Healthcare Improvement Scotland | ihub

Focus on Dementia Learning System

Personal planning and person-centred care planning in practice

Wednesday 19 May 2021
14:00 – 16:00

Enabling health and social care improvement

Welcome and introduction

Michelle Miller
Portfolio Lead, Focus on Dementia/Mental Health
Healthcare Improvement Scotland

Enabling health and social care improvement

Today's session

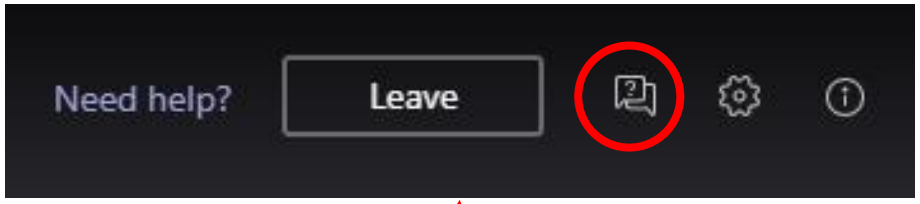
Time	Title	Presenter
14:00	Welcome and introduction	Michelle Miller Healthcare improvement Scotland
14:05	The history and evolution of person-centred care	Dr Jean McQueen NHS Education for Scotland
14:15	The Promoting Excellence Framework	Patricia Howie NHS Education for Scotland
14:25	Person-centred planning and dementia: a literature search	Iain Stewart Healthcare improvement Scotland
14:35	Anticipatory Care Planning	Tom McCarthy Healthcare improvement Scotland
14:45	Personal plans and post-diagnostic support	Julia Mackenzie Alzheimer Scotland
15:00	Questions	
15:15	**COMFORT BREAK – 10 MINUTES**	
15:25	Essentials of Safe Care	Joanne Matthews Healthcare Improvement Scotland
15:30	Person-centred care planning: Dementia in Hospitals Collaborative	Christine Proudfoot NHS Borders
15:35	Person-centred care planning in practice: NHS Highland Stress and Distress team	Shirley Campbell NHS Highland
15:45	Questions and evaluation	
16:00	Next steps and closing remarks	Michelle Miller Healthcare improvement Scotland

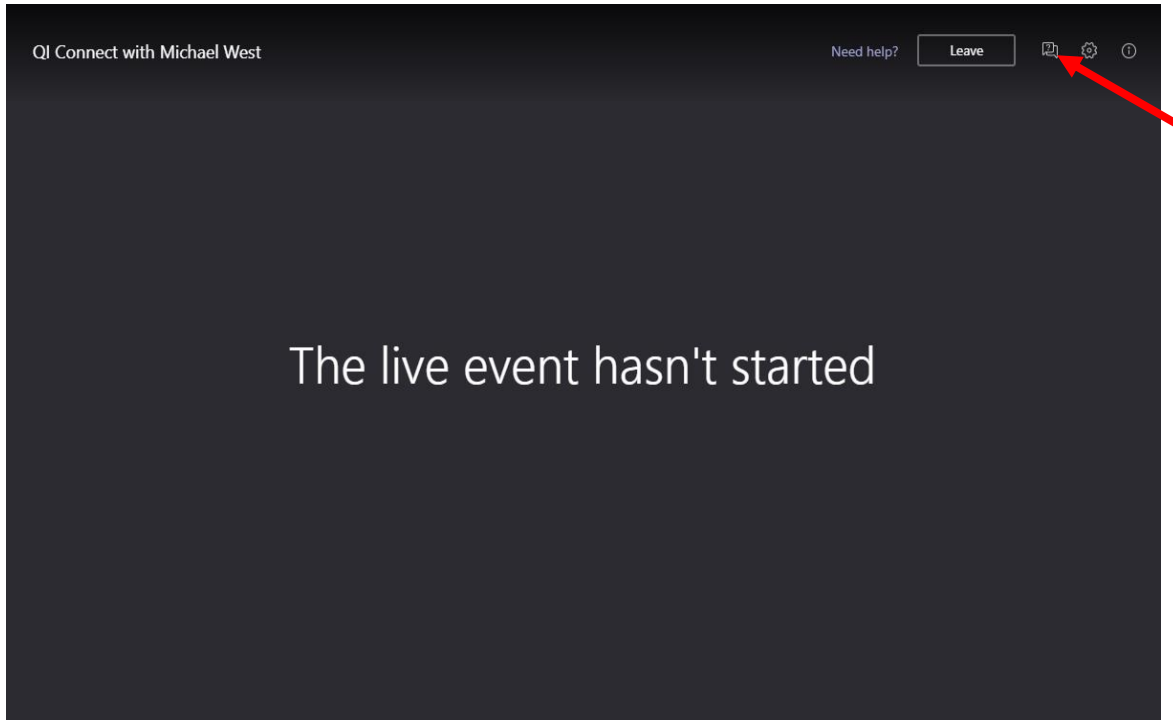
We are on MS Teams Live Events

MS Teams Live housekeeping

- Live Events is different from a regular MS Teams meeting in that it does not allow for the audience to use cameras or microphones – only the presenters
- At present, it is not possible to interact with other attendees via chat, but you can upvote by ‘liking’ any submitted questions you’d particularly like to see put to the speaker
- Please use the Q&A function to submit your questions for the speaker. These will need to be moderated so it may take a minute or two for your question to show up in the live chat
- Any resources covered will be made available following the session date
- In the event of technical issues, please bear with us and we will work to bring the session back at the earliest opportunity

How to use the Q&A function

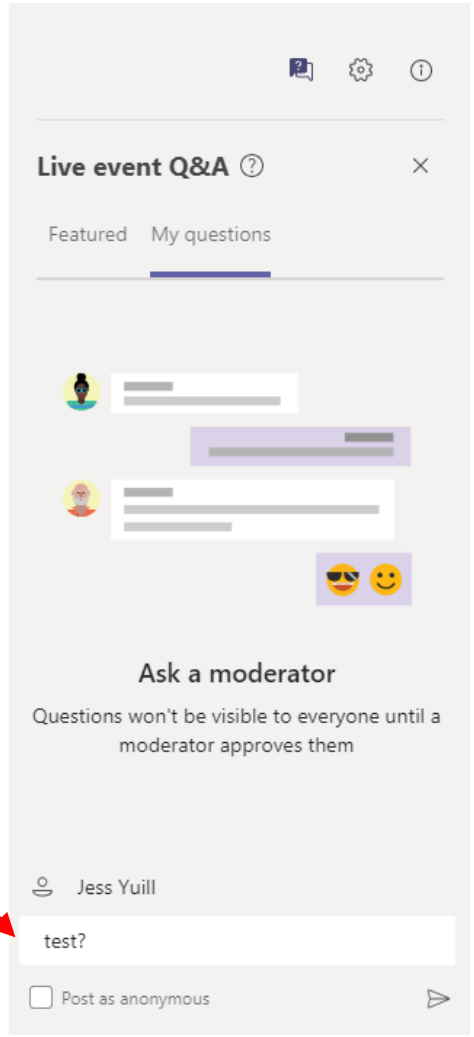




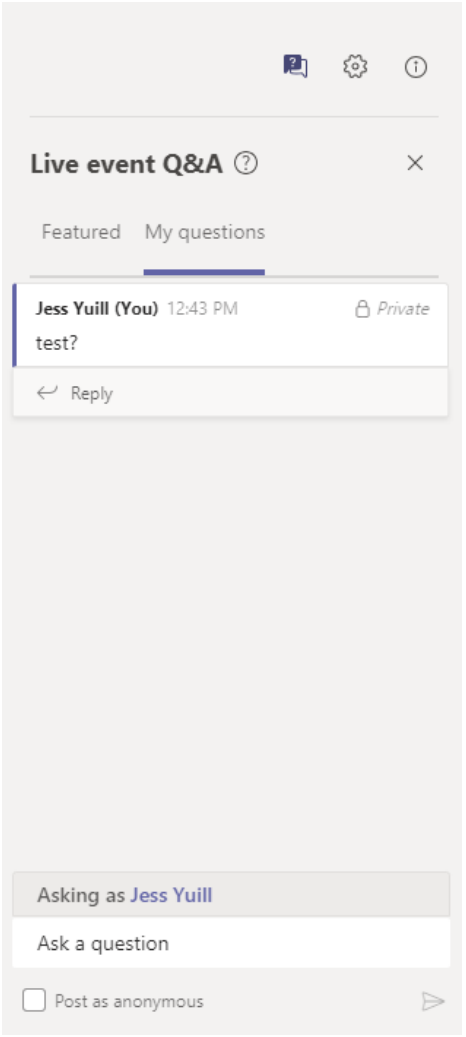
The Q&A Panel shows up when you click on the icon shown on the top right-hand side of your screen

How to use the Q&A function

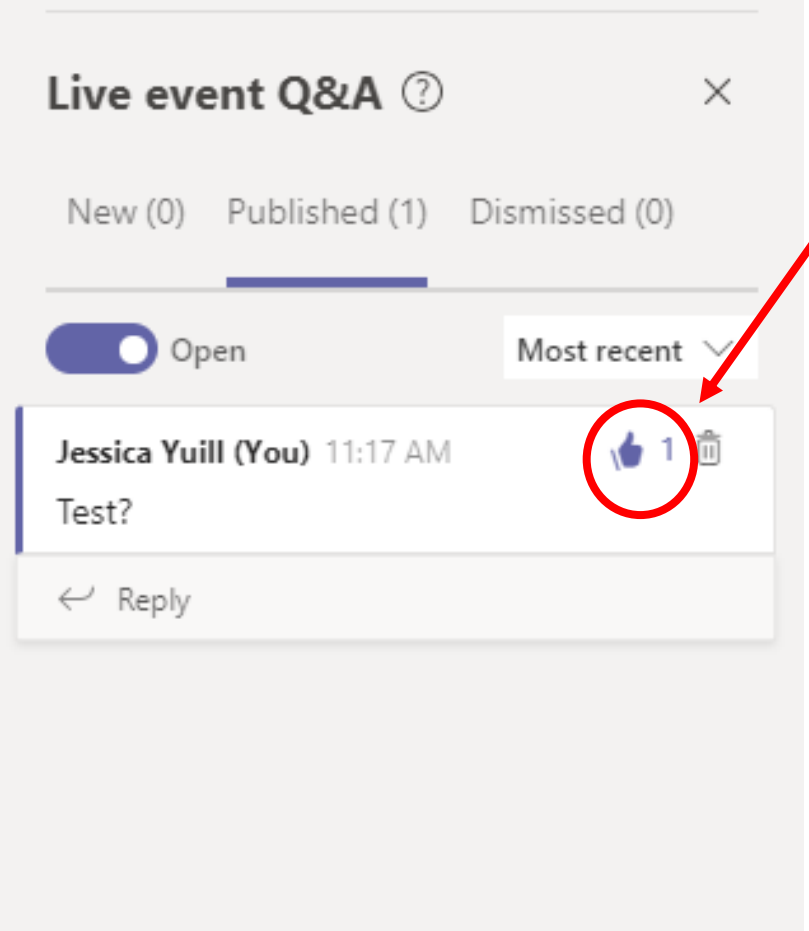
1. Submit your question using the text box shown



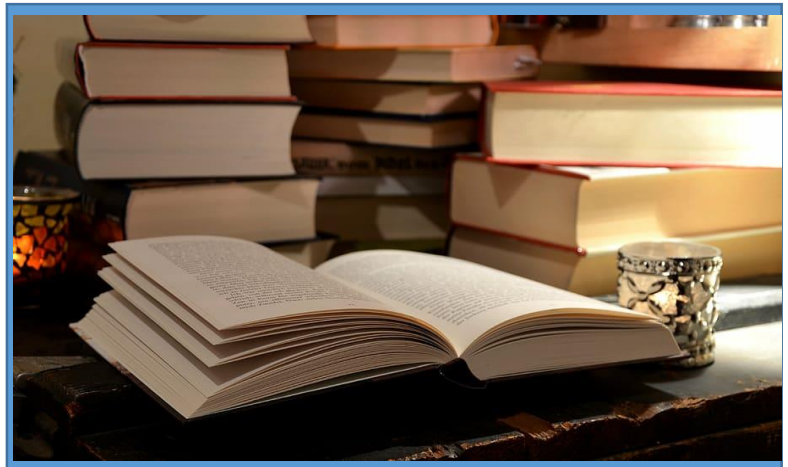
2. Submitted questions show up in your **My Questions** tab here. Once approved, it will show up in the Featured panel



How to use the Q&A function



You can like your favourite questions!



