

Dignity in Dementia: Transforming general hospital care

Results from an online survey consultation of professionals
Prepared for the Royal College of Nursing, March 2011

Geoff Pike and Kate Beveridge

Employment Research Ltd
45 Portland Road
Hove
BN3 5DQ

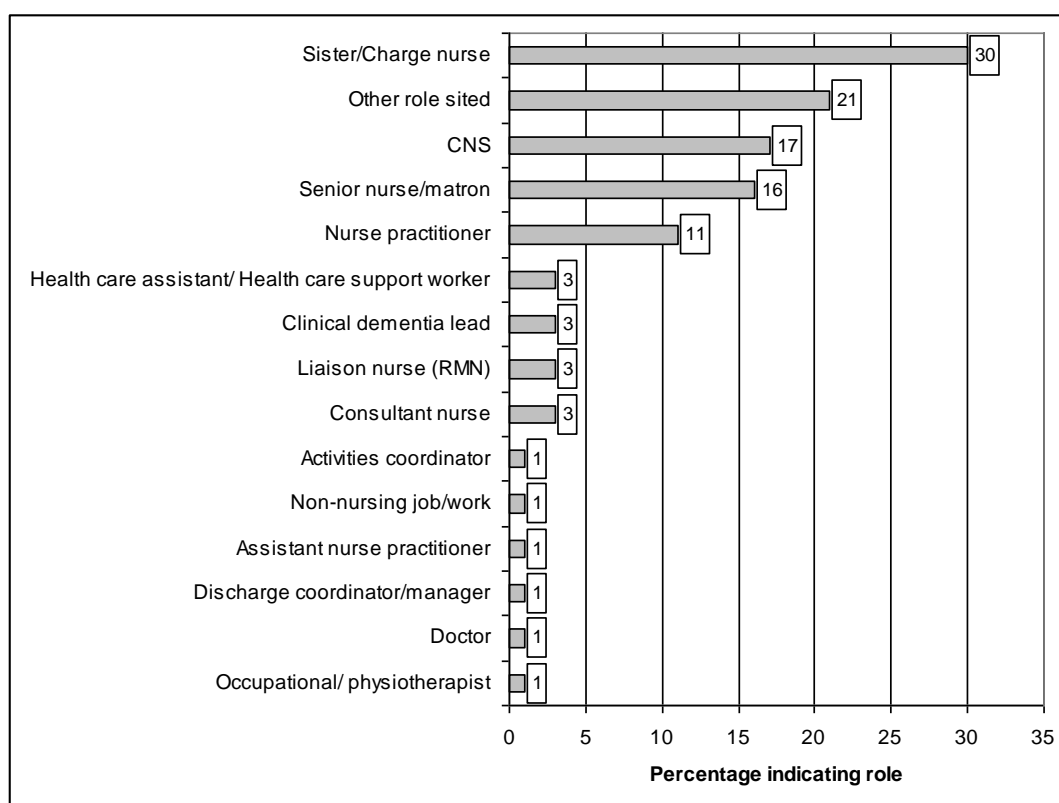
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1. Introduction and respondent profile

In January 2011 the Royal College of Nursing (RCN) invited responses from professionals working in Dementia care settings. During January and February responses were collated and when the survey was closed on 25th February 2011 712 completed questionnaires had been received. Most respondents (82%) accessed the survey by clicking on a link sent by the RCN, 4% ‘came across it on the RCN website’, 4% ‘read about it in RCN Bulletin or an RCN newsletter’ and 4% were told about it by someone else.

Figure 1 below presents a summary of the range of professionals that took part in the survey.

Figure 1: Respondent role (percentages¹)



Source: *Employment Research/RCN Dignity in Dementia Survey, 2011*

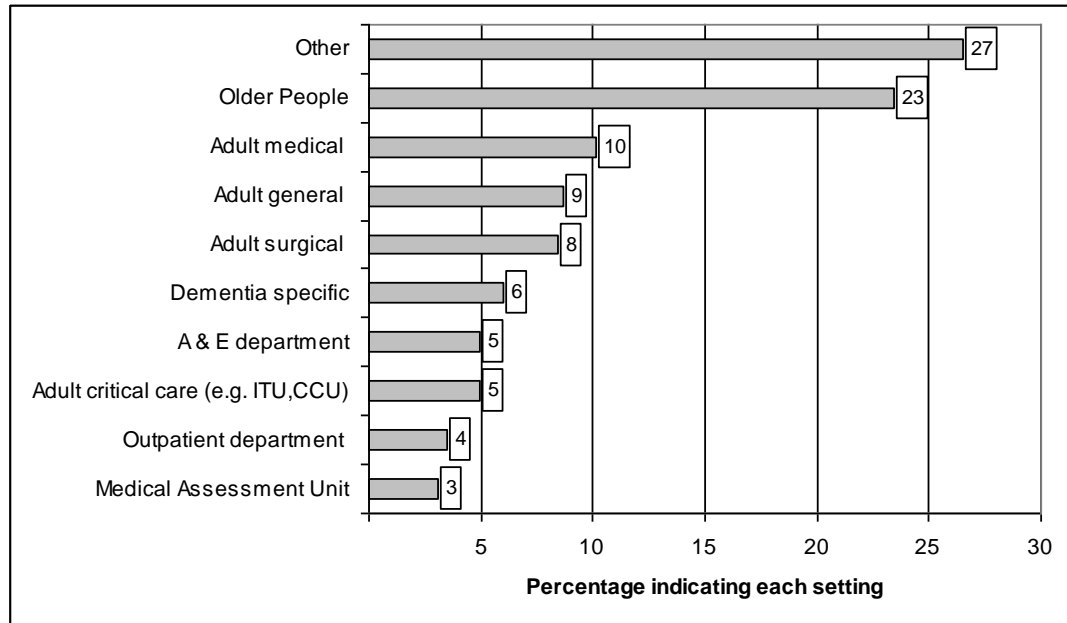
One in five respondents also indicated ‘other’ roles not listed. Most of these responses were ‘staff nurse/RGN’ approximately two thirds of all responses in this category. There were also a small number of student nurses, practice nurses, lecturers, care managers etc. completing the survey. Approximately, one in five respondents indicated non-nursing roles but this is difficult to establish accurately as respondents were able to indicate more than one role.

Respondents were also asked to give details of their field of work/specialty. One in four worked in older people’s nursing (24%), one in ten (10%) in adult medical, 9% adult general and 8% in adult medical, 5% in adult critical care.

¹ Note that the percentages do not sum to 100% as some respondents indicated more than one role

Again small numbers were working in medical assessment units, dementia specific settings (6%) and outpatients. Again one in four mentioned ‘other’ settings, these included; stroke units/theatres, palliative care units, general practice and community settings, orthopaedics, neurological settings, mental health and learning disabilities, hospices, haematology, mixed wards/settings. Figure 2 presents the full results.

Figure 2: Field of practice/specialty (percentages)



Source: Employment Research/RCN Dignity in Dementia Survey, 2011

As well as providing details of where they work, respondents were also asked a few demographic questions. In terms of ethnic origin, nearly nine in ten respondents were white (89%), 6% Asian/Asian British, 5% Black/Black British and 3% mixed ethnic origin².

