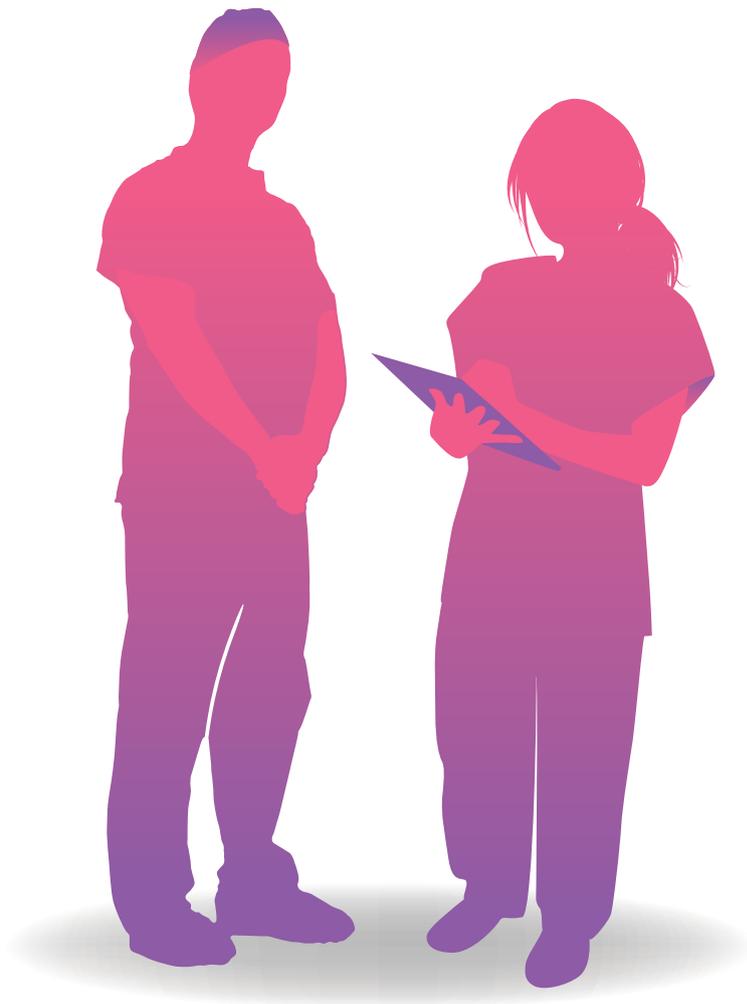


Shifting the paradigm together:

Alzheimer Scotland Dementia Nurse Consultants and Allied Health Professional Consultants



Annual review 2014–15



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Glossary

4AT	Rapid Assessment Test for Delirium	IHI	Institute for Healthcare Improvement
ACE-III	Addenbrooke's Cognitive Examination – Third Edition	IRISS	Institute for Research and Innovation in Social Services
ACP	Anticipatory Care Planning	LGBT	Lesbian Gay Bisexual and Transgender
AHP	Allied Health Professional. These are: Arts Therapists, Dietitians, Occupational Therapists, Orthoptists, Paramedics, Podiatrists, Prosthetists & Orthotists, Physiotherapists, Radiographers (diagnostic & therapeutic) and Speech & Language Therapists	learnPro	NHS learning content management system
AMT10	Abbreviated Mental Test	MMSE	Mini Mental State Examination
AMT4	Abbreviated Mental Test – 4	MoA	Memorandum of Agreement
AMTS	Abbreviated Mental Test Score	MoCA	Montreal Cognitive Assessment
ASDNC	Alzheimer Scotland Dementia Nurse Consultant	MRI scan	Magnetic Resonance Imaging scan
AWIA	Adults with Incapacity (Scotland) Act 2000	NES	NHS Education for Scotland
CAAS	Care Assurance Accreditation System	NEWS	National Early Warning Score
CAM tool	Confusion Assessment Method tool	NICE	National Institute for Health and Care Excellence
CHP	Community Health Partnership	NPI	Neuropsychiatric Inventory
CT scan	Computed Tomography scan	OPAC	Older People in Acute Care
DME	Department of Medicine for the Elderly	OPAH	Older People in Acute Hospital
EPiC	Equal Partners in Care	OPCB	Older People's Clinical Board
FMN	Forget-me-not	PAL	Pool Activity Level
HCSW	Health Care Support Workers	PMAV	Prevention and Management of Aggression and Violence
IDEAS	Intervention in Dementia: Education, Assessment and Support	PoA	Power of Attorney
		SCN	Senior Charge Nurse
		SQid	Single Question in Delirium
		TIME	Think Investigate Management Engage (Delirium Care bundle)

Foreword

This review comes to you at a time when the agenda to enhance the care and support offered to people with dementia in Scotland has gathered great momentum as well as a respected international reputation.

Alzheimer Scotland and the Scottish Government support and resource an Alzheimer Scotland Dementia Nurse Consultant in all territorial Boards. Work is also underway to support the role in a number of the specialist Boards, such as NHS 24. They work with three Allied Health Professional Consultants and are joined by over 600 Dementia Champions, and more than 700 Dementia Ambassadors in social services. Represented within this growing network is every health and social care discipline – staff from varied backgrounds but with a shared commitment to provide the best possible support to people with dementia, their family, friends and carers.

Our Dementia Nurse Consultants and AHP Consultants are experts operating at a level of strategic influence within each NHS Board and have a lead role in taking forward the national agenda for improvement in dementia care.

An evaluation of the impact of the work of the Alzheimer Scotland Dementia Nurse Consultants and Dementia Champions completed in 2014 indicates we are on the right track – although there is still much to do. www.nes.scot.nhs.uk/media/2711493/impact_evaluation_-_final_report.pdf

An evaluation of the role of Allied Health Professionals was commissioned by Alzheimer Scotland 2015, entitled *What is the impact of the Allied Health Professional Dementia Consultants in Dementia in Scotland?* www.alzscot.org/campaigning/policy_reports/3525_evaluation_of_ahp_dementia_consultants

Three reports published jointly by Alzheimer Scotland and the Scottish Government also show how AHPs are delivering improvement for people living with dementia and those who care for them, as well as leading change in practice. Within the first publication, *Allied Health Professionals Dementia Champions, Agents of Change* you can see examples of the fabulous work being implemented by a selection of our AHP Dementia Champions and the supporting and leadership role of the AHP Dementia Consultants and Alzheimer Scotland Nurse Consultants. When you read the publication you can hear the enthusiasm, dedication and commitment they have given to their roles as Dementia Champions and the real difference they are making to people with dementia that they connect with on a day to day basis.

www.alzscot.org/ahps

The Dementia Nurse Consultants, AHP Consultants and their associated networks are a key component of Scotland's National Dementia Strategy. www.gov.scot/Topics/Health/Services/Mental-Health/Dementia

Commitment 10 of Scotland's current dementia strategy includes the 10 Care Actions (illustrated on page 2), which have been identified as key to meeting the desired standards of care for people with dementia and improving their support within our Scottish hospitals.

These 10 care actions are a major focus for the Alzheimer Scotland Dementia Nurse and AHP Consultants and other staff.

We must ensure that as we move forward with the publication of Scotland's third dementia strategy later this year, that we continue to drive forward the current commitments and resources to support people with dementia, their families and carers being cared for in general hospitals.



Henry Simmons,
Chief Executive,
Alzheimer Scotland



Hugh Masters,
Associate Chief
Nursing Officer,
Scottish Government



Tracy MacInnes,
Acting Chief Health
Professions Officer,
Scottish Government

This review can only provide a snapshot of the wide range of work that has been undertaken over the past year but the work represented here is being replicated right across Scotland.

While the developments reported in this review owe much to the dedicated efforts of our Dementia Nurses, the AHP consultants and their colleagues, we gratefully acknowledge the collaboration and support of Scotland's NHS Boards, NHS Education for Scotland, the Scottish Social Services Council and the University of the West of Scotland, as well as the members of the Scottish Dementia Working Group and the National Dementia Carers Action Network who contribute so much to Scotland's vision for change in dementia care.

We would also like to acknowledge the support of the Focus on Dementia team. Through this collaboration we are truly shifting the paradigm and improving care for people with dementia.

The Alzheimer Scotland Dementia Nurse and AHP Consultants put on a poster display at the January 2015 Dementia Champions' graduation ceremony to illustrate the range of activity and achievements in their NHS Boards. To view the posters and more information on the Nurse Consultants visit:

www.knowledge.scot.nhs.uk/dementiainhospitals

10 Dementia Care Actions in Hospital		NHS SCOTLAND
1	Identify a leadership structure within NHS Boards to drive and monitor improvements	
2	Develop the workforce in line with Promoting Excellence	
3	Plan and prepare for admission and discharge	
4	Develop and embed person-centred assessment and care planning	
5	Promote a rights-based and anti-discriminatory culture	
6	Develop a safe and therapeutic environment	
7	Use evidence-based screening and assessment tools for diagnosis	
8	Work as equal partners with families, friends and carers	
9	Minimise and respond appropriately to stress and distress	
10	Evidence the impact of changes against patient experience and outcomes	

Helen Skinner Alzheimer Scotland Dementia Nurse Consultant, NHS Fife

1. Identify a leadership structure within NHS Boards to drive and monitor improvements

NHS Fife has a clear leadership structure in place to drive and monitor improvements in dementia care. We have a named executive lead for dementia as well as a named Associate Director of Nursing who has the strategic nursing responsibility for Commitment 10. Operationally I lead the implementation of the 10 Dementia Care Actions in Hospitals. My role involves overseeing the implementation of Commitment 10 of the National Dementia Strategy across all inpatient settings in Fife (not just acute services). We have a Fife-wide Commitment 10 group and an improvement action plan for all inpatient settings across NHS Fife, both acute and community. There has been an improvement plan for acute services since 2012 and when this workstream expanded to include community hospitals I led the community service areas in carrying out a benchmarking exercise. Based on their feedback the joint action plan was developed. As the Alzheimer Scotland Dementia Nurse Consultant I report progress against Commitment 10 to the NHS Fife Frailty Steering Group. This is a strategic group with an influencing role right up to Health Board level. From June 2014 until March 2016 we have funded a Band 6 nurse to support the dementia improvement work.

This nurse works closely with me facilitating and driving the implementation of the 10 Dementia Care Actions across NHS Fife.

2. Develop the workforce in line with Promoting Excellence

I deliver dementia education using a variety of approaches. This includes using the NHS Education for Scotland resources available through learnPro, as well as delivering face-to-face teaching with support from the practice development department. We have set targets in relation to the number of staff we expect to be trained at the Informed and Skilled level of Promoting Excellence. Additional workforce development is taking place around the Adults with Incapacity (Scotland) Act 2000 (AWIA), and we are in the process of creating an annual programme of dementia-related learning opportunities. The training I deliver is predominantly aimed at nursing and AHP staff, but can also involve support staff, medical staff and managers. As NHS Fife is one of the smaller health boards, people know me and if they have a specific training request they often contact me directly. We also have a formal training timetable that is circulated to all wards, and dementia-related training is advertised as part of that. One of the first things I did in my professional development role (the post I held before being appointed Dementia



'We maintain a database of staff that have completed dementia education, whether via learnPro or face-to-face.'

Nurse Consultant) was to arrange for information about all dementia-related training to be published on the intranet so that staff can easily find details about courses. We maintain a database of staff that have completed dementia education, whether via learnPro or face-to-face, so we know who has participated.

3. Plan and prepare for admission and discharge

We have carried out significant work around admission and discharge that links to Getting to Know Me (a profile detailing important individual information and preferences). This has been delivered in conjunction with our Dementia Champions. As part of their action plan the champions have focused on embedding the use of the document in practice. I have supported them to take that forward at ward level, as well as disseminating the document at a more strategic level across the organisation and beyond. This has involved working with managers, as well as voluntary organisations such as Alzheimer Scotland, the Fife Carers Centre, and carer liaison groups. Additional work around planning for admission has involved me linking with our pre-assessment clinic. The clinic works with

DEMENTIA & DELIRIUM CARERS' CAFE

A place to exchange views and news, get information and support

- Informal relaxed atmosphere
- Tea and coffee provided
- Expert guidance

An informal event where carers can chat, meet other carers and staff from Alzheimer Scotland and NHS Fife Dementia Team

14th October 1-2 pm Training Room 4 Level 8 VHK
4th November 1-2 pm Training Room 4 Level 8 VHK
9th December 1-2 pm Training room 4 Level 8 VHK

Contact: Helen Skinner, Alzheimer Scotland Dementia Nurse Consultant: Extension 28429
Mahri Edgar, Alzheimer Scotland Professional Development Link Worker: Extension 28112

patients who have a planned hospital admission. My input has involved educating the nurses in the clinic around the use of Getting to Know Me, and also developing a scheme to offer patients with dementia and their carers an orientation visit, if they would like one. This enables them to visit the ward where they will be treated, if they would like to, so they can prepare for their admission.

4. Develop and embed person-centred assessment and care planning

My work in this area links principally to embedding the use of Getting to Know Me, combined with education on how the information gathered can be used to develop person-centred care plans. I have started a nurse-led ward round, with an education focus, exploring and role-modelling how nursing staff can use their assessment and care planning skills to ensure the care they deliver for people with dementia is person-centred.

5. Promote a rights-based and anti-discriminatory culture

A lot of my work around Care Action 5 relates to fulfilling our obligations under the AWIA. In partnership with the Associate Medical Director I developed the NHS Fife Capacity Document. This encompasses all the information and required forms in one document. It includes a section for documenting the assessment of capacity, details welfare Power of Attorney/Guardian/next of kin information, contains a Section 47 certificate, and the treatment plan. It is printed on bright yellow paper to make it easy for doctors, nurses and AHPs to find within the patients' notes. The document has been very well received, and NHS Fife has shared it with other health boards, some of whom have also adopted it. We also audit our practice around Adults with Incapacity and I lead on that work, carrying out audits across the organisation. These audits were initially limited to acute settings, but will soon cover the whole of NHS Fife.

I lead specific education around the AWIA using the NES resource 'Think Capacity, Think Consent', complemented with face-to-face training for nurses, AHPs and medical staff.

NHS Fife has just established an Older People's Collaborative across five acute care wards. Each ward will test different improvement projects, and staff will then come together for regular learning sessions to share learning between the wards and then disseminate it more widely. We have set targets in relation to core education that the staff on these five wards are expected to complete. This includes Adults with Incapacity training, as well as completing NES's resources on dementia, delirium, stress and distress.

6. Develop a safe and therapeutic environment

Core improvements have been made in all wards including the introduction of large analogue clocks and dementia-friendly signage for areas such as toilets, showers, bathrooms and sitting rooms. The Band 6 nurse and I have led a series of dementia environment audits in the acute services and this process is being widened to include wards in community service areas. The audits were completed using the Dementia Services Development Centre's design audit tool. All wards to date have received either a bronze or silver level of attainment which means either an adequate or good example of design for people with dementia. As part of the audit, each ward received a report with recommendations for improvements. We are currently reviewing what improvements the wards have been able to make.

I have also developed a guidance and information poster for nursing staff, featuring strategies they can use to help orientate patients within the ward environment. Finally, we have an ongoing goal to



improve garden areas and outside spaces that are used by people with dementia, and although a recent funding application was not successful, this is something we hope to progress in the future.

7. Use evidence-based screening and assessment tools for diagnosis

This work is being taken forward by our team of geriatricians and Nurse Consultants for Older People. They have developed a frailty screening tool and frailty assessment tool. My work in this area has centred on promoting the use of the 4AT delirium assessment tool. In February we held a delirium awareness week in our admissions department, featuring a combination of educational and promotional activities. Delirium and the use of the 4AT will be a central strand of the improvement work of the new Older People's Collaborative, as understanding, prevention and management of delirium is a major part of our work.

8. Work as equal partners with families, friends and carers

We have set up a project called Partners in Care where we invite family members to participate in the care of their loved ones while in hospital, if they wish to. It is completely voluntary, but is underpinned by the view that carers know that individual best, and involving a carer can help reduce the stress of a hospital admission for a person with dementia. This initiative was started by one of our Dementia Champions and I am now in the process of rolling it out across NHS Fife. We have also set up a Dementia and Delirium Carers' Cafe within our acute hospital to provide a support and information network for carers. This takes place just before visiting time starts. We are testing this over a six-month period to see what uptake there is. Numbers have been modest so far, but the people who have come have found it hugely beneficial. It has been supported by the local Alzheimer Scotland Dementia Advisors.

9. Minimise and respond appropriately to stress and distress

Based on feedback from one of our Occupational Therapy Dementia Champions, we have introduced 'activity boxes' across all acute care wards. The champion identified that patients were often bored and lacked stimulation. The boxes contain a variety of therapeutic and meaningful activities, some of which are specific to people with dementia, such

as reminiscence cards and jigsaw puzzles with large pieces (these feature pictures for adults rather than designs for children). If a patient is distressed, one of the strategies staff will consider is to look at activities they might be interested in doing. This can be a very successful therapeutic intervention. We have also been working with Playlist for Life. We secured funding from the Friends of Queen Margaret Hospital to buy equipment to allow us to implement Playlist for Life in an acute ward setting. Through linking with Glasgow Caledonian University and Playlist for Life, this project has developed into a research project, and once ethical approval has been secured it will be piloted on two acute wards. Afterwards we hope to extend Playlist for Life to our care of the elderly wards. We believe that music therapy can be a really effective way of managing and responding to stress and distress.

10. Evidence the impact of changes against patient experience and outcomes

I previously completed some work in partnership with our Dementia Champions that explored the experience of patients who were admitted to acute care. This involved observational work, followed by interviews with patients and carers. The findings from this allowed us to learn what was important to people when in hospital and so promote person-centred care. For our Partners in Care project, we are circulating a relatives' questionnaire, which we are using to find out about the experiences of relatives when a loved one is admitted to hospital. Pre- and post-care questionnaires will be completed to see if Partners in Care is having the impact we hope it will.

'Core improvements have been made in all wards including the introduction of large analogue clocks and dementia-friendly signage.'

Other work

I work closely with our Dementia Champions and maintain a database with details of all champions we have working across the board area. I completed Dementia Champion training myself and was a member of the first cohort of graduates, so this is an initiative I have a personal connection with and a particularly strong interest in. Through my training I built links with others on the course, and an informal network began to develop from that. I have subsequently established links with champions in social services and the local ambulance service as well. Our network is now more formal and includes a bimonthly meeting, usually with an educational theme that the champions have identified they want to know more about. They also have an action plan as a group, and this previously looked at Getting to Know Me and environmental issues. Each champion also has a local action point. The plan has just been updated with new actions including the implementation of Partners in Care, continuing improvements to the environment, and to maintain the supply of dementia and dementia-related information leaflets kept on the ward for patients and relatives. At the network meetings the champions share learning, discuss challenges, and help and support each other. They formally provide a progress report that is shared with their managers and the Associate Director of Nursing for Commitment 10.

The above describes just a few examples of the work I do. All the work I do is as part of a team. I could not do my job effectively without a network of healthcare staff that are also driving improvements in dementia care.