A summary of resources covered will be made available along with the link to a short evaluation after the session.

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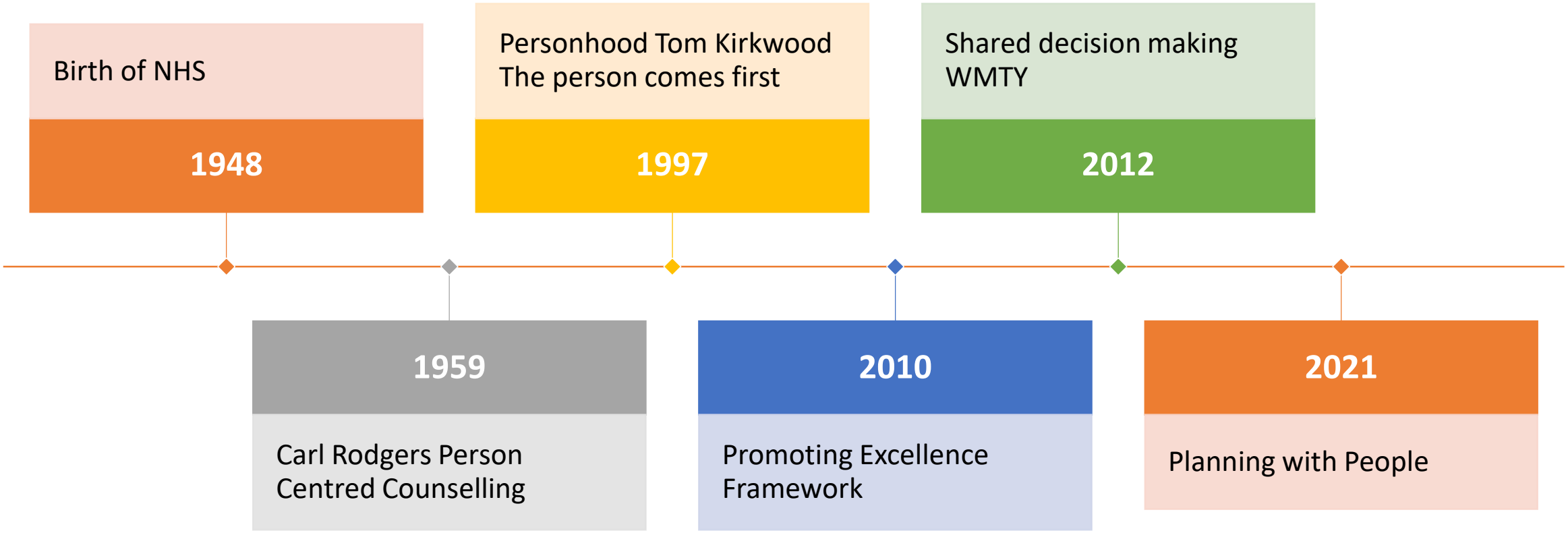
The history and evolution of person-centred care

Dr Jean McQueen
Principal Educator, Person Centred Care Programme
NHS Education for Scotland

Enabling health and social care improvement

Person Centred Care: A journey through time

Dr Jean McQueen
jean.mcqueen2@nhs.scot


Birth of NHS
1948
Personhood Tom Kirkwood
The person comes first
1997
Shared decision making
WMTY
2012
1959
Carl Rodgers Person
Centred Counselling
2010
Promoting Excellence
Framework
2021
Planning with People

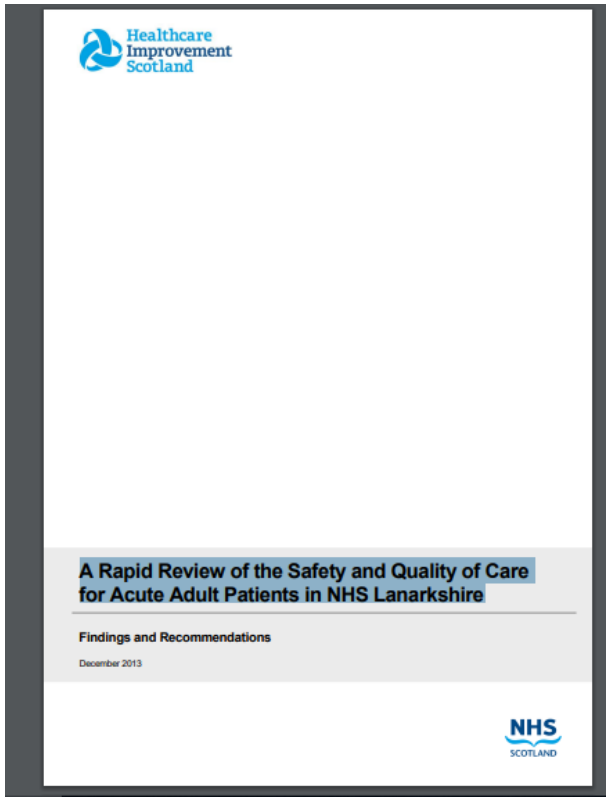
Affording people dignity, compassion and respect.

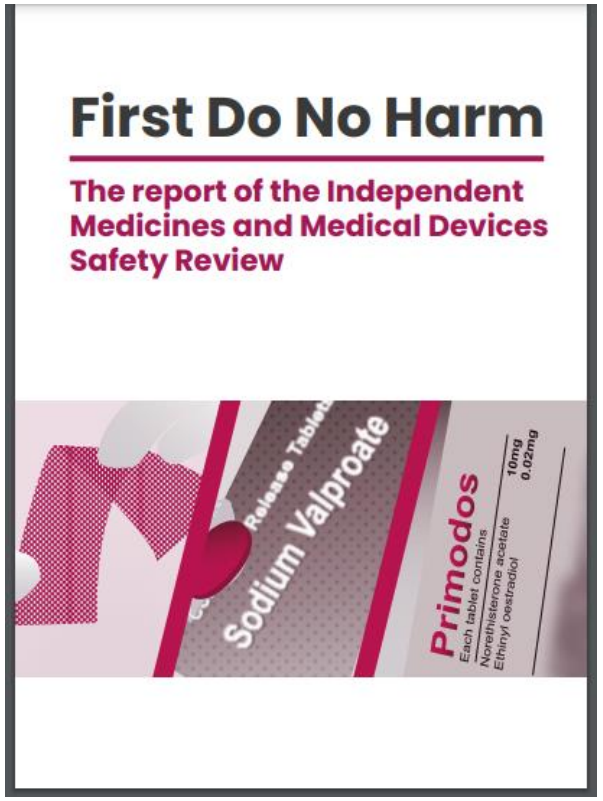
Offering coordinated care, support or treatment.

Offering personalised care, support or treatment.

Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life. (health foundation)

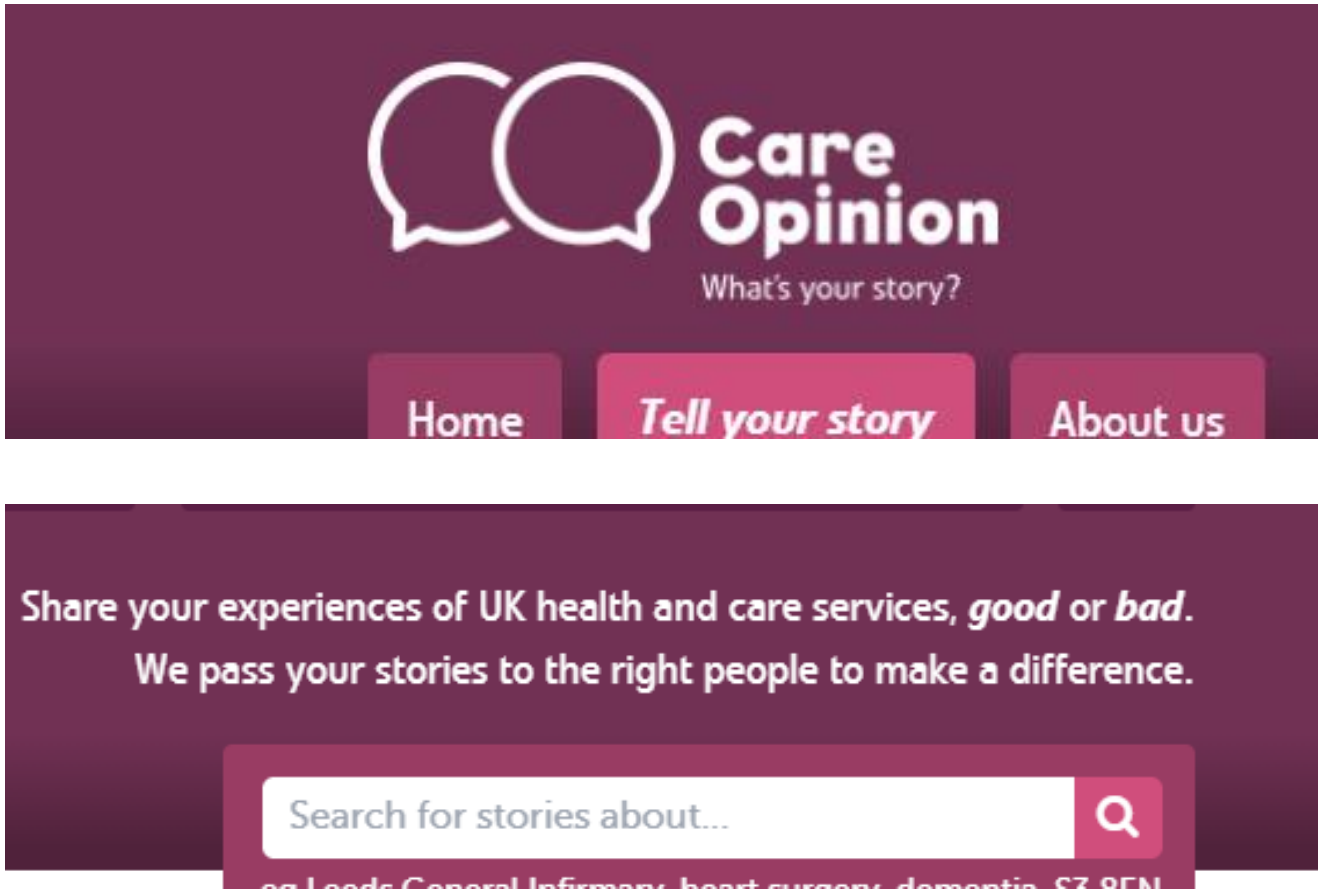
Health Foundation 2016
https://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf





Common themes?

Common Themes



- **‘attitude, listened to, helpful, empathic, thoughtful, kind, good communication, considerate’**

- **Reassured, delighted, lucky, supported, grateful, happy, heard**

We can all play our part

- **Little things do make a big difference**
- **Be the change you want to see**
- **Model the behaviours you want others to display**
- **Walk the walk – alongside people**
- **Actively seek out, listen to and act upon feedback**
- **Challenge unacceptable behaviours but in a constructive way**
- **Congratulate colleagues on a job well done daily**
- **Be honest and open when things go wrong**

Ideas for involvement

- What matters to you day #WMTY2021 https://www.whatmatterstoyou.scot/

- Care Experience Improvement Model https://ihub.scot/improvement-programmes/people-led-care/person-centred-health-and-care/care-experience-improvement-model/

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The Promoting Excellence Framework

Patricia Howie
Senior Educator, Dementia
NHS Education for Scotland

Enabling health and social care improvement

Promoting Excellence

Promoting Excellence 2021

Promoting Excellence

- Promoting Excellence is a knowledge and skills framework for the entire health and social services workforce
- Promoting Excellence was written in 2010 as an action from the 1st National Dementia Strategy.
- It was developed in partnership with people with dementia and their families and carers and through national consultation and engagement exercises.
- At its core is the 'Charter of Rights', Quality of Life Outcome Indicators and the voice of people with dementia
- Intended to be aspirational and future focussed
- Refreshed Promoting Excellence 2021

Quality of Life Outcome Indicators

01
People with dementia have access to a timely and accurate diagnosis of dementia that includes high-quality support before, during and after their diagnosis

02
People with dementia feel empowered and enabled to exercise rights and choice, maintain their identity and be treated with dignity and equity.

03
People with dementia have access to individuals, groups and organisations that can support their spiritual or personal beliefs and reflect their cultural wishes.

04
People with dementia have access to quality services and can continue to participate in community life and valued activities.

05
People with dementia maintain their best level of physical, mental, social and emotional wellbeing.

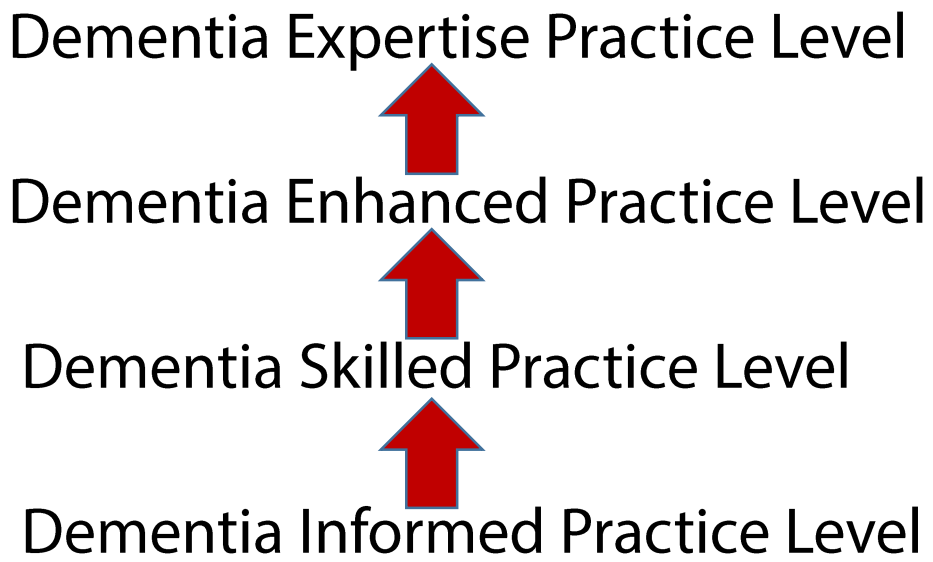
06
People with dementia feel safe and secure and are able to be as independent as possible.

07
People with dementia are able to maintain valued relationships and networks and have the opportunity to develop new ones, both personal and professional.

08
People with dementia, with their families, friends and carers, have access to the information, education and support that promotes their rights and enhances their wellbeing.

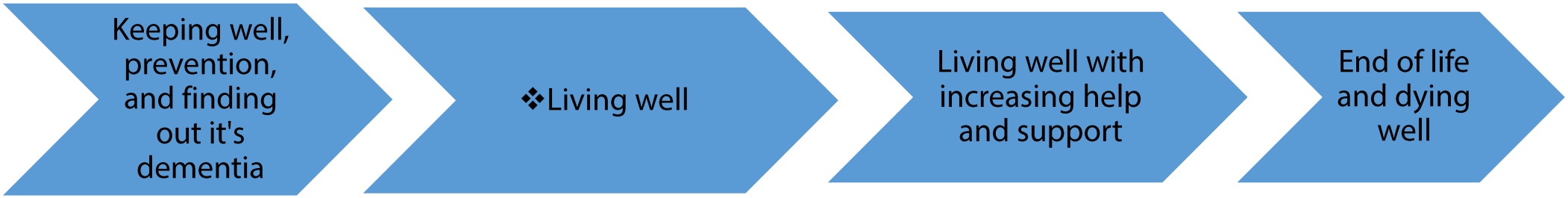
Levels of Knowledge and Skills

The range of knowledge and skills staff need is set out in the framework at 4 different levels



Stages of Dementia Journey

and 4 stages of the dementia journey



The range of knowledge and skills each member of staff needs will depend on their role in working with people with dementia and the stage of the dementia journey the person with dementia is experiencing.

Stage **Living well with dementia**

What staff know (knowledge)	What staff are able to do (skills)
• Appreciate the importance of getting to know the person, both in the present and the past, using a range of approaches, including life-story work and reminiscence. • Appreciate how life-story work can positively facilitate a person's sense of self and self-value and inform future planning. • Appreciate how life-story work and reminiscence can be used to communicate with people with dementia and engage them in meaningful and valued interactions, activities and experiences. • Understand the value to families and carers of recording a life story to maintain the sense of person and their relationships. • Appreciate the benefits of engaging in life-story work for families and carers. • Appreciate the role of emerging technology in providing a creative means of exploring, compiling and recording life stories.	• Use a range of approaches, including life-story work and reminiscence, to get to know the person and support their engagement in meaningful and valued activities relating to their interests, abilities and experiences. • Work with families, carers and the person to compile and record their life story in their preferred format, including the use of emerging technology.

Stage **End of life and dying well**

What staff know (knowledge)	What staff are able to do (skills)
• Understand the interdependence of the physical, psychological, emotional and spiritual care needs of a person with dementia, their family and carers in relation to palliative and end of life care. • Understand the importance of values, beliefs and communication in the delivery of person-centred palliative and end of life care for people with dementia, their families and carers.	• Work as part of the multi-disciplinary team and in partnership with the family and carers to provide palliative and end of life care that reflects the unique needs, wishes and choices of the person with dementia.
• Understand that anticipatory care plans or advance plans should help inform decisions relating to the person's needs, wishes and choices to support dying well. • Understand the complexities of decision-making and the legal and ethical framework necessary to ensure the wishes of the person with dementia are heard and respected.	• Working as part of the multi-disciplinary team and in partnership with the family and carers, ensure the wishes of the person with dementia are heard and reflected in the care and support provided, which takes account of relevant legal and ethical frameworks.

Stage **Keeping well, prevention and finding out it's dementia**

What staff know (knowledge)

- Have knowledge of how to work sensitively and empathetically alongside people with dementia to support them to identify and record their priorities for the future.
- Recognise the complexities for people with dementia in planning for times when they have reducing capacity and when making decisions regarding end of life care.
- Have detailed knowledge and understanding of health promotion and its impact on the progression of dementia.
- Have knowledge of the signs of common mental and physical health problems for people with dementia, their families and carers.
- Have knowledge of local services that provide specialist psychological interventions and therapies.
- Have detailed knowledge and understanding of the underlying causes and signs of stress for the person with dementia, their family and carers.

What staff are able to do (skills)

- Using advanced communication skills, sensitively work with people with dementia to identify and record their priorities for the future and the elements of advanced planning they wish to undertake.
- Ensure that planning for the future is at a pace that suits the person with dementia, their family and carers.
- Actively support people with dementia to access physical and mental health assessments, treatments and services to maintain or improve their health and wellbeing.
- Recognise and respond appropriately when a person with dementia, their family and carers are experiencing anxiety and/or depression and, if necessary, make referral to specialist services.
- Use a range of preventative and proactive strategies to reduce the likelihood of the person with dementia becoming stressed or distressed.
- Adopt a holistic approach to responding to a person with dementia who is stressed or distressed.

Stage	Living well with dementia

What staff know (knowledge)	What staff are able to do (skills)
• Appreciate the potential emotional complexities that could be associated with future planning for people with dementia, their families and carers. • Appreciate how to engage empathetically in meaningful and timely conversations as part of advance planning.	• Recognise and interpret cues that indicate when the person with dementia is ready to embark on advance planning. • As part of advance planning, sensitively engage in meaningful and timely conversations with the person with dementia, their family and carers. • Sensitively and empathetically support the person with dementia to make plans and identify their priorities for the future, including their wishes regarding times when reducing capacity and end of life issues need to be addressed. • Support the person with dementia, their family and carers to record any advance decisions and future plans.
• Have detailed knowledge of how sensitively to support people in the creation of a life story that informs understanding of their cultural, spiritual and personal history, and supports implementation of their present and future wishes and choices.	• Work sensitively with people with dementia, their families and carers to support them in developing a life story that reflects and promotes their wishes and choices.

Stage — Living well with increasing help and support

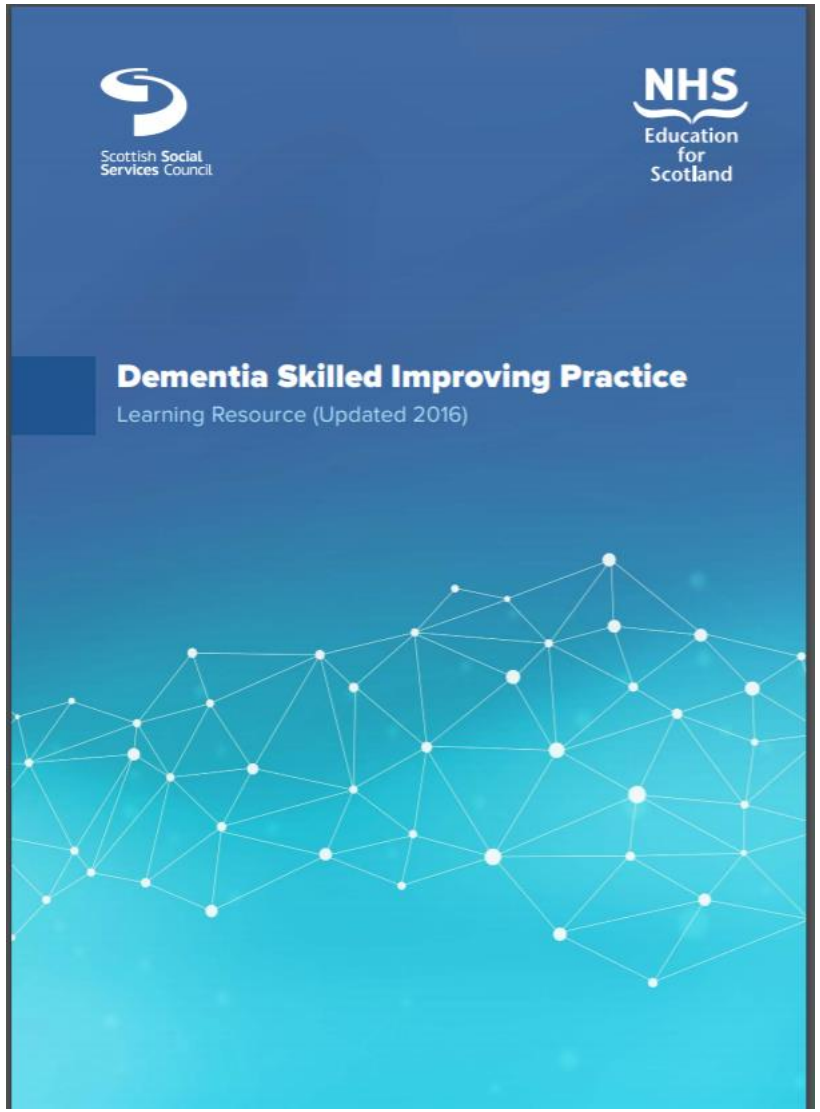
What staff know (knowledge)	What staff are able to do (skills)
• Appreciate the contribution that can be made to the quality of life of people with dementia by the timely gathering of personal details and information from all sources, such as families, carers and friends.	• Work in partnership with people with dementia, their families, carers and friends to gather pertinent information to support the promotion of the best quality of life.

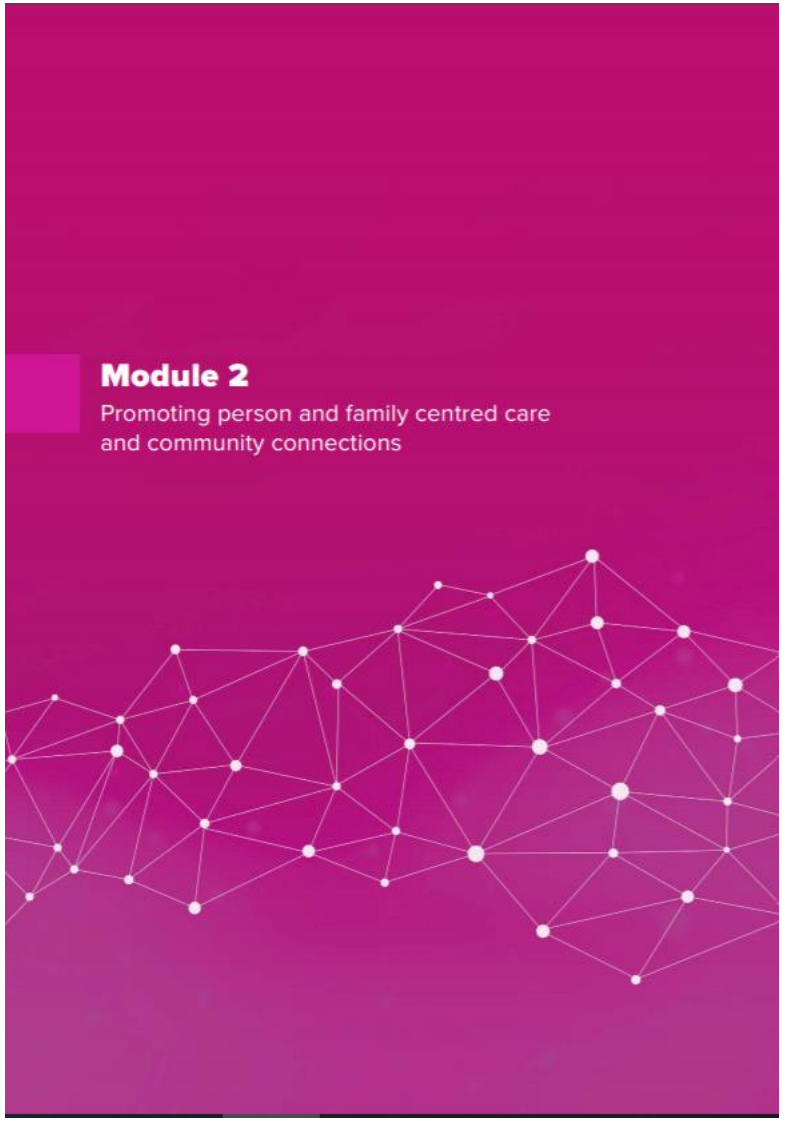
Stage — End of life and dying well

• Understand how to apply the implications of advance plans, advance directives and proxy decision-makers on treatment, interventions and care, including expressed refusals.	• Use the person with dementia's advance plan and advance directive and confer with proxy decision-makers relating to their choices for palliative and end of life care.

Stage **Living well with dementia**

What staff know (knowledge)	What staff are able to do (skills)
• Have expert understanding of advance planning, taking into consideration any substitute decision-making arrangements that are in place.	• Support people with dementia, their families and carers to engage in advance planning, including palliative and end of life care.
• Have expert understanding of the sensitivities associated with advance planning conversations and processes for people with dementia, their familiesand carers.	• Provide support and advice to services and professionals involved in supporting people with dementia, their families and carers to engage in advance planning.
• Have expert knowledge of evidence-based approaches and techniques for assessing neglect and abuse. • Have critical knowledge of legislation, national and local guidelines, and protocols to respond to neglect and abuse.	• Provide support and advice to services, professionals and people with dementia in relation to assessing risk, including areas of potential neglect and abuse. • Take appropriate action that reflects legislation, national and local guidelines, and protocols to safeguard people, to prevent neglect and abuse, and respond to people who are concerned about or experiencing neglect and abuse


Scottish Social Services Council
NHS Education for Scotland
Dementia Skilled Improving Practice
Learning Resource (Updated 2016)


Module 2
Promoting person and family centred care and community connections

Four key elements of person-centred care

Valuing people with dementia and those who care for them and promoting their rights and entitlements regardless of age or cognitive ability.

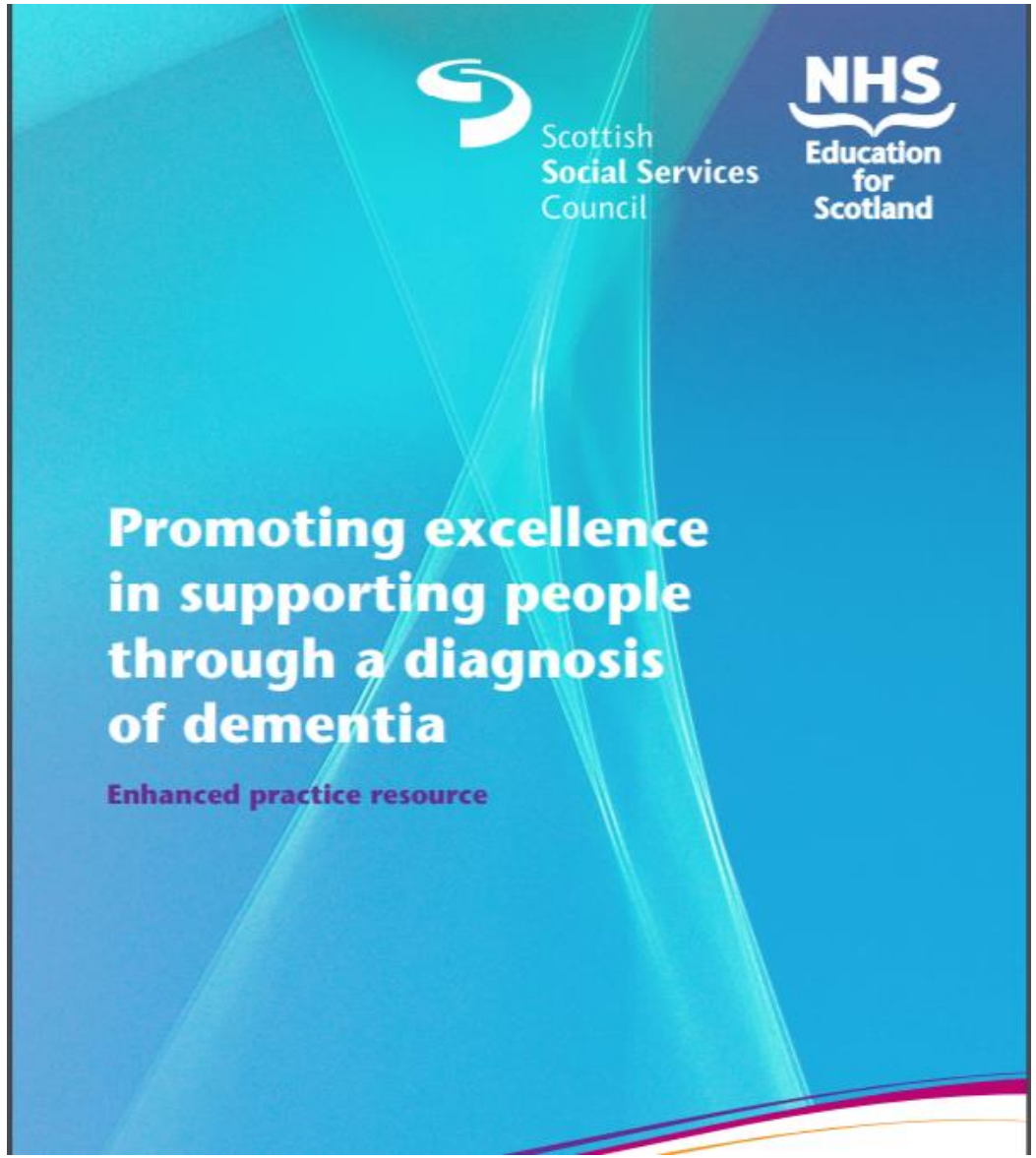
Valuing the person with dementia as an individual; appreciating that the person has a unique history, personality and life experience that will affect their response to dementia.

Taking the perspective of the person with dementia; recognise that it is this perspective and experience that will influence how the person acts.

Supporting the person's social environment; recognising the importance of relationships and a positive social environment to support psychological well-being.

Module 2
Promoting person and family centred care and community connections

Elements required for developing a person-centred care plan	
Biography or life history	■ Where did the person grow up? ■ What jobs did the person have? ■ Who is in the person's family?
Personality	■ What they are like as a person? ■ What motivates the person? ■ What influences the person's mood?
How the person is responding to their current situation	■ Does the person appear distressed, anxious, withdrawn? ■ Is the person happy and calm?
Capacity for doing	■ What are the person's strengths? ■ What are the person's abilities?
Health and Cognitive support needs	■ How the person behaves. ■ How the person thinks. ■ How the person communicates. ■ How the person relates to the world and everything around them.



4.8 Developing a support plan

Developing a personal support plan is a key aspect of the HEAT target mentioned earlier and relates to the 'Support to plan the shape of their future care from their own perspective' pillar.

We introduced the concept of outcomes-focused approaches in Module 1. The approach expands the scope of our engagement with people with dementia and their families. Rather than beginning by establishing what people have difficulty with, the starting point for an outcomes-focused approach is an understanding of what is going on in their life and what they want to achieve. We can then go on to identify barriers to people achieving their outcomes and how they can be overcome, building on their abilities, assets and strengths.

Developing a personal support plan is a key aspect of this process. There is no single 'best' way of developing one, but the process will involve all of the skills that have been discussed throughout this learning resource, particularly those around outcomes-focused conversation. A personal outcomes-focused assessment, as described in Module 1, is an important source of information in the development of a plan, and there is a range of person-centred planning approaches that staff can use to facilitate its development (Box 4.2).

Box 4.2 Examples of person-centred planning approaches

Essential lifestyle planning (ELP)

ELP is a tool that lets you know how someone wants to live. It reveals what is important to people and the support they need (from their perspective) to remain healthy and safe. A good plan reflects the perceptions of the person and those who love and care about them.

ELP looks at:

- what people like and admire about the person
- what is important to the person
- communication
- how to provide support
- identification of successful methods
- how to solve problems.

ELP is a good approach to starting to get to know people and working out what they feel is needed to support them on a day-to-day basis. It does not focus on 'dreams', unlike some of the other methods.

Planning alternate tomorrows with hope (PATH)

PATH is a fast-moving tool that is usually graphically presented and has a powerful impact on those involved. It focuses mostly on the process of change and helps a group of people who are committed to the person to understand the plan and how it will progress. This is not so much about gathering information, but centres on planning action. It focuses on the 'dream' and works its way back from there, mapping actions required along the way *(Forest et al, 1993)*.

Making action plans (MAPS)

MAPS is similar to PATH in that it focuses on desirable futures or dreams and how service users might try to achieve these. It covers people's history and identifies their gifts.

Source: *Realising Recovery Learning Materials (NES, 2007)* [http://www.nes.scot.nhs.uk/media/376420/13875-nes-mental_health-all_modules.pdf]

NES Dementia Learning Resources are available on our website at the link below

https://www.nes.scot.nhs.uk/our-work/mental-health-learning-disabilities-and-dementia-nmahp/

Patricia Howie

Senior Educator

NHS Education for Scotland

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Person-centred planning and dementia: a literature search

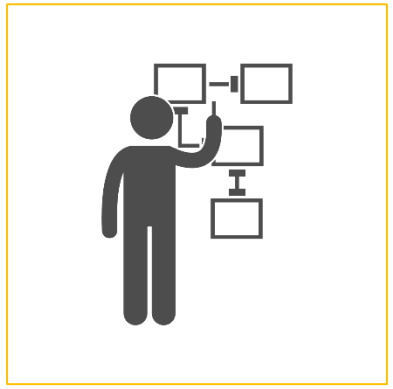
Iain Stewart
Health Information Scientist
Healthcare improvement Scotland

Enabling health and social care improvement

What to expect

- About EEvIT
- Literature search
- What we found
- Next steps

An introduction to EEvIT



Use evidence to inform the development of improvement / redesign programs

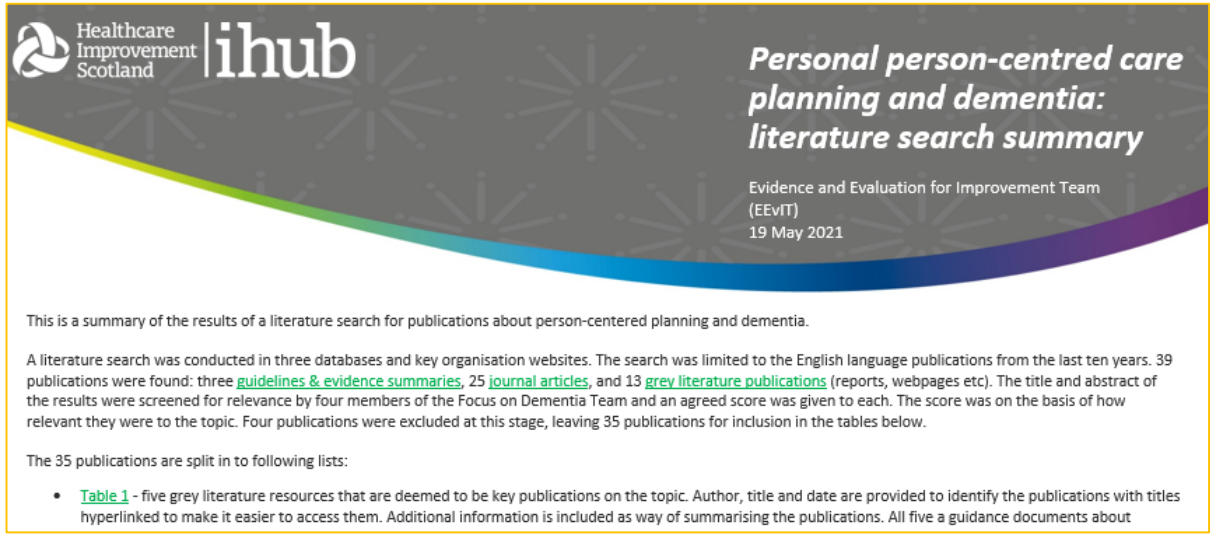
Work with teams to develop evaluation plans for their improvement / redesign work

Collect and analyse data as part of evaluation

Capture and share key findings / learning from improvement / redesign work as part of learning system

Literature search

- A focused search
- English language publications from last 10 years
- Selected relevant publications
- We rated them for inclusion in a summary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Personal person-centred care planning and dementia: literature search summary

Evidence and Evaluation for Improvement Team (EEvIT)
19 May 2021

This is a summary of the results of a literature search for publications about person-centered planning and dementia.

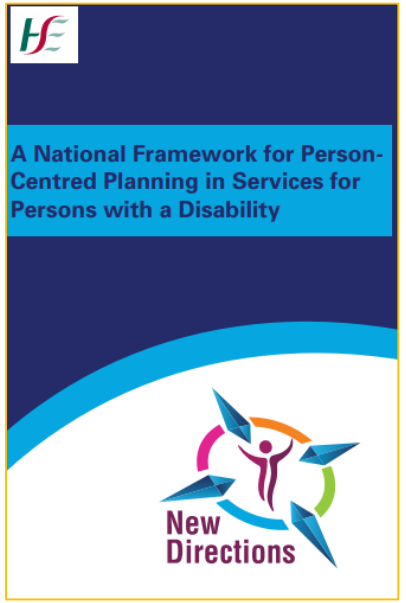
A literature search was conducted in three databases and key organisation websites. The search was limited to the English language publications from the last ten years. 39 publications were found: three guidelines & evidence summaries, 25 journal articles, and 13 grey literature publications (reports, webpages etc). The title and abstract of the results were screened for relevance by four members of the Focus on Dementia Team and an agreed score was given to each. The score was on the basis of how relevant they were to the topic. Four publications were excluded at this stage, leaving 35 publications for inclusion in the tables below.

The 35 publications are split in to following lists:

- Table 1 - five grey literature resources that are deemed to be key publications on the topic. Author, title and date are provided to identify the publications with titles hyperlinked to make it easier to access them. Additional information is included as way of summarising the publications. All five a guidance documents about

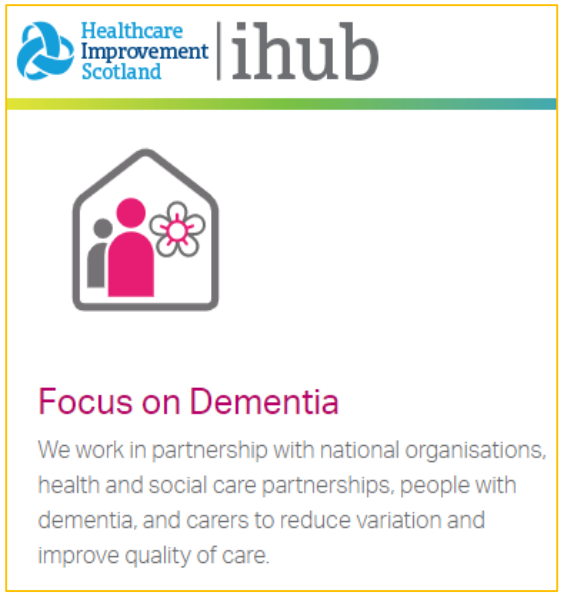
What we found

- 35 publications
- Key publications are guidance documents
- Post-diagnostic support
- Dementia in hospitals
- Anticipatory Care Planning



Next steps

- Share summary
- Publications can be added to
- Create alerts to capture newly published resources

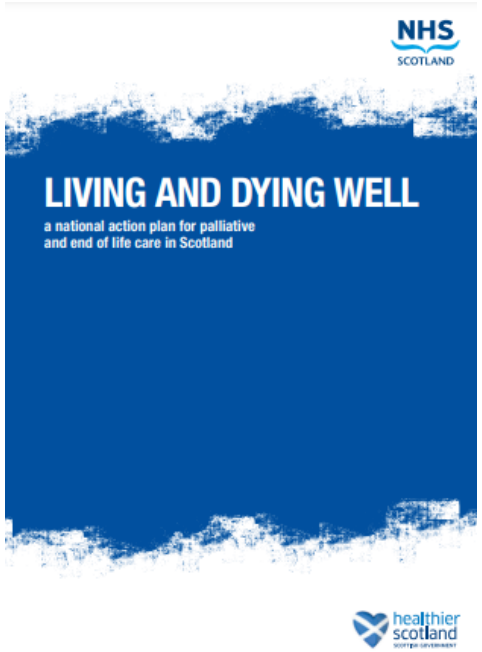


Anticipatory Care Planning

Tom McCarthy
Improvement Advisor
Healthcare improvement Scotland

Enabling health and social care improvement

What is Anticipatory Care Planning?



Published 2008
Access here

…The aim of advance care planning is to develop better communication and recording of decisions, thereby leading to provision of care based on the needs and preferences of patients and carers…

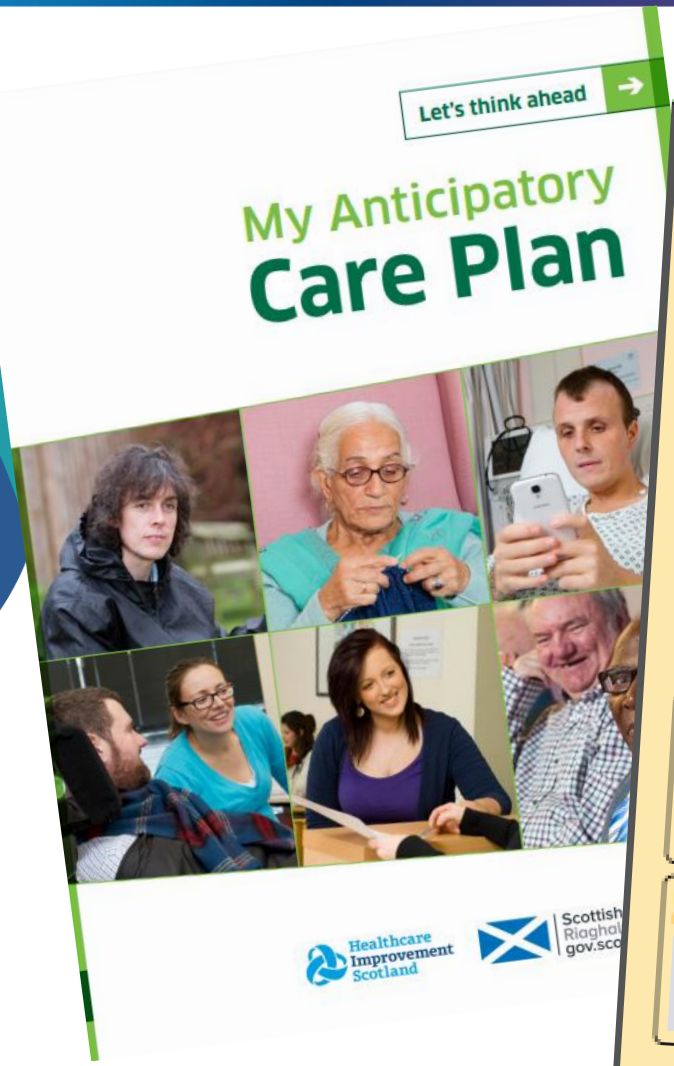
Glossary (p31)

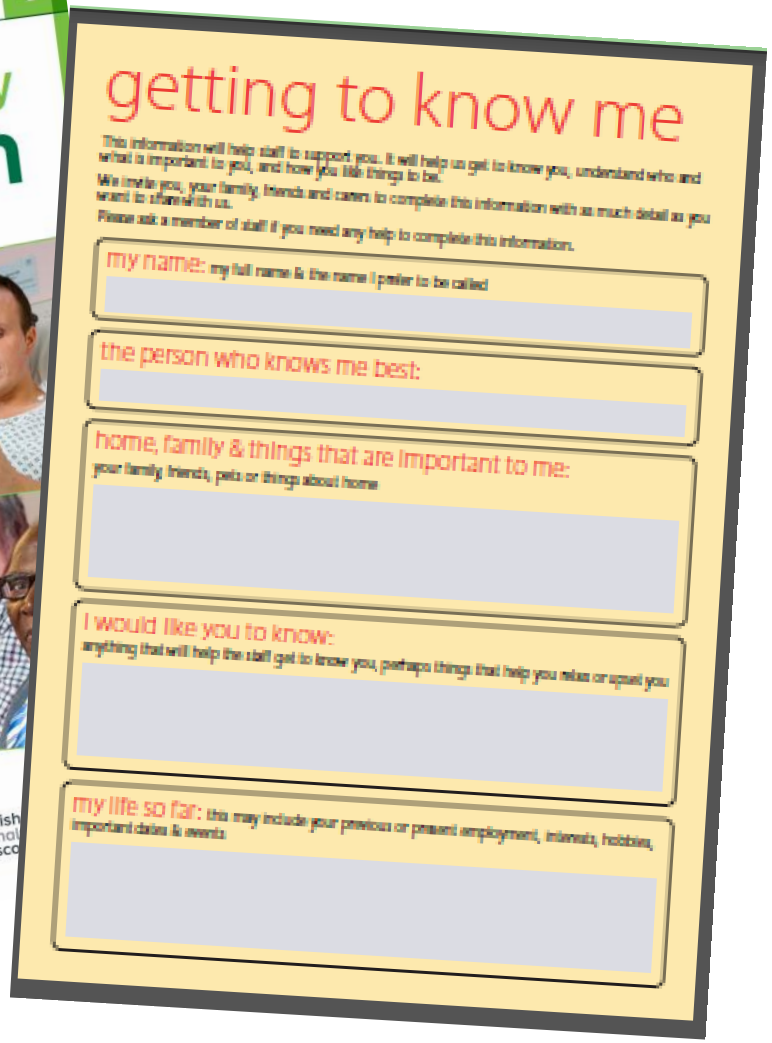
Published 2010
Access here

…a "thinking ahead" philosophy of care that allows practitioners and their teams to work with people and those close to them to set and achieve common goals that will ensure the right thing is being done at the right time by the right person(s) with the right outcome…

Page 1

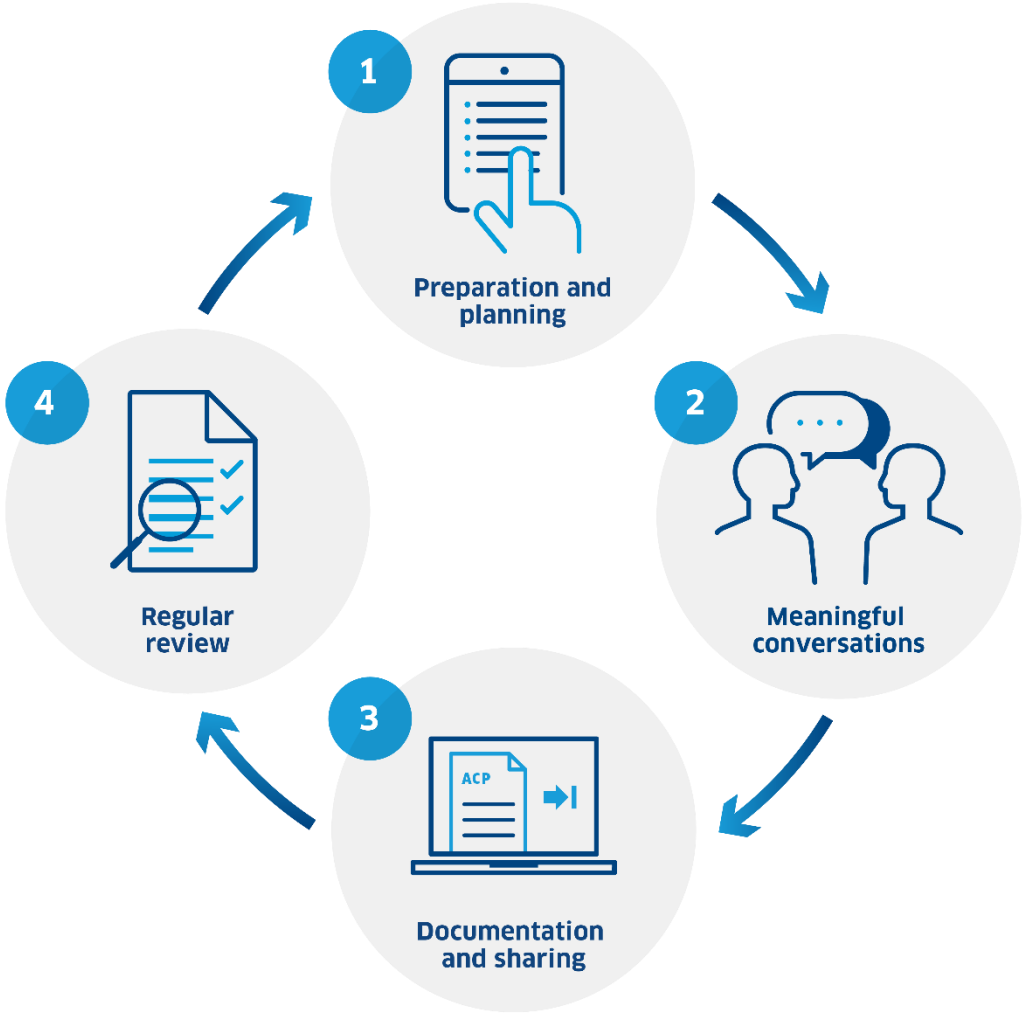
What is Anticipatory Care Planning?





4 steps to ACP: Toolkit

- Access the toolkit at ihub.scot/acp
- Developed in conjunction with a range of stakeholders and published in March 2021 in a webinar (link to listen)
- Not condition specific- apply to any setting and augment with a range of existing materials
- Find out more in this blog by Dr Paul Baughan (GP)



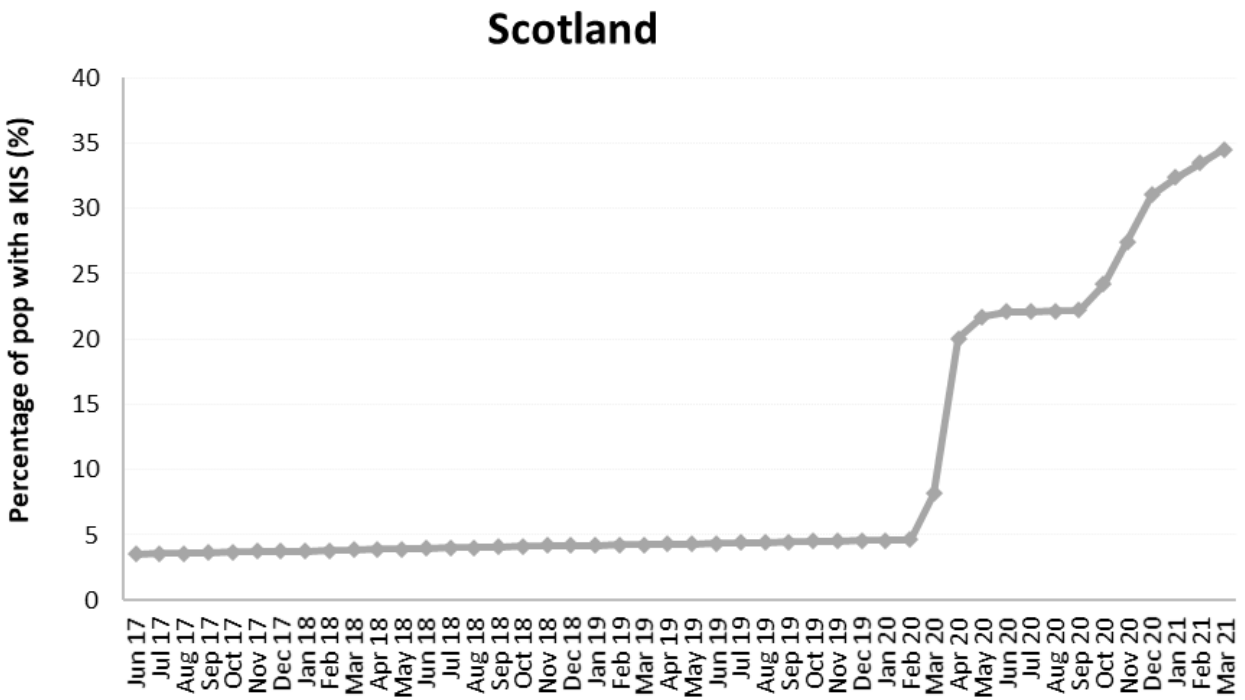
A word on tools

- Don’t focus on the tool, the focus should be on the conversation with the person, their relatives/ carers/ families
- Lots of different tools: suit different contexts
- BUT: Key Information Summary

The impact of COVID-19

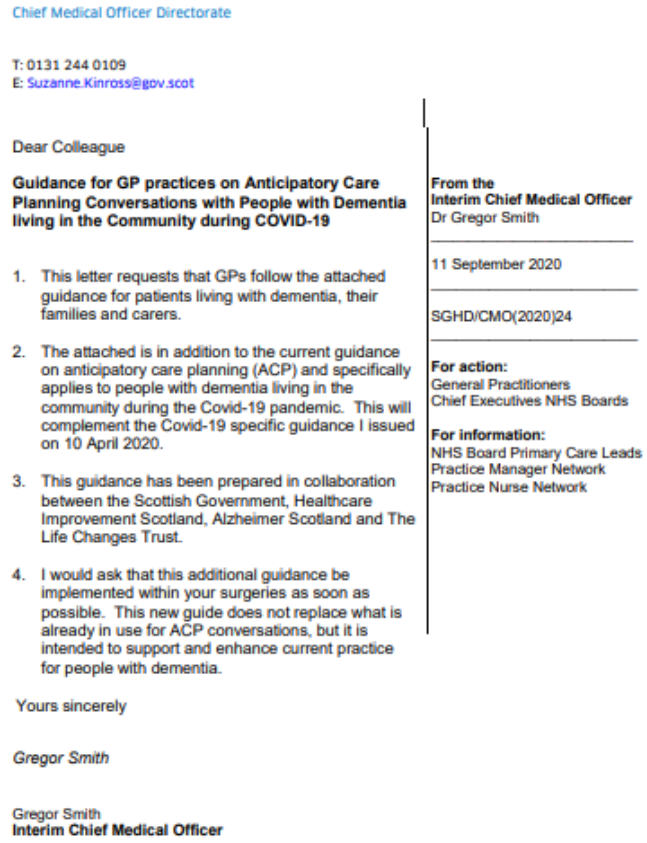
- In March 2021, there were circa 1.9 million patients with a Key Information Summary (KIS) in Scotland - compared with ~250k in February 2020
- Guidance issued to GP's to create KIS for patients in March 2021
- Healthcare Improvement Scotland has worked with range of partners to develop guidance for GP Practices to support them updating the KIS
- See the guidance here

Patients with a KIS, as a percentage of the Scotland population. June 2017 to March 2021



ACP and dementia

- Dementia ACP Guidance: https://www.sehd.scot.nhs.uk/cmo/CMO(2020)24.pdf
- Developed by Scottish Government, Healthcare Improvement Scotland, Alzheimers Scotland and Life Changes Trust. Published September 2020
- Supplements other materials to support Anticipatory Care Planning in people with dementia



Chief Medical Officer Directorate

T: 0131 244 0109
E: Suzanne.Kinross@gov.scot

Dear Colleague

Guidance for GP practices on Anticipatory Care Planning Conversations with People with Dementia living in the Community during COVID-19

1. This letter requests that GPs follow the attached guidance for patients living with dementia, their families and carers.
2. The attached is in addition to the current guidance on anticipatory care planning (ACP) and specifically applies to people with dementia living in the community during the Covid-19 pandemic. This will complement the Covid-19 specific guidance I issued on 10 April 2020.
3. This guidance has been prepared in collaboration between the Scottish Government, Healthcare Improvement Scotland, Alzheimer Scotland and The Life Changes Trust.
4. I would ask that this additional guidance be implemented within your surgeries as soon as possible. This new guide does not replace what is already in use for ACP conversations, but it is intended to support and enhance current practice for people with dementia.

Yours sincerely

Gregor Smith

Gregor Smith
Interim Chief Medical Officer

From the
Interim Chief Medical Officer
Dr Gregor Smith

11 September 2020

SGHD/CMO(2020)24

For action:
General Practitioners
Chief Executives NHS Boards

For information:
NHS Board Primary Care Leads
Practice Manager Network
Practice Nurse Network

What's next in 2021-22?

Aim: create the conditions to support good between conversations in all health and social care settings that enable high quality anticipatory care planning.

Method:

- Continue the ACP learning system we have already initiated. Focus on developing networks, sharing learning and the raising the profile of this work
  - Webinar's being planned: watch this space!
  - Developing our webpages
- Offer of bespoke support to health and social care. E.g. the work with Glasgow HSCP who are looking to improve ACP in Care Homes.
- Undertake a '90 day' review process to develop further strategy and vision for this work

Contact

tom.mccarthy@nhs.scot

his.pcpteam@nhs.scot

Twitter: @SPSP_PC / @tmccarthy1984

Visit: ihub.scot/acp

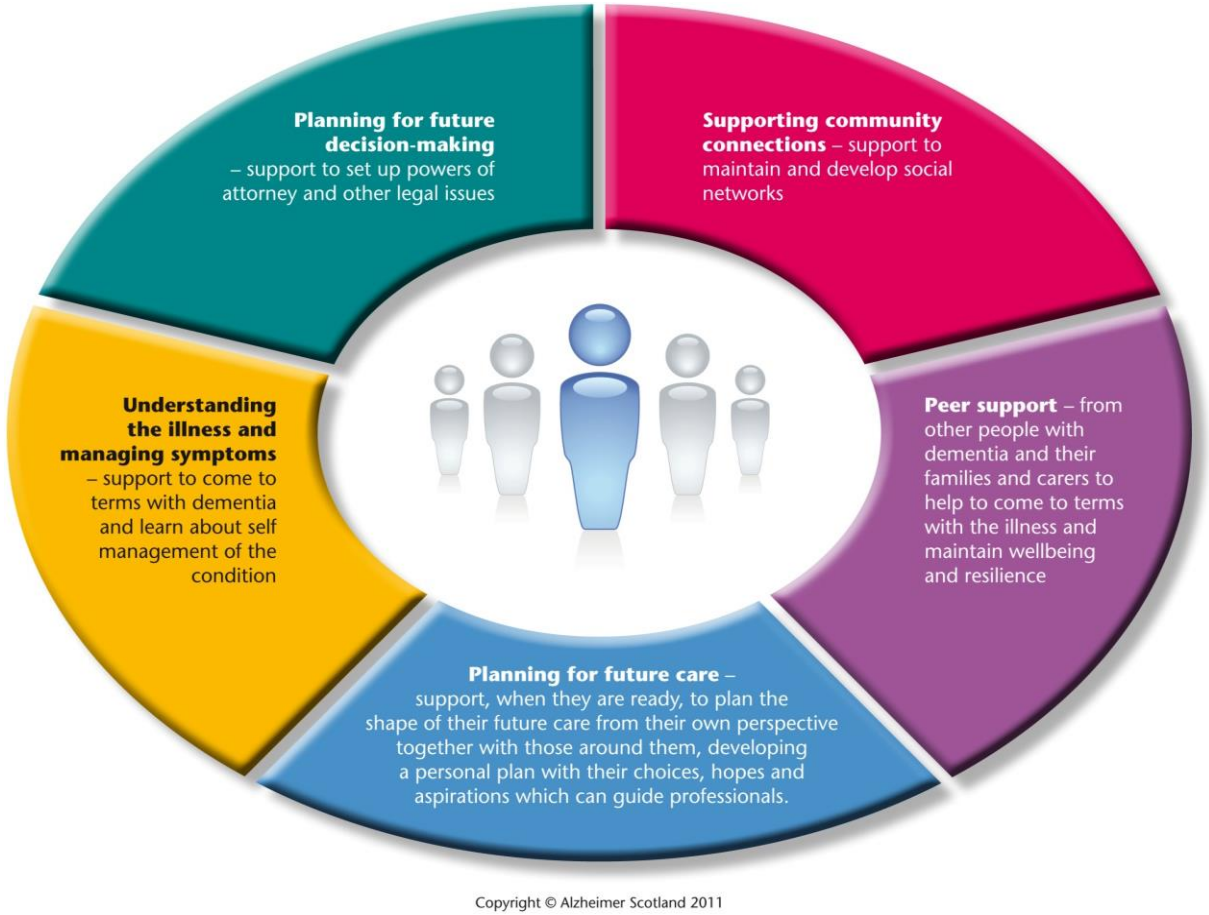
Healthcare Improvement Scotland | ihub

Personal plans and post-diagnostic support

Julia Mackenzie
Post-diagnostic Support Lead
Alzheimer Scotland

Enabling health and social care improvement

Alzheimer Scotland
Action on Dementia



Making sure nobody faces dementia alone.

Alzheimer Scotland

Where we start

- Building trusting relationship
- Good conversations
- Active listening
- Right time
- Seizing opportunities
- Overcoming barriers

CONTENT OF PLAN

- ❑Captures the essence of the person and what makes them unique – life, family, work, like and dislikes
- ❑Their dreams and aspirations
- ❑Informs others of what is important to them
- ❑Identifies natural supports in their life

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- ❑ Reminds them of what helps them to manage as well as they can
- ❑ Reminds them of where they need support
- ❑ Includes sources of support they may need in the future
- ❑ Any advanced planning information
- ❑ Anything else the person wants to include

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Healthcare Improvement Scotland
Essential 5 Criteria Bundle

1. Person is at the centre of the plan
2. Personal outcomes
3. Person has ownership of the plan
4. Personal resilience
5. Plan is reviewed

Examples of Personal Support Plans

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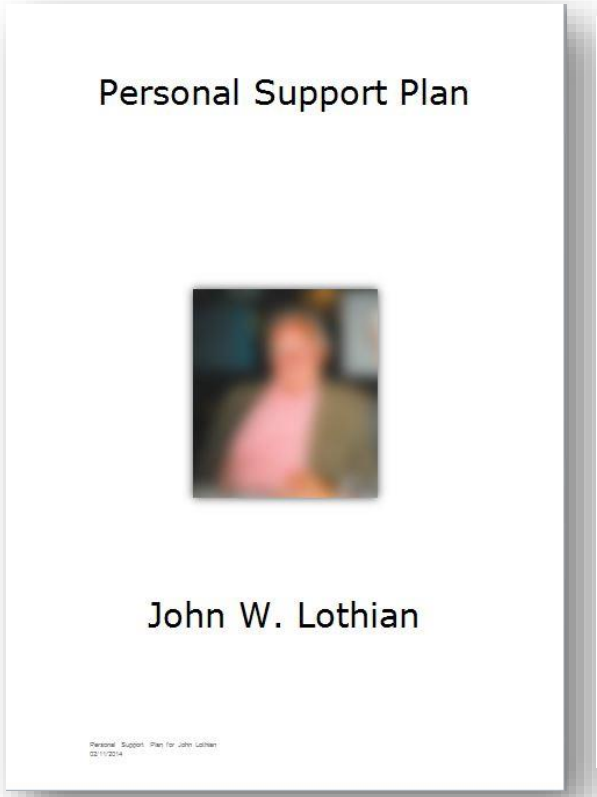


Personal Support Plan

John W. Lothian

Personal Support Plan for John Lothian
02/11/2014

Important information about me and my life
(my background, skills and interests)

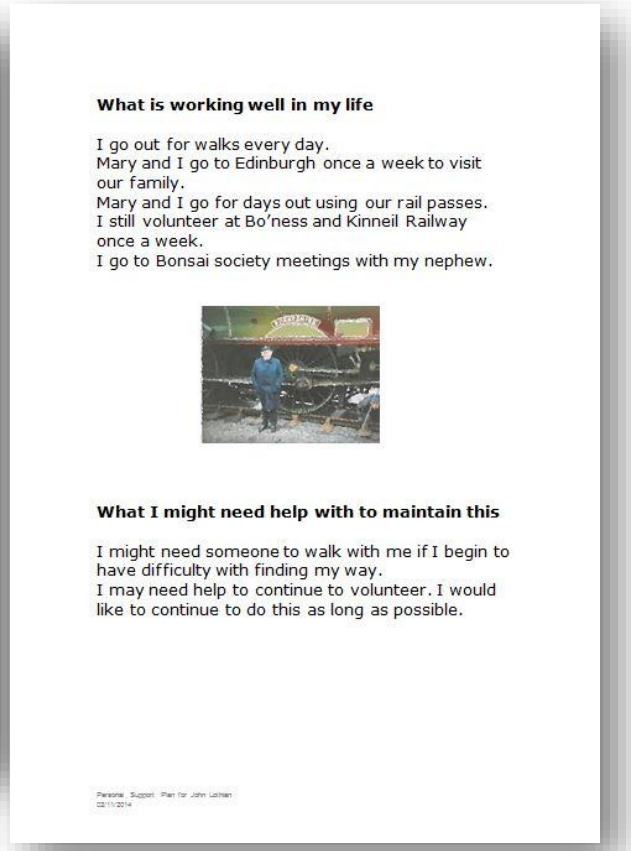
I was born in 1933 in West Calder. I was the second youngest of 5 children. I had 4 sisters. I remember a happy childhood playing out with friends in the village and around the local countryside. I enjoyed school and did well but I had to leave school aged 14 to work and help support my family. My first job was as a delivery boy for a local shop. I was then lucky to get a start in the railways as an apprentice fireman. I then trained to be a train driver. I drove mostly goods trains but did drive passenger trains at times as well. I remained working with what became British Rail until I retired. I still have a passion for all things railway related.

At work

I used to go to the dancing with my friends and my younger sister. It was while at a dance in Bathgate that my sister introduced me to Mary. We were married in 1958 in Bathgate. My mother had died before we were married so Mary moved in to our family home once we were married and helped care for my father. Our first daughter Susan was born in 1960 and our second daughter Carol was born in 1963. Unfortunately my father died shortly after Carol was born.

We enjoyed many family holidays when the children were young travelling by train to England to visit family. We also enjoyed holidays to Butlins at Minehead, Skegness, Bognor Regis and others. Mary and I had our first holiday abroad to our nephew's caravan in the South of France. We travelled there by train and loved it. We went back every year while he had it. My daughter Susan worked in Brussels for 6 years and we used to visit

Personal Support Plan for John Lothian
02/11/2014



What is working well in my life

I go out for walks every day.
Mary and I go to Edinburgh once a week to visit our family.
Mary and I go for days out using our rail passes.
I still volunteer at Bo'ness and Kinneil Railway once a week.
I go to Bonsai society meetings with my nephew.

What I might need help with to maintain this

I might need someone to walk with me if I begin to have difficulty with finding my way.
I may need help to continue to volunteer. I would like to continue to do this as long as possible.

Personal Support Plan for John Lothian
02/11/2014

Making sure nobody faces dementia alone.

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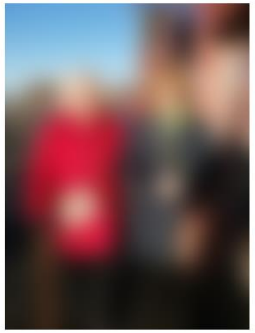
Name of Client

Life Story and Personal Plan



Things I enjoy:

- Sleeping!
- Reading the newspaper (Daily Mail and Sunday Post)
- Watching my grandson xxx perform in shows. xxx is studying Musical Theatre
- Going to the cinema, theatre events etc with my Art Link worker
- Going to the hairdresser every Friday
- Going out for lunch with my daughter xxx. We like to go to Toni Macaroni, Beijing Banquet and Ronaq (Indian restaurant in Comely Bank)
- Attending Murrayfield Dementia Project every Thursday

My Future.....

My Power of Attorney is welfare and financial. This is assigned to my daughter xxx and son-in-law xxx

If one day I can no longer live in my own home I would like:

I would prefer to stay at home even if that means increasing my POC.

I would not like to stay with my family.

I have spent time at Murrayfield Care Home so if I was unable to stay at home I would like to move there.

Who I would like to be involved in my care:

Questions

Comfort break

Essentials of Safe Care

Joanne Matthews
Head of Improvement Support and Safety
Healthcare Improvement Scotland

Enabling health and social care improvement

Our Design Team

- Mental Health Leads Group
- GP Practice Managers Network
- Primary Care Leads

Driver Diagram

Aim	Primary Drivers	Secondary Drivers
To enable the delivery of Safe Care for every person within every system every time	Person centred systems and behaviours are embedded and support safety for everyone	Structures & processes that enable safe, person centred care
		Inclusion and involvement
		Workforce capacity and capability
	Safe communications within and between teams	Skills : appropriate language, format and content
		Practice : use of standardised tools for communication
		Critical Situations : management of communication in different situations
	Leadership to promote a culture of safety at all levels	Psychological safety
		Staff wellbeing
		System for learning
	Safe consistent clinical and care processes across health and social care settings	Reliable implementation of Standard Infection Prevention and Control Precautions (SICPS)
		Safe Staffing

The package

Essentials of Safe Care Package

Accessible online tools, including a measurement framework

Creating the conditions to support local implementation

Embedding within each MCQIC, Acute Care, Mental Health, Primary Care, Medicines

All activity will be underpinned by the **Essentials of Safe Care Learning System**

Key Resources

ihub.scot/spsp

ihub.scot/TheEoSC

#spsp247

#TheEoSC

his.pspcontact@nhs.scot

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Person-centred care planning: Dementia in Hospitals Collaborative

Christine Proudfoot
Deputy Chair, Alzheimer Scotland Dementia Nurse Consultant
NHS Borders

Enabling health and social care improvement

Dementia in Hospitals Collaborative

- A Collaborative approach with hospital 24 teams on 5 key areas
- Healthcare Improvement Scotland and Alzheimer Scotland Dementia Nurse/ AHP Consultants
- Focus on person centred care plans with 8 teams following stakeholder consultation
- Paused twice during pandemic
- Commencing person-centred care planning in June 2021

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Dementia in hospitals programme timeline

Person centred care planning driver diagram

By April 2023, the hospital care of 95% of people in the ward will be informed by a personalised care plan which reflects their strengths, needs, wishes and choices. The person centred approach will support the prevention and management of stress and distress

Care plans are completed and documented for all people in the ward

Care plans are co-produced with involvement of the person, their family and carers

Staff feel competent and supported to use person centred approaches and are using them to inform practice

There are effective processes for care planning and documentation

Recommended guidance including Getting to Know Me and MWC is used in person centred care planning

Patients, families and carers are meaningfully involved in the process

Build workforce capabilities in personalising care and support

Build workforce capabilities in inclusion and involvement

Aim

By April 2023, the hospital care of 95% of people in the ward will be informed by a personalised care plan which reflects their strengths, needs, wishes and choices. The person-centred approach will support the prevention and management of stress and distress.

Next steps

- Hospitals teams TBC
- Set measures in place
- First learning session for teams in June
- Teams will be supported to identify local change ideas
- Monthly QI calls to support teams
- Launch of Dementia in Hospitals Toolkit

Healthcare Improvement Scotland | ihub

Person-centred care planning in practice: NHS Highland Stress and Distress team

Shirley Campbell
Trainee Advanced Nurse Practitioner OAMH
NHS Highland

Enabling health and social care improvement

Stress and Distress Team

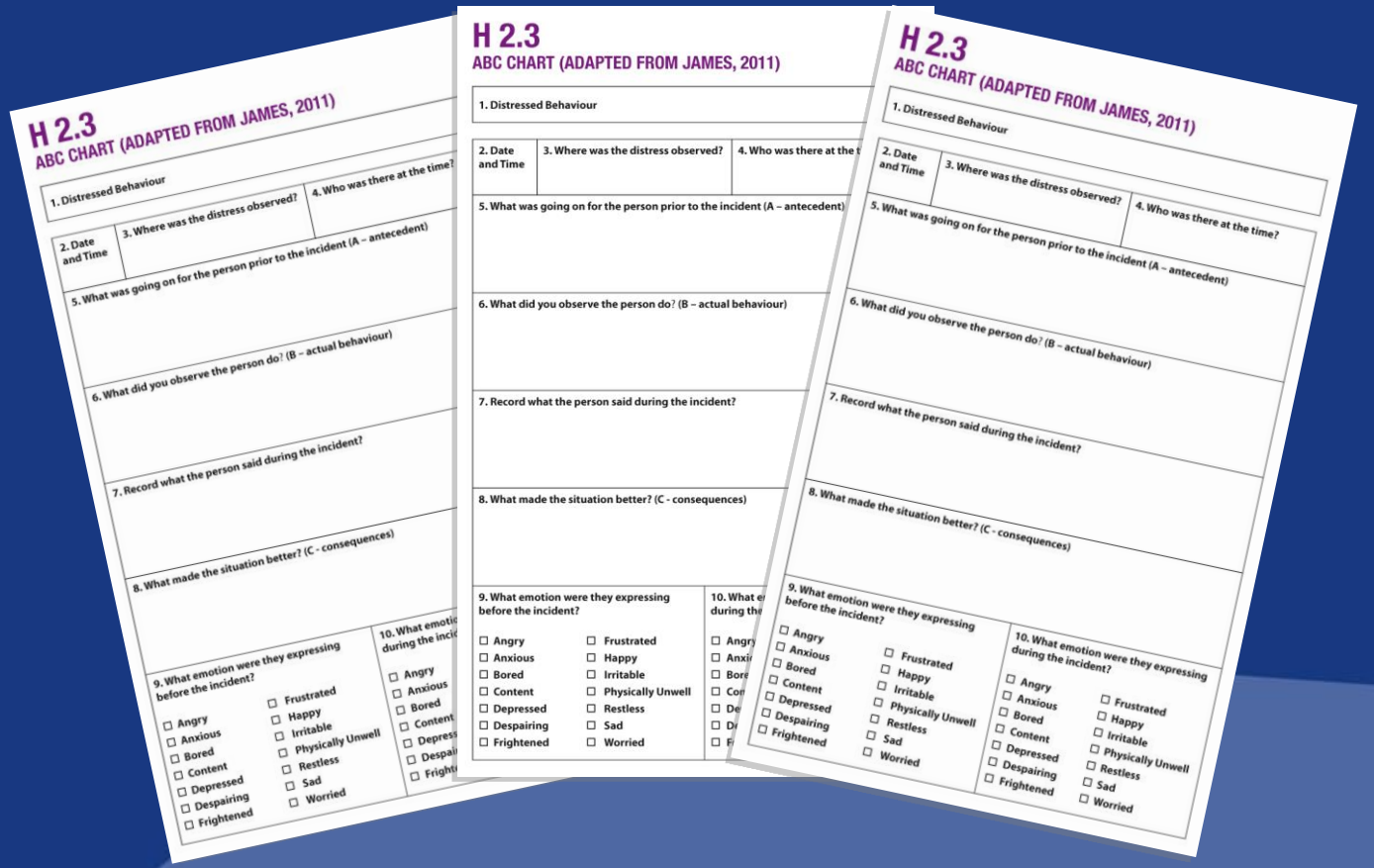
- Operational since 1st June 2020
  - Comprises of:
    - Clinical Psychologist (Service Lead)
    - 1 full time ANP (B7)
    - 1 full time Care Home Liaison Nurse (B6)
    - Input from Occupational Therapist
- Aims
  - To improve the Mental Health and outcomes for residents in care homes, the staff and family members
  - Prevent inappropriate hospital admissions
  - Prevent inappropriate use of antipsychotic medications

What we do

- Work primarily with care homes in Inverness
- Establish relationships with residents, family carers and care staff
- Offer NES Essentials and Stress and Distress Training to all NHS and Care Home Staff
- Undertake mental health reviews in care homes, including medication reviews and non-pharmacological interventions and person-centred care
- Liaise with Older Adult wards during transitions to and from care homes

The Process

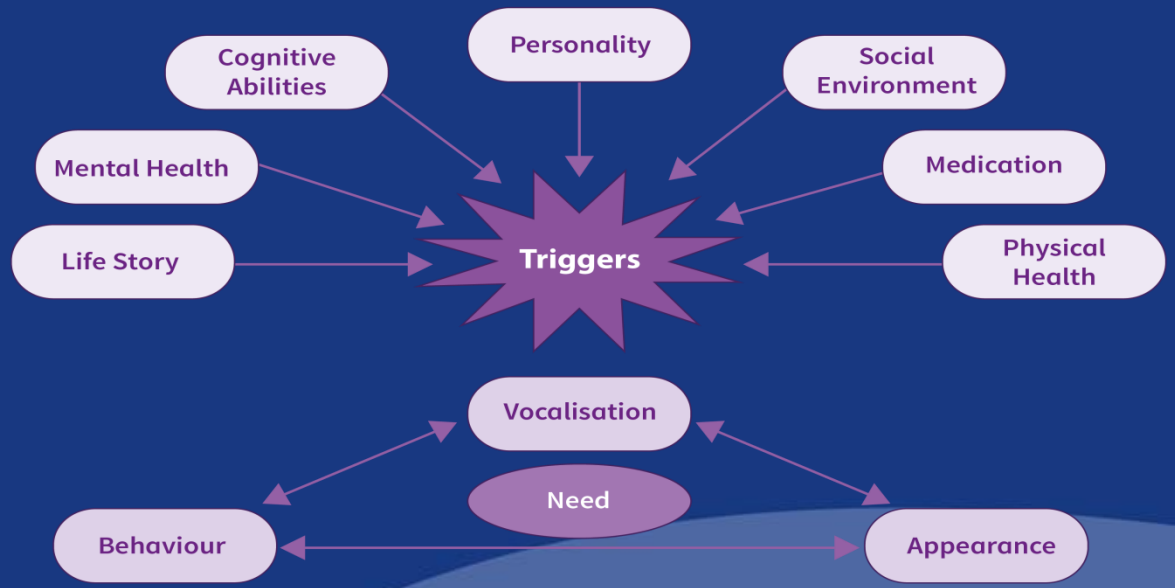
- Referral via Gp/Geriatician/Psychiatrist
- Initial Assessment:
  - Interview the person
  - Case notes
  - Gain info from Family/ Care home staff
  - Life story work/Getting to know me
- Functional Analysis:
  - ABC Charts
  - Frequency charts
- Information sharing session to develop formulation
- Plan of care: Non-pharmacological and Pharmacological
- Evaluate/Review


H 2.3
ABC CHART (ADAPTED FROM JAMES, 2011)
1. Distressed Behaviour
2. Date and Time
3. Where was the distress observed?
4. Who was there at the time?
5. What was going on for the person prior to the incident (A – antecedent)
6. What did you observe the person do? (B – actual behaviour)
7. Record what the person said during the incident?
8. What made the situation better? (C - consequences)
9. What emotion were they expressing before the incident?
10. What emotion were they expressing during the incident?
Angry
Anxious
Bored
Content
Depressed
Despairing
Frightened
Frustrated
Happy
Irritable
Physically Unwell
Restless
Sad
Worried

Why use this approach?

- Formulation led
- Person-centred Principles
- Encompasses person thoughts/cognition
- Considers unmet need
- How others respond to unmet need/behaviors
- Considers environment factors
- Carer focused
- Team approach

Newcastle Model (James, 2011)



Personality

Values feeling needed by others. She has always been very organised. She was always a shy lady who took great enjoyment from music & enjoyed listening to Elvis. She never liked crowds. She has had a high pain threshold throughout her life.

Life Story

She married young and had 3 children whom she raised while working in her husband's business keeping the accounts.

Social Environment

- Living at home with daughter
- Attends integrated day centre

Mental Health

She has a history of anxiety difficulties & some years ago attended an anxiety management programme

Triggers and Behaviours

Different problematic behaviours identified, thus two situations and two triggers

1. Searching for meds – physical &verbal aggression – when confronted directly
2. Pacing & following – In the hallway of the day centre

Cognitive abilities

- Diagnosis of mixed dementia
- She has poor recent memory & concentration
- She has frontal lobe impairment & can be disinhibited

Physical Health

- Arthritis
- Hand Tremor
- High blood pressure
- High cholesterol

Medication

- Donepezil
- Diazapam

Situation 1

Appearance – Angry

Trigger – When being stopped by daughter

Behaviour – Verbal & physical aggression & shouting

Vocal – "leave me alone, where are my tablets"

Need/thought – Needs respect, thoughts "who does she think she is stopping me"

Situation 2

Appearance – Anxious / fearful

Trigger – Under stimulation at day service

Behaviour – Pacing & following others

Vocal – "I need to get home, the accounts are late"

Need/thought - Need for comfort, thought – "I don't know why I'm not allowed to leave, I don't know what's going on, who are all these people?"

Phase 1 of Interventions: Suggested Strategies to utilise for Ellen – Pacing & following

Early warning signs: From the ABC charts we noticed that Ellen tended to start tapping her hand on the chair rest or her feet on the floor or patting herself shortly before she begins pacing or following…

Preventing triggers for stress & distress	Triggers for Ellen's pacing and following others seem to be inactivity & understimulation, this period of inactivity leads to a build up of anxiety which she respond to by pacing and following (normally after lunch). She also does not like crowds of people and lots of noise appears to be a triggering factor. Try to make sure she is engaged in stimulating activity, she used to keep the books for her husbands company and enjoys feeling that she is contributing in a meaningful way e.g could she have a role in the day service such as ticking people's names when they arrive. Like to have her home organised, could she be prompted to help staff fold & put away tea towels after lunch. Staff may need to prompt her to engage in activities such as simple crosswords. When the day service is very full have planned quiet times throughout her day where she is directed to a quiet lounge area where there are fewer clients but ensure that she has activity. Previously because staff realised she did not like crowds they tended to move her into a quiet sitting room however she was not engaged in an activity. When Ellen is anxious she follows staff and tries to leave reduce the stimuli/prompting her desire to go home by making staff change over's throughout the day very subtle, do not verbalise that people are leaving i.e. not saying goodbye in front of Ellen.
What to do when Ellen begins pacing and following others	Ellen needs comfort & to reduce her anxiety, however do not try to meet this need by directly touching Ellen as she often has pain, instead put your making eye contact and stating 'you're ok Ellen, you're at the day centre today' or use the Simulated Presence Therapy recording that Caroline did to remind her that she is at the day service today and she will be going home and seeing her [Caroline] tonight. Say to Ellen 'Ellen I can see that your upset, let's do some breathing together to make you feel better' sit in front of Ellen and model some basic breathing exercises. Use distraction if required – Use Ellen's 'memory box' to engage her in pleasurable activity.

Challenges and Successes

- Culture of blame
  - Resident blamed for being difficult
  - Care home feel being blamed
- The quick fix
- Carer stress/ fears

- Training well received
- Improved Relationships with Care Homes
- Increased staff confidence
- Reduced hospital admissions
- Reduction in antipsychotics

Feedback

- “ I had previously completed this training, this was as excellent refresher. Listening to everyone's experience in practice was helpful”.
- Question: what was the most helpful? : “ Understanding how dementia can mean someone's reality is absolutely different you yours”.
- “ everyone in the home should get this training to have some understanding”
- “ relaxed” and “informative”.
- “ Loved the session”
- “I had a gran with Alzheimer's who passed away years ago and being more educated and knowing what she could have been feeling or going through helped me a lot”
- “Informative and relatable to practice”
- “This course should be mandatory”
- “It has changes my practice. The therapeutic lie was a game changer for me”
- “I just want to say thank you to both of you for sharing all your wisdom and expertise on the Stress & Distress course last week. I found it very beneficial. I am back on the ward today and already trying to put into practise some of the useful points that arose over the two days.

Thanks for listening

DISCLAIMER: SLIDES 6-9 TAKEN FROM NES (2018) STRESS AND DISTRESS TRAINING PACKAGE. PLEASE DO NOT COPY

Questions and evaluation

The link to the evaluation is available in the chat-box

Next steps

First follow on practical session:

Thursday 19 August 2021
14:00 - 16:00

his.focusondementia@nhs.scot