isles and includes documentation for performing formal wound assessments, planning treatment and evaluating effects. Boards are also using their own pressure area care guidance and wound care formularies: they generally have access to specialist tissue viability services and have high-level strategic steering groups (or equivalent) in place. Therapeutic equipment (including pressure-reducing mattresses and cushions) is commonly available and nurse advisers are usually on hand to provide training and education for staff.

NHS Greater Glasgow & Clyde commissioned prevalence studies over three years to capture pressure ulcer incidence in a defined 24-hour period. Mental health services had an incidence of less than 4% in the first two studies, and it was acknowledged that the future focus should be on prevention, management and further reduction in ulcers developed by patients while in the board's care.

Boards and their contracted care providers aim to provide appropriate assessment, individual management and care for all patients living with dementia with continence needs. The objectives of the continence assessment process in NHS Lanarkshire, for instance, are to establish the cause and contributing factors, initiate an agreed personal care plan, enable the person to achieve and maintain the optimum level of continence and quality of life, and review continence status regularly. Where appropriate, referrals are made to the specialist continence service. All care environments have been assessed and adapted to dementia specifications, which includes easily identifiable toilets with clear signage and features within each toilet to help patients to be as independent as possible.

Outcome 8. Safe and effective care – falls care

Where avoidable, people with dementia do not fall during their stay in hospital. A systematic process is in place to assess people for the risk of falling (which includes medication review) and individualised controls are implemented to prevent falls or reduce any risk to a minimum.

Actions on falls care across the boards tend to focus on audit, risk assessment, compliance with national and local guidance, environmental adjustments, appropriate recording and, where necessary, physiotherapy referral. Prevention measures such as the Scottish Patient Safety Programme Falls Care bundle, the Fallsafe bundle and the Clinical Quality Indicators are commonly used.

There is awareness throughout the boards that the causes of falls are complex and that older people accessing mental health services are particularly vulnerable because of dementia or depression, side-effects from medication and/or problems with balance, strength and mobility. There is also a pressing need to reconcile the natural inclination to protect patients from risk of falls by restricting their mobility and independence with the requirement to respect and promote their rights, wishes and quality of life. Patient safety and actions to reduce falls need to be balanced with ideas of independence, rehabilitation, personal choice, privacy and dignity.

The NHS Grampian approach to risk assessment begins at admission. All newly admitted patients undertake a falls risk assessment and a patient risk-management and handling plan is developed. The assessments, which must be completed within the first 24 hours, take into account not only the risks to, but also the strengths of, the individual patient, detailing what he or she is able to do as well as issues that may require interventions. This allows for safer risk enablement. All patients with a high risk of falls are referred to a physiotherapist and are discussed with medical staff.

The team takes a positive approach to risk and supports risk enablement through working with physiotherapy, occupational therapy and visual impairment teams, using mobility aids appropriately and deploying equipment such as bed sensors and telecare. All nursing staff receive mandatory falls-risk training from a physiotherapist, including discussion of environmental issues that increase falls risks. Wards are kept clutter-free and signage is used to indicate wet floors and other hazards.

NHS Ayrshire & Arran has a bone-health and falls-prevention strategy in place, aligned to the National Falls Pathway and Delivery Framework for Adult Rehabilitation. The model has five principle tiers spanning community and hospital provision and aims to deliver a whole-system approach to anticipatory care for falls prevention and bone health. Locally, attention is given to issues such as ensuring flooring design accommodates the difficulties some people with dementia experience in relation to depth of perception.

Falls prevention is a strategic priority for NHS Fife. The Scottish Patient Safety Programme bundles approach is being used to provide a framework to deliver improvement activity. A frailty screening tool that includes falls-screening questions is completed on admission for each patient, after which the falls pathway is followed.

The aim of the approach is that by the end of 2015, falls in hospital will be reduced by 25% and emergency admissions of people aged 65 and over for falls will be reduced by 20% (by April 2015). Hip fractures will be reduced by 5%.

Improvement work in NHS Borders led to an overall 54% reduction in falls incidents between May 2011 and April 2014. The board recognised in 2011 that a 14-bed older-adult continuing-care ward for patients with dementia had the highest falls incidence in the board area. The ward team began improvement work in collaboration with the Falls Lead, fully recognising the complex factors in dementia that affect the risk of falling but also aiming to reduce the number of falls and the level of harm sustained by patients. Active trend analysis identified the time of day and locations in the ward in which falls were occurring: staffing levels were consequently reviewed and an activity coordinator role introduced. Patients at high risk of falling were identified and active interventions put in place to modify risk factors. A falls log was developed to capture activity concisely.