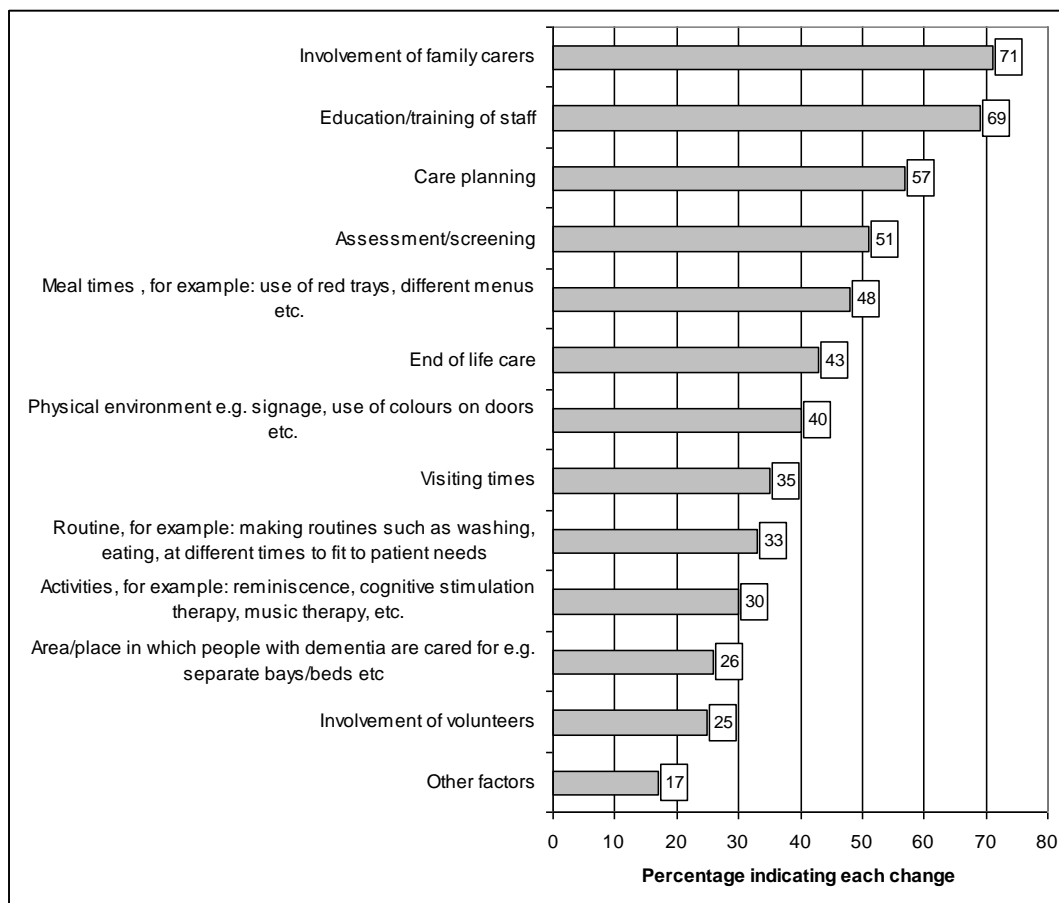
Responses were distributed across the UK with the largest group of respondents located in the South East of England (16%), North West (13%), South West (12%) and London (10%). In terms of the other UK countries 9% of responses were from professionals working Scotland, 4% Wales and 2% Northern Ireland.

² Again the numbers do not total 100% as respondents were able to indicate more than one category of ethnic origin.

2. Development of dementia care

The first substantive questions in the survey concerned the development of dementia care at respondents' places of work. First professionals involved in dementia care were asked to indicate from a range of approaches which had been implemented where they work. Figure 3 summarises responses to this question.

Figure 3: Development of approaches to dementia care (percentages)



Source: *Employment Research/RCN Dignity in Dementia Survey, 2011*

The two most frequently cited changes introduced, both by around seven in ten respondents, were the 'involvement of family carers' (71%) and the 'education/training of staff' (69%). More than half of all respondents indicated that 'care planning' (57%) had been introduced and (51%) mentioned assessment/screening of patients. Significant minorities of respondents said changes had been made in relation to meal times, for example, use of coloured trays, different menus etc (48%), end of life care had been addressed (43%), and the physical environment had been altered (e.g. signage use of colours, different designs and fonts etc) in 40% of cases. Around a third of respondents highlighted visiting times (35%), changes to routines (33%) and introduced activities to stimulate patients (30%).

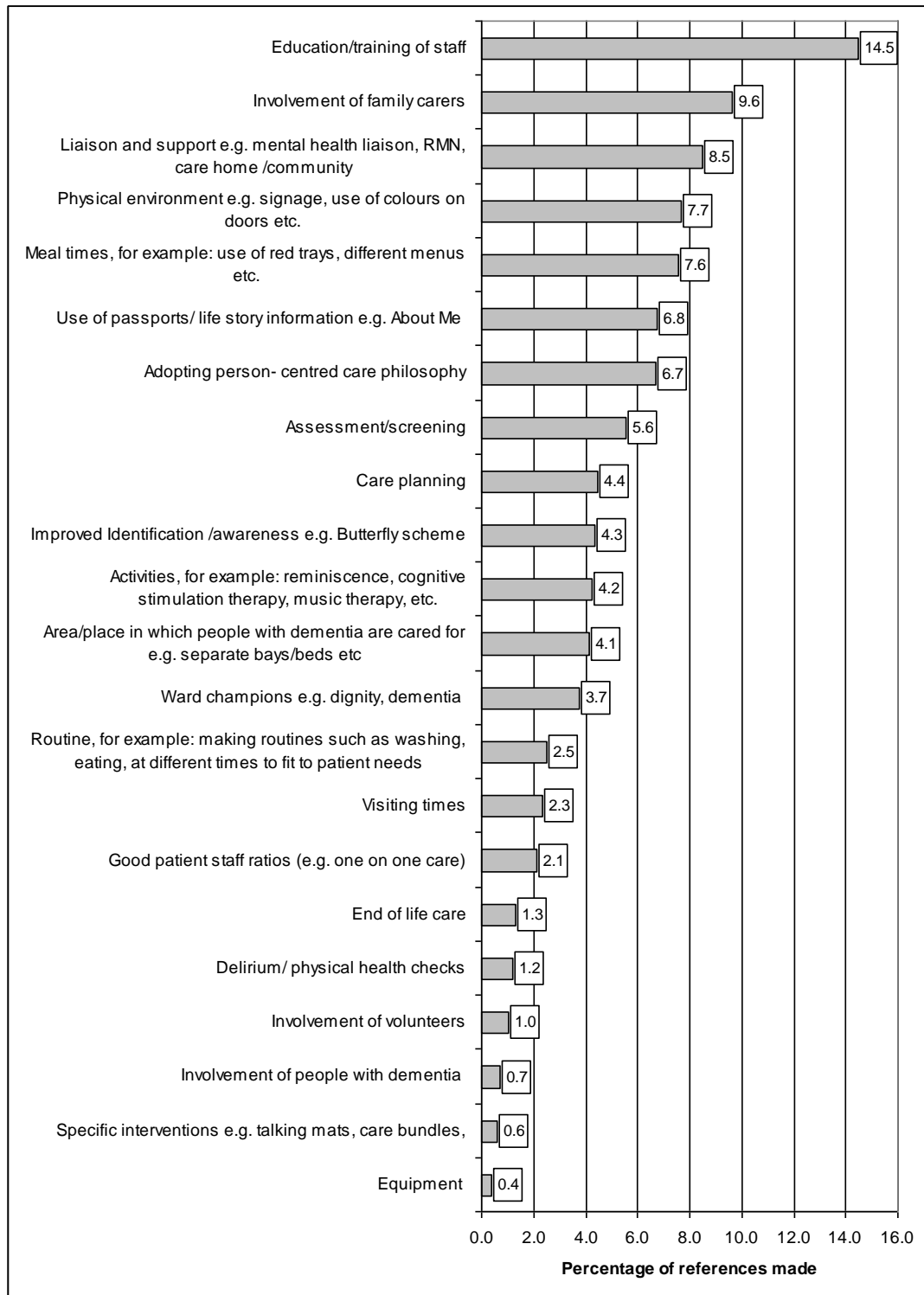
Approximately one in six respondents mentioned other changes that had been made to dementia care. These included continence care and support, introducing dementia champion/specialist with dementia responsibility, details of changes to meal times e.g. social mealtimes, training to enhance empathy, risk assessment, link and liaison nurses introduced, life history work and maintenance of routines etc.

The average number of interventions and changes mentioned by respondents was 5-6 with 20% describing one or two interventions, one in four (23%) cited 3-4 interventions and 21% mentioned 5-6. 15% cited 7-8 improvements and 20% cited nine or more changes they had made.

As well as being asked to indicate from a range of options which approaches had been adopted at their places of work, the professionals responding to the survey were also asked to provide details of the approach taken in around 100 words. Figure 4 summarises the responses into broad themes including the approaches listed above. In approximately 15% of cases respondents mentioned activities linked to education and training of staff. This was the most frequently cited change that had been introduced. In one in ten cases family carers had been involved in the process and liaison and support had been developed in 9% of cases.