Sandra Shields Alzheimer Scotland Dementia Nurse Consultant, NHS Greater Glasgow and Clyde

1. Identify a leadership structure within NHS Boards to drive and monitor improvements

NHS Greater Glasgow and Clyde (NHSGGC) has a clearly defined executive and operational leadership structure in place to deliver the National Dementia Strategy. Commitment 10 of the strategy is led by the acute services division, which is where my role is based. Acute services are represented at board meetings by the chief nurse with acute-wide responsibility for dementia, myself, our AHP Dementia Consultant and a variety of clinicians from the multidisciplinary team. The chief nurse heads the acute services dementia group, which is the vehicle that I and Christine Steel, our AHP Dementia Consultant, use for sharing practice, identifying improvements in care, establishing priorities and identifying the resources required to successfully implement sustainable change. It also ensures that ownership for implementing the care actions within commitment 10 is held by the management teams within each of the six sectors that make up acute services.

NHSGGC has demonstrated its commitment to the National Dementia Strategy by recently confirming both my Alzheimer Scotland Dementia Nurse Consultant role and that of



our AHP Dementia Consultant as substantive posts. The board is the first to convert the AHP Consultant national seconded post to a substantive post. This is an enormously valuable step towards ensuring that improving dementia care remains a multidisciplinary team responsibility.

2. Develop the workforce in line with Promoting Excellence

A wide variety of measures are in place to develop the workforce in line with Promoting Excellence. These include access (via learnPro) to a variety of in-house modules converted from NES. Team leads can now report on where their staff are in relation to learning, and this information can be linked with the electronic Knowledge and Skills Framework and personal development programmes. I deliver face-to-face training in Understanding Behaviour in Dementia and have reached in excess of 450 multiprofessional staff. This training allows the exploration of attitudes towards behaviour in dementia and also the use of Getting to Know Me. Mandatory induction training at Informed level has been introduced and links with local nursing and AHP undergraduate courses to ensure that new graduates have the required skills. I have taken a strategic stance when identifying placement of Dementia Champions. Not all places have gone to individuals with responsibility for a ward or department (i.e. nurses and AHPs). Instead, my aim has been to ensure that our specialist nursing teams, who support our ward based staff with complex care requirements, have dementia specialist knowledge embedded within their own team. We now have champions on the following key teams: pharmacy;



pain; moving and handling; palliative care; tissue viability; and falls. Our next cohort of Dementia Champions will target our infection control and discharge teams. In addition, our facilities educator will train as a champion to fully support learning among our porters, domestic and clerical staff. My role fully supports these Dementia Champions to influence change and decision-making in all relevant areas of acute care – not just those traditionally associated with dementia. Much of this work is about challenging embedded behaviours in care practice and spreading the knowledge to as wide an audience within acute care as possible. For example, a Dementia Champion in pharmacy is now writing a bimonthly article for PostScript, an in-house pharmacy magazine. By ensuring this knowledge becomes embedded in practice beyond individual champions, we are creating sustainability in delivering change across the board. My ultimate goal is to have a Dementia Champion in every ward, on every shift, seven days a week. NHSGGC is still some way off achieving this, but I am passionate that it is achievable.

3. Plan and prepare for admission and discharge

New measures have been put in place in a number of settings to improve admission and access to services. The appointments system for day cases has been modified to improve identification of patients with cognitive impairment, and patients can now choose both the day and time of their appointment. Our surgical pre-assessment teams are using Getting to Know Me to gather relevant, personalised information about patients. We are rolling out the 'Making dementia a priority at the front door' training and service model for AHPs in medical receiving areas. In addition,

AHP services are using 'The enablement framework' to promote and support risk enablement and discharge planning.

4. Develop and embed person-centred assessment and care planning

We have taken a range of steps to develop and embed person-centred assessment and care planning. Getting to Know Me has been rolled out widely and linked with both the delirium TIME bundle and What Matters Most, a bedside tool promoting person-centred care planning.

5. Promote a rights-based and anti-discriminatory culture

The face-to-face Understanding Behaviour in Dementia training described under action 2 includes discussion of appropriate language and behaviour when working with people with dementia, to ensure that staff do not inadvertently discriminate against them by, for example, assuming that they are less able to participate in decision-making than other patients. The NES resource Think Capacity, Think Consent has been targeted on learnPro as a priority for staff, with supplementary face-to-face training relating to the role of the Adults with Incapacity (Scotland) Act 2000 in acute settings underway.

6. Develop a safe and therapeutic environment

We have introduced a person-centred environmental strategy in acute services, and this forms part of our acute dementia work plan. Achievements to date include: standardised use of national signage; introduction of appropriate clocks in all wards and departments; and provision of activity and games compendiums on

'My ultimate goal is to have a Dementia Champion in every ward, on every shift, seven days a week.'

wards. Open visiting is also in place across NHSGGC to support relatives and carers to participate in care.

One of our most important achievements in developing a therapeutic environment has been the creation of four gardens that support people with dementia. These provide safe access to outdoor space, opening up a whole range of therapeutic activities relating both to gardening and the simple pleasure of being able to take a walk outside. They have had the dual benefit of increasing people's confidence, while also normalising situations such as interacting with visitors. Visiting can sometimes be stilted and uncomfortable at the bedside, but being able to go outside with visitors and walk around in the fresh air can enable people to relax and help overcome tensions. We don't interrupt anyone who is using the gardens. They can come and go as they please, in complete safety. This freedom of movement stops anxiety levels becoming raised and has reduced incidences of distressed behaviour that can often be seen when someone has no access to outside space. The gardens project is ongoing across Glasgow and we are now working to develop our fifth garden. This work has been made possible by an incredibly generous donation of £50,000 per garden from the Royal Voluntary Service.

7. Use evidence-based screening and assessment tools for diagnosis

We completed a Delirium Guidelines Research Project to inform the development of updated delirium guidelines. This is part of a coordinated strategy to equip staff to identify and treat patients with delirium. Other strands of this work include testing of the delirium TIME bundle to ensure it is being implemented reliably and to make sure that we achieve optimal levels

of compliance. AMT4 screening has been introduced to surgical pre-assessment clinics, A&E departments and to all wards. We have produced and distributed a leaflet for patients and relatives about delirium. We ran a one-week multisite education programme across acute services that was supported by the multidisciplinary team of Dementia Champions. I work with our national colleagues at Healthcare Improvement Scotland to learn from and share learning from the implementation of the bundle, and we are now looking to progress this from identifying and managing delirium to its prevention among people at risk. A referral pathway has been developed to signpost those people who have received a diagnosis of dementia while in acute care towards post-diagnostic support, enabling them to receive a minimum of a year's personalised post-diagnostic support in line with the Scottish Government's commitment to this.

8. Work as equal partners with families, friends and carers

We have established a multidisciplinary team to lead our Focus on Dementia improvement programme. They are ensuring that a range of measures is being introduced to fulfil our commitment to work as equal partners with families, friends and carers. Getting to Know Me is being used to support care planning for those patients with a cognitive impairment, and our activity coordinators are working with friends, families and carers to provide cognitive stimulation activities in partnership with their relatives, if they would like to be involved. This work is also being supported with the help of volunteers. Open visiting is in place on all wards and is enabling families, friends and carers to visit their relative when they would like to and for as long as they would like.

9. Minimise and respond appropriately to stress and distress

Minimising and responding to stress and distress is one of the core aims of the Focus on Dementia improvement programme. NHSGGC has been piloting NHS Education for Scotland's e-learning resource on understanding stress and distress in dementia in acute settings. To reduce the likelihood of stress and distress arising in the first place, we have introduced a variety of measures to ensure that people with dementia have access to appropriate meaningful activity and stimuli. Our pharmacist Dementia Champion has used the education of pharmacists to support the development of pharmacy processes to minimise the use of psychoactive medication. Our work around action points 8 and 9, in particular, is being carried out in a very collaborative way in partnership with Christine Steel and our Dementia Champions. This is a truly multidisciplinary approach and is central to cascading the relevant knowledge, skills and attitude towards dementia care across such a large board area.

10. Evidence the impact of changes against patient experience and outcomes

Evaluation is being incorporated into each cycle of service improvement that we are carrying out across the board area. The work on our delirium programme is being evaluated and supported in partnership

'We have established a multidisciplinary team to lead our Focus on Dementia improvement programme.'

with Healthcare Improvement Scotland. Teams within the Focus on Dementia programme have been tasked with specifically evaluating the change we are achieving in our work towards care actions 8 and 9.

Other work

As described above, we are taking a strong multidisciplinary approach to deliver Commitment 10 of Scotland's National Dementia Strategy. The Dementia Champions feature centrally in this approach. For example, one of our champions is a tissue viability nurse and visits five or six different wards a day. This is creating opportunities to provide advice and support across a huge range of environments where only a minority of patients might have dementia. The roving expertise of the Dementia Champions means that we can work together collaboratively across a very wide range of settings, both within and beyond acute care.

I am actively involved in education work which extends both beyond acute care, and beyond the boundaries of NHSGGC. I have previously delivered to a national tissue viability conference. Myself and Christine Steel joined colleagues at the British Society of Gerontology's international conference, again providing opportunities to share best practice at a national level.

Christine Steel AHP Dementia Consultant, NHS Greater Glasgow and Clyde

Up until 31 August 2015, I was in the fortunate position to have been seconded to one of four National AHP Dementia Consultant posts in a role funded by the Scottish Government. The post was hosted within NHS Greater Glasgow and Clyde (NHSGGC) and had a remit for improving the care of people with dementia in acute and general hospitals in relation to AHPs across Scotland. Although the secondment has now reached its conclusion, I am pleased to say that the board's AHP and Nursing directors agreed to make the post substantive and widen the scope to include the entire patient journey across NHSGGC services.

Commitment 10 of the National Dementia Strategy has been a key focus for my role and provides a clear framework for improvement activity. In order for transformational change to occur, it is essential that the entire multidisciplinary team is engaged in the process. NHSGGC has demonstrated its commitment to this agenda by securing the future of both the Alzheimer Scotland Dementia Nurse Consultant role and my own post. NHSGGC is the only board to have taken this

approach and this has allowed our project work to be built on a strong foundation of multidisciplinary engagement and leadership.

In addition to these multidisciplinary projects, I have led on a range of initiatives focusing on maximising the skills and interventions of AHPs within the care pathway. I use 'Appreciative inquiry' as a starting point for most of my improvement activity. Appreciative inquiry is based on the simple premise that discussion focussing on problems generates more problems, whilst appreciative discussion generates solutions. This approach addresses areas for improvement by building on existing skills or good practice, which I have found to be hugely motivating for staff involved.

One example of this process is a piece of work I am leading on with occupational therapy staff to ensure our approach to assessment and intervention is best suited to meet the needs of people with dementia, their families, friends and carers. The project focused on one small specialist dementia/delirium ward and a significant outcome has been a change in the assessment tools and



'I have led on a range of initiatives focusing on maximising the skills and interventions of AHPs within the care pathway.'

model of practice used to underpin practice. The model now being implemented is the 'Cognitive disability model', which asks what the person can do, will do and may do. I am currently in the process of applying for funding to carry out more robust research in partnership into the impact of this change, as I begin rolling the recommendations from this project out more widely across the board area.

Improvement activity can be very practical and sometimes simple changes can have the most impact. For example, analysis of falls data highlighted how often walking aids (such as Zimmer frames) are implicated when people experience a fall. I am working closely with physiotherapy staff to evaluate a pilot using red-coloured walking frames. These are much more visible than traditional grey frames, and we are the first board in Scotland to trial their use.

Education is always central to the ongoing integration of any change, and approaches to developing the workforce in line with Promoting Excellence need to be as individualised as our approaches to intervention. I strive to ensure our AHP Dementia Champions feel supported in their role, have a clear direction and hold meetings with them every eight weeks to sustain momentum for this pivotal role within the wider dementia improvement agenda. I also have an active role in facilitating the roll-out of 'Skilled' level training on the Promoting Excellence

framework, and offering individualised training to teams, such as 'Making dementia a priority at the front door'. This targets staff from medical admission areas and is intended to support a new service model for AHPs in 'front door' services.

One over-arching project I led, which aimed to support all of the other clinical workstreams, is the development and roll-out of the 'enablement framework'. This is an advanced clinical reasoning tool designed to assist AHP clinical reasoning when faced with complex situations within acute/general hospital practice, and to support discharge planning. The framework signifies a move away from more traditional, tick-box approaches to risks, and is about starting a conversation about positive risk taking. It can be used for self-reflection, supervision, or as part of a wider discussion with the multidisciplinary team. A key aspect is that it can be used for any situation where risk arises; from ward-based behaviours such as walking, to social tasks such as making a cup of tea, to decisions about community life. Initial feedback from staff using the tool has been positive and it is now being used in many health board areas and across the patient journey. Evaluation is ongoing and has included incorporating its use into NHSGGC's pilot of the 8 Pillars Model. You can view or download the risk enablement tool at www.alzscot.org/framework

'Education is always central to the ongoing integration of any change.'

Gladys Haining, Alzheimer Scotland Dementia Nurse Consultant, NHS Dumfries & Galloway

1. Identify a leadership structure within NHS Boards to drive and monitor improvements

In NHS Dumfries and Galloway, there is a multidisciplinary, multi-agency Dementia Standards Strategy group. This group works closely with and links into the board's Older People in Acute Hospital (OPAH) group. The OPAH group provides monitoring and governance for the Dementia Standards Strategy group. The executive lead for the OPAH group is the board's Deputy Director of Nursing who is the board lead for older people and dementia.

I took retirement from post on 31 August 2015, but the Alzheimer Scotland Dementia Nurse Consultant was a major contributor to both these groups.

As the lead for the wider dementia agenda, I worked in a leadership role with our Dementia Champions. In conjunction with the Deputy Nurse Director, we developed a Dementia Champions register which is reviewed annually. The Dementia Champions are included on the register once they have completed either the local or national training programme, and to remain on the register our Dementia Champions are expected to attend at least one of four 'development sessions' offered throughout the year. As part of this ongoing work, the Dementia Champions designed and agreed on a Dementia Champions Charter which they sign upon completion of their training. This supports them to contribute to core tenets of supporting people with dementia in the acute setting. This charter is shared with senior staff and managers who have agreed that they will support and monitor the implementation of the charter.

2. Develop the workforce in line with Promoting Excellence

As well as training staff through the national Dementia Champions programme, NHS Dumfries and Galloway has its own internal Dementia Champions training programme. In total, over 130 staff are on the Dementia Champions register, which includes locally trained Champions who sit at level 2 ('Skilled') of the Promoting Excellence framework, and nationally certified champions who are trained to level 3 ('Enhanced').

The Dementia Champions come from a variety of professional backgrounds including nursing, Allied Healthcare Professionals (AHPs), Social Workers, CEOs, Consultant Psychiatrists and Non-Executive Board Members.

The four annual 'master classes' for Dementia Champions are given by staff from various multidisciplinary backgrounds. We draw on the expertise from those within our board area to deliver training. Topics have included:

- Adults with Incapacity (Scotland) Act 2000 (AWIA)
- continence
- LGBT
- social media
- spirituality.

The sessions are also an opportunity for the Dementia Champions to network, share examples of good practice and for peer support.

Between October 2014 and March 2015 the board's IDEAS Team (Intervention in



Dementia: Education, Assessment and Support) were awarded funding from the board to carry out a six month training programme for staff within the Dumfries and Galloway Royal Infirmary (DGRI) and the Galloway Community Hospital (GCH). The Alzheimer Scotland Dementia Nurse Consultant was the lead for this six month project.

In total, 425 staff attended the sessions at DGRI with a range of clinicians from senior/charge nurses, staff nurses, healthcare support workers (HCSWs) and AHPs and the session Understanding Dementia was also attended by 79 ancillary staff.

In GCH, 204 staff attending Understanding Dementia and 139 staff attended the Delirium and Capacity and Consent session. This attendance equates to over 90% of staff working in the GCH, with attendees from all departments across the hospital from senior/charge nurses, staff nurses, HCSW and AHPs, volunteers, radiographers, ancillary catering and admin staff. Three doctors also attended the session.

A report on the training across DGRI and GCH has been compiled by the team and will be available for sharing once it has been approved by the board.

Permanent funding for this team has been secured following the initiative's consistently positive training outcomes. The Alzheimer Scotland Dementia Nurse Consultant will continue to provide guidance to the team around the specific training requirements across the acute and community hospitals.

3. Plan and prepare for admission and discharge

In NHS Dumfries and Galloway, my dementia-focused remit linked closely with the OPAH group's agenda. The OPAH group continue to drive improvements in areas such as admission and discharge processes. The Alzheimer Scotland Dementia Nurse Consultant ensured that dementia remained a high priority in this improvement process.

For arranged admissions, our pre-assessment unit uses the AMT4 tool and the This is Me document with any patients who have a diagnosis of dementia. Before the development of the national Getting to Know Me document, NHS Dumfries and Galloway had developed and implemented the This is Me document, which collects similar key information. Consultation with users and carers around This is Me and Getting to Know Me determined that they wished Dumfries and Galloway to continue using This is Me. This is Me collects information about who or what matters to the person, their dietary intake and preferences, their medicine, and requests in terms of personal care. There is a drive to ensure that the document remains with the person at all times, rather than being kept in the nursing or medical documentation.

For unplanned admissions, the AMT4 is used to assess cognition and, if relevant, the Psychiatric Liaison Service may be asked to conduct further assessments. Staff within DGRI have access to electronic medical records which can inform them whether a person has a formal diagnosis of dementia. This information can inform the use of other admission assessment tools, care planning and treatment. If the This is Me document hasn't already been completed or isn't available, this is an opportunity for it to be offered and completed.

As I was finishing in my post, new funding allowed for the appointment of a Service Improvement Nurse who will expand the link between the Alzheimer Scotland Dementia Nurse Consultant and the OPAH group.

4. Develop and embed person-centred assessment and care planning

We have been doing work around person-centred care and how we can embed the '5 Must Do With Me' themes. As part of the pre-assessment process, people with dementia or cognitive impairment are asked who or what matters to them. This is documented and incorporated into their care

and treatment as far as possible. Current documentation is being reviewed and it is anticipated that the five key points will be incorporated into the pathway at the point of contact or admission, so that people are asked these important questions when it matters most. Where applicable, these responses are used to aid the formulation of care and treatment plans.

Our Dementia Champions' work, and the broader Dementia Friends network, ensures that there is a greater awareness and understanding of dementia than before. We are also in the early stages of developing a pilot project in one department which will determine how we can deliver a person centred service utilising recognised screening and assessment tools. This will involve an evaluation of staff knowledge and awareness of dementia and delirium, their approach to screening or assessment, and how they can involve people with dementia and their carers in the process. Training, education and support will be offered as identified by the evaluation. The goal is to identify key aspects of the pathway which can be personalised to ensure improvements across the acute hospital context.

5. Promote a rights-based and anti-discriminatory culture

Our Dementia Champions are agents of change and awareness for the rights of people with dementia. They raise awareness of dementia in general, but can also support staff when a person presents with stressed or distressed behaviours, and highlight the importance of managing this as well as their acute illness. The Dementia Champions, as well as being able to support their colleagues, are also encouraging as many staff as possible to become Dementia Friends. This raises even more awareness about dementia and its potential impact on people who are physically unwell.

Across the DGRI and GCH, there has been widespread training around the legal aspects and rights of people with dementia.

To support the learning from the training, staff were given various tools and handouts when attending the training sessions and each ward and department was provided with two IDEAS folders, one with information on dementia and delirium and stress and distress, including assessment tools and training materials and the other, a legal folder with information from

the Mental Welfare Commission, Office of the Public Guardian and the Scottish Government on aspects of legal and ethical decision making related to capacity and consent.

