Identifying critical success factors for improved outcomes for people with dementia and their carers in acute care

A focus on NHS Grampian

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Introduction

An estimated 93,000 people have dementia in Scotland in 2017. Around 3,200 of these people are under the age of 65. As our population ages, the number of people with dementia will increase; we expect the number to double over the next 25 years. People with dementia are more likely to be admitted to hospital than people without dementia due to co-existing conditions and/or secondary complications of dementia such as falls, fractures and infections. People with dementia over the age of 65 occupy an estimated 25% of acute beds. When admitted to acute care they tend to have a longer length of stay, have adverse outcomes such as falls, pressure ulcers and infections and are more likely to be discharged to a care home.

In Scotland, the importance of improving outcomes for people with dementia in acute care and their carers has long been recognised, with commitments in our three national dementia strategies. The third national dementia strategy, to be published in 2017, will continue this commitment to improve services for people with dementia in acute care and specialist NHS care, strengthening links between this work and activity on delayed discharge, avoidable admissions and inappropriate long stays in hospital. This will ensure that when hospital admission is unavoidable for people with dementia, they experience, on every occasion, safe, effective, dignified, person-centred care. The Standards of Care for Dementia in Scotland, Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers and the Charter of Rights for People with Dementia and their Carers in Scotland have also provided important frameworks to improve care for people with dementia and their carers in acute care.

Commitment 10 of Scotland’s second national dementia strategy focused on improving acute care for people with dementia. To support this commitment, 10 Dementia Care Actions were agreed (Figure 1). Good practice has taken place across Scotland since the development of the 10 Dementia Care Actions, supported by an infrastructure of leadership provided by Alzheimer Scotland Nurse Consultants, Allied Health Professional Consultants and Dementia Champions.
Healthcare Improvement Scotland’s Focus on Dementia portfolio is providing improvement support throughout the whole dementia pathway, including acute care. This work is not undertaken in isolation but builds on existing work already undertaken around inpatient care for older people, through the work of the Older People in Acute Hospitals (OPAH) Inspection Programme, the Scottish Patient Safety Programme (SPSP) and the Older People in Acute Care (OPAC) Improvement Programme.

Focus on Dementia aims to improve the quality of care, experience and outcomes for people with dementia in acute general hospital, carers and staff, in accordance with the 10 Dementia Care Actions.

This review and publication builds further on *Focus on Dementia; Supporting Improvements for People with Dementia in Acute Care* which features a selection of good practice case studies from across Scotland. Whilst good practice exists in many areas across Scotland, this publication describes the methodology and findings of work undertaken between January and March 2017 in four wards in NHS Grampian’s Aberdeen Royal Infirmary that have been recognised as delivering particularly good practice in relation to the 10 Dementia Care Actions. The four wards which this review was based on are in the Department of Medicine for the Elderly (DOME) – wards 102 (the Geriatric Assessment Unit), 303, 304 and 306.

The aim of this work was to identify and share the critical success factors associated with improved outcomes for people with dementia, their carers, friends, family and staff in acute care. Using an appreciative inquiry approach, a range of activities were undertaken, including a multidisciplinary workshop, conversations with staff, stakeholder questionnaires, data collection and thematic analysis using the 10 Dementia Care Actions as a framework.

This publication describes the 10 Dementia Care Actions and the associated critical success factors identified following the review. We highlight why they are critical to success and share some examples of how they have been achieved in practice.
Department of Medicine for the Elderly – Critical success factors

Care Action 1

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

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Leadership is recognised as an essential requirement to drive improvements in the delivery of healthcare transformational change. The Scottish Government, as part of *Everyone Matters: 2020 Workforce Vision*, has identified effective leadership and management as one of its five priorities. It recognises the importance of leadership to help drive quality improvement and for leaders to be from all levels and professions within the workforce.

**Leadership for improvement**

**Support of senior managers**

A crucial element to the success of the improvements in the Department of Medicine for the Elderly (DOME) in Aberdeen Royal Infirmary is the support the team has received from their line management, who see quality improvement as a priority. The team recognise the importance of staying connected and of sharing information, so they set up a department Twitter account. They have used #PermissionToChange as one of their hash tags to demonstrate their commitment to improvement.
Throughout the developments there have been opportunities for members of the MDT to participate in education relating to key topics including; delirium, stress/distress and environmental design improvements to support people with a diagnosis of dementia or delirium.

This has been reflected in the reduction of the transfer of patients to specialist dementia units. Staff feel more confident and competent with additional specialist support from the Older Adult Mental Health Liaison Team when required.