In Appendix A there are a sample of case studies provided that give more detailed information of what has been done and the positive outcomes and challenges faced by professionals working in dementia care. These case studies have been selected as the ones where the most detailed information was provided by respondents.

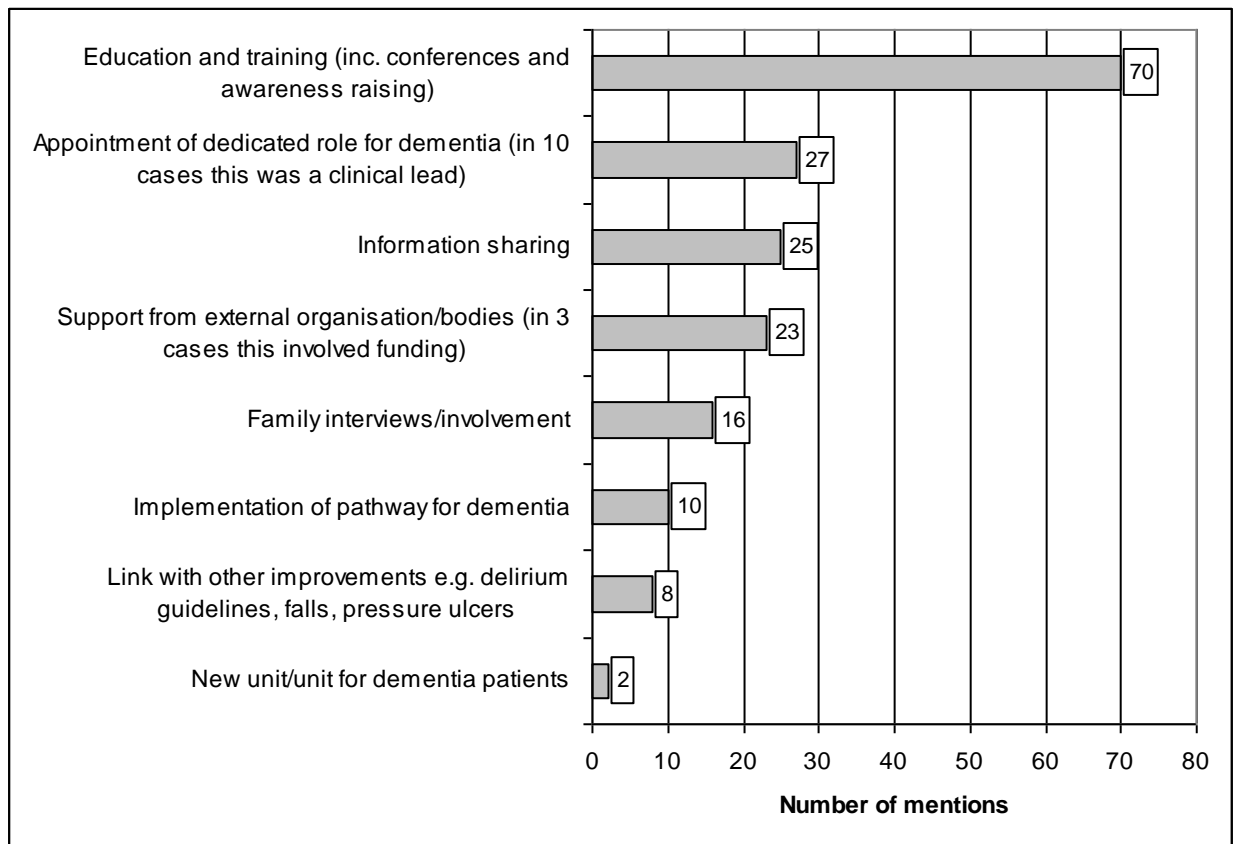
Figure 4: Description of the detail of approach undertaken (percentage of all comments made)



Source: Employment Research/RCN Dignity in Dementia Survey, 2011

Respondents were asked again if there were any other improvements that had been made to the service not previously mentioned. There was some repetition here although some more details was provided and is highlighted in Appendix A.

Figure 5: Other improvement made to the service (number of references)



Source: Employment Research/RCN Dignity in Dementia Survey, 2011

Key messages in delivering positive approaches to dementia care

There were a number of themes that emerged following a question requesting any further thoughts/ comments about how respondents had made improvements to care.

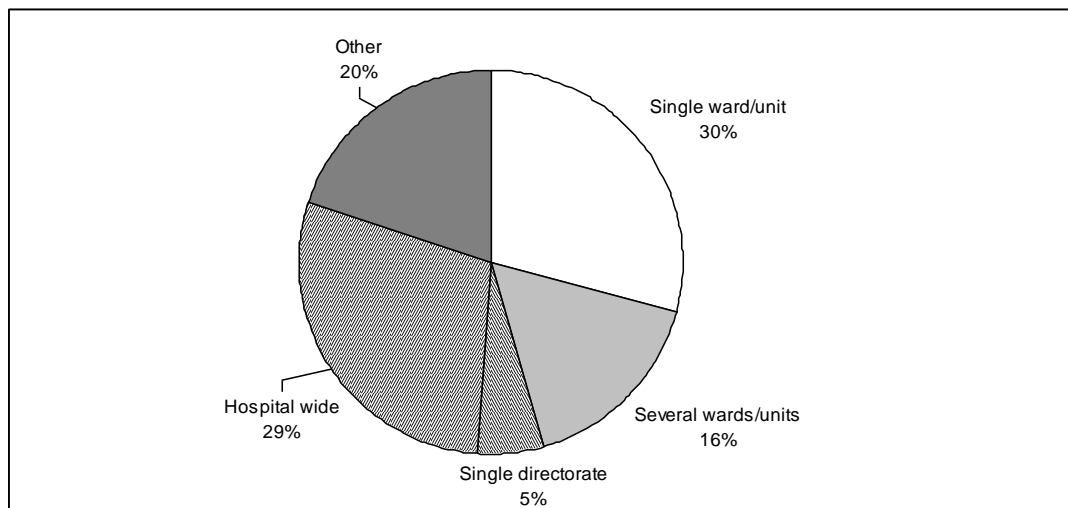
Training was mentioned within 39% of feedback (70 comments) and this also includes a range of activities from awareness sessions to attending external conferences. However in considering training interventions there were several areas highlighted. Some mentioned the need to recruit people with little prior experience as bad habits can be difficult to undo. The importance of addressing skills/attributes rather than academic qualities was raised in making training more beneficial. Improving leadership and management and having the support of trust boards and senior nurses was mentioned by a few respondents and this might be evidenced by the appointment of senior staff to dementia lead positions. Team building and creating a positive environment was also cited as important factors. Improvements in communication between agencies and support services was also seen as important by some. Information sharing was mentioned in 25 cases, involving both sharing of knowledge within teams and sharing best practice within and between organisations. This also relates to the development of improved relationships between staff, patients and family/friends which is also seen as key to improving the care environment and was mentioned in a number of cases at different stages of the survey.

Wider influences included improved awareness more generally with better media coverage of the condition in recent years which is likely to result in a more informed use of the service.

Coverage of dementia development

Professionals responding to the survey were asked to indicate how widespread the development of care has been where they work. In 30% of cases respondents indicated that the development of dementia care was a single ward/unit level, in 16% of cases it covered several wards/units, in 5% of cases a single directorate and in 29% of cases it was hospital wide.