6. Develop a safe and therapeutic environment

Our local Dementia Champions and Alzheimer Scotland Dementia Nurse Consultant have taken steps to audit the hospital environment and make suggestions. As a part of this initiative, there is an informal agreement that at times of refurbishment the environment will be considered as part of NHS Dumfries and Galloway's dementia-friendly commitment.

Our current hospital has dementia-friendly signage throughout. We also use contrasting coloured trays and crockery for people with dementia to aid dietary and fluid intake. If the kitchen receives a coloured tray of food which hasn't been touched, the catering department will flag up to the ward that the person isn't eating their meals.

Dumfries and Galloway are in the process of building a new general hospital, and while in post I worked closely with the development team on this process. I sat on the reference group for the new hospital for two and a half years, giving close feedback on flooring, signposting, and room layout. Before I finished in my post, the team had a mock-up of the dementia-friendly single rooms for patients.

7. Use evidence-based screening and assessment tools for diagnosis

Our initial cognitive assessment tool is the AMT4, and if this doesn't provide a categorical result, the 4AT screening tool is used to further screen for delirium. If further assessment or support is required, a referral to our Psychiatric Liaison Service will be made and they can further assess using the MMSE and the ACE-III tool for diagnostic purposes.

In NHS Dumfries and Galloway, we try not to diagnose dementia in the acute setting, as we focus on treating the physical illness as a priority. Instead, we ensure that the person is referred to the memory clinic or back to their GP as part of the discharge process. This helps ensure our diagnosis isn't influenced by delirium or other physical illnesses.

8. Work as equal partners with families, friends and carers

A requirement of the Dementia Champions charter is that Dementia Champions should introduce themselves to any person with dementia who is admitted to the hospital, as well as their families, friends or carers. They are a point of contact who can respond to any questions or signpost as necessary. This process has been in place since 2014.

Within my role as Alzheimer Scotland Dementia Nurse Consultant, I had an agreement that people with dementia, their relatives or carers could contact me directly. Sometimes there is reluctance to speak to staff on the ward and I ensured that anybody with concerns could approach me. I extended this agreement to encompass Senior Charge Nurses, who can also be approached directly, and I helped ensure that discussions and meetings were carried out between care staff and the relatives or carers. This ensures that all the important aspects of a person's care can be addressed and are embedded in the workforce's approach to caring for somebody with dementia. The This is Me document provides valuable information for staff and as a focus in these conversations can ensure that carers, families and friends are involved in the person's care as much as possible.

We have a supported mealtimes policy across our wards, so that family, friends or carers can be involved in supporting the person with dementia at mealtimes. The new hospital premises will also feature spaces in each individual room for family to stay overnight if they wish.

9. Minimise and respond appropriately to stress and distress

Our Psychiatric Liaison Service is of key importance to the management of stress and distress on our wards. In recent years, the team has increased in size. They are a mobile, responsive team who can assess and offer guidance and recommendations to support staff when a person with dementia is on a ward and presenting with stress and distress.

'If somebody has a positive experience, we ask how we can mirror that and recreate it.'

10. Evidence the impact of changes against patient experience and outcomes

We are currently evaluating our processes surrounding patient experience. Currently, we review and learn from compliments and complaints including Patient Opinion. If somebody has a positive experience, we ask how we can mirror that and recreate it; if they have a negative outcome, we ask how we prevent it. This is an ongoing learning process.

An Active Patient Care system is also in place for all patients. We are currently considering how we can further extend and evaluate the information we gather from Active Patient Care. In the last 12 months I gathered data which revealed that a thousand copies of the This is Me document were distributed through many sources to people living with dementia. We are currently looking at how we can evaluate the impact of this document, for instance what stage it is introduced at, and if it is used to gather any extra information which specifically had an impact on a person's experience.

Other work

In relation to Commitment 11 of the National Dementia Strategy, we have been looking at education and training for staff within the mental health sector. There can sometimes be an assumption that mental health staff have a full understanding of dementia by default, but in reality this is still a specialism. As I left post, a programme was organised in Midpark Mental Health Hospital to bring inpatient staff, Community Psychiatric Nurses, Mental Health Liaisons and Crisis Teams training on the NHS NES Promoting Excellence framework for dementia care. The board report back to the Scottish Government on the progress of this work.

Dumfries and Galloway was awarded almost half a million pounds from the Life Changes Trust to develop Dementia Friendly Communities. This bid was developed by the Dementia Standards Strategic Group who will oversee the project from a clinical governance and delivery perspective.

Janice McAlister Alzheimer Scotland Dementia Nurse Consultant, NHS Ayrshire and Arran

1. Identify a leadership structure within NHS Boards to drive and monitor improvements

Our leadership structure is to drive and monitor improvements centres around the Dementia Champions network. Derek Barron, Associate Nurse Director for Mental Health, is the lead for dementia, supported by myself. I co-ordinate the Dementia Champions programme across the service, promoting recruitment and supporting nominees. I also work closely with the training team at the University of the West of Scotland (UWS). At a local level, I meet with the champions bimonthly and we work towards action plans that improve patient care and clinical outcomes. The focus of their work is primarily driven by the 10 care actions and the National Dementia Strategy as a whole. I support the champions through mentoring and personal development to enhance their level of skills and knowledge. Clinical supervision is available at any time,



and although not all the champions take this up, many do.

In order to improve both services and clinical outcomes for people with dementia, within NHS Ayrshire and Arran we have established an OPAH steering group. As part of the group's action plan, we carry out mock OPAC inspections within clinical areas, the outcomes of which formulate future improvement plans.

2. Develop the workforce in line with Promoting Excellence

I continue to lead on the development and delivery of dementia training to staff across services within NHS Ayrshire and Arran, in line with Promoting Excellence. I have been doing this since 2012, but recent developments have allowed us to expand the training programme, developing a role for associate trainers. I now have the support of an associate trainer who provides training at skilled level within acute care settings. We established a core training team whose primary focus was the delivery of training at enhanced and expert level. With the training team recently completing delivery of expert level training to all elderly mental health staff. I support two of our Dementia Champions who deliver Promoting Excellence at informed level to ancillary and voluntary staff within acute care settings. In conjunction with the Consultant Liaison Psychiatrist, we have added delirium and Adults with Incapacity (Scotland) Act 2000 (AWIA) training packages to learnPro, and have been delivering twice-monthly delirium sessions in conjunction with one of geriatricians and the liaison psychiatry team. This training has now been formalised and delivered to a wider audience across the service.



3. Plan and prepare for admission and discharge; 4. Develop and embed person-centred assessment and care planning

Getting to Know Me is now being completed as standard on admission. We are now focusing on a work plan to ensure the information featured within the document feeds into individual care planning process. Although we have been using standardised care plans for dementia, delirium, stress and distress, we are in the process of taking this a stage further by developing a person-centred care plan. This is currently being tested across four clinical areas, in conjunction with the clinical improvement team. The approach being used is based on the Newcastle Model template, but has been adapted for use in acute care. This is being used in conjunction with 5 Must Do's. Rather than see the care plan in isolation, we are taking steps to ensure that the assessment and care planning process are part of a holistic care package which is central to good dementia care. Similarly in relation to delirium, we are now in a roll-out phase of the pathway which incorporates the use of 4AT, TIME bundle and pathway. This will be supported by the Dementia Champions.

Two of our Dementia Champions – one in radiology and the other in the preoperative assessment department – are leading a complementary piece of work. They are developing care pathways that are specific to each of these areas in recognition that they work slightly differently from other clinical areas. The radiology department now has agreement from consultants that they will arrange appointment times that are appropriate for the person with dementia. For example, some people don't function so well at certain times of day, and we can now work with them to avoid these times. We don't have any hard data yet, but the anecdotal evidence is that the new system has reduced the number of missed appointments and 'failed' appointments (where the person wasn't well enough to attend). The work in preoperative assessment has led to a pathway that takes cognisance of individual patient needs prior to admission. A further development within one of our frail elderly wards is piloting the provision of food packages to aid the transition from hospital to home on discharge. If this has positive outcomes and feedback from patients, there are plans to implement in similar clinical areas.

5. Promote a rights-based and anti-discriminatory culture

I have introduced a range of measures to ensure that we not only comply with the legal requirements of the AWIA, but also with a key role of improving patient care. There was already a good level of compliance in assessing capacity and subsequent completion of Section 47 forms, but medical treatment plans were not always being completed as standard. Part of the problem appeared to be the format, which comprised of two separate documents. Following discussions with the Mental Welfare Commission for Scotland it was agreed that we could combine both the section 47 form and medical treatment plan into a single document. The outcome of which appears to be an increase in levels of compliance. NHS Fife have also created a document which includes identification of assessment and decision making process, and we are currently testing this within specific clinical areas. In a separate piece of work, we helped acute care wards introduce changes to their core documentation to include sections relating to legal status such as AWIA, Power of Attorney and Guardianship. We have also been using the Forget me Not scheme quite widely to discreetly identify patients with an increased level of need. This has been very successful in raising awareness and enabling staff to respond appropriately.

6. Develop a safe and therapeutic environment

In common with several other health boards, we have made small but important environmental changes such as introducing crockery, cutlery and jugs that contrast in colour with the person's surroundings. At Crosshouse Hospital we have recently completed a re-zoning and wayfinding exercise which has involved signage being upgraded and the introduction of colour-coded zones. These changes have been designed to support not only people with dementia, but those with a broad range of needs. The same changes will be introduced in Ayr Hospital in 2016 as part of a planned upgrade. One of the first pieces of work we completed with the Dementia Champions was to develop an inter-ward transfer pathway to reduce the number of moves experienced by a person with dementia. This worked well initially, but pressure on beds has meant this issue has now come to the fore again. We are revisiting it and as part of this process are developing an audit tool which will enable us to follow individual patients' journeys through our hospitals, and identify good practice and areas where we need to focus on improvement measures.

7. Use evidence-based screening and assessment tools for diagnosis

The 4AT and TIME bundle are now being used in a cross-section of acute care settings, and we are working towards a planned roll-out to all acute care areas with a subsequent spread to community hospitals. I am currently doing some work with locations on the islands, including Arran and Cumbrae, where the 4AT has been linked to more detailed work relating to delirium. This includes looking at what happens after 4AT screening has been carried out, and is linked to the wider delirium and dementia pathway. In particular, we are promoting retesting with the 4AT as a standard procedure. There is good compliance on admission, but we want it to become embedded as a tool that is used regularly for reassessment. We believe this has the potential to improve clinical outcomes. In support of this, I have organized a regional dementia/delirium conference for NHS Ayrshire and Arran, supported by Healthcare Improvement Scotland. This will take place in early 2016.

8. Work as equal partners with families, friends and carers

We use information gathered from Getting to Know Me to inform partnership working with families, friends and carers. For example, if a person would benefit from support from a family member or carer at a specific time whilst in hospital, we try to encourage and facilitate that. Equally, if a carer would like to stay overnight to improve patient experience and outcomes, we always try and accommodate their request. While open visiting remains a challenge in high care areas, in non-acute wards we now offer flexible visiting. We facilitated a joint working programme with Dementia Carers Voices, led by Scottish dementia campaigner Tommy Whitelaw, which led to 250 staff pledging support for the 'You can make a difference' campaign. We recently carried out a Survey Monkey to follow up with staff and ask them what changes they had made since pledging their support, the information from this is currently being analysed. As part of our work to enhance person-centred care planning, one of the test sites (a GP unit in one of our community hospitals) is now supporting relatives to complete parts of the assessment and care plan.

9. Minimise and respond appropriately to stress and distress

All of the dementia training we deliver is aligned to Promoting Excellence, which in turn is underpinned by the Newcastle Model. Through this training, staff are equipped to recognise and respond appropriately to stress and distress. The model for person-centred care plans that we are testing is based on the principle that if an appropriate care plan is in place, episodes of distressed behaviour should be minimised, with a focus on proactive care planning and delivery. All our clinical areas now have non-pharmacological resources which are designed to meet individual needs and minimise levels of stress and distress. This includes the use of reminiscence books, photo albums, rummage boxes, iPods and so on. Registered staff within Elderly Mental Health Service have all received training in stress and distress.

10. Evidence the impact of changes against patient experience and outcomes

This is an area where we plan to carry out work in future. Patients, carers and family members are currently encouraged to provide feedback through the Patient Opinion website. However, in due course we would like to carry out detailed and focused work that relates specifically to the experiences of people with dementia.

Other work

In relation to education and training; although my main focus is on acute care and mental health services, this has extended to include care homes, hospices and GP CPD events.

I am involved with the UWS and have recently worked with the "Food for Thought" research programme with Erskine Hospital. This looked at issues around dietary intake for people with advanced dementia. The evaluation of the project was well received and has been nominated for several awards. Margaret Brown, Senior Lecturer at UWS, recently presented the work at Alzheimer Europe's 2015 conference. I also presented some of the aspects of my role (in poster format) at the conference. Further work with UWS includes input to second and third year student nurse training programme.

Iona McKay Alzheimer Scotland Lead Nurse for Dementia, Golden Jubilee National Hospital



1. Identify a leadership structure within NHS Boards to drive and monitor improvements

At the Golden Jubilee National Hospital (GJNH), we recently completed our own local dementia strategy, which was directly informed by the Scottish Government's National Dementia Strategy. This document details and exemplifies the hospital's 2015–2018 workstreams and how they link closely with the experiences of people with dementia and the hospital's remit. Dementia Care Actions 1, 2, 8 and 9 were identified as priorities for 2015.

10 Dementia Champions are in post at GJNH, and I work directly with them as Lead Nurse for Dementia (in a part-time capacity) to ensure that the leadership's dementia planning cascades down to outcomes for patients on the wards.

2. Develop the workforce in line with Promoting Excellence

At GJNH, we organise rolling programmes which provide staff with dementia training and Dementia Services Development Centre (DSDC) Best Practice training. The Best Practice in Dementia programme runs over six months, and involves training for



Healthcare support workers who completed the Best Practice in Dementia Course, 2013

cohorts of eight or nine staff at a time to the 'Skilled' level on the Promoting Excellence Framework. The most recent tranche all passed their examinations. Following the implementation of the Dementia Champions programme, we organised a Dementia Champions Group, with its own documentation to define the objectives and structures of the Dementia Champions network. This includes having an active involvement in future programmes of training for hospital staff to ensure the workforce can improve their knowledge of dementia.

48 members of staff at GJNH are currently trained to Promoting Excellence level 2 ('Skilled') using the NHS Education for Scotland training provision. A further 10 are trained to level 3 ('Enhanced') following completion of the Dementia Champion Programme at the University West of Scotland.

We have also commenced full-day training courses for any members of staff in the hospital which do not formally fit into the Promoting Excellence framework, offering training to the first framework level (Informed). These will run four times a year – budget and planning has been placed in the clinical education calendar for this initiative. We call these events Dementia Education Days and the first one in September 2015 was attended by 10 participants.

During our corporate induction for every new member of staff, I give a 45-minute session about dementia. This ensures that, no matter what role people have in the hospital, we provide them with an important basic understanding of dementia.

At GJNH we also organise a lot of training for local workers who may encounter people with dementia, their families or carers – yet aren't necessarily hospital staff. For instance, the hospital receives a lot of support from local volunteers and we're encouraging them to link into our Dementia Education Days so they have a foundational understanding of dementia. Our site is also unique in that it has an on-site hotel – the Beardmore Hotel. We are currently in discussions with the hotel to organise dementia-related training for their staff. The relatives of people with dementia often stay in the hotel, and this will help to ensure any worker on the GJNH site is trained fully.

3. Plan and prepare for admission and discharge

The main initiative we have undertaken around admission and discharge is the introduction of the 4 Question Abbreviated Mental Test (AMT4) form for outpatients and pre-operation patients. At GJNH, we mainly receive patients visiting for elective surgery. This means that initial assessments and admissions processes have already been completed by the time they arrive. The AMT4 form is a smaller, streamlined version of the full 4AT form, consisting of only the 4AT's second step (simple questions about their age, date of birth, and where they are). This quick test is performed after admission and before operations, as a quick evaluation

of whether the person has cognitive impairment or dementia. If the person fails the AMT4 that flags up that our staff need to use a full 4AT form. I have been performing a monthly audit on all the care notes across our five wards, and compliance to-date has been 100 per cent. We plan on moving this tool forward to tie to other assessments surrounding delirium.

At the end of 2014, GJNH also updated its boarding policy, and I took this opportunity to put a statement in the documentation to specify that people with dementia who arrive in GJNH should not be boarded out to other areas if possible. This ensures that there is a directive to avoid unnecessary transmission or discharge from our hospital, which can be a challenging experience for a person with dementia.

4. Develop and embed person-centred assessment and care planning

If a person is recognised as having a cognitive impairment pre-admission assessment, the patient and family are given the opportunity to fill out a Getting to Know Me document, which helps us identify any cognitive impairment but also helps us plan our care around their preferences. We begin with a strong position at GJNH regarding person-centred care planning, as patients are typically here for elective surgery – they have



often specified their needs and backgrounds before arrival, and the previous healthcare service will pass this information to us.

5. Promote a rights-based and anti-discriminatory culture

Recently we organised a very successful education day about capacity and consent. As a national group, the Alzheimer Scotland Dementia Nurse Consultants are developing capacity and consent paperwork which we would attach to the delirium TIME bundle at the GJNH. This brings together the Adults with Incapacity (Scotland) Act 2000, section 47 and associated treatment plan. 30 people attended the training day, from various backgrounds including Dementia Champions, the Clinical Education Team, Senior Charge Nurses, Nurse Practitioners and AHPs. This will help ensure that the rights of people with dementia are adhered to fully throughout our daily guidance processes.

We have recently organised a community engagement initiative at GJNH and performed a 'Fairness Test' around this. Our Fairness Test protocol ensures that our initiatives or programmes are not discriminatory in any way, taking into account the Human Rights Act 1998.

Our community engagement project consists of a monthly Dementia Café, organised in support of Alzheimer Scotland's West Dunbartonshire services. This initiative raises awareness of people with dementia and how they can be treated respectfully in the hospital context. We offered the space for the local Dementia Advisor Fiona Kane who was encountering challenges in terms of finding space for the café. The café runs every two weeks, from mid-September through to mid-December. It is being held in the hospital canteen, during a quiet time of day and will include reminiscence. We will reassess the café and its impact after the initial project is completed.

6. Develop a safe and therapeutic environment

We have organised dementia-friendly rooms in our four main ward areas. In each ward area (two orthopaedic wards, one thoracic ward and one cardiothoracic ward) we have two dementia-friendly rooms (eight in total). This year we completed a refurbishment programme in the orthopaedic wards, which finalised the four most recent rooms. These areas have clear toilet signs and orientation signs, large clocks and white boards, and we encourage relatives to bring in personalised items or activities for people with dementia. The rooms are also large enough for families, friends or carers to stay in overnight if they wish in line with our flexible opening hours, ensuring that people with dementia feel as safe and secure as possible in the hospital environment.

7. Use evidence-based screening and assessment tools for diagnosis

The AMT4 and 4AT assessment tools are both used on our wards for diagnosis at the admission stage for patients over the age of



65. Both of these are validated assessment tools and we have subsequently found that wards have been in 100% compliance with the AMT-4 tool, since my audits began in April.

Since September we have begun organising an education programme to help roll-out and embed the use of the delirium TIME bundle. This comprehensive delirium support toolkit is currently used in two of our four wards, and we are taking it forward to our cardiothoracic and thoracic wards.