Other measures included the identification of falls link nurses, development of a training programme, performance of environmental and lighting assessments, and the introduction of bed sensors. Use of the Scottish Patient Safety Programme Falls Care bundle commenced in November 2013, with reinforcement of the NHS Borders post-fall protocol. The result of this collective improvement work was a reduction in falls from almost 500 between May 2011 and April 2012 to 225 over the equivalent period in 2013/2014.

An enhanced falls care-rounding programme has been introduced on the wards in NHS Lothian.

Outcome 9. Workforce planning and development

People with dementia are cared for by staff who are knowledgeable, competent and accountable for the care they deliver. A clinical and care governance framework is in place to underpin the quality improvement agenda and safeguard high standards of care. Staff are aware of relevant legislation, national standards and key strategies that support this framework. People with dementia have access to high-quality general medical care.

The Promoting Excellence Framework provides the infrastructure against which staff knowledge and competency levels are assessed and supported. The boards are using the framework to ensure all grades of staff have the appropriate competences to match their level of involvement with people with dementia and their carers, with education opportunities ranging from induction training, through ward-based and in-service activities, to postgraduate study.

All NHS Forth Valley staff, including junior doctors, nurses, allied health professionals and hotel-service staff, are provided with basic training in dementia and delirium that includes the board's Butterfly Scheme (an opt-in scheme for the support of people with dementia). A workforce plan for Promoting Excellence is being developed, with a pilot programme of dementia education at Dementia Informed Practice Level being rolled out to over 500 staff. In addition, the Values-based Reflective Practice approach to caring for people who have dementia has now been introduced to training days.

The intention in Clisham Ward in NHS Western Isles is to address Promoting Excellence through practice education facilitators' priority training days. The proposed programme will allow for all registered staff to be trained to Dementia Skilled Practice Level, with Enhanced and Expertise-level education being driven by staff in the ward.

All appropriate staff in NHS Grampian undergo a training programme aimed at delivering the Promoting Excellence Framework. New staff are required to undertake Informed Level training as part of their induction and a plan is in place to enable local nursing students to also complete this level as part of their programmes. Training is embedded in induction programmes and the Knowledge and Skills Framework (KSF) through e-KSF appraisal. A high percentage of healthcare support workers have completed the Best Practice in Dementia course, supported by ward-based facilitators trained at Stirling University. Other staff groups are actively involved in professional development activity through processes such as e-KSF, forums, workshops, in-house training delivered by experienced staff and postgraduate study.

Supervision options are discussed at staff meetings and staff are encouraged to make use of them. NHS Grampian has recently refreshed its policy on clinical supervision and a steering group has been tasked with liaising with the Clinical Effectiveness Team to discuss the feasibility of undertaking an online survey and audit of personal objectives relating to clinical supervision, to be undertaken during 2015.

The e-KSF also features strongly in training initiatives in NHS Lothian, where staff members' personal development plans are mapped to the Promoting Excellence Framework to ensure all are evidencing their competences at the appropriate level. This also helps to ensure staff have clear guidelines on the expectations of working with people with dementia.

An analysis of dementia-specific training in the board suggested, however, that the training had been pitched at a lower level than would be expected for staff working in wards whose primary role was providing care for people with dementia: it was at Skilled, rather than Enhanced, Level. The aim now is to look at developing a pan-Lothian programme to provide training at appropriate levels. While staff induction programmes in the board do not currently feature dementia awareness, such sessions do form part of the newly qualified practitioner programme.

All NHS boards are now mandated by the Scottish Government to use the suite of tools provided by the Nursing & Midwifery Workforce & Workload Planning Programme (NMWWPP) to plan and deploy their nursing establishments. An example of this in action is provided by NHS Lanarkshire's mental health service, which has undertaken two inpatient workforce planning exercises in line with the triangulation approach advocated by the NMWWPP.

The NMWWPP commissioned a national run of the Mental Health Nursing Workforce Planning Tool across all mental health wards in 2014. NHS Lanarkshire submitted data to the Scottish Government as part of this process and local analysis and senior professional judgement has been applied to develop a proposed future resourcing model, building on previous improvements in skill-mix and numbers in inpatient wards for people with dementia in the board area. Nursing establishments will in future reflect the complex care needs of patients in these wards and will support increases in therapeutic activities, assessment and individualised patient care.

Outcome 10. Leadership

People with dementia are cared for by staff who are led and supported by effective managers/leadership at every level (from line manager to executive team and NHS board members). The NHS board is able to demonstrate that there is strong leadership from the board downwards throughout the whole organisation. The management structure of the NHS board can be clearly articulated and evidence is available to show it is being put into practice at ward level, to the benefit of people with dementia.