Figure 6: Extent of coverage in developing approaches to dementia care (percentages)



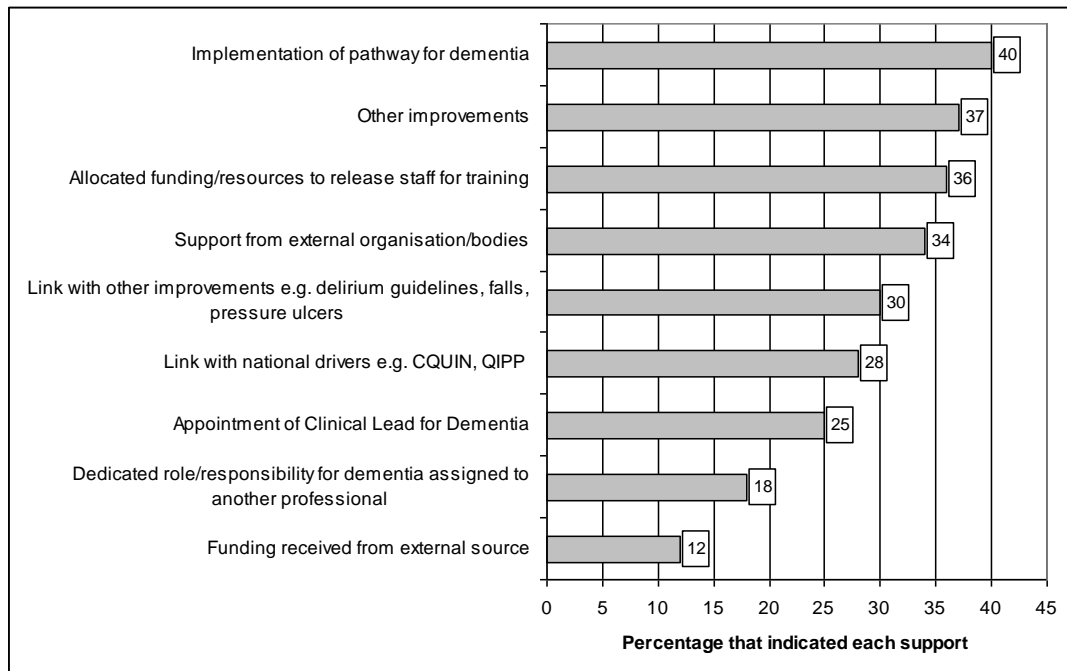
Source: *Employment Research/RCN Dignity in Dementia Survey, 2011*

The ‘other’ levels of coverage applied to consortia of GP practices, community settings, specialties and in a number of cases care homes were covered by the developments.

There was no difference in likelihood of different approaches to dementia care being adopted in relation to how widespread the development of dementia care was reported to be.

Respondents were also asked to indicate what had been done at their workplace to support the development of dementia care.

Figure 7: Support provided for development of dementia care (percentages)



Source: *Employment Research/RCN Dignity in Dementia Survey, 2011*

Four in ten respondents (40%) said that pathway for dementia had been implemented where they work, 37% mentioned ‘other’ improvements which covered much the same ground as in the previous question concerning changing approaches to dementia care. This included implementing new training (for example all staff completing level 1 dementia awareness training), raising awareness sessions more generally, sometimes hospital wide, having senior nursing staff who are supportive of the drive to improve dementia care. Also mentioned was having dignity link nurses, implementing comprehensive and appropriate care plans, taking account of relatives concerns.

More than a third (36%) of respondents said that funding had been allocated to release staff for training in dementia care and a third (34%) said that there had been support from external organisations and bodies.

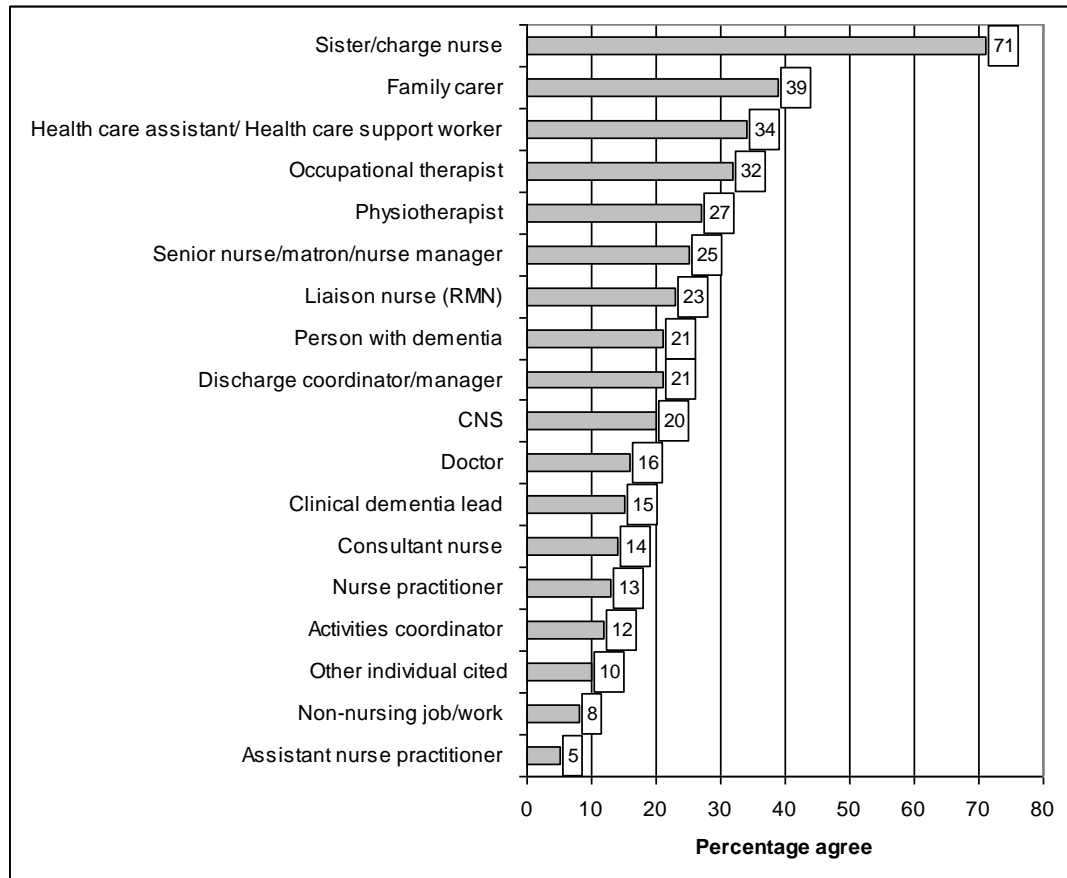
Just under one in three respondents said that improvements were linked to other changes at the workplace, often mentioning the changes that had been discussed in the previous question. Falls and pressure ulcers/sores were mentioned by most respondents as linked changes as well as delirium policies, while many mentioned several changes taking place concurrently. Other conditions that were mentioned by respondents included: diabetes, nutrition and mental health.

Links with national drivers were cited by one in four respondents (28%) and these included in roughly equal numbers reference to CQUIN and QIPP, many mentioning both, as well as NICE guidelines, the National Dementia Strategy/Audit, LTCs and LCP and CQC guidelines. Just under one in five respondents said that a dedicated role had been assigned to another professional – in some cases dementia specialists/care teams, sisters/charge nurses.

3. Who develops approaches to dementia care?

Respondents were asked to indicate who had been involved in developing approaches to dementia care. In most cases (71%) it is the sister/charge nurse on a ward/home or unit that is responsible for developing new approaches to dementia care. However, in most cases other professionals and interested parties are also involved, on average between 3-4 people support the development of dementia care. Most typically this might include family carers (in 39% of cases), a healthcare assistants (34%), occupational therapists (32%), physiotherapists (27%) and senior nurses/matrons (25%).

Figure 8: Who involved in developing approaches to dementia care (percentages)



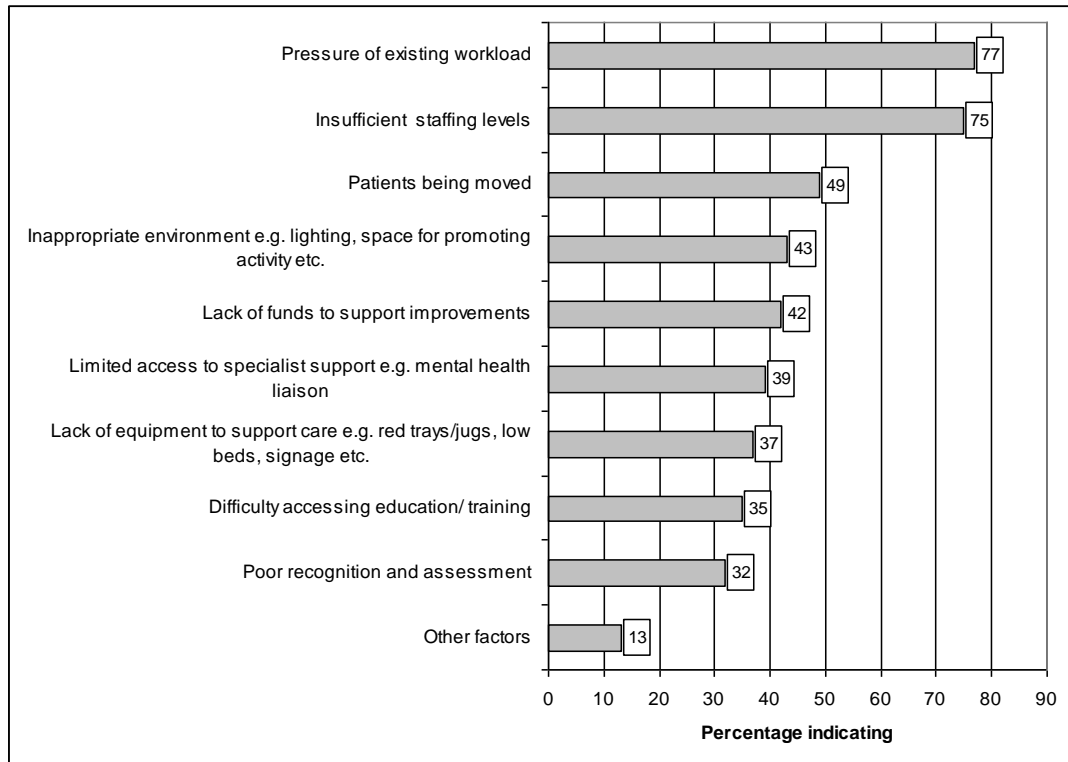
Source: *Employment Research/RCN Dignity in Dementia Survey, 2011*

Again, there is little discernible difference in the likelihood of different individuals/professionals being involved in developing approaches to dementia care in relation to how widespread the development has been.

4. Barriers to effective dementia care

Next the survey asked respondents to indicate what, in their view, were the barriers to them improving dementia care. Pressure of existing workload (77%) and insufficient staffing levels (75% were mentioned by around three quarters of all respondents). Approximately a half mentioned the movement of patients (49%) and four in ten said an inappropriate environment in terms of lighting and space etc (43%) or a lack of funds to support improvements (42%).

Figure 9: Barriers to improving dementia care (percentages)

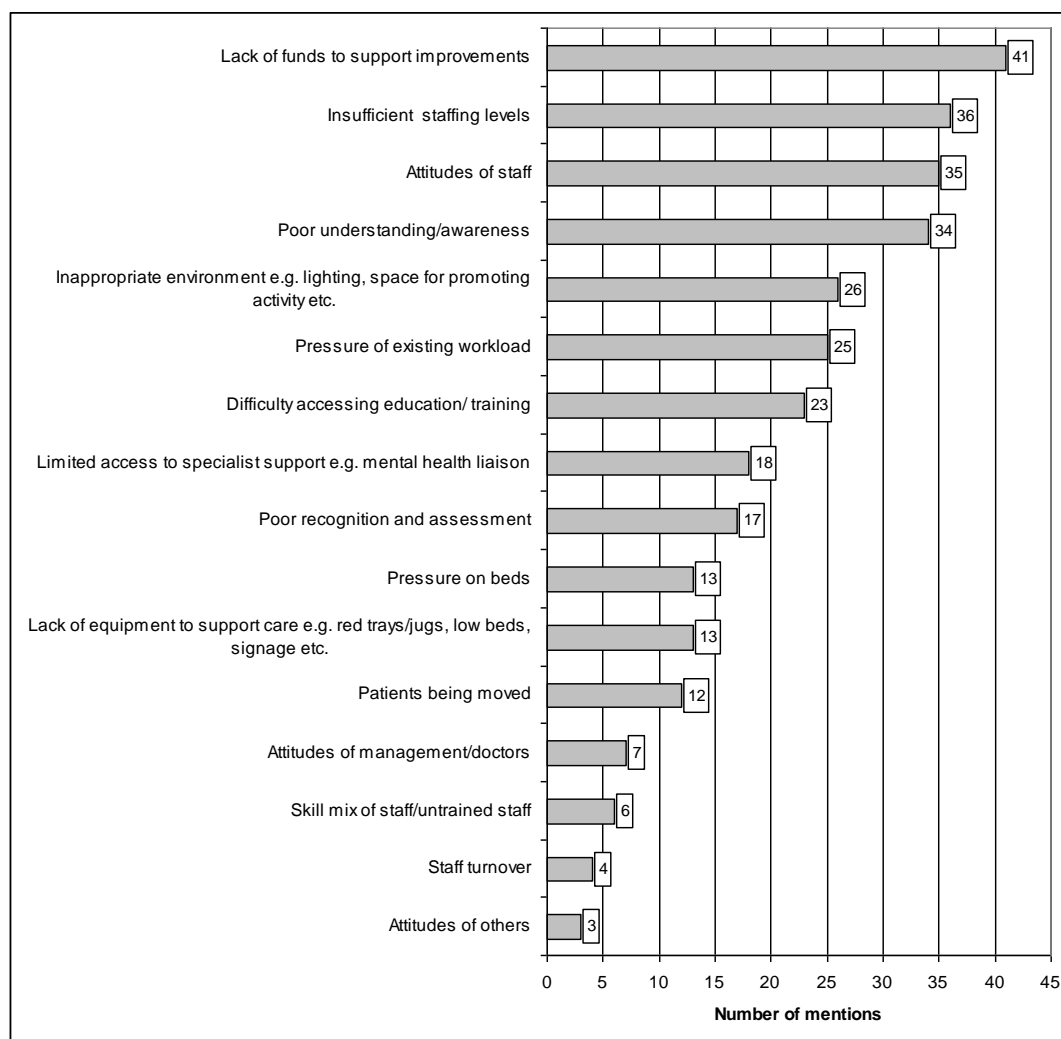


Source: *Employment Research/RCN Dignity in Dementia Survey, 2011*

Many, more than a third in each case, indicated that; limited access to specialist support, a lack of appropriate equipment to support care, and difficulty in accessing education and training affected the ability of professionals to implement more effective dementia care.

Respondents also mentioned another of other issues that hinder improving dementia care. These are listed in Figure 7 below and included: attitudes of management, staff and others, skill mix, pressure on beds, staff turnover, poor understanding and awareness of the issues.

Figure 10: Other hindrances/barriers to improving dementia care (percentages)



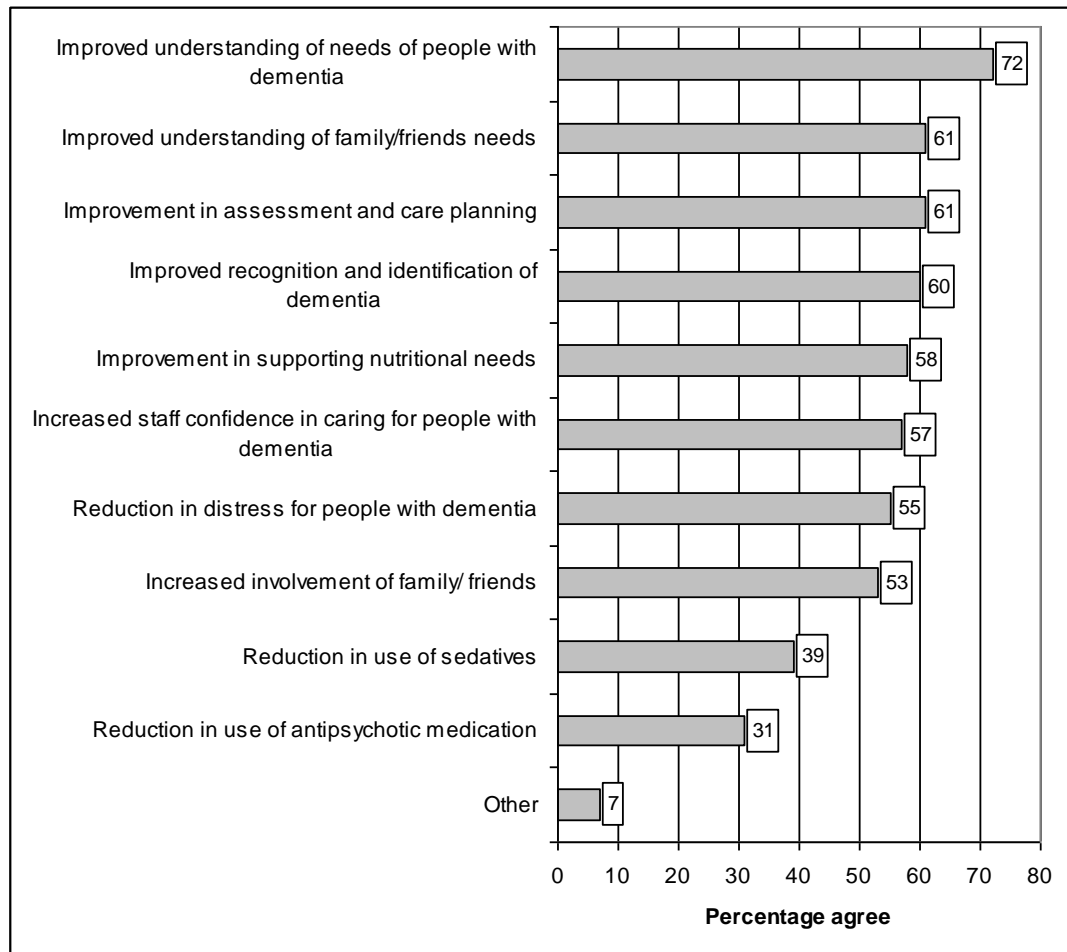
Source: *Employment Research/RCN Dignity in Dementia Survey, 2011*

5. Value added from changes

Respondents were asked to indicate the differences made through the changes to dementia care that had been implemented. Nearly three quarters of respondents said that there had been an improved understanding of the needs of people with dementia (72%) and around six in ten had mentioned improved understanding of the needs of families/friends (61%), improvement in assessment and care planning (61%), improved recognition and identification of dementia (60%), improvements in supporting nutritional needs (58%) and increased staff confidence in treating people with dementia (57%). These data are shown in Figure 11.

In a third of cases (31%) there had been a reduction in use of antipsychotic medication and in 39% of cases there had been a reduction in use of sedatives.

Figure 11: Difference made as a result of changes to dementia care (percentages)



Source: Employment Research/RCN Dignity in Dementia Survey, 2011

One in five respondents said they had evaluated the impact of the changes made to dementia care where they work. Among those that provided details of the evaluations undertaken most mentioned audits of their own roles or specialist audits of dementia care. In surveying patients and their families some had found there to be less anxiety and more trust built up through better understanding of needs. There were examples of improved communication with other services to improve understanding of patient needs. Specific interventions e.g. care plans, nutrition changes, or specific training/awareness raising have also been evaluated. In a number of cases evaluations are currently in progress so it was too early to tell. It seemed also that some of the evaluation undertaken was of an ad hoc or informal nature, seeking the views of patients/staff of changes and then acting on the feedback. Some also referred to more tangible audit measures of less distress, longer lives and fewer patient incidents e.g. falls etc. but did not provide specific evidence in their response.

Appendix A Case Studies of detailed responses

All the responses below are from respondents who are happy to be contacted to provide further information if required.

ID: 14
Includes: Physical environment/training/specialist staff/person-centred care/about me
<p>I work in a Medical and Mental Health Unit at Nottingham University NHS Trust which has been developed as part of a research programme, comparing a specialist unit with 'standard care'. Full details of how the ward has been developed are found here: http://www.nottingham.ac.uk/mcop/documents/papers/mcop-issn2044-4230-issue5.pdf Medical Crises In Older People</p>
<p>The changes include environmental adaptation, staff training, specialist staff recruitment, the implementation of person-centred care, an activities programme etc. I am nurse on the ward and the main role I have had is implementing an 'About Me' document (aimed at gathering personal profile information quickly after hospital admission and to a level which suits the specific needs of patients with dementia who are hospitalised). 'About Me' has been evaluated through a survey with staff and carers. The ward, and its effectiveness, is being measured through a randomised controlled trial. At the moment, I am in the process of writing a paper with some other members of the team, documenting our experiences of trying to implement the philosophy of person-centred care in the acute setting.</p>

ID: 27
Includes: Training/adapting routines/dementia liaison/early diagnosis and intervention/nostalgia rooms/volunteers/this is me/importance of improving care
<p>Monthly training for all hospital staff, clinical and non clinical aimed at increasing confidence in communicating and understanding the needs of people with dementia and adapting our routines to best meet their needs. Support to implement this in practice. Inpatient dementia liaison service to assess people with cognitive impairment and enable early diagnosis and intervention.</p> <p>Nostalgia room and volunteers trained to provide reminiscence sessions with individuals and groups. Resources on the wards to help keep people with dementia occupied whilst in hospital. Completion of "This is Me" document with relatives and early involvement of relatives in care. Supporting staff in managing challenging behaviour and discouraging the use of antipsychotic drugs. Support of senior nursing, medical and management colleagues who have recognised the importance of improving care for people with dementia.</p> <p>All staff, nursing and medical, are quicker to recognise when there may be a problem with someone's cognition which enables an earlier diagnosis and intervention. Education has increased staff confidence and also made them more likely to ask for help in meeting someone's needs. Having a document to complete with relatives helps staff to understand what information is crucial and assures relatives that we are interested in knowing about their loved one with dementia.</p>

ID: 31
Includes: Ward champion/training/financial constraints/lack of staff understanding
<p>As the Safeguarding Named Nurse for the Trust I have become a Dementia Link/champion. I include safeguarding abuse examples pertaining to patients with dementia in all training. I emphasise risk of this vulnerable group who often have no voice or advocates. I have led on 2 SUIs and use learning from those poor patient experience to improve care of patients with dementia in the acute setting.</p> <p>All staff to complete Level 1 Dementia Awareness training. Dementia link workers group launched with training. Dementia Care Conference at RCHT hosted by us and the PCT facilitated by Dementia Care Matters. RCHT Dignity Champions Group.</p>
<p>Hindrances</p> <p>Financial constraints. Poor environments. Patients with co-morbidities require specialist wards not geared up to support their needs. Lack of understanding. "Patient should not be here" said by many staff as they find behaviours too difficult to manage.</p>

ID: 90
Includes: Planning meetings/"all about me"/"Let's Respect Tool"/activities/volunteers/liasing with outside agencies
<p>A Delirious About Dementia project addressing both delirium and dementia in acute hospital. Weekly planning meeting. Promoting All About Me and Let's Respect Tool. Super MDT reviewing patients with dementia. Working with other dementia leads across SHA. Employed activities coordinator working with volunteers focus on social meal times and other activities to improve communication, food and fluid intake and mobility. Linking with Birmingham Conservatoire to provide music.</p> <p>Workforce bid has provided RMN nurse researcher with track record of developing competencies and training in mental health trust and also Stakeholder involvement, Alzheimer's Society, local universities etc. Working with carer organisations to provide support to carers, overnight stay etc. Support from Chief nurse and Trust Board. Weekly rolling training programme Delirium and Dementia throughout 2009 now ongoing Dementia Café established Dec 2009. Careful action planning and review of outcomes.</p> <p>We are seeking via informatics to design acute hospital metrics that will link in with our PICS system and dashboard to provide detailed information about above categories</p>

ID: 121

Includes: Ward champion/raised awareness/training/dementia policy/care pathway/person-centred care/screening & assessment/equipment/family and carer involvement

I have joined the Dignity Champion website, I have raised awareness of Delirium and staff have access to Dementia Training after I attended the Alzheimer's Society Training Programme. A Dementia Policy is now ratified and in place and a Care Pathway for cognitively impaired Older People, Distinguishing between Delirium, Depression and Dementia, A Person Centred Care approach is encouraged around the hospital and appropriate screening, assessment according to the NICE guidelines and diagnosis are now implemented. I have introduced Talking Mats to enable people with communication difficulties to be better involved in their care decision making and expression of needs. Staff involvement of informal carers is encouraged.

Other documents are Acute Awareness: improving hospital care for people with dementia, Strengthening the involvement of people with dementia, Safeguarding Vulnerable Adults - Mental capacity Act and Deprivation of Liberty safeguards, Liberating the NHS, Nothing ventured Nothing Gained, risk guidance for people with dementia. I have high visibility and respond to a bleep, intervention is rapid, staff know me and feel confident to bleep me and I will work with them on an issue, I also help patients and carers come to terms with the diagnosis.

I have helped with recognition of end stage dementia and end of life care needs and provided evidence based practice / information regarding aggressive intervention at the end of a person with dementias life. Talking mats have helped people make decisions about PEG feeding.

ID: 216
Includes: involvement & understanding/including dementia patient/reduced distress
Regardless of how busy and many multiple matters need to be attended to it is vital at all times to:
<p>1) 'Put your self in the patient's shoes and into their world';</p> <p>2) You can only do this if you care about their real world and thus use your nursing assessment to find out more about it. I have used some simple articles on relating with the person with dementia to do this;</p> <p>3) It is always possible to relate. This does not take time. You do it while you are doing everything else- it can be a look in the eye, an encouraging arm on the shoulder or hand on arm, a kind few words, a wave as you move on to other people or things. When attending the person with dementia, there is ample opportunity to use relationship skills so foundational to nursing that you can engage therapeutically whilst also 'assessing' better what the person's needs are. Talking about the weekend with my colleague while making the person's bed is not on my priority list but engaging the patient while doing this is;</p> <p>4) Always get informed consent or a reasonable legal consent before touching or relating. Normal basic courtesy and respect. Knowing that the person with dementia is not a child or a sub-human but fully and really as human as I or another healthy person is. They do not lose their personhood and deep need of dignity and their deep insight on life. I apply these ideas routinely.</p> <p>I personally teach by example and want to develop ways of improving practice on my ward. I work in an area which is somewhat resistant to real unit development and there is a leadership problem which I can not directly change.</p> <p>It is always very clear that the right approach makes a massive difference to the person's experience. I have witnessed the wrong thing done far too many times and it is distressing. When the right approach is taken, the patient appears calmer and more oriented, happier, will eat and drink more, is far less 'aggressive' or 'angry' in their behaviour and presumably their feelings.</p>

ID: 221
Includes: training programme/improving care/pathway/dementia café/liaison with community
<p>Setting up a multi skill mix, inter-professional group to look at and improve the care and environment we look after people with dementia in. Also developing a teaching/ learning programme accessible for all professions to raise understanding of the disease and the care required to better help people with dementia and their carers. Establishing a standard that all students passing through our hospital on placement will learn about dementia and dementia care. Setting up a pathway for the new graduate curriculum focussed on dementia, even though we are a general hospital. Also set up a dementia cafe with the Alzheimers Society to run in the hospital open to anyone with any link with dementia in the hospital and in the wider community</p>

ID: 223
Includes: nutrition/weight monitoring/visiting times/family and friends involvement/training
<p>Avoid use of Dementia as a labelling title to those with dementia. Distressed reaction to be used instead of being aggressive. Try to find out causes of distress reactions. To keep each individual well groomed and be assisted regularly with continence care.</p> <p>Improved diet with adequate oral fluids intake calculated as per each individual body weight. Weekly or monthly weight monitoring of each individual and review of monthly Nutrition Care plans. Prompt reporting of any weight loss of 2kg to GP/ dietician for prompt action. Any medical concern is referred and action taken. Family encouraged to be actively involved in the care and other significant others. Visiting times are flexible but encourage meal times to be protected unless one is actively involved in the actual feeding of an individual.</p> <p>Training sessions in Dementia Care are rare and not all staff caring for those with dementia have undergone the training. Some of those with the Dementia Care training are not doing 'Hands on' and thus contribute very little to the actual care of those with dementia. Family members need some Health Education on Dementia Care so that they understand what it involves as some of them, if not all, usually look forward to their beloved ones with dementia to get well and have a reunion at home! Lack of remuneration to those who take care of those with dementia as it is a speciality, not just caring for geriatrics in general. This leads to poor retention of potential staff and reduced care as new staff take time to undergo appropriate trainings.</p> <p>Slow progress of Dementia, improved sleeping patterns, improved feeding habits, improved family acceptance, improved general wellbeing and improved approaches to better care of those with dementia by staff and significant others.</p>

ID: 229
Includes: person-centred care/areas & quiet places/activities/family involvement/ involving person with dementia/
<p>We have developed a holistic approach to care for the dementia suffering people because they all present with different signs and symptoms. Dementia is usually seen in elderly people who may also have other medical and psychological issues so we find treating each person individually very pertinent. We have managed to group people according to their presenting signs and symptoms to avoid confrontations for example some demented people prefer to be in a quiet place where as others would enjoy going around the units, talking to people or even shouting on top of their voices. Music, cookery and sowing are some of the activities we have implemented because most of the people with dementia seem to enjoy dressmaking, knitting and making cakes for example.</p> <p>We found that involving members of their families to be beneficial as this enables us to know the people behind dementia .This also enables us to treat them in such a way that they like and are happy with. This is not to ignore the fact that demented peoples decisions are not taken seriously because their needs and taste can change. We are listening and act according to their best interest.</p>
<p>Hindrances</p> <p>Sometimes there is a lack of continuation of care as some staff are not willing to uphold the quality of care according to the laid down care plans. The other reason is the high rate of staff turnover which hampers the continuation of care.</p>

ID: 248
Includes: Training/protected meal times/physical environment/coloured trays/routine/assessments/end of life/equipment/
<p>The hospital has had a week of information by our hospital Dignity and Privacy team which includes care of elderly and dementia care. They have instigated training days for staff, our Manager is treating this as mandatory training. We have a protected meal time, all but ward staff leave ward, all left help serve and feed patients, food charts used. Blue trays for assisted feeding. If relatives can help feed they are invited to do so, and we ask relatives for familiar items e.g. pictures or for diaries to write in.</p> <p>We still tend to have a regular routine of washing, but will review our patient's needs, leaving them to sleep and washing them later. We check for additional causes of confusion (UTI, Chest infection etc) and use assessment tools such as Mini mental tests. Our ortho-geriatrician and care of elderly nurse specialist have been part of the team adjusting the Abbey pain score tool to our needs. Our ward has been part of this trial and of the End of Life trial that palliative care are evaluating. We have hi-lo beds (not enough!) and hourly checks for 'out of view' patients.</p> <p>Chaplains and mortuary techs are also involved in our dignity and privacy team.</p> <p>Our ward meetings allow information exchange, we are encouraged to share articles and our ward manager encourages our Nursing Assistants to give teaching sessions to each other which shares experience too. We are still in the process of training but have rarely made use of sedatives or antipsychotic, we have used tools for assessment for many years and use our Ortho-geriatrician's recognition of undiagnosed dementia to good effect (a post that has been with us for over 5 years). I feel this year will bring more changes.</p>
<p>Hindrances</p> <p>Being unable to put recent training in action due to lack of funding, time constraints, lack of space and equipment. We are only able to do small things. Also we are an acute ward but have nowhere to send patients who need rehab and dementia care if their dementia is severely affecting them. This means they have constant changes around them. Also they may have had 2 to 3 moves prior to arriving with us, e.g. A&E and SAU.</p>

ID: 287

Includes: Assessment and diagnosis/specialist staff/ward champions/Butterfly scheme/person-centred care/family and carer involvement/training/care plan

Assessment and diagnosis for confused patients on MAU and short stay including delirium screen and pathway. Dementia matron and MH in reach team assist the assessment process and provide supported discharge for up to 6 weeks for patients with no medical reason for hospital. Dementia champions trained to lead care on selected wards (testing the model). Butterfly scheme introduced on these wards. Promotes person centred care, carer involvement, education for all staff, and clearly identifies patients who may require support to make decisions. Anticipatory care plan on discharge for complex patients.

The local quality improvement strategy has several quality care streams. Dementia care sits within the patient experience steering group and as such has corporate sign up. Links within the local health and social care networks facilitate a community wide approach to the care pathway development. This is supported by the CSED team from DOH. Productive and exemplar ward initiatives help facilitate and monitor change. This whole systems approach promotes a willingness to change and a culture of quality focus. Patient experience, clinical effectiveness and patient safety.

All of the above are being addressed within our improvement strategy. We are addressing the issues within 8 clinical areas initially and will spread the pathway once tested and embedded in these areas.

It is early days in regard to these improvements. However, feedback from carers and staff reflect that the use of the pathway has improved outcomes in terms of experience, length of stay, communication and clinical outcomes such as early intervention, reduced unnecessary use of medication etc. Anticipatory care planning for a complex younger patient with dementia led to a shorter admission with much improved understanding and delivery of care needs

ID: 306

Involves: Family involvement/involvement of patient/"wandering care plans"/equipment/specialist staff/discharge care package

Patients with dementia are nursed as close to the nurse's station if possible. I work in CCU so if an acutely ill patient, requiring very close observation, takes priority then they would take priority as many of these patients are on Intra Aortic Balloon Pumps, have temporary pacing wires in situ etc. Relatives of patient's with dementia are included in all aspects of both nursing and medical care.

Patients with dementia are treated with respect and, depending on severity of dementia, are regularly orientated to time and place. All aspects of nursing intervention are explained to every patient regardless of whether they have dementia or not and all patients are treated with the respect that they should be. The unit that I work on also now have 'Wandering' care plans and so that their behaviour can be charted and so an idea of when they become more disorientated etc can be anticipated as much as is possible. Patients with dementia are treated as people and not just as their diagnosis of dementia.

Patient's with dementia are nursed on low beds if they are available.

The intensive working environment of a CCU sometimes means that emergency admissions, cardiac arrest etc sometimes take priority. The unit where I work try to overcome this barrier by asking a HCA to sit by the bedside of a patient with dementia. A CCU environment can be very intimidating to patients anyway and so this is taken in to account with patients with dementia.

I strongly believe that the staff on the CCU where I work try, to the best of our ability, try and recognise how fearful such an environment can be to a patient with dementia. We also try and support their relatives as much as we can. We have a Matron who is Clinical Specialist for Vulnerable Adults. Patients with dementia are also referred to OT & Physio so that they can be assessed for any increase/starting of package of care needed on discharge

ID: 325
Includes: “about me”/individualised care/training/social mealtimes/activities/
<p>Introduction of an Information “About Me” booklet for carers/relatives to complete and enable individualised care. Introduction of dementia awareness training for all staff groups. Induction talk about confused patients/patients with dementia for all nurses and HCA's. Social mealtime once a week including reminiscence by SALT.</p> <p>All patients that can sitting out to lunch together on one ward, each day with social activity following. Bay with activities on another ward. Development of Dementia Toolkit for Trustwide spread. BPSD care bundle pilot. Recruitment of MHLT older people.</p> <p>Joint Dementia Steering Group including outside agencies and patient members.</p> <p>Approval of bid for MHLT (older people) by the PCT. Team due to start in April 2011.Funds made available for 10 dementia awareness days (Trustwide). Free places at a local 2 day course on dementia awareness. Funds via a patient panel member for attendance at a four-day dementia awareness course.</p>
<p>Hindrances</p> <p>Difficulty in 'quality assurance.' It is not possible to monitor whether education and training is reflected in practice all of the time. We would love to provide 1:1 care for all those who need it, but this is not feasible within the resources available. We could and should be improving the environment, signposting, etc but resources are not available for this.</p>

ID: 437
Includes: Steering group/training/specialist staff/"this is me"/assessment
<p>Dementia Strategy Steering group has been established. Basic dementia care awareness training (not to all staff). Two MFE nurses to undertake basic Dementia Care Mapping in February 2011. Two MFE wards are receiving prevention and management of aggression training. Currently two older peoples' Mental Health Liaison Nurses in post. One mental health specialist OT in post. This is me and another similar patient preference booklet is being piloted on a couple of the MFE wards.</p> <p>Recognition that meaningful change requires an overhaul of how acute care is delivered, i.e. there needs to be a real change in the skill mix of staff such as employing mental health nurses to work as staff nurses etc on the acute medical wards.</p> <p>With the recent appointments of a second mental health liaison nurse and a mental health specialist OT, patients are receiving a more prompt mental health assessment than they were previously.</p>

<p>ID: 507</p>
<p>Includes: “all about me”/care plans/person-centred care/separate bays/training/ involving person with dementia/environment/activities/meal times/greater understanding</p>
<p>We use the "All about Me" care plans. Care is person centred and given according to the patients wants and desires. The Forget Me Not bay is designated for our trauma patients with dementia. The atmosphere and culture is different to the rest of the unit with an emphasis on attempting to provide a calm, stress free environment. Staff can choose on a daily basis to work in the area, enabling the team to be motivated and pro active when working in the room.</p> <p>Training provided by Jan Dewing (Consultant in Dementia Practice) has transformed the care delivery on the unit. Greater understanding and knowledge has led to improved care delivery. Task orientated care no longer exists and the individual is now focal to the care given. We can now enter into the experience the patient may be having and offer friendship, support and understanding by being able to communicate with them and being with them in the experience. The work shops provided us the skills and knowledge to help provide care that meets their needs and go along with the patient rather than expecting the patient to conform to the ward routine.</p> <p>We have raised the profile for patients with dementia on the unit. The Forget Me Not bay has created its own special atmosphere which is unique. The music, decor, eating facilities, games, and fridge have helped to make the room cosy and friendly. The pace of care delivery is less hurried and ore relaxed and has become a popular place to work. The Forget Me Not patients are now considered special and an important part of the ward.</p> <p>I believe we have transformed the hospital experience for the patient with dementia by highlighting and promoting their needs and ensuring they are the focal point for the care delivery. Knowledge and understanding of their needs is vital and training needs to be delivered in a practical and interactive manner with the use of work shops as opposed to the lecture method.</p> <p>I wrote a paper Haak, N. (2009) "Maintaining Privacy and Dignity of Patients Admitted to a District General Hospital NHS Trust" In Shaw, T. and Sanders, K. (Eds) Foundation of Nursing Studies Dissemination Series. Vol.5. No 2.This highlights how increasing the awareness and understanding of the needs of patients with dementia appears to promote person centred care delivery. Questionnaires were used to obtain feed back</p>
<p>Hindrances</p> <p>Lack of interest and support of the work the Forget Me Not work. No recognition or interest.</p>

ID: 579

Our organisation has built new care villages under the name of Belong www.belong.org.uk. The villages are based on dementia design principles, and focused on small open plan households with kitchens and living facilities. Access to gardens and balconies provides fresh air, and community facilities for residents and families to enjoy e.g. bistro, hair salon, village hall. Staffing ratios are 1:4 and training is delivered in house by practice development facilitators.

An organisational belief and understanding of the needs of the older persons market, and the need to design buildings and services that meet people's needs both now and in the future. If we get it right for people living with dementia we get it right for everyone. Our architect has travelled the world to bring back ideas to put into plan and product.

The family approach to care. The Life plans identify every aspect of the person's needs wishes and history. The small households with functional kitchens encourage purposeful activity. Safe access to outdoors. Regular events in the bistro and venue. Active exercise in our gyms. Use of the electronic medication administration and tracking of antipsychotic use.

ID: 648**Includes: Steering group/training/ward champions/liaison with others/assessment and early diagnosis**

We have a Dementia steering group led by Lead Nurse for Medicine for Older people, an action plan based on the NDS. We have participated in the NDS RCP Audit and then amended action plan to align with the standards. We have secured training money from the EoE board and identified Dementia Champions to be skilled up using this money, we have 24 named staff as dementia champions for all the wards, training to commence in March/April 2011. Dementia presentation has already been delivered to the ward managers of every ward.

We have direct links with CPFT, our mental health partners. They are funding a Band 7 Dementia Liaison Nurse post to work in the acute, this post is currently advertised, we are very keen to work in partnership, and have identified a desk and space for this nurse.

We have a good working relationship with the Crisis team, the CPN's attend after a referral from us to assess and diagnose patients for appropriate placement and also to attend the MDT if needed for complex case management.