8. Work as equal partners with families, friends and carers

We have rolled out the Getting to Know Me document in our cardiology wards at the pre-assessment stage. It is currently used with orthopaedic outpatients and we receive positive feedback from the use of this document. We are going to audit our implementation further, analysing how frequently they are being used. Our Dementia Champion in Cardiology and her Senior Charge Nurse will take this project forward.

We work with members of the GJNH volunteers group, who offer help and support on our wards. This includes support for carers, family members or friends of people with dementia. The Alzheimer Scotland Dementia Café held in our canteen is open to inpatients with dementia and their relatives or carers. Across all of our wards we have placed posters of the hospital's Dementia Champions, so that carers know who to contact on the ward if they need any further support or advice.

9. Minimise and respond appropriately to stress and distress

An important factor in stress and distress relates to delirium and the management of delirium. From October, we are implementing the delirium TIME bundle where

appropriate to manage stress and distress. Four of our wards are rolling this out as a test project. In addition to this, a delirium-focused question, SQiD (Single Question in Delirium) has been added into every nurse's care rounding paperwork, which has a yes/no answer and can be asked by any member of staff. If the answer is yes, a senior member of staff is notified and the assessment is escalated to the delirium TIME bundle.

We have organised broader systems regarding delirium to ensure that guidelines for prevention, diagnosis and management of delirium are in place across our wards. We are implementing filing and management systems so that, from October, I can access case notes at any time and analyse how our guidelines and paperwork is being used. We are aiming to report fully on outcomes surrounding the use of these bundles and guidelines by the end of the year.

10. Evidence the impact of changes against patient experience and outcomes

During my monthly audits of the AMT4 tool implementation, whenever I encounter a patient who scored low on the test, I make sure to check their care as a follow-up process. I examine their notes to ensure their care pathway was appropriate and person-centred, for example how their care continued and if they experienced any cognitive improvement. I look at how care can be improved in this context by talking to staff who were involved in their pathway. We also work with nurses from our wards to gain admission feedback from the Getting to Know Me document, and hand out feedback forms during the Alzheimer Scotland Dementia Café in the canteen. Currently, our change measurement processes are quantitative, although as we receive more data from the recently implemented delirium TIME bundle, we will combine qualitative and quantitative data into this audit process.

'The Alzheimer Scotland Dementia Café held in our canteen is open to inpatients with dementia and their relatives or carers.'

Ruth Mantle

Alzheimer Scotland Dementia Nurse Consultant, NHS Highland



1. Identify a leadership structure within NHS Boards to drive and monitor improvements

NHS Highland has developed its leadership structure to include a 'care experience group' which leads on the work in the Board around dementia, person-centred care and the Older People in Acute Hospital (OPAH) standards of care (2015). This group is accountable to the NHS Highland Clinical Governance Committee, which monitors whether care delivered is consistent with national standards of care and also how this aligns with the vision of NHS Highland's Quality Approach, aiming to put quality first. This ensures our work is linked directly with the experiences of people with dementia in hospital settings, and that we are able to advise members of the board and individual hospitals on areas for improvement.

Our board nurse director is the executive lead for the 10 Dementia Care Actions and I am the operational lead. NHS Highland also has a dementia nurse practitioner who focuses on supporting the implementation of the Standards of Care for Dementia in the general hospital setting.

2. Develop the workforce in line with Promoting Excellence

We have been promoting the development of the Dementia Champions as leaders in dementia care in hospital and community settings. The last hour of the recently established 'Dementia Action Network' meetings provides dedicated time for the Dementia Champions to meet together, and a community of practice has been developed for the Dementia Champions and others interested in making a difference

in dementia care. We now have 35 active champions in the NHS Highland region, with nine more just finishing our sixth cohort. The board nursing director has authorised a directive for Dementia Champions to receive a minimum of 7.5 hours per month pro rota of protected learning time to undertake this role. We have found that the majority of them do now receive protected learning time.

We have developed a dementia training guide which brings together all the training opportunities available to staff across the four levels of the Promoting Excellence framework (2011). The guide is being used widely, and we continue to evaluate uptake and map this against the Promoting Excellence skill levels.

NHS Highland has worked in partnership with Alzheimer Scotland and the University of Stirling's (UoS) School of Health Sciences (Highland campus) to develop the 'Being Dementia Smart' programme. This is at the 'Enhanced' level of Promoting Excellence framework, and from September 2014 it became mandatory for all UoS's nursing students on the adult and older adult mental health courses to take part in 'Being Dementia Smart'. This work also extends to the Western Isles, and is helping ensure that newly qualified nursing staff have the appropriate knowledge and skills to care for people with dementia. The programme was shortlisted as a finalist in Scotland's Dementia Awards 2015.

We use learnPro across NHS Highland to ensure our staff have access to appropriate directed learning whenever they need it. A variety of modules are available to NHS Highland staff, including dementia

awareness training that is specific to acute hospital and emergency departments; training in the Adults with Incapacity (Scotland) Act 2000 (AWIA); and delirium modules developed by NES. learnPro also enables me to keep track of staff progress – who has used it, what they have accessed, and where we need to target specific training. There are also opportunities for face-to-face training which are adapted to meet specific requirements and identified need of each audience

3. Plan and prepare for admission and discharge

We have revised the guidance around our admission, transfer and discharge protocol to ensure that these practises take into account the needs of people living with dementia. For instance, that people with dementia should only be moved from ward to ward or within a ward where it is essential for their care and treatment. More detailed guidance is included in the policy for the movement of people with dementia, cognitive impairment and/or delirium.

In the last year, we have worked with the Scottish Ambulance Service to help support them to introduce the 4AT assessment tool. This has been linked into work to ensure that the 4AT is incorporated fully into the NHS Highland frailty pathway being developed, from the ambulance service's role through to our wards – making sure there is a streamlined and tailored journey for people with dementia. The NHS Highland frailty screening tools are based on the national work being taken forward by Healthcare Improvement Scotland, but have been adapted to reflect the different services delivered by a rural general hospital.

4. Develop and embed person-centred assessment and care planning

As well as rolling out Getting to Know Me across all of the ward areas in NHS Highland, we have also included a clear prompt for its use within our revised nursing documentation, which has helped increase awareness and its uptake. The focus is now on ensuring key personal information from the Getting to Know Me document (or similar) helps to inform the care given to people with dementia. With the support from the dementia nurse practitioner and the national Person-Centred Health and Care Collaborative, the Belford Hospital in Fort William has been undertaking small tests of change to improve care planning and ensure that these are personalised through information

gathered from the Getting to Know Me and capture what is important to the person. The tool is also having a positive impact on multidisciplinary and partnership working.

We have introduced changes to how we use Getting to Know Me, as it was originally nationally promoted to be completed upon/during a person's admission to hospital, but because this isn't always practical we emphasise completion at the earliest appropriate opportunity in the community. We have worked with our local Alzheimer Scotland Link Workers who are using Getting to Know Me as part of the post-diagnostic support they provide as well as community health and social care teams.

5. Promote a rights-based and anti-discriminatory culture

The NHS Highland board is the first NHS Scotland board to have introduced the Dementia Friends programme at board level. Our board members undertook Dementia Friends training at the beginning of 2015, and we are making a broader drive to train as many of our staff as possible as dementia friends. This has helped ensure that dementia continues to have a high profile on the board and that the rights and voices of people with dementia and carers are taken into account from the very top of our leadership structure.

We have developed a board-wide training programme focusing on the AWIA. It is mandatory for all staff involved in the clinical care of a person with dementia to take part in the training so that they fully understand the ramifications of decisions surrounding the care of people with dementia. We deliver training face-to-face or using learnPro. To date, almost 800 staff have completed the training.

6. Develop a safe and therapeutic environment

Over the last year, our general hospitals have started using the King's Fund's 'Enhancing the Healing Environment' assessment tool. This enables us to identify ways in which we can improve the environment, for instance by using appropriate colour contrast for walls or doors, or improving lighting. NHS Highland's estate team has made preparations for dementia-friendly upgrades to be completed whenever renovation work is required. Members of the estate team have also attended Dementia Services Development Centre environment and design training at the University of

Stirling to give them an overview of the type of changes that will benefit people with dementia in a hospital environment.

I have been working with the NHS Highland procurement team to create a list of core dementia-friendly items. These include toilet seats that contrast in colour with their surroundings, coloured crockery and easy to read analogue clocks. The project has been formally incorporated into the board's procurement programme.

7. Use evidence-based screening and assessment tools for diagnosis

People with dementia are at an increased risk of developing delirium which can lead to poor outcomes of care including a premature death. In recognition of the importance of identifying delirium at the earliest opportunity, we have rolled out use of the 4AT assessment tool for delirium. This has been incorporated into the National Early Warning Score (NEWS) system which is a structured framework developed by the Royal College of Physicians in partnership with patients and other professional groups to standardise the assessment of acute-illness severity in the NHS. As well as the 4AT tool, we are in the process of introducing the delirium TIME bundle, developed in partnership with the Scottish Delirium Association, which assists with the early identification and management of delirium.

This year we received an unannounced OPAH inspection at Caithness General Hospital. Their report provided positive feedback on the implementation of 4AT and the TIME bundle. Both were described as being embedded and implemented very well throughout the hospital. Across the board, we have achieved an increase in the use of the 4AT, and our next step is to ensure that the TIME bundle is introduced and used across all our hospitals.

8. Work as equal partners with families, friends and carers

NHS Highland produces a local newspaper which is delivered to households across the board area. We use this as an opportunity to communicate with the public about initiatives or developments that are taking place, including those relating to dementia. Earlier this year, I met with the board's chief operations officer to discuss ways of raising awareness around key issues affecting people with dementia and their families, for example, promoting the use of Power of Attorney. This has helped ensure that dementia issues have high visibility in the newspaper including the Getting to Know Me tool and how its use can positively support people with dementia admitted into hospital.

We work with a local voluntary organisation, Connecting Carers who offer assistance to carers for example through the completion of support plans to help meet their individual needs and with discharge planning. I have linked with them to help raise awareness and ensure that carers, family members and staff know about this invaluable service.

Raigmore Hospital in Inverness is also a member of the Butterfly Scheme which enables staff to identify people with dementia at the earliest opportunity and provides a system of hospital care for people with dementia, making it easier for carers and families to opt into a specific care response and information sharing network. We are also exploring ways to support similar work in our other general hospitals.

I link in with local carers groups and attend Alzheimer Scotland's dementia cafés whenever I can. This provides a chance to meet with local people with dementia and carers, and liaise with hospital staff for instance if a loved one has been admitted to hospital and they have any concerns.

9. Minimise and respond appropriately to stress and distress

I have completed NES's Psychology and Psychological Interventions in Dementia training and am now a trainer for that course. I, along with other colleagues, deliver training workshops about stress and distress in dementia to health and social care staff with targeted sessions provided for the acute general hospital setting. These have been delivered in all four acute general hospitals but colleagues from the community, including care homes and general hospitals, are also welcome. We are establishing a monthly programme of stress and distress workshops in the NHS Highland region to commence early 2016 to further support and develop the knowledge and understanding of staff around stress and distress.

The workshops' overall aim is to support staff to meet the needs of a person with dementia who is distressed and to understand the different types, causes and triggers of stress and distressed behaviour from a biological, psychological, social and environmental perspective.

This ensures that teams are optimally equipped to promote the wellbeing of people with dementia in our hospitals. We deliver training relating to stress and distress both face-to-face and through learnPro.

10. Evidence the impact of changes against patient experience and outcomes

We are currently reviewing the information we gather to ensure that we are collecting the type of data that will enable us to measure the effect of our work against the person's experiences and outcomes. To do this, I have been liaising with the Clinical Governance Team and exploring ways to maximise opportunities for capturing the person with dementia, their carers and the workforce's experiences.

Other work

I believe it is important to ensure that the voices of people living with dementia and carers are at the heart of the work we take forward to help improve the care experience, and with this in mind we have developed close links with the Highland Dementia Working Group, Alzheimer Scotland and carer groups.

I have established a dementia action network in the NHS Highland board area in partnership with Alzheimer Scotland. This provides a forum to bring together staff working in health and social care, third sector organisations, people with dementia, carers to discuss their experiences, along with key pieces of work being taken forward and identifying next steps.

I have been doing a lot of awareness-raising around positive risk-taking in dementia. It is sometimes too easy to focus on what someone can't do rather than what they can. In this work I highlight how risk-averse we can be as an organisation, particularly when supporting people with dementia, and how this can negatively impact on a person's wellbeing. I promote an approach which maximises a person's strengths and abilities. I delivered a NES masterclass in Edinburgh with a national dementia AHP consultant colleague, and received very positive feedback from the health and social care staff audience. I was approached by Professor Charlotte Clarke to co-author a paper on positive risk-taking in dementia which has been accepted for publication in the national nursing journal the Nursing Standard.

At the beginning of this year, I was awarded a Winston Churchill Memorial Trust Travel Fellowship which has enabled me to travel and gather information about different approaches to dementia in the USA and Australia. As part of the fellowship I presented at the Alzheimer Disease International Conference in Australia on Scotland's National Dementia Strategy and the work taking place to improve the experience for people with dementia admitted into hospital. I have established many positive links with colleagues from around the world including the national lead for dementia care in acute hospitals in Australia.

Lyn Irvine-Brinklow Alzheimer Scotland Dementia Nurse Consultant, NHS Grampian



1. Identify a leadership structure within NHS Boards to drive and monitor improvements

Within the NHS Grampian board there is a clear leadership structure in place to monitor and drive improvements. There is an established Older People's Acute Hospital Steering Group (OPAH), which meets monthly and is chaired by the Director of Nursing, Midwifery and AHPs. An Acute Dementia Strategy Group has been developed in the acute sector, chaired by myself. This group reports directly to the OPAH group. This ensures there is a consistent approach to driving forward commitment 10 of Scotland's National Dementia Strategy 2013-2016.

Within the Acute Dementia Strategy Group, each division/sector report monthly on activity being implemented at a local level. These sectors report to the group using the national template supplied by the Scottish Government, which we are using as a concurrent activity document. This enables us to highlight clinical progress and action plans that support the implementation of the 10 dementia care actions in hospital, documenting improvements and highlighting challenges. These divisional reports provide



the Acute Dementia Strategy Group with the information to evidence improvement in relation to the 10 dementia care actions in the acute setting.

I provide leadership to the Dementia Champion and Best Practice network across NHS Grampian, and provide support to the local networks at Dr Gray's Hospital and Woodend Hospital. These networks pertain to our board's Dementia Champions and our staff trained in the Dementia Services Development Centre's (DSDC) 'Best practice in dementia care' programme, both of which are educational and learning programmes for healthcare staff. By meeting with and supporting these two key staff groups, we can ensure that these staff are utilising their knowledge and skills.

2. Develop the workforce in line with Promoting Excellence

We consistently work with NHS Education for Scotland, Alzheimer Scotland, Robert Gordon University (RGU), the University of the West of Scotland (UWS) and the DSDC at the University of Stirling to ensure that our staff are educated and are competent and confident in their roles in line with the Promoting Excellence framework. We



recently reviewed and updated our NHS Grampian education and training guidance: a document which highlights all the education and training opportunities that are available locally and nationally for staff to support their learning needs (including topics relating to dementia care). I am currently involved with and deliver education in RGU's School of Nursing and Midwifery and the School of Pharmacy to support pre and post-registration education this is done in collaboration with a variety of stakeholders.

I am the NHS Grampian lead for the Dementia Champions programme, handling all recruitment and identifying staff to be nominated for the participation and supporting staff throughout the programme and on completion. I do this by meeting staff individually and/or meeting with their manager on a regular basis. We now have 55 Dementia Champions across the board, with an exceptionally high completion rate.

To ensure that our staff and professional groups have access to education surrounding dementia, we organise regular training meetings with key experts and workstream leads. For example, our Dementia in the Acute Hospital study day includes input from expert leads, medical colleagues, Dementia Champions and carers, who share their experiences and knowledge with staff.

3. Plan and prepare for admission and discharge

We recently developed our policy regarding the assessment of cognitive impairment in older adults and impact on capacity to consent to care and treatment. This includes making sure our admission pathways support people with dementia as much as possible, for example simple processes like completing a Getting to Know Me document or involving family members or carers in every discussion about the person's care.

This approach extends to our policies, principles and guidance surrounding transfers and discharge. We ensure that ward or room transfers are limited as much as possible, because this is shown to increase length of stays and levels of stress. Supporting people who may experience stress and distress is also a key aspect of our pathway guidance.

Several of our clinical areas also have discharge co-ordinators in place. These members of the team

focus on supporting the person throughout their admission and preparation for discharge, ensuring the pathway and process is as person-centred as possible.

4. Develop and embed person-centred assessment and care planning

The Getting to Know Me document has been rolled out across all of our acute hospitals and wards. This tool helps staff collect all the information they need to get to know the person they are caring for and understand who and what is important to them. We also offer the document within Aberdeen Royal Infirmary and across Grampian in our Healthpoint/ Carerspoint facilities. These are resource centres which provide a dedicated area of resources for members of the public, people with dementia, their carers and families. It has information about older people's care, legislation, dementia care including the Getting to Know Me document.

The document has also impacted on other areas of improvement. There are currently Dementia Champions and colleagues carrying out improvement work developing person centred care plans supported by tools such as the getting to know me document and the Abbey pain tool (a tool which allows us to overcome the challenge of diagnosing pain in people who are unable to clearly articulate their needs or verbalise pain). The OPAH collaborative approach supports opportunities to test changes and make improvements.

We have also implemented systems developed by the Person-Centred Health and Care Collaborative to listen to people with dementia in our acute hospitals and meet their needs more appropriately. These include the five 'Must do with me' topics, which are useful planning points that work effectively in tandem with the Getting to Know Me document. They help us understand who is important to the person, what is important to them in their care, and ensure they have all the information and support they need.

5. Promote a rights-based and anti-discriminatory culture

We primarily promote the rights and wellbeing of people with dementia through the sharing of learning across our services. Dementia Champions and DSDC Best Practice trained staff are integral to this.

This year we also rolled out NES's Think Capacity Think Consent learning resource, which ensures staff have the opportunity to increase their knowledge and understanding of the legal processes surrounding dementia and consent. This ensures that the rights of people with dementia are safeguarded. We have delivered education on this topic face-to-face and online – providing different approaches and methods to learning.

We have used the Institute for Healthcare Improvement's (IHI) Breakthrough Series improvement methodology to implement a test of change in relation to the Adults with Incapacity (Scotland) Act 2000 (AWIA), Section 47 documentation. This has been adapted from work developed by NHS Fife and has been well received.

6. Develop a safe and therapeutic environment

We have rolled out national dementia-friendly signage across our hospital sites and developed our own NHS Grampian dementia design guidelines earlier this year. This work was developed with colleagues in our older adult mental health team who are trained auditors with the DSDC's design school. We are actively involved in any refurbishments to the acute hospital settings, providing guidance on the principles of dementia-enabling and dementia-friendly environments.

I support staff across the region to implement environmental changes in the clinical context. For example, staff at Woodend Hospital in Aberdeen recently purchased a RemPod which can be placed in the ward or room setting, featuring familiar places or images for people with dementia. Several of my colleagues are also developing 'activity boxes' on the wards. These consist of a selection of reminiscence or interactive items, for example football memorabilia, postcards or skittles and bowls. One of our hospitals also features a 'reminiscence wall,' which is a wall-sized mural displaying historic places of interest

in Aberdeen. We have received positive feedback about these projects from patients, family members, carers and staff. We have introduced dementia-friendly crockery across NHS Grampian in all in-patient settings. This ensures that we provide an equitable service for all.