Some boards provide evidence of dementia awareness at the highest levels of leadership in the organisation. The Chief Executive of NHS Dumfries & Galloway, for instance, has taken training as a Dementia Champion; dementia features as a performance objective of the Executive Nurse Director of NHS Tayside; the Chief Nurse and Older People's Clinical Services Development Manager are the senior sponsors for the Commitment 11 programme for NHS Lothian; and the Director of Nursing of NHS Western Isles chairs the board's Dementia Steering Group.

Senior NHS board directors in all boards carry out leadership walk-rounds as part of the Scottish Patient Safety Programme – mental health units have been included in this walk-round in NHS Ayrshire & Arran since the outset of the programme. Senior management in NHS Grampian regularly participate in “Back to the Floor” exercises, guided by the Associate Director of Nursing for Mental Health and Learning Disabilities.

At clinical leadership level, the role of senior charge nurses (SCNs) is central. SCNs in NHS Forth Valley are directed and supported to deliver the highest quality of care and professional practice under the auspices of Leading Better Care. The board has developed a framework dedicated to the four national agreed components of the SCN role and ensures that SCNs are non-case-holding to enable them to carry out the leadership elements.

A nurse-sensitive Balanced Scorecard has been in place in the board since 2008 to ensure a consistent focus on improvement. The process is owned by the SCNs and is tested, monitored and reported to patients, carers, peers and senior management.

SCNs in NHS Ayrshire & Arran are responsible for undertaking regular and planned audits using an agreed quality assurance tool. The aim is to give assurance to the board that all wards and departments are meeting required standards of patient care. Audit criteria include the availability of appropriate care plans that support the delivery of person-centred care, staff being observed to demonstrate caring, safe and respectful interactions with patients and carers, and actions being taken to respond to “You said, we did ...” exercises. The Clinical Nurse Manager for inpatient areas has worked with the Clinical Improvement Unit to develop and complete an audit in the elderly mental health wards that looked at environment, staff/patient interactions and record-keeping.

Work is underway in NHS Fife to clarify leadership responsibilities and roles and create a structure of strategic oversight and governance for a series of dementia-related workstreams, including initiatives focused on achieving Commitments 10 and 11 from Scotland's Dementia Strategy and the national post-diagnostic HEAT target. Work on Commitment 11 has been adopted as a workstream priority, with monthly updates being provided to the Mental Health Strategic Management Team. In NHS Lothian, QESDC meetings have been set up monthly; the group includes all of the nurses participating in the Commitment 11 "Train the trainer" programme who represent NHS Lothian.

Outcome 11. Carer involvement

Carers are involved as agreed in the person with dementia's care plan.

Carers are the primary and most important source of support for people with dementia. The boards provide evidence that they are not only involving carers in patients' care, but are also conscious of the need to take steps to support and protect carers from the pressures of their caring role.

Common practices reported by wards involved in the survey include:

- “You said, we did ...” methods in place to respond to carers' comments, ideas and complaints
- admission packs being provided to carers
- visiting times being clearly defined and personally convenient
- general information on dementia and support services being available in ward areas
- carers being invited to multidisciplinary family meetings, enabling them to meet with caregivers and be involved in decision-making (in NHS Western Isles, carers are able to join these meetings via Skype)
- provision of social areas to meet and talk with others (NHS Ayrshire & Arran, for instance, has a well-attended dementia cafe where people with dementia and their carers can socialise and access information, advice and support; and Maple Villa in NHS Lothian hosts “Liz's Lounge” every three months, enabling carers to meet with the charge nurse to discuss in a private setting issues they may not want to talk about in more public forums)
- activity sessions to which carers are encouraged to attend and participate
- promotion of carer/peer support networks and groups (NHS Lanarkshire has a Carer Co-ordinators for Mental Health Team that provides short-term support and directs carers to other appropriate agencies and third-sector services)
- involvement in Patient Focus, Public Involvement activities and on steering and operational groups
- consultation on care planning, particularly for those with welfare proxy powers
- provision of individualised assessments and development of personal care plans
- access to independent advocacy services
- access to training in areas such as recovery and values-based approaches (NHS Tayside), opportunities to participate in sessions on Enhanced Level training (NHS Lothian), and attendance at annual dementia conferences (NHS Borders).

NHS Grampian is in the early stages of implementing the “Triangle of Care” best-practice guidelines on engaging carers and service users in partnership-working with healthcare professionals. The approach builds on and formalises existing work in dementia services, where informal carers often have legal and welfare, as well as caring, roles.

Evidence is emerging in some boards of carers being involved in staff appointments. In NHS Ayrshire & Arran, for instance, people with dementia, carers and third-sector personnel were involved in the recruitment of the Alzheimer Scotland Dementia Nurse Consultant, and a relative of a continuing care patient in the elderly mental health service was involved in recruiting nursing assistants.

Comment by the Associate Chief Nursing Officer

The care of people with dementia is a high priority for the Scottish Government and the Chief Nursing Officer Directorate. A number of very important initiatives, such as the Quality and Excellence in Specialist Dementia Care (QESDC) programme of work, are consequently being driven forward to ensure that people with dementia and their carers receive the best possible services at all stages of the condition, from diagnosis to end of life.

As part of this endeavour, we conducted this survey of NHS boards in Scotland to provide a baseline of services being delivered in specialist dementia care settings. We wanted to identify good practice that could be shared, but also areas in which improvement was needed. [Commitment 11](#) of *Scotland's National Dementia Strategy 2013–2016*, which includes specialist mental health dementia care settings, provided an ideal framework from which to take the work forward.

The survey results show us that much of the practice in boards is of good quality. Boards and their staff are working hard to ensure that people with dementia and their carers receive comprehensive assessments of their needs at or close to admission and that carers are made to feel valued contributors to care-planning and delivery. They are complying with policy and legislative requirements across a range of areas, demonstrating not only awareness of their responsibilities, but also practical application of statute.

The survey suggests that the needs of people at particular stages, such as end of life, are being sensitively and appropriately addressed. Evidence emerges of ward teams seeking the expertise of specialist palliative and end-of-life services and pursuing education to help them deliver the care people need at this crucial life stage. They are also applying national guidance around DNACPR orders and end-of-life care and using validated tools to enable them to assess vital issues such as patients' pain levels.

Enthusiasm and willingness to pursue non-pharmacological models of care is clearly demonstrated. Boards provide evidence of appropriate review procedures in place to ensure people with dementia receive only those medicines they need, but just as important, staff are looking to meaningful activities to engage with people, help them realise value in their lives once again and avoid, if possible, the occurrence of stress and distress. Part of this involves the creation of a calming and therapeutic physical environment, and the survey provides examples of ward staff working with colleagues in boards to bring about changes in ward design. Many of these changes are relatively simple – posting appropriate signage, for example – but it is recognised that little things can make a big difference. It is striking too to find that a number of staff have trained in dementia design at Stirling University, are using environmental tools from the Dementia Services Development Centre and are contributing to high-level NHS board groups looking into environmental and design issues.

Safety is clearly a vital element of care for all patients and staff in NHSScotland, but the three specific areas highlighted in Commitment 11 – food, fluid and nutrition, pressure area care/continence care, and falls – have particular resonance for people living with dementia, many of whom have physical and mental conditions that make

them particularly vulnerable. The survey provides examples of staff in the boards demonstrating awareness of this by taking measures to ensure appropriate risk assessments are completed for every patient and safeguards are in place in wards and units. But they are doing so with an acute consciousness that the understandable desire to protect patients from harm must be balanced by a recognition that patients have rights, that over-protection can lead to increasing dependence, and that people's dignity must be respected and maintained.

It is encouraging to see the educational opportunities available at board and national levels to help staff achieve the understanding and competence they need to care for people with dementia and their carers. The Promoting Excellence Framework is the bedrock of this educational endeavour and is providing a national structure not only for assessing staff education needs, but also for determining workforce requirements. With the KSF, personal development plans, clinical supervision, the NMWWPP tools (particularly the Mental Health Nursing Workforce Planning Tool) and other mechanisms boards have at their disposal, a powerful structure for workforce planning and development in dementia services emerges.

Strong leadership is central to the delivery of person-centred, safe and effective services, and the survey provides evidence of strategic and clinical leadership involvement in dementia services. Leaders at the very top levels of some boards are actively engaged in promoting quality in dementia care and senior charge nurses are using the tools and strategies provided by Leading Better Care to drive improvement for their patients and staff by setting standards and auditing quality.

Staff caring for people with dementia and their carers often work in difficult circumstances with patients whose complex needs require a high degree of skill, sensitivity and innovation. The survey suggests that NHS boards have in place the fundamental structures to support staff to provide the care these patients and carers require. There is undoubtedly, however, some way to go, and the need to drive ongoing improvement in services must remain a priority for all NHSScotland specialist dementia care settings.

We have therefore commissioned Healthcare Improvement Scotland to commence improvement and scrutiny work in specialist dementia care settings. While the full details are still to be finalised, this will most probably include a quality improvement programme to support boards to make changes and drive improvements in practice that will be complemented, over time, by a scrutiny programme. The initial focus, however, will be on getting the improvement programme into the wards to help staff develop the services they offer.

On behalf of the Chief Nursing Officer Directorate, I would like to thank all of the board staff who conducted the surveys on which this report is based and developed improvement plans to address the weaknesses they identified. Your determination, commitment, skill, knowledge and compassion are NHSScotland's greatest assets in improving the lives of people with dementia and their carers.

Hugh Masters

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