This has provided a positive experience for staff, relatives and people living with dementia being cared for within the department. This is also reflected in feedback that the clinical teams receive from family members and carers.

- Dr Donald Newnham, Unit Clinical Director

I am pleased to see the Department of Medicine for the Elderly Team receive recognition for the improvement work that they have been driving forward. This work within the Department has highlighted what an excellent multidisciplinary team approach can achieve. The creation of a culture for shared learning and improvement has highlighted and provided evidence of positive outcomes for people with dementia, their families and carers.

- Caroline Hiscox, (Deputy Director of Nursing)
  Operational Lead Commitment 10

The commitment as a multidisciplinary team within the Department of Medicine for the Elderly has achieved some superb improvements for the people that the teams are caring for, their family members and carers as well as the experiences of the team members themselves. The developments demonstrate strategy in action within the clinical environment. Commitment 10 of Scotland’s National Dementia Strategy (2013-2016) embedded in practice. I am delighted to see the approach of the department being recognised at a national level.

- Professor Amanda Croft, (Director of Nursing, Midwifery and AHPs)
  Executive Lead Commitment 10
This support has been reflected in feedback from staff. As part of this inquiry, staff, patients and carers or relatives were asked to complete a questionnaire about their experience of the department. Staff who responded to the questionnaire identified a number of factors that contributed to a positive view of working in the department, including:

- feeling involved in the quality improvement work and shift handovers
- good multidisciplinary working
- staff appreciated regular appraisals and supervision, and
- feeling listened to by their manager.

There has been an effort in the department to create the right conditions to facilitate change by creating a supportive and happy environment for staff. The senior charge nurses use iMatter data to support this. Another initiative to facilitate this was a simple staff feedback approach to allow staff to feedback at the end of each shift about how they were feeling. The approach involved staff putting a marble in a jar which indicated if they felt “happy” or “sad”. Staff who put a marble in the “sad” jar were encouraged to feedback why they had placed their marble there. It provided a mechanism for staff to feedback in real time and meant that any issues could be dealt with in a timely fashion (figures 2 and 3).

We had happy staff every day for two months besides one day where we had one unhappy marble. The unhappy marble person approached me and the problem that they had was around not feeling confident in their role and that members of the team seemed too busy to approach/didn’t want to burden others. We discussed options to improve this and came up with a different way of offering support to them to develop their confidence and recognised that we needed more time together as a team to discuss issues. We then started the monthly Geriatric Occupational Therapy QI Group which provided a space where everyone could talk about their frustrations/successes and we could problem solve together.

– Brooke Grant, Occupational Therapist
Alzheimer Scotland Dementia Nurse Consultant support

The 2014 evaluation report by NHS Education for Scotland, *Evaluating the Impact of the Alzheimer Scotland Nurse Consultants/Specialists and Dementia Champions in Bringing Improvements to Dementia Care in Acute General Hospitals*, stated notable improvements had been made in acute care facilitated by these roles. It also stated: “Despite the enormity of the task and the relative small scale and immaturity of the initiatives, a significant amount of change and improvement work has been initiated by the two roles, and would likely not have happened without them.”

NHS Grampian’s Alzheimer Scotland Dementia Nurse Consultant provides strategic leadership and direction, influences change, provides expert clinical advice and supports the local Dementia Champions through a local Dementia Champion Network. This network helps provide the leadership infrastructure to support change. These roles have proved invaluable to drive improvements around the 10 Dementia Care Actions in Aberdeen Royal Infirmary.

The improvement work within the Department of Medicine for the Elderly (DOME) has supported and embedded developments in relation to the care of older people. This has included Commitment 10 of Scotland’s National Dementia Strategy (2013-2016). These changes continue to demonstrate improvements for people living with dementia, their families, carers and staff. If we get it right for people with dementia, we get it right for everyone.

The quote from Emerson reflects my observations: “Nothing great was ever achieved without enthusiasm.”

It has been a pleasure to work alongside my colleagues within DOME and the Older Adults Mental Health Liaison Team, highlighting and sharing how things can be taken forward and demonstrating person-centred care for the people we serve.

– Lyn Irvine-Brinklow, Alzheimer Scotland Dementia Nurse Consultant

**Figure 3: Marble data**

Source: NHS Grampian local data
Quality improvement knowledge, skills and support

Leadership and quality improvement knowledge and skills to drive and monitor improvements are also evident throughout the DOME particularly through the QI Friday Collaborative. This multidisciplinary collaborative has been in existence since 2014 and provides the infrastructure for many of the improvements that have been made in the department.

Healthcare Improvement Scotland’s Improving Older People’s Acute Care Programme (OPAC) blended local improvement collaborative took place between June 2015 and August 2016 and built further on the learning from this work. The OPAC project tested the impact of local improvement advisors within three NHS boards, including NHS Grampian, to co-ordinate improvement activity, facilitate a local collaborative approach and to blend inter-related domains of older people’s care at NHS board level. This formed the foundation of a blended model of improvement which looked at areas such as falls, delirium, capacity and confidence of staff, complaints and pressure ulcers.

The participating NHS boards were then supported to develop local priorities and solutions. Positive outcomes from this approach were reported from colleagues in NHS Grampian and learning from what worked well and what could be done differently is captured in a report on the blended local collaborative. This project helped build a good infrastructure of quality improvement capability in Aberdeen Royal Infirmary. There is no doubt that the additional Improvement Advisor acted as a catalyst during the collaborative. Staff have reported having dedicated improvement advisor support would enhance their improvement efforts further and aid sustainability as this can be a challenge for busy clinical staff.

Whole team approach to quality improvement

A whole team approach to quality improvement ensures that improvements fit the local context and also ensures that staff identify and own their improvement goals, rather than goals imposed by others. The DOME collaborative created a shared vision for delivering the best quality of patient care. It develops common goals which are shared on social media as part of a public commitment to achieve them. The collaborative uses a collective twitter account to share their work and celebrate wins - @AbdnGeriatrics. Use of hash tags helps engage and build motivation and momentum - #FridayisQIday #DoYourPDSAs (Figure 4).
The collaborative initially agreed five quality improvement workstreams, developed driver diagrams and a measurement matrix and used rapid Plan Do Study Act (PDSA) cycles to drive improvements (Figure 5). Workstream areas agreed were:

- immobility and falls
- delirium and dementia
- person-centred care practices
- discharge processes and flow, and
- leadership quality improvement.

**Figure 5: Example of workstream driver diagram**
Improvements within these workstreams have been made possible due to a multidisciplinary team effort. An example of the use of run charts to drive improvement can be seen below with falls bundle compliance, compliance of 4AT, completed Single Question in Delirium (SQiD) and baseline data for a mobility PDSA. Data (Figure 6) is collected and analysed until it is felt that the changes have been embedded into practice so that data is not collected unnecessarily burdening staff with data collection.

**Figure 6: Examples of run charts**

![Examples of run charts](image)

Source: NHS Grampian local data

**Quality Improvement Collaborative/QI Fridays**

Despite working in a busy clinical environment, the team makes the commitment to meet every week as part of their QI Friday meetings (Figure 7). This commitment has been made possible by the team having leaders who lead by example, seeing this as a priority, and by staff being given the permission to attend. This is essential to keep the momentum going on the improvement efforts and so that data and the results of PDSA cycles can be reviewed. Shared responsibility for data collection is facilitated with the use of a shared space (Figure 8).
We rapidly adopted and successfully fully embedded the 4AT and TIME bundle to screen and optimally manage delirium, using the QI Friday infrastructure. Before this, getting staff to correctly use the AMT tool took years and we were still not doing it correctly every time.

– Dr Roy Soiza, Consultant Physician

Focus on involving all staff in improvement

The collaborative also host learning sessions with the wider multidisciplinary team to engage and increase the quality improvement capacity and capability (Figure 9).

Figure 9: A QI collaborative learning session

To maintain the momentum in the improvement work, different monthly themes are given extra priority and posters with the themes are displayed in clinical areas by members of the collaborative. The commitment to improvement is also visible in clinical areas with the use of improvement trees, staff newsletters and improvement boards (Figure 10).
Meeting regularly as a multidisciplinary team is key to our department being able to drive change and improve patient care - and to feeling valued as a member of an innovative, collaborative department. Ensuring a structured approach with regular check-ins with colleagues has enabled us to focus our approach on those areas where we feel we can achieve sustained improvement that directly benefits patients and their carers and relatives. The challenges have been around enabling consistent input and data collection - there is always room for improvement!

– Dr Marion Slater, Consultant Physician
Care Action 2

Develop the workforce in line with Promoting Excellence

| Critical success factor | Focus on all staff having dementia-specific knowledge and skills at the most appropriate level in line with the Promoting Excellence framework |

Promoting Excellence: A