7. Use evidence-based screening and assessment tools for diagnosis

In July we launched the 4AT screening tool within the acute sector. This will support the Older People's Acute Hospital Standards, June 2015 and commitment 10 of Scotland's National Dementia Strategy. These have been integrated within our acute hospital improvement work in partnership with our OPAH Collaborative. This is currently supporting over 20 wards to implement positive changes to support care of older people and their families and carers.

We have held educational sessions in relation to the 4AT, which were delivered jointly by myself, the improvement advisor, and medical colleagues to raise awareness and understanding of the tool and its role in supporting people with cognitive impairment, dementia and delirium in the acute hospital setting.

8. Work as equal partners with families, friends and carers

An example of the widespread improvements to our acute hospital care is the adoption of open or person-centred visiting hours in several of our clinical areas. The flexibility for the families and carers of people with dementia to visit flexibly. This supports and enhances the importance of family, friends and carers as equal partners in care. We have received very positive feedback across the region about this initiative, from patients as well as family members.

We have made the first level of Equal Partners in Care (EPiC) training available to our workforce through our online learning platform. EPiC informs staff about the

importance of working closely with the carers, family and friends of anyone in our care, and emphasises the importance of working equally with family and carers to ensure that we deliver person centred care.

9. Minimise and respond appropriately to stress and distress

A significant piece of work relating to stress and distress relates to our nationally-recognised partnership with the charity Playlist for Life. In February, the Playlist for Life lead for NHS Grampian organised a steering group for the Playlist for Life project, consisting of professional staff from various clinical teams including older adult mental health liaison colleagues. 28 Playlist for Life 'starter packs' were distributed across NHS Grampian – these include an iPod, disposable headphones, and speakers.

We have experienced positive feedback from families and carers about the impact of the Playlist for Life project. It was featured on BBC Scotland news and national radio stations, and has been promoted as part of Playlist for Life's national marketing. Researchers from Glasgow Caledonian University made contact with us to conduct research based on our initiative. As part of the project we plan to communicate with care services when the person is discharged from the acute setting, to ensure that where the Playlist for Life has provided a positive experience and reduced stress and distress levels that this can continue to be utilised and supported in the community environment as well as the hospital one.

10. Evidence the impact of changes against patient experience and outcomes

NHS Grampian participates in patient opinions and real-time feedback processes. For example, we have carer involvement to share their experiences within our OPAH collaborative learning sessions and educational events.

The Older People in Acute Care collaborative, which is being taken forward as part of our overall improvement planning. We have support from an OPAH improvement advisor three days a week at local level who works nationally with Health Improvement Scotland two days

a week. Our clinical teams, as part of the collaborative, make small changes to their practice and test these changes. This partnership ensures that improvements and changes support the 10 dementia care actions in hospital and support positive outcomes for people with dementia being cared for in our clinical settings, and for their family, friends and carers also.

Other work

We held our inaugural dementia conference in June, just after Alzheimer Scotland's Dementia Awareness Week. I was a member of the steering group for the event, and a key speaker on the day, which was attended by 250 delegates. It involved close partnership working with the Scottish Dementia Working Group, Alzheimer Scotland and the senior staff of the DSDC. Representation from acute care, primary care, secondary care. The conference provided the opportunity for concurrent sessions on a varied number of topics relating to dementia care, evidence based practice and innovation.

In my role I am the lead for dementia care mapping in NHS Grampian. Dementia care mapping has been implemented to support the work in relation to Commitment 11 of Scotland's National Dementia Strategy, 2013–2016. dementia care mapping encompasses the person-centred care approach to care, turning the philosophy of person-centred care, into actions.

In my role I have supported two change fund projects in relation to the Promoting Excellence framework. The first involved training council, social care and volunteer workers across the region in the 'Informed' level of the framework. I developed the proposal with colleagues, and in total, 186 individuals across the NHS Grampian region were trained and supported as part of this initiative. The second project involved offering staff within the Older Adult Mental Health Directorate the opportunity to attend facilitated workshops in the 'Informed' and 'Skilled' levels of the Promoting Excellence framework. I also supported a third change fund project in Aberdeen City, working with GP practice managers, Alzheimer Scotland in relation to dementia education and awareness.

Colin MacDonald Alzheimer Scotland Dementia Nurse Consultant, NHS Lothian



1. Identify a leadership structure within NHS Boards to drive and monitor improvements

NHS Lothian has set up a steering group focusing on improving care for vulnerable patients, and I am a key member of this group. Supporting patients with dementia is a major strand of this work. The steering group is underpinned by a Quality Improvement Framework and action plan. This links directly to the Standards for Older People in Hospitals (OPAH), and Commitment 10 (Dementia Care Actions) and provides the necessary leadership structure to drive and monitor improvements. The Action Plan is reviewed on an ongoing basis via the steering group.

2. Develop the workforce in line with Promoting Excellence

The steering group described above includes an education strand, and I am a key member of the group taking forward this work. I am also involved in delivering training to a range of different staff groups including doctors, nurses and AHPs. This has included informal, ad hoc training which is provided on demand, as well more formal approaches such as speaking to groups



of undergraduates at Queen Margaret or Napier Universities (e.g. dementia presentation on the Clinical decision making course). The majority of these nurses work in acute settings. This training is enabling existing staff to enhance their knowledge of dementia in relation to their clinical decision-making capabilities.

3. Plan and prepare for admission and discharge

I have been centrally involved in the roll-out of the 4AT delirium screening tool across all acute wards. This process began with a piloting phase more than 18 months ago, and I was one of the team involved in this process. New documentation has also been introduced and the whole process of hospital admission has been reviewed, particularly for people over the age of 65. Pilot areas continue to expand and develop the use of the 4AT. This includes the introduction of the delirium TIME bundle, with mechanisms in place to reassess patients if a change in their clinical condition is observed. Data is being gathered on the impact of introducing the 4AT through the steering group described above, and a test site in ward 120 of the Edinburgh Royal Infirmary (further expanded on in point 8). Getting to Know Me forms have now been introduced in all clinical areas across the main acute hospitals in Lothian to provide more person-centred information at the earliest point of admission. This links with further testing and developments of this form in action point 8.

4. Develop and embed person-centred assessment and care planning

My work towards this action point links to Getting to Know Me and how we are using the information we gather to enhance person-centred care. For instance, when writing care plans there is a strong emphasis on including relevant personalised information. Good, personalised care planning continues to be a challenge, but staff are being supported to improve care planning and make this more relevant to individual patients. NHS Lothian's Bridging Team are a group of mental health nurses and an occupational therapist who are based in the acute hospital. They provide staff in clinical areas with specialist advice and support if they require help when caring for older people with mental health needs on a wide range of issues, including care planning. The Bridging Team provides a visible and responsive service from 9 to 5, Monday to Friday, across three sites: Edinburgh Royal Infirmary; the Royal Victoria Building and Western General Hospital; and Liberton Hospital. I was instrumental in setting up this service which is now embedded into the acute hospital system, and highly regarded by hospital clinicians.

5. Promote a rights-based and anti-discriminatory culture

Ensuring staff understand issues around capacity and consent continues to be a major part of my role. This has been integrated into key clinical training provided to staff across NHS Lothian. The training and education team deliver two-hourly presentations on dementia and cognitive impairment, which I helped to set up. In addition, 'Think capacity, think consent' training has been developed for the learnPro platform, providing a means for all staff to stay up to date with issues around capacity and consent.

6. Develop a safe and therapeutic environment

I led the 'environment and communication' strand of the Quality Improvement framework. A major outcome of this strand was to plan and oversee the implementation of dementia-friendly environmental adaptations as part of a rolling programme to almost all clinical areas in our main acute hospitals in Lothian. This included new dementia friendly signage; installation of new clocks and calendars; and the provision of toilet seats that

contrast clearly with the surroundings. This work was completed with significant support from Jenny Reid, AHP Dementia Consultant, along with two members of the NHS Lothian estates team, one of whom had undergone specialist training with the Dementia Services Development Centre (University of Stirling). The work included development of a guidance form to enable departments to assess what new materials they required. During the roll-out phase we made significant efforts to ensure maximum consistency across locations.

7. Use evidence-based screening and assessment tools for diagnosis

In addition to the work described under point 3 relating to the 4AT, I have developed a dementia toolkit that is available to all staff via the intranet. Among other items, this includes examples of a range of tools that staff can use to assess for depression, delirium and pain. This is also linked to the vulnerable patients resource pack, which has been made available in both written and printed form. It is helping to ensure that staff know where to find the information they require, as well as providing a clear route to best practice.

8. Work as equal partners with families, friends and carers

Getting to Know Me forms have now been introduced in all clinical areas across the main acute hospitals in Lothian. Again, the steering group has been monitoring how these are being used, and in the majority of wards completion of the forms has been standardised as routine practice. A test site has also been set up in ward 106 at Edinburgh Royal Infirmary and we are using this to evaluate what Getting to Know Me is changing in practical terms. For example, we want to know what impact it is having on people with dementia and their families. Questionnaires have been circulated to staff and carers with a view to measuring impact. Data will be available in the early part of 2017.

9. Minimise and respond appropriately to stress and distress

I have developed a checklist which forms part of the dementia toolkit and this relates to behaviour that challenges (stress and distress). It provides a robust assessment tool that helps staff to either identify

or rule out factors that can lead to behaviour that challenges, such as pain, infection or depression.

Another part of my work involves measuring the impact of how staff deal with patients who present with stress and distress. Piloting is underway in ward 120 at Edinburgh Royal Infirmary (as a test site) to measure baseline levels of stress and distress among patients with dementia and delirium, and then see if the approaches we subsequently introduced are leading to a reduction in this, or improved outcomes. Questionnaires have been circulated to staff and relatives to obtain initial measurements, after which staff will be trained to be more aware of situations that may lead to stress and distress, and to respond to them optimally. This includes the use of the dementia toolkit, education and training, and the introduction of the TIME bundle (Think; Investigate; Manage; Engage) to help identify and manage delirium. Questionnaires alongside other measurable data will be collected every three months, to establish the impact of these approaches.

An initiative that I am particularly proud of is the Edinburgh Behaviour Support Service (EBSS). Although this was community-based, it was designed to avoid the need for people to be admitted to acute care, and to support them in their most familiar home setting (this may have been a care home). I was instrumental in the design and set-up of this service, which started in January 2013. It was formally evaluated by Queen Margaret University, and highlighted some amazing results and outcomes. Of the 381 patients who were formally evaluated only 19 (>5%) required a hospital admission, and 324 (85%) stayed in the place they called home without moving. On a follow-up audit it was found that, of those patients originally seen by the EBSS, >1% were re-referred to the Mental Health service/EBSS in the following year indicating the sustainability of this intervention. Another significant outcome was the average reduction of 50% in the stress and distress of people with dementia, as well as similar results for staff who cared for them (using the Neuropsychiatric Inventory or NPI). Other positive outcomes included a reduction in the use of antipsychotic medications and improved carer (and care home staff) satisfaction. Sadly, funding could not be secured to fund the service beyond March 2015.

10. Evidence the impact of changes against patient experience and outcomes

This action point links with the piloting work described above being carried out on two wards (test sites) at Edinburgh Royal Infirmary, where questionnaires are being used to measure the experiences of patients and their carers. A related initiative within NHS Lothian that I am not directly associated with, but which complements the work of Care action 8, is the 'Tell me ten things' questionnaire.

Other work

I am a key member of the Post Diagnostic Project Group in Edinburgh, which is an integrated team that has helped to review and develop post-diagnostic services for people with dementia in Edinburgh. This has included introducing and embedding six Alzheimer Scotland Post Diagnostic Support workers across Edinburgh. This group has also launched a dementia anti-stigma campaign and continues to work with community partners and businesses to make Edinburgh a dementia-friendly city.

In addition, both myself and Jenny Reid play an important role in supporting our local Dementia Champions. Support meetings are held every two months across four site-based groups. Jenny or I lead the meetings, which provide an opportunity to bring the champions up to date with new developments, while also giving them a chance to feed back to us on the work they are doing and any support they need.

A significant part of my work relates to clinical care, and I provide specialist input into clinical cases, working with the community mental health team in this area. This work includes meeting people with dementia and their families in their own homes, in hospitals and in care homes. This means that in addition to influencing important things like staff training, part of my job also involves working as a role model to demonstrate and share good practice.

Jenny Reid AHP Dementia Consultant, NHS Lothian

In NHS Lothian, the AHP Dementia Consultant has a memorandum agreement (MoA) like the Alzheimer Scotland Dementia Nurse Consultants, but ours has a slightly different focus with a different funding structure. One action from my MoA is focused on the second care action point of Commitment 10.

To achieve this goal, I have worked with AHP colleagues and the AHP director in NHS Lothian to create a Train the Trainer project. This offers a sustainable way of ensuring that staff are trained to the Skilled level of the Promoting Excellence framework, and a huge number of AHPs and professionals have taken part in the initiative. This year, our first cohort of 30 AHPs completed the training in NHS Lothian and the three surrounding local authority areas. The staff who took part have rolled the training out to their own colleagues using NHS NES resources available online.

We evaluated the programme under NES learning outcomes, and asked the staff to tell us about the impact of the training on their colleagues and practise. This ensures the training isn't just a box-ticking

exercise – we received positive feedback and more useful qualitative data about how these AHPs put their learning into practice. Recently we have started training the programme's second cohort of AHPs. Out of the 30 who are already trained, this includes some teams of staff from across the allied health professions – we call these 'dementia-friendly AHP teams'.

Another project which links directly with Commitment 10 is our AHP initiative called Delivering Leadership Excellence. This involves leadership training delivered through a series of study days which take place throughout the year. Halfway through the programme, the members are asked to create a project based on one of the 10 Dementia Care Actions in Hospital. One example of this initiative is the work of a team of occupational therapists, physiotherapists and podiatrists, who are implementing the Getting to Know Me document fully within the AHP acute hospital care pathway. This will run up to December, at which point we will evaluate it and help them roll this out as a leadership system.



'I have worked with AHP colleagues and the AHP director in NHS Lothian to create a Train the Trainer project.'

Delivering Leadership Excellence has been implemented across four wards on two of our hospital sites. We have looked at many factors to evaluate the project, including: the AHPs' notes, the patients' outcomes, how many patients have a diagnosis of dementia, and how many have a Getting to Know Me document completed. One ward was especially excellent, seeing a 100% uptake of Getting to Know Me and the implementation of robust systems to ensure relatives and carers had input on the document.

In this context we are currently performing a test for change, developing 'Getting to Know Me Champions'. These staff have an extra duty to keep an eye on the Getting to Know Me process on admission and discharge. So far, they have implemented improvements like ensuring that the document goes home with the person, rather than being completed by staff and filed at the end of the admission process. More detailed feedback will be available for this project in December.



'Delivering Leadership Excellence has been implemented across four wards on two of our hospital sites.'

The AHP Director in NHS Lothian has asked me to co-ordinate Dementia Champions from an AHP perspective. Over 20 AHPs across the region have been accredited as Dementia Champions – the most that any Scottish board has. When a call for new Dementia Champion candidates is announced, I ensure I distribute the message to all our AHPs and prompt them for feedback. This allows me to see what sites required Dementia Champions in different professions and roles. AHP staff work across broad geographic areas, so I ensure that we organise a link-up event for them, which also allows them to speak to non-AHP Dementia Champions to share experiences. I work closely with Colin MacDonald, NHS Lothian's Dementia Nurse Consultant, to co-ordinate dementia education for AHPs and ensure that AHPs have a point of contact with Dementia Nurses and Dementia Champions.

Alan Murdoch Alzheimer Scotland Dementia Nurse Consultant, NHS Shetland

1. Identify a leadership structure within NHS Boards to drive and monitor improvements

I am the NHS Shetland lead for our local dementia strategy, which has been completed and approved by the board committee. In my role I focus on the strategic planning for dementia care, and collaborate with several board members and managers to roll out improvements. These include the Director of Health and Social Care who drives forward the changes structurally and our Nursing Director who sits on acute sector committees to lead on changes in the acute setting.

When I first arrived, our board made the decision to create the Clinical Nurse Specialist role to work alongside me and help by focusing on nurse-led dementia assessment and diagnosis. Between my role and our Clinical Nurse Specialist, Stephen Mullay, we handle a broad care pathway for people with dementia, from assessment to post-diagnostic support, encompassing all the roles of a consultant. We extend our focus on the 10 care actions for acute hospitals into being community initiatives as well as hospital initiatives. There are no community hospitals in NHS Shetland, so we extend our work to integrate with local care centres.



NHS Shetland's general hospital is in an unusual context. It is the only hospital in the region and at any given time we only have one or two people with dementia on our wards. We have not had a person admitted due to dementia specifically since 2014. This means that our care provision surrounding dementia focuses closely on integration with social care services and third sector services, like those of Alzheimer Scotland.

We have trained Dementia Champions in all of our wards – two acute wards, one surgical ward and an accident and emergency department. Our Clinical Nurse Specialist works closely with them, and we have appointed Dementia Ambassadors among the Dementia Champions who report back to my colleagues at the board and management levels. We currently have six trained champions in the hospital, with two currently in training. In the social care context, two community nurses and a social care team Team Leader are trained as Dementia Champions. Three social care staff are also trained as Dementia Ambassadors.

2. Develop the workforce in line with Promoting Excellence

It is now a mandatory requirement that all NHS staff are trained to the 'Informed' level of the Promoting Excellence framework. We ensure that this is rolled out across our board using the online learning programme learnPro.

Our Clinical Nurse Specialist takes a lead role in rolling this training out to nursing staff in the hospital. We work closely with social care colleagues and social workers, so they have been provided with hard copies of the 'Skilled' level manuals. All the hospital



staff on the surgical ward are in the process of completing this level of training, and six senior charge nurses on our acute wards are completing it also (one of them has finished it already.) In total, 28 staff in our hospital are completing the 'Skilled' level of the PE framework.

We have agreed to take forward a facilitated workshop at the 'Skilled' level for a mixture of hospital and community care staff. New Nursing and Midwifery Council requirements for nursing revalidation require 20 hours of participatory learning per month, and this workshop will link with that initiative.

3. Plan and prepare for admission and discharge

NHS Shetland sees significantly fewer than the national average of admissions of people with dementia. Due to our close partnership working with community services in terms of diagnosis and referral, we focus on the discharge stage of a person with dementia's care pathway. Despite this, we still ensure that social care staff, general practitioners and our own care staff use validated assessments like the Mini Mental State Examination (MMSE), Montreal Cognitive Assessment or ACE-III mobile component.

Our Clinical Nurse Specialist is mainly involved in the co-ordination of a person's discharge. We organise a fortnightly Dementia Services Partnership, composed of health staff, social care staff, Alzheimer Scotland staff, and any other staff relevant to a current patient's needs. When this



group meets, we discuss discharge and work through a planning checklist for anyone who requires discharge. This partnership combines social care and third sector care: the support workers will discuss at-home support or good care home options, while Alzheimer Scotland will discuss supporting the individual and the family with more information and support.

Over 2014–2015, we saw a distinct drop in delayed discharges following the implementation of this group. During the period July–September 2014, we found between one and five people with dementia experiencing delayed discharges on our wards at any given time, while from February–June 2015 we found between zero and two people with dementia experiencing delayed discharges at any given time.

4. Develop and embed person-centred assessment and care planning

Our assessment process is entirely focused around the person with dementia and we have introduced widespread improvements to this system in the last year. We use the Getting to Know Me document to ensure we have their perspective and opinion on their care, and we discuss this with their relatives or carers as part of the same process. All three admissions wards now use the Getting to Know Me document and we have introduced local social care staff to the document too, so it is used in the community at various stages. This helps ensure our person-centred approach continues into post-diagnostic support and community support.

5. Promote a rights-based and anti-discriminatory culture

Our Dementia Champions promote rights-based and person-centred attitudes towards people with dementia across our wards and this has impacted our care on many ways. They have ensured that the charter of rights is displayed on all of our wards and is

built into our nurse's documentation which is used on a daily basis.

NHS Shetland's general hospital is closely linked with the community. We work with members of the public, social care services and third sector support services. Because of this, it is important for us to promote the rights of people with dementia and reduce discrimination in the community as much as the hospital. If we act as agents for change outside of the hospital, this will result in change within the hospital. I have worked with our Alzheimer Scotland Dementia Advisor to train around 170 Dementia Friends in Shetland from a range of backgrounds, including library staff, cinema staff and community staff.

6. Develop a safe and therapeutic environment

We have performed environmental audits in all of our clinical areas. Two of our staff attended the Dementia Services Development Centre's (DSDC) Dementia Design course in Shetland two years ago and a range of people completed it, receiving Dementia Audit Certificates. Two of these members – our Clinical Nurse Specialist and an Estates Team manager – have visited all our acute wards, as well as the outpatients and accident and emergency department, and have undertaken adjustments to ensure the environment is as dementia-friendly as possible. From September 2015, the Clinical Nurse Specialist will liaise with the hospital's Finance Departments to work out a programme for further achievable improvements. At present, we have implemented standardised national dementia-friendly signage in all of our clinical areas: including clearer toilet signs, signage for bedroom areas and large clocks.

Our Clinical Nurse Specialist also gave a seminar to a local housing association, and we are developing an initiative to work with them and develop a new care housing unit for people with dementia. In the past we have developed shared flats for people with dementia, which links with our discharge processes, and have provided very positive outcomes people with dementia following discharge. We believe we have a commitment to continue providing care for people after they have left the acute hospital. If we ensure they are in a safe and therapeutic environment after discharge, it is less likely or delayed until they will be admitted again.

7. Use evidence-based screening and assessment tools for diagnosis

I lead our Dementia Assessment Service with clinical leadership from a consultant in Old Age Psychiatry at Royal Cornhill Psychiatric Hospital in Aberdeen. We have a weekly clinical meeting with her and discuss new referrals, assessments we have carried out and ongoing cases. The assessments are carried out in the person's own home, the hospital or the Care Centre if the person is resident there. Both in these assessments and during the hospital's admissions and assessment process, several validated assessment tools are used to assist with the diagnosis and assessment of people suspected of having dementia. These include the MMSE, the MoCA tool and the ACE-III mobile application. Our procedures implement these tools and also take into account the person's personal background and contacts, physical examinations, and screening for common symptoms of dementia.

The ACE-III on a tablet computer is incredibly useful for diagnosis. The person's answers to our questions are recorded digitally and results are automatically generated as you fill it in – you can then print the documentation. This helps streamline the process and give an immediate, clear idea of where deficits are, more so than the MoCA or MMSE assessments.

8. Work as equal partners with families, friends and carers

Our care planning processes fully involve the families, friends and carers of a person with dementia. They work with the person on the Getting to Know Me document, and we separately ask the families to fill in specific sections and discuss it with them. In Shetland, the families are involved at the outset of assessment, all the way through the pathway to delivering diagnosis and post-diagnostic support. We work closely with Alzheimer Scotland's Dementia Advisor for Shetland, who has begun two carer's groups – one for the partners of people with dementia, and one for the children of people with dementia. A core group of 6–8 people with dementia attend these open sessions.

We are investigating becoming participants in an international, English-led initiative called 'John's campaign', which enables carers or relatives to stay in hospital with people with dementia. The NHS Shetland board considered this a realistic idea which may have substantial benefits for people with dementia, their carers and families, and it would fit with our flexible visiting hours and our 'relatives room' where family can stay overnight. Our ward staff encourage relatives to stay for mealtimes and bring activities for people with dementia while they're in the hospital, and we are currently working to ensure our hospital meets the criteria to take part in John's Campaign.

9. Minimise and respond appropriately to stress and distress

Our Clinical Nurse Specialist, who I work with jointly, is mainly responsible for the management of stress in our acute settings and in the community. In the community, he educates social care staff about how people present with stress and distress, and ensures they know how to manage it. This helps minimise admissions to our hospital for acute stress, distress or delirium. Stephen has a wide range of experience in working in these areas and has a PhD in nursing focussing specifically on dementia. In addition, we both have access to advice from our consultant in old age psychiatry and their behavioural management team in Aberdeen if required. When the person at the hospital presents with stress or distress, our staff are trained to use the same recognised techniques to respond to stress. This includes keeping the person occupied or distracted and providing them with good lighting.

Several of our Dementia Champions have developed tailored reminiscence books to help manage stress. These large, sturdy books use a photo-album style to display Shetland's history of the fishing industry which many people with dementia used to work in. If a person with dementia presents with stress or distress on any of our wards, including accident and emergency, these reminiscence tools are on hand to ensure staff can respond with them. Through this work in the community

and in the hospital, we have reduced occurrences of patients with behaviour that is challenging due to stress or distress.

10. Evidence the impact of changes against patient experience and outcomes

NHS Shetland's Clinical Nurse Specialist has developed a questionnaire to follow-up on the experiences of people with dementia and their carers on our wards, and identify areas of change. This form collects feedback about the ward environment, the discharge process, and their personal outcomes. It also includes a section focusing about the quality of care provided, in terms of being dementia-aware, dementia-friendly or stimulating.

Feedback from our patients with dementia has improved following the implementation of our Dementia Services Partnership. If a person with dementia is admitted to the acute hospital for medical or surgical procedures, they are discharged quickly once the acute care has been delivered, and we then work closely with local social care and third sector services to ensure they are provided for in the community. The holistic nature of our care pathway, which focuses on patients on their journey from the community into the hospital and back into the community has seen reductions in stress and waiting times on our wards, as well as improved form-based feedback.

Other work

In terms of our community support, myself and the Clinical Nurse Specialist work closely together with Alzheimer Scotland in providing post-diagnostic support activities. We are actively involved in the Lerwick Dementia Café which is attended by around 40 people on a fortnightly basis for two hours. We ensure we can talk to the people who have a diagnosis and their family members or carers. We also help to organise a monthly reminiscence group at the Shetland Museum and monthly community art therapy group with a local artist, which won one of Scotland's Dementia Awards last year.

Helen Fox Alzheimer Scotland Dementia Nurse Consultant, NHS Lanarkshire

1. Identify a leadership structure within NHS Boards to drive and monitor improvements

I came into post in July 2015, and my remit is slightly different to many of the other Alzheimer Scotland Dementia Nurse Consultants. I do not work entirely within the acute hospitals context. In my role I focus on outcomes surrounding Commitments 10 and 11 of the Scottish Government's National Dementia Strategy. With this perspective, I can influence the patient's journey through a wider care pathway, from before admission all the way to post-discharge.

Within NHS Lanarkshire we have organised an Older People in Acute Hospitals (OPAH) Improvement Board, which is led by the Acute Director of Nursing and our Chief Medical Officer with multidisciplinary membership from across the board's three general hospitals (Hairmyres Hospital, Monklands Hospital and Wishaw General Hospital). The group has a robust meeting schedule and a priority within the agenda of this meeting is improving dementia care. Meeting with nurses based in the acute hospitals allows me to influence acute staff and communicate leadership goals.

I also meet with the three Mental Health Liaison Nurses for acute care to provide professional leadership/support. This includes discussing specific patients, teaching, and working with the leadership to embed improvements for patients across the board. Our Senior Nurses also hold local meetings with our Dementia Champions, and I have linked in with that process so I can provide leadership and direction for the Dementia Champions.

2. Develop the workforce in line with Promoting Excellence

I have been working closely with our Nurse Consultant for Older People, who is based in the acute hospital context. We are embedding the Promoting Excellence framework throughout our sites using various tools and platforms, and are currently establishing a benchmark for evaluation. This will allow us to profile all ward specialties and stipulate a standard of training within each of these wards to match the workforce's current level of Promoting Excellence training. We are checking that the relevant dementia-specific training has been made available to relevant staff groups, which will help to identify gaps. We are also creating 'ward profiles' to ensure that the senior charge nurse for every ward can see what level their staff are, what is appropriate for their speciality, and what is available to them, so that every ward has the relevant level of training.

NHS Lanarkshire also has 36 trained Dementia Champions across its three sites. A new tranche of eight champions are about to graduate. These champions come from various clinical backgrounds – not just nursing – so that they can advise staff they liaise with.

3. Plan and prepare for admission and discharge

I am working with our Nurse Consultant for Older People to develop a streamlined admission, transfer and discharge pathway for people with cognitive impairment or dementia. The original form of this pathway was devised before I came into post, and we are currently reassessing our protocols.



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so that patients are they are admitted and discharged sooner. This includes ensuring that staff within acute care know what tools are available to them by embedding a lot of signposting and prompting within our documentation. For instance, placing a sentence or notification about when people might need referral elsewhere in a nurse's rounds documentation. Once this trigger is seen by a nurse, the person with dementia will be linked with the ward's liaison nurse, who will prompt the next stages of admission, diagnosis or discharge.

NHS Lanarkshire's Hospital at Home service is now rolled out multiple across sites. This service featured multidisciplinary working and aims to deliver acute care within the home setting – avoiding admission or to support early discharge. We are improving links between Acute, Primary Care and Mental Health for Older Adults, and in turn our partner agencies and third sector, to ensure support measures are in place for the person with a diagnosis of dementia stay in their own home during an acute episode of illness. This helps us control acute admissions and streamline the discharge process, as we can help keep people with dementia at home for longer and discharge sooner.

4. Develop and embed person-centred assessment and care planning

When I took up post, I began working with the Nurse Consultant for Older People to improve our person-centred approach to assessment and care planning. We looked at this from a multidisciplinary perspective, tying together nursing, AHP and medical feedback.

In terms of nursing, we are focused on patient's personal outcomes. This includes assessing and working with the person's set of preferred outcomes, rather than a set of challenges. These outcomes are in line with the wishes of the person with dementia, and we can assess this using the Getting to Know Me document, which was

in place across the board before I took up post. We also use the Anticipatory Care Planning (ACP) structure to ensure that a patient's records and preferences are stored dynamically throughout their care pathway. This system is being used increasingly across our boards following the introduction of post-diagnosis counselling.

5. Promote a rights-based and anti-discriminatory culture

In Wishaw General Hospital we have worked with Alzheimer Scotland to train 500 staff as Dementia Friends. The short Dementia Friends training programme ensures that participants are aware of the needs, perspectives and experiences of people with dementia, and in the acute care setting this will help remove stigma which may surround dementia or people with dementia. We are developing plans to roll out the programme across the Hairmyres Hospital (East Kilbride) and Monklands Hospital (Airdrie) sites.

We have also recently delivered a safety brief to all of our wards about the Adults with Incapacity (Scotland) Act 2000 (AWIA). Subsequently, we visited all of the wards to increase staff's understanding of the AWIA and the rights of a patient. The safety brief has been left in wards for staff to discuss and sign, ensuring they have read and understood it. These visits also included awareness-raising on our revised paperwork for section 47 of the AWIA, which has been devised to ensure the care planning section is completed correctly. 'Think Capacity, Think Consent' was also revisited and plans are in place to monitor this.

6. Develop a safe and therapeutic environment

Several Dementia Champions have been working on dementia-friendly environment projects in NHS Lanarkshire. One of them travelled internationally and shared her experiences regarding the best practices in dementia design.

I have been liaising with the NHS Lanarkshire's property Support and Service department to ensure that any new buildings or renovations are developed with dementia-friendly practices in mind. Before I entered this post, work had already been completed and a specification list for dementia-friendly and dementia-specific environments had been endorsed. This list can be passed on to any contractors hired for building developments. This document includes dementia-friendly details, for example the ideal height of signs, font styles, and overall colour schemes or lighting approaches etc.

Within Wishaw General Hospital, care of the elderly department, and prior to my appointment, an activity area/group was set up, which sits out with the wards; this has been named 'The Club' by those who attend it. This allows for a group of patients, who have a cognitive impairment, to attend daily for therapeutic activity outside of the ward environment. Up to eight patients can participate in this group, and it is organised by three staff who are employed specifically to run it. It gives people with dementia the opportunity to take part in reminiscence activities in a safe environment, based on their own specific interests (for example writing letters or playing music).

Myself and the Mental Health Liaison Nurse for Wishaw General Hospital have provided support and influence regarding the introduction of some meaningful activities, training and record keeping. We have also introduced the Pool Activity Level (PAL) tool, which allows staff involved in 'The Club' to tailor the level of activity to the participants. The tool was developed in line with the National Clinical Practice Guideline for Dementia (NICE) and helps ensure that we do not perform any exercises with people with dementia at a level that may cause stress or distress. Staff can use the tool to evaluate the person's level of activity and ability in a personalised framework. This has proved successful for relatives and staff, who say on feedback forms that levels of stress have been minimised. Patient and relative feedback has also been positive due to the stimulating nature

of the group, and it was nominated for the Scotland's Dementia Awards in September 2015.

7. Use evidence-based screening and assessment tools for diagnosis

There is a Cognitive impairment pathway in NHS Lanarkshire for staff to follow when a patient is presenting with confusion or delirium, a 4AT is carried out and pathway will guide staff to appropriate intervention or further testing, this could include assessment using the Addenbrooke's Cognitive Examination – Third Edition (ACE-III) tool for more detailed evaluation of a patient's capacity. In addition, the Mental Health liaison service will carry out further mental health assessments including the Montreal Cognitive Assessment (MoCA). This battery of tests ensures that patients are assessed fully and appropriately for capacity and cognition. We have one Mental Health Liaison nurse on each acute site who supports staff, sharing knowledge on how to relieve or assess the behaviour of people with dementia. We have also introduced the Abbey pain scale; staff reminders are in all Medication trolleys to perform this test with any patients who have delirium or dementia.

8. Work as equal partners with families, friends and carers

The Getting to Know Me tool has been rolled out across all of our inpatient contexts. This ensures that our care is personalised to each patient with dementia or cognitive impairment, and that their family are involved in the process. As well as using the tool, we separately speak to carers or family members to gather any additional information that might impact our care.

In NHS Lanarkshire we also have a number of Carer's Champions throughout the acute hospitals, who support carers and are more informed regarding signposting. The Carer's Champions link in with Carer Co-ordinators who provide a well-established support and guidance service for relatives and carers.

9. Minimise and respond appropriately to stress and distress

300 Clinical Support Workers in NHS Lanarkshire have been trained in the Dementia Services Development Centre's Best Practice in dementia care for healthcare staff programme, which includes detailed sections on stress and distress. NHS Education Scotland mini-modules in stress and distress have also been rolled out to approximately 60 registered nursing staff. The topics in the mini-modules include 'the time machine', ABC, stress and distress in dementia and models of understanding. Prior to stress and distress training for registered nurses, the Acute Senior Nurses undertook this training, in order to have the level of knowledge to influence some changes within their area of responsibility. I have discussed the continuing roll-out of these mini-modules with the Mental Liaison service for older Adults, who are all trainers, and this will be undertaken by them and supported by myself. I am also a trainer in stress and distress. I have encouraged a few of the Dementia Champions to undertake the training for trainers programme in stress and distress, which will aid the roll-out within acute care.

10. Evidence the impact of changes against patient experience and outcomes

Patient feedback and carer feedback are blended in a combined approach across our feedback systems in NHS Lanarkshire. We give patient experience indicator forms to patients across our Acute Care of the

Elderly wards. After we have evaluated and implemented change based on this feedback, we use a 'You said, we did' system. This publicly highlights different issues on a weekly basis, and matches the verbatim statements from patients and carers to our follow-up actions on their requests. We found that the NHS's electronic feedback systems were efficient for gathering patient feedback, but weren't as effective as physical documents or verbal processes, which we have prioritised.

NHS Lanarkshire is piloting CAAS, Care Assurance Accreditation System and has ensured the 10 key actions for dementia care are included in the documentation.

Other work

As previously mentioned, my post differs from most of the other Dementia Nurse Consultants, in that it stretches across acute, mental health and primary care. I'm one of the 36 participants in the National Dementia Specialist Improvement Leaders Programme, which relates to Commitment 11 of the National Dementia Strategy. This is an 18 month programme, which I am in the process of completing. This programme has included being trained as a trainer in Stress and Distress, Palliative Care, Supporting Change and Complex Care Needs of people with dementia, further training for trainers will include Pharmacology in Dementia and Cognitive Stimulation therapy. It is my intention that I can use this experience and training to further develop the skill of the Dementia Champions within Lanarkshire.

'The Getting to Know Me tool has been rolled out across all of our inpatient contexts.'

Sandra Shafi Former AHP Dementia Consultant, NHS Lanarkshire



My term as AHP Dementia Consultant was funded from October 2010 to the end of September 2015. During my last year in post, my main goal was to ensure I left a legacy of improved care for people with dementia and that local arrangements were in place in NHS Lanarkshire to ensure improvements continued and were sustainable.

During 2015 I worked closely with NHS Grampian's AHP Director Susan Carr and her AHP colleague Jane Fletcher to deliver training to AHPs in line with the Promoting Excellence framework (Commitment 10, point 2). We organised a series of training sessions which led NHS Grampian AHPs through key elements of the Skilled Level of the framework, including topics like person-centred care, communication, and stress and distress. I delivered sessions to over 240 AHPs, with a focus on understanding the hospital experience of people with dementia. The sessions focused on areas within the Skilled Level on which the AHPs would not routinely receive training during their learning pathway.

More locally, in NHS Lanarkshire I established an AHP Dementia Forum. This group is comprised of local AHP representatives, including those from across

the hospital sites as well as the community and local authority. The Forum focused on different themes surrounding dementia and produced resources about topics that were important to people with dementia and their carers. AHPs in each specialism developed their own leaflets and shared these with the others during the development, ensuring that we all had access to the best information on simple, yet key, topics. The topics included physical health, swallowing, communication, mobility, home safety, reminiscence and memory management. The Forum allowed us to learn more about each other's roles and what we all do as a group, building mutual respect but also ensuring we were all well-equipped to support people with dementia and their carers in any way possible. The leaflets are available through a variety of websites and resource centres. The Dementia Forum was organised to promote sustainability after my term ended. Dementia Champions and representatives from all AHP and care settings sit on the group, to ensure they build a strong future for acute care and health and social care partnerships.

In the last year, I participated in a project focused on Commitment 11 which resonates with acute hospital care. I supported a ward

'I delivered sessions to over 240 AHPs, with a focus on understanding the hospital experience of people with dementia.'

in NHS Fife's Stratheden Hospital in Cupar to look at improving the experience of people with dementia. Their goal was to develop a care plan based on the 'Make every moment count' document, a resource which focuses on person-centred care (Commitment 10, point 4). I supported the nursing staff by leading them through the resource and how it embodies person-centred care. This initiative created a two-way dialogue between the AHP role and the nurse role, revealing the value of multidisciplinary working and enabling an AHP like myself to share my knowledge with nursing staff in the acute care setting. Learning together leads to better team working.

I worked alongside carers, partners in care and nursing students from the University of the West of Scotland to develop a carer-focused DVD called 'This worked for me'. The resource consisted of candid interviews with those who care for people with

advanced dementia about their experience of caring and how they overcame personal challenges and practical problems. The raw materials from the production of the DVD have been redeveloped as a resource pack for nurses. This includes verbatim recordings of carers talking about what was challenging about the acute hospital or nursing experience, and what should be taken on board to inform future interventions and practices. We hope the information will be used in the acute care setting to assist in nursing practices in the future.

In the hospital and ward setting, nurses are the ones who have continuing 24-hour responsibility to support people with dementia. As AHPs and nurses, we are all reaching out to each other to share our knowledge and improve our practice. This is the essence of the AHP Consultant and Alzheimer Scotland Dementia Nurse Consultant roles.

'In the hospital and ward setting, nurses are the ones who have continuing 24-hour responsibility to support people with dementia.'

Andy Shewan Alzheimer Scotland Dementia Nurse Consultant, NHS Tayside

1. Identify a leadership structure within NHS Boards to drive and monitor improvements

Dementia is at the forefront of the acute care agenda in NHS Tayside. Our leadership structure is headed by an Older People's Clinical Board (OPCB), which meets every two months. This board has three priorities – frailty, delirium and dementia. The remit of the OPCB is wide-ranging, covering all areas of older adult care, including acute hospital care, community hospitals and psychiatry of old age, each of which closely link with the care of people with dementia. NHS Tayside's Medical Directors, Nursing and AHP managers and key clinicians are invited to this group, alongside NHS Tayside's Associate Medical Director and Associate Nurse Director who jointly chair it with the authority of the NHS Board.

Several sub groups feed into the OPCB and I chair the Dementia Clinical Improvement Group. This group focuses on reportable aspects of dementia care – including Scottish Dementia Strategy Commitments 10 and 11 and Post-Diagnostic Support. There are further sub groups which involve clinical multidisciplinary staff from a variety of areas working on various initiatives.



As Consultant Nurse, I liaise with NHS Tayside's 49 Dementia Champions (a further six are close to graduating). I hold regular forums for the champions linking into different areas for ease of attendance. There are further opportunities for development distributed by email and post.



2. Develop the workforce in line with Promoting Excellence

Several rolling training programmes have been developed by staff, and are helping ensure the NHS Tayside workforce are trained to Promoting Excellence levels 1 and 2 as a minimum. For instance, one of our Dementia Champions has taken the level 2 Promoting Excellence training resource and has developed this into a rolling course which over 100 staff have taken part in. This includes training on the main topics of Promoting Excellence level 2, for example understanding dementia, person-centred care and communication. Certificates are awarded to those who successfully completed the course. Other champions are doing this individually. Our Psychiatry Liaison staff also run regular courses for small groups.

NHS Tayside has implemented the electronic learnPro system to offer staff a number of effective educational resources which fit with the Promoting Excellence framework and NHS Tayside's broader structure. This learning network features tailored courses which help staff learn about delirium, consent and capacity, dementia in acute along with other pertinent training. There are also dedicated psychology programmes on stress and distress and formulation. "Formulation" is a person-centred concept that links with person-centred care

framework, helping healthcare staff care for a person by learning about a person's relationships, social circumstances, life events and experiences.

3. Plan and prepare for admission and discharge

We have a dedicated team of staff working in our Early Supported Discharge team who share a 'hub' with social work and Psychiatry of Old Age colleagues. This improves communication and information sharing. NHS Tayside covers 7,497 square kilometres, so we are developing models of care which allow for older people including those with dementia to be transferred back to community hospitals close to their home. This initiative includes geriatricians, GPs, AHPs, Pharmacists and nurses from various specialities. We hope this will limit the time patients require to remain in hospital.

The OPCB conducted an important piece of partnership working with the Institute for Research and Innovation in Social Services (IRISS) regarding admission and discharge. IRISS is a charitable organisation which focuses on ensuring that those who use social services in Scotland receive the best possible support. For NHS Tayside, this involved working with IRISS to find out what various service users experienced during our admissions and discharge processes. This is impacting on our admissions and discharge pathways by taking into account the patient experience throughout the process. Generally a person's discharge planning begins the day they were admitted.

4. Develop and embed person-centred assessment and care planning

As with many health boards NHS Tayside has become more flexible when engaging with the people it serves. We offer flexible visiting, allowing relatives and friends the opportunity to be with patients at times which suit them, occasionally to remain overnight if required. We also provide opportunity for visitors at mealtimes to support nutrition. It can be tricky balancing the patients' clinical needs with their visiting times but generally visitors appreciate confidentiality.

NHS Tayside is also a participant in the Butterfly Scheme. This programme ensures that our nursing staff utilise person-centred approaches when working with people with dementia. For example, explaining what is happening around the person, or explaining what staff are doing with them.

We have developed our core admission and discharge documentation to include a dementia focus. The document records many different types of information about the person. We assess an individual's cognition routinely when they are over 65, for instance whether they have a diagnosis of dementia, whether they have Power of Attorney (PoA), and their level of capacity (if necessary, using section 47 forms from the Adults with Incapacity (Scotland) Act 2000 (AWIA). The documentation also helps staff identify important friends, family or carers in the discharge process. The Getting to Know Me document is available and used widely across NHS Tayside. This document can further support those being cared for under AWIA, where information about a person informs our care.

5. Promote a rights-based and anti-discriminatory culture

In my role I frequently advise staff on legislation such as Adults with Incapacity, the Mental Health Act and Human Rights. Recently, our Clinical Governance and Risk department organised three major educational sessions about informed consent called 'Getting it right'. The sessions focussed on the AWIA, specifically on people with cognitive impairment of dementia. Over 500 staff took part in these sessions, helping ensure they fully understand the rights of adults with incapacity and how we tailor our care for people with dementia or cognitive impairment. NHS Tayside staff has been involved in a campaign to increase the uptake of PoA processes among those we support. Locally, solicitors are reporting an upsurge in requests for PoA.

6. Develop a safe and therapeutic environment

In the last few years, NHS Tayside secured just under £1 million to develop the environment at Ninewells Hospital (Dundee) in line with dementia-friendly design principles. Along with other staff from management and the Estates Department, I took part in a three-day Dementia Services Development Centre (DSDC) Dementia Design School course. We have since embedded design ideas about contrast and clarity to ensure people with dementia find their ward a comfortable and clear place to stay. Examples of this include light coloured bathrooms with contrasting blue toilet seats and blue toilet arm rests, or ensuring floor colouring changes are limited in a ward, to prevent the 'image' of steps.

7. Use evidence-based screening and assessment tools for diagnosis

Most NHS boards across the country are working with the 4AT assessment tool, and in our case we have embedded this tool in our pre-existing documentation to standardise the approach to testing cognition. In

addition to this, NHS Tayside as yet is the only NHS board to have appointed a specialist Delirium Nurse, and she has done a huge amount of work embedding delirium assessment documentation into our admission documentation. The 4AT is so simple and effective to administer, we are encouraging all staff to use it.

We use a number of other approved tests for more in-depth assessment such as the Montreal Cognitive Assessment (MoCA). Within the acute context, this is used mainly by occupational therapists but easy for any member of staff to use. As the assessment of cognition progresses, a psychiatric liaison team would then possibly utilise the Addenbrooke's Cognitive Examination – Third Edition (ACE-III) tool. This ensures that our admission pathways have a progression of assessment tools to ensure that people with dementia or cognitive impairment are assessed and diagnosed appropriately throughout the care pathway. Beyond these tools are most specialised psychology assessments and access to CT and MRI scans as appropriate.

8. Work as equal partners with families, friends and carers

Through its assessment process, NHS Tayside aims to identify those people who are vulnerable enough to require family or friends to speak up for them. Our documentation enables the patient or their relative to complete certain sections of documentation which are pertinent to them.

We have developed strong links with other local and national organisations such as Alzheimer Scotland, Age Concern and local authority bodies to ensure that the carers and families of people with dementia are supported across NHS Tayside's region. Much of this is connected through the Post Diagnostic Support Service we offer however the links extend far beyond the minimum year of support. This allows representatives of carers to speak on their behalf.

'NHS Tayside has become more flexible when engaging with the people it serves.'

In Dundee, Angus, and Perth and Kinross there are local Carer's Services. Within Ninewells Hospital concourse we have regular information stands from carer's agencies providing valuable support to people as well as a 'health information shop' where patients and visitors can get a variety of information. We also have a strong public involvement department where any new initiatives are developed in partnership.

9. Minimise and respond appropriately to stress and distress

An important aspect of our care surrounding stress and distress relates to limiting the use of antipsychotic drugs in dementia care. NHS Tayside has three liaison Psychiatry Teams who support our acute staff with advice on relevant medications and appropriate use. This ensures that antipsychotic drugs are not relied on and are used in appropriate situations only. Our pharmacists have reported that the prescription rate of antipsychotic medications has decreased substantially in recent years.

NHS Tayside has also appointed a specialist nurse for delirium and two further Consultant Nurses for Older People, one with an academic role. Delirium can often be misidentified as dementia and this misunderstanding can have an impact on

both conditions, leading to further distress. By embedding specific protocols and assessments within our documentation, we are identifying delirium more quickly and responding to it appropriately. There are specific protocols for when to use non-pharmacological interventions and when medication is used clear guidelines on dosage.

We plan to develop environmental changes within our Medicine for the Elderly unit to create a lounge area which provides a relaxing environment where relatives and carers can spend time with people who are distressed.

10. Evidence the impact of changes against patient experience and outcomes

At NHS Tayside, we actively evaluate and demonstrate our work which supports people with dementia, and we are focused on improving our information collation pathways to enable this further. We audit ourselves against the Dementia Standards and Older People in Acute Hospital Standards. These are reflected in the inspections all hospitals receive from Healthcare Improvement Scotland. Patients are encouraged to complete 'exit questionnaires' on discharge to describe their experiences.

'At NHS Tayside, we actively evaluate and demonstrate our work which supports people with dementia.'

Audrey Melrose Alzheimer Scotland Dementia Nurse Consultant, NHS Forth Valley

1. Identify a leadership structure to drive and monitor improvement

In NHS Forth Valley, we have developed a Dementia Steering Group to draw all of our dementia activity together and ensure that the board is informed of our progress. The group is jointly supported by our Executive Director of Nursing and the chair of our Community Health Partnership (CHP) Professional committee. We have identified operational and executive leads for Commitment 10.

NHS Forth Valley Currently have 19 Dementia Champions with five of those recently having been part of the most recent cohort.

2. Develop the Workforce against Promoting Excellence

In January, NHS Forth Valley released one of our Dementia Champions, Yvonne Cairns, from her clinical assessment unit role to support the knowledge and training of staff on dementia across NHS Forth Valley. This has involved a range of activities to enhance the care and support delivered to people with dementia and their families. In a very short time she has achieved a great deal in both practice improvement and staff learning. She has worked effectively on achieving consistent standards in assessment, and in enhancing staff awareness and good practice in important areas such as communication and personalising care. In a really positive example of co-operative team work, she links with other champions and the Liaison Psychiatry Team to plan and deliver training together across a range of disciplines. The team has delivered training which focuses on staff acquiring a better understanding of dementia and dementia standards of care,

including the strategically important 10 care actions for acute hospitals. Also included in this joint training initiative is the importance of screening and recognising delirium.

Between March and September 2015, 490 staff including 170 domestic staff have been supported to undertake NHS Forth Valley's local dementia training. This initiative also recognises the key role domestic staff play in engaging with people with dementia.

Work is also underway with the staff of the Scottish Ambulance Service to provide them with greater insight into the experiences and needs of people with dementia and to reduce the repetitive questions sometimes experienced by families.

Various master classes offered by NES have been accessed by staff in NHS Forth Valley. These classes provide training for staff at 'Enhanced' level of the Promoting Excellence in Dementia Framework. With support from NES, we were able to hold a local master class in End of Life Care in Dementia. This class allowed delegates to attend from other areas in Scotland and was attended by over 40 staff, representing a broad spectrum of health and social care disciplines. We have now held a second masterclass locally, and have been able to educate more than 60 of our own health professionals on this topic.

We are participants in the Butterfly Scheme, which is designed to provide an easy way for staff to support patients who have dementia and access NHS services. The initiative is being rolled out across all of our services. It helps staff from all disciplines to understand the needs of patients who have dementia, how to interact with them and reduce their distress.



During Dementia Awareness Week 2015, we distributed information relating to dementia, dementia education and the 10 Dementia Care Actions to all clinical areas within the acute care sector.

3. Plan and prepare for admission and discharge

NHS Forth Valley has developed its admission and discharge policy to meet the needs of individuals, including people who have dementia. Discharge support is arranged according to individual need and discharge co-ordinators support complex discharge needs.

A pilot project was undertaken in NHS Forth Valley in response to concerns expressed by the Scottish Ambulance Service for patients discharged from hospitals across Scotland who live alone. The project, developed by voluntary services, provided small food packs for vulnerable older patients that met the criteria being discharged at home in identified wards within Forth Valley Royal Hospital. This project has received positive feedback from those who have benefited from it and the pilot is currently under review.

4. Develop and embed person-centred assessment and care planning

NHS Forth Valley has a strong history of improving patient care and experience. The development of the Forth Valley Person Centred & Care Strategy reaffirms our vision and commitment to ensure that everyone receives appropriate care and that the principles and standards of care, respect and dignity have been implemented across all health care settings in Forth Valley. Several initiatives currently embedded in NHS Forth Valley's care pathways for people with dementia include: the Butterfly Scheme, Promoting Excellence in Dementia Care and NES Values Based Reflective Practice.

5. Promote a rights based & anti discriminatory culture

The rights of people with dementia form a fundamental aspect of all of our training relating to dementia. This augments the rights based and anti-discriminatory culture already supported in NHS Forth Valley by local and national policies.

6. Develop a safe and therapeutic environment

We strive to support all of our patients within a safe and therapeutic environment. The needs of people who have dementia highlight the need to enhance this further. Improvements include the installation of dementia-friendly clocks with calendars which are being installed in all of our clinical areas for adult patients. In tandem with the installation of clocks, we are placing dementia-friendly signage in all of our clinical areas. This work is underpinned by our use of the Butterfly Scheme, which supports the development of a safe and therapeutic environment.

Furthermore, we are improving the ward environment in creative ways to ensure people with dementia are stimulated and engaged. The use of Art Link in creating a therapeutic environment has also been beneficial to patients within our integrated care ward. This also provides stimulation within the inpatient environment. The Integrated Care ward have a therapeutic day room where patients can spend their day along with their families and volunteers.

7. Use evidence based screening and assessment tools for diagnosis

NHS Forth Valley has been testing the use of the 4AT, linked with the national Older People in Acute Care (OPAC) improvement programme led by Healthcare Improvement Scotland. The 4AT assesses for delirium, and is completed by the use of the AMT10 and, in certain clinical environments, the CAM tool. NHS Forth Valley are about to commence roll out of the use of the 4AT across the whole organisation.

Our Liaison Psychiatry (for Older People) Team, along with our dedicated Dementia Champion, is currently providing training on the use of the 4AT. Between July and September, 241 staff received training on the 4AT.

8. Work as equal partners with families, friends and carers

We encourage all patients who have dementia to complete a Getting to Know Me document, or have one done for them by their family or carers. The training delivered by our dedicated Dementia Champion includes information on the use of the Getting to Know Me document and the importance of using each person's preferred name.

Our extended visiting policy has been implemented throughout our inpatient settings and encourages all those close to the patient to be more involved in their care and decision making. We recognise that when a loved one is in hospital it can be a very stressful time and it is important for families to be close and support one another at these difficult times in life. With this in mind we have extended our visiting hours at Forth Valley Royal and our community hospitals at Falkirk, Stirling, Clackmannan and Boness.

Promoting dementia care within our service is an important aspect of our work with patients, families, friends and carers. This year we placed information stands at both entrances to our hospital and gave out approximately two hundred leaflets about dementia, dementia-related services and carers support. This enabled more people to find out more about dementia and how to access services for themselves, their families or friends. This year we drew even more attention by having a prominent author visit the hospital to sign her popular children's story book.

We have been fortunate to work with two of our local Carer Centre staff (one of whom is based in the hospital) in the development of information and signposting for 'Coffee and a Chat' events. These are held on a monthly basis as a pilot project within our Mental Health Unit.

9. Minimise and respond appropriately to stress and distress

Training for staff through our Butterfly Scheme and the 'Informed' level of Promoting Excellence in Dementia Care provides initial education for staff

around interacting effectively to minimise stress and distress for people who have dementia. The theory can be accessed on learnPro with regards to Stress and Distress. Our Liaison Psychiatric Department (Older People) and Dementia Champions support patients and staff in in-patient areas, when patients may be at risk of developing stress and distress.

The Playlist for Life project; on learning about the effect personal music can have on patients with a diagnosis of dementia, nursing staff within NHS Forth Valley community hospitals specialising in dementia care, were enthusiastic to explore this concept further. Therefore, following consultation, the agreed aim of this project was to implement and evaluate whether the use of music personal to the patient had an effect on their social engagement or interaction such as eye contact, vocalisation or touch and the value of this to both patient and relative during visits. Data is collected around these interactions including observations of verbal and non-verbal communicative responses and capturing the quality of the experience for the person with dementia and their relative.

10. Evidence the impact of changes against patient experience and outcomes

NHS Forth Valley continues to monitor patient experience using a number of methods. These included the Transforming Care at the Bedside/SCN balance score card questionnaire, the national patient experience survey, gathering patient opinions and monitoring feedback, comments, concerns and complaints. Values Based Reflective Practice has also been used to learn from complaints, with action plans developed for each complaint received. We are currently developing family focus groups within the community hospitals to improve both family and patient experience.

Two of our staff nurses from Specialist Dementia Wards have now been trained in Dementia Care Mapping at Bradford University. They have carried out their first pilot mapping exercise and are currently completing their report. This work is intended to give us base line information relating to the care of patients who are unable to convey their experience to us. Although the initial project is intended for use in Specialist Dementia Wards, we are looking into the usefulness of this system for patients within acute care.

Peter Lerpiniere Alzheimer Scotland Dementia Nurse Consultant, NHS Borders



1. Identify a leadership structure within NHS Boards to drive and monitor improvements.

NHS Borders and our integrated partner, the Scottish Borders Council, have an established Executive Leadership structure at a senior level to drive and monitor improvements and are working to cascade that structure throughout our hospitals and the wider service. In our hospitals the recently appointed Consultant Nurse will have a designated link nurse for dementia in every inpatient unit and clinical area where this is appropriate (obviously for some departments, such as maternity units, this is not part of their fundamental remit).

Our aspiration is that the link nurse will be a Dementia Champion. For those areas where we don't currently have a Dementia Champion we will identify a nurse lead to work alongside the Dementia Nurse Consultant in delivering the 10 care actions.

We currently have 11 Dementia Champions, with a further four due to graduate soon. Two of our current champions work in our accident and emergency department and strive to promote the highest standards of care for people with dementia at a time of increased vulnerability. One champion is a senior manager, and is well placed to act as an agent of change. A number of champions

work in multiple clinical areas. Collectively, this means we have a core team of people informed about what we are aiming to do all the way through the organisation.

From this strong start we will recruit additional champions to represent other clinical areas.

2. Develop the workforce against the Promoting Excellence

I am meeting with the chair of our Dementia Training Group to consider whether we currently maximise existing training opportunities across NHS Borders.

Over the next four months, with my support, our Dementia Champions will each support five people to complete Skilled Practitioner level training. This will ensure a further 75 people are then trained at this level.

One of our Dementia Champions delivers an open, rolling programme of weekly training at the Skilled level of the framework.

Currently I am working with a unit that proactively highlighted its own lack of expertise in dementia care. They are now undergoing training to ensure every member of staff in the unit will have completed the Skilled practitioner level programme by the end of 2015. I am using training in this unit to

'Our aspiration is that the link nurse will be a Dementia Champion.'

evaluate impact on perceived practice. Having conducted an initial subjective assessment of staff knowledge, I will ask the staff for feedback on how their skills and practice have changed.

I am keen to find additional ways to monitor and assess the impact of training. I am looking at how it links to the delivery of the 10 key actions of Commitment 10, including the impact on the experience of people with dementia and their families.

As a supplementary training measure we aim to embed some of the modules covering stress and distress into our mandatory Prevention and Management of Aggression and Violence (PMAV) training.

3. Plan and prepare for admission and discharge

As Dementia Nurse Consultant I am part of a joint Department of Medicine for the Elderly (DME)/Frailty team project to better co-ordinate discharge planning in unplanned admissions. There is clear evidence that optimising admission and discharge procedures benefits patients with dementia and maximises resources.

I recently worked with a colleague to reschedule a surgical admission for one of her patients with dementia to make sure it was at a suitable time for this patient. The lady had previously undergone a model preoperative assessment, during which staff were patient, helpful and supportive, but was then given an 8am appointment for the day of her surgery.

She lived 20 miles from the hospital, could not travel independently and needed to fast beforehand, the colleague supporting her realised this would in all likelihood lead to a failed appointment.

Alternative arrangements were made to admit her the night before, allowing her to sleep in a hospital bed, have the procedure and return to the same, more familiar, bed. The patient was successfully discharged on time.

The alternative would have been a missed appointment and a wasted admission bed.

We recognise that all patients present with different challenges and we are continuing to develop a more person-centred approach to clinical pathways, which includes appropriate flexibility. Following the case described above I will follow up with the team involved

to look at how we can identify similar cases in future and find person centred ways of managing them.

There are two areas where we see opportunities to improve practice: communicating with relatives and care agencies when co-ordinating discharges, and ensuring the relevant services are notified of new admission and discharge plans when a patient requires multi-service support.

I am also exploring a proactive approach in our orthopaedic unit. If we know a patient attending for elective surgery has a cognitive impairment, and consequent increased likelihood of confusion following by surgery, we provide them with additional information and support.

4. Develop and embed person-centred assessment and care planning.

Getting to Know Me is in widespread use across the Scottish Borders and considered a very valuable resource. Patients, families or carers are asked to complete Getting to Know Me document on admission, and we are considering making copies available and on display to the public in community settings such as health centres, surgeries and pharmacies. The intention is to foster a culture where people are familiar with Getting to Know Me and proactively bring a completed version with them to hospital. The goal is to create an expectation among the public that healthcare staff should be offering them a person-centred assessment and knowledge of the patient as an individual.

Getting to Know Me forms part of the work I am involved in with the development of the Frailty Pathway, ensuring good management of frailty as part of our practice. In the same way that we want to ensure we identify people with dementia to ensure we can deliver the right support, we want to ensure we know which patients need extra support because of frailty. My role is to ensure that people with dementia and frailty are appropriately supported through both clinical pathways.

5. Promote a rights based anti-discriminatory culture

If we successfully create a rights-based culture, many of the other dementia care actions will fall into place. The work I have described in relation to Action 4 relates directly to Action 5. Ensuring people with dementia are not disenfranchised because of their dementia or

because of co-morbidities is integral to everything we do. The National Dementia Standards in Scotland are all rights-based and we continually take steps to reinforce the fundamental importance of these standards in our practice. Posters displaying the standards are on display throughout NHS Borders in designated prominent, public locations.

One available mechanism for the measurement of rights-based care is through the monitoring of cognitive assessment and the use of the Adults with Incapacity (Scotland) Act 2000 (AWIA). This is an area where as the Dementia Nurse Consultant, I will look to support the Dementia Champions to lead on in their clinical areas.

Consideration is also being given to access and exit to a number of wards/units. Work is progressing to ensure that where such measures are in place they are lawful, in line with Mental Welfare Commission for Scotland (MWCS) guidelines ("Rights, risks and limits to freedom" 2013) and that records accurately report the reasons for doing so.

The Scottish Borders Council and NHS Borders have invited people to join a Borders Dementia Working Group as a consultative body in helping us to design and deliver services appropriately.

6. Develop a safe and therapeutic environment

Developing a safe and therapeutic environment across our estate is under constant review. As with so many areas of practice if we get the environment right for people with dementia it supports people without dementia too. We have an Older People in Acute Hospitals environmental reference guide and assess our acute environments against best practice guidelines when considering refurbishment. I am looking at key sites for specific environmental improvement opportunities with recommendations to be fed into the estates renovation programme. These

include the unit referred to under Action 2 where, in addition to tailored staff training an environmental assessment may identify changes which will create a more dementia friendly environment.

We are aiming to have the Forget-me-not (FMN) scheme embedded as accepted practice within all acute wards by the end of 2015. This goes significantly beyond simply introducing stickers and is complemented by the work which continues to emphasise the importance of the Standards of Care for Dementia in Scotland. We should be able to ask any staff member in contexts where the FMN signifier is used what it means and for them to explain it. The sticker is applied to the person's notes and to the bed-board – it is not publicly displayed, respecting privacy and dignity while still alerting staff the patient requires extra support.

We are ordering coloured tumblers, which are easier for patients to see and potentially enhance independence. We will introduce a picture menu to offer people who have difficulties with verbal communication the option to choose their own food.

7. Use evidence-based screening and assessment tools for diagnosis

As part of our dementia care pathway colleagues are expected to use the Abbreviated Mental Test Score (AMTS) and the 4AT to assess people over 65 for signs of cognitive impairment on admission to hospital and to deliver an appropriate response. These tests are not always completed and we are working towards universal compliance.

There is work underway to establish three evidence-based pain assessment tools into the National Early Warning Score (NEWS) as part of the Deteriorating Patient Pathway. Which pain tool is used depends on the needs of the person:

- the numeric pain rating scale where the person indicates how severe their pain is on a scale of 1 to 10

- the Wong-Baker FACES pain rating scale for those patients who are unable to speak but who can indicate or respond to a question using expressions or gestures
- the Abbey Pain Scale for people with dementia who have severe communication difficulties.

The Abbey scale is already in use in a number of clinical areas including A&E, orthopaedics and the DME.

We are piloting the Single Question in Delirium (SQiD), aiming to keep delirium in staff's frame of reference. The SQiD is not an assessment tool, but a trigger to indicate if a delirium assessment is required.

8. Work as equal partners with families, friends and carers

Patients who are engaged with their own care, and are given choices and encouraged to participate in decisions about their treatment, can experience better outcomes. A Collaborative Carers scheme is established in the DME where carers are supported to work alongside staff with family members and loved ones. Supported by NHS Borders I am trying to spread that model more widely and will evaluate it in areas where it is rolled out.

Involving family carers is an extension of this philosophy. We are also implementing 'What matters' information boards behind people's beds, listing to the things that matter to that person. This can be as simple as the name they like to be addressed by, which may not be their 'given name' which appears in the notes. A preferred name noted behind the person's bed, used by staff, can reduce alienation and put people more at ease.

In one area we are piloting communication sheets where staff record all communication with relatives. For example, updating relatives on things the person will need to be assisted with following discharge from hospital. These are intended to ensure staff members can tell if this key information has already been shared or not, reducing the likelihood of it being missed.

If this proves successful we will consider how to incorporate this into our under-development care plan model.

9. Minimise and respond appropriately to stress and distress

We have been awarded £160,000 through the Integrated Care Fund to deliver the two day Stress and Distress training to around 500 staff across the health board. This will include NHS staff in the acute settings, in the dedicated dementia units, staff employed in the social work care homes (now part of an 'arms-length organisation') and to private sector colleagues.

As well as providing high-quality dedicated training, this will help us achieve our goal of embedding the stress and distress modules into PMAV training, as outlined under Action 2.

We are in a strong position to achieve this, and I hope to have evidence within two years of the impact of how it has been put into practice.

10. Evidence the impact of changes against patient experience and outcomes

Evidencing the impact of change is often difficult, but we currently distribute patient and carer questionnaires and I am working with our Public Involvement Team to consider how we can evaluate responses as our practice changes are introduced. For example: In the unit where we have set out to deliver focused training to all staff, we want to determine whether there is a change in the experience of both patients and carers. The same is true for the units where communication sheets and 'What matters to me' boards have been introduced. This will allow us to assess the impact of any new measures on patients and carers described experience and I am exploring how to keep this clear, separate and discrete from more general feedback.

The Alzheimer Scotland National Support Team

This section introduces the key staff at Alzheimer Scotland who make up our national support team, underpinning the work of the Dementia Nurse and Allied Health Professional Consultants. This section demonstrates not only how the Dementia Nurses and AHPs have been supported in recent years, but also how Alzheimer Scotland are working, in partnership with the Scottish Government, to develop this work beyond the acute sector and across healthcare in Scotland.

Barbara Sharp, Policy and Research Advisor



I have had the pleasure of working closely with the Alzheimer Scotland Dementia Nurse Consultants and the Allied Health Professional (AHP) Consultants for the last three years. My role provides a direct link between the Dementia Nurse Consultants and Alzheimer Scotland. Having worked at Alzheimer Scotland for many years, and now also having a role within the Alzheimer Scotland Centre for Policy and Practice, University of West of Scotland (UWS), I try to ensure that my experience and networks work to the benefit of the consultant group in supporting their vital development role. I facilitate the coming together of the consultant network on a monthly basis, where we address operational, policy and practice issues together. We also consider opportunities to engage in research and disseminate the positive improvements being realised in our hospitals across Scotland.

My relationship with the Dementia Nurse and AHP consultants is very much a reciprocal one. I assist in ensuring that the group's practice is supported and that the interests of Alzheimer Scotland in contributing to these posts remain central. The consultant group keep me connected with the world of acute care, which informs

my wider role within Alzheimer Scotland. We have worked together on resources such as the personal profile, Getting to Know Me which now has an established role in the personalised support of people with dementia both at home and in hospital. Since 2011, I have been a member of the national Dementia Champions training team, in partnership with UWS. My key role with the Dementia Champions is in their education and preparation as the agents of change they need to be. The Dementia Nurse Consultants assist with the strategic recruitment of Dementia Champions and work in partnership with them in their areas of practice to ensure they are supported to effect necessary improvements. Our shared experience with the Dementia Champions informs the development of the training programme and their ongoing support. The 10 care actions (see page 2) to improve the standards of care in hospital provide a shared focus to the work we are all involved in.

The Dementia Nurse and AHP consultants are also key members of a practice collaborative which I facilitate as part of my role within UWS. The collaborative aims to enhance evidence informed practice by engaging more practitioners in research.

Over the course of the past year, the Dementia Nurse and AHP consultants have collected data which will contribute to the picture of support experienced by people with dementia who develop difficulties in maintaining continence. We are working in partnership to analyse this data and develop the research project. We regularly work together to share practice and contribute to educational developments within our Scottish Universities and on NHS Education

for Scotland programmes which support the implementation of the National Dementia Strategy (2010; 2013).

I look forward to maintaining my connection with this expert group as they continue to bring essential informed direction, motivation and commitment to our shared agenda for the highest standards of care for people with dementia, their families, friends and carers.

Elaine Hunter, National Allied Health Professional Consultant

A significant part of my role as Alzheimer Scotland National Allied Health Professions Consultant involves working with the allied health professional (AHP) community, in partnership with the Alzheimer Scotland Dementia Nurse Consultants. I am currently developing an evidence-based policy document outlining the contribution of AHPs in ensuring the testing of the 8 Pillars Model of Community Support, along with other key messages from within the second National Dementia Strategy. This piece of work will be completed by June 2016. An important focus over the last 18 months has been gathering evidence for this policy document in partnership with colleagues. It will be based on three types of evidence:

1. Engagement with people with dementia to identify their aspirations and wishes for living well with dementia, then matching these to the skills-base of AHPs and ways in which we can offer support
2. Identifying clinical expertise that exists within the AHP community, and which could be shared more widely to benefit people with dementia
3. Carry out literature reviews, scope current practice and evaluate the impact of the AHP Dementia Consultants.

To engage people living with dementia, ten AHPs worked with people with dementia and their families, asking them a series of appreciative, powerful questions to engage in their stories and narratives. They asked questions like 'Tell us about what enables you to live your life the way you want to'. Themes that emerged as important included: family and relationships with significant others; maintaining their independence and a sense of freedom; engaging in activities that they considered important; and having a connection with the people who cared for them.

Over the summer, AHPs also worked with the Dementia Nurse Consultants and colleagues at Alzheimer Scotland to gather more information in different ways. We hosted AHP 'blether spots' during Dementia Awareness Week 2015 in a number of different locations, including Strathclyde Park, garden centres, Alzheimer Scotland resource centres and local libraries. We also had a significant presence at Alzheimer Scotland's national conference in early June 2015.



Gathering the second category of evidence has involved ongoing engagement with the AHP community, and much of this good practice was captured in three publications we produced last year. These are entitled:

- Allied Health Professionals Dementia Champions: Agents of Change
- Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia
- Allied Health Professionals Delivering Integrated Dementia Care: Living Well with Community Support.

The examples featured in these publications were identified through Alzheimer Scotland's AHP dementia expert group, which has a remit to share and disseminate best practice across Scotland. The publications were circulated widely to all chief executives in health boards and all leads in local authorities. You can view these publications online at www.alzscot.org/ahps

The third type of evidence includes a report published in 2015 that describes the impact of the AHP Dementia Consultants in Scotland. The foreword to this report summarised the role of the AHP Dementia Consultants:

"The AHP Dementia Consultants, as senior strategic leaders of transformational change working alongside Alzheimer Scotland Dementia Nurses, Dementia Champions and the recently established Alzheimer

Scotland AHP Dementia expert group, are a substantial force for change and for delivering improvement in dementia in Scotland. The AHP Dementia Consultants are a valued resource and this evaluation demonstrates they have been highly effective leaders who have increased knowledge skills and good dementia practices in targeted settings."

This report emphasised the key role of the Alzheimer Scotland AHP dementia expert group, which has been in existence for the last two years. This group includes AHPs from across Scotland and is a great platform for sharing practice and supporting change.

The work of AHPs links closely with the aims and objectives of Dementia Nurse Consultants in the acute context. This is because appropriate acute care, combined with supportive and complementary community care, is essential to provide high quality support for people with dementia, including well planned admission to and discharge from hospital. Achieving this goal is underpinned by a multidisciplinary and multi-agency approach. I am part of the Alzheimer Scotland Dementia Nurse Consultant Group and work with the Dementia Nurse Consultants to implement change both nationally and locally. I am working particularly closely with National Dementia Nurse Consultant Maureen Taggart as she develops a model for specialist dementia care. The evidence I am gathering for our policy document will also directly link with Maureen Taggart's work.



Anne Buchanan, Nursing Development Manager

I am in post with Alzheimer Scotland as the Nursing Development Manager, but when I joined the organisation in December 2013, I was the Deputy Regional Manager for Fife and Forth Valley. Prior to this I worked in the NHS for 40 years, 12 of which were at director-level. In this post I bring a strategic perspective to nursing leadership for the care of people with dementia.

The role is funded by the Scottish Government, with a key focus on renegotiating the revised Memorandum of Agreement (MoA) for the continued funding of the Alzheimer Scotland Dementia Nurse Consultant (ASDNC) role. The revised MoA makes clear the expectation that the ASDNCs remain focussed on acute care, provide leadership and support to their local Dementia Champions and are active participants in the Dementia Nurse Consultant AHP network.

An important aspect of my role is to support the Dementia Nurse Consultants and enable them to work effectively at a strategic level. I aim to visit them all twice a year to catch up with how their job is going and

can also offer individual mentoring and coaching. I am also looking for opportunities around research that the Dementia Nurse Consultants can get involved in, to ensure their work is showcased as widely as possible. A substantial aspect of the Dementia Nurse Consultant role is the clinical-academic research component, so I want to support the development of their skills and expertise in that area.

NHS 24 is currently in the process of creating a Dementia Nurse Consultant post to improve triage and advice given to people with dementia who contact the service.

We are keen to promote and foster the excellent partnership working between the Scottish Government, NHS and Alzheimer Scotland. We have held local events showcasing the work of the Nurse Consultants, and the Dementia Champions are holding dementia cafés in NHS premises. Both roles are promoting more partnership work going forward.



'We are keen to promote and foster the excellent partnership working between the Scottish Government, NHS and Alzheimer Scotland.'

Maureen Taggart, National Dementia Nurse Consultant



My role as National Dementia Nurse Consultant was created following the publication of the Mental Welfare Commission for Scotland's report 'Dignity and respect: dementia continuing care visits', and the implementation of commitment 11 of the National Dementia Strategy which sets out plans for extending the work on quality of care in general hospitals to other hospitals and NHS settings. My role is joint funded by the Scottish Government and Alzheimer Scotland.

'Dignity and respect' was published in June 2014, and has been a key driver in highlighting variations in the quality and consistency of specialist long-term dementia care settings, as well as continuing care for people with dementia in general. There was also a round table event in September 2014, co-hosted by Alzheimer Scotland and the University of the West of Scotland, and chaired by Professor Graham Jackson. This brought together representatives from the Scottish Government and Royal College of Psychiatrists, along with staff from a number of health boards to discuss the pressure on resources in continuing care and to consider what needed to be done.

'Dignity and respect' included 17 recommendations for health boards and three for the Scottish Government. The three that were identified as requiring coordination at government level were: the wide variation in the level of provision of continuing care beds across health boards; establishing whether the overall level of

provision was appropriate; and establishing whether there was equity of access nationally. I was appointed in the autumn and took up my post in January 2015.

My key priorities are to support the development of a model for change and improvement within specialist long-term NHS dementia continuing care. Since taking up the post, I have been meeting with staff at health boards across Scotland, including mental health leads, consultant psychiatrists, psychologists, associate directors of nursing, lead nurses and AHPs, as well as with carers and families, where appropriate. This has enabled me to develop an in-depth understanding of the current situation, along with key issues affecting the safe transition of people with dementia to an alternative care environment that is appropriate for their needs. As a result I have started developing a proposed model of change, while also identifying some of the challenges of caring for this group of people with complex care needs.

Dementia care has been a key priority since 2007, and I am delighted that the focus has now shifted to long-term care and specialist units. The Scottish Government has made a huge commitment to improving these areas, with a raft of work now underway in partnership with organisations such as Healthcare Improvement Scotland and the third sector. I am optimistic that we can achieve significant positive change and am looking forward to reporting on this work as it progresses.

'I have started developing a proposed model of change.'

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Making sure nobody faces dementia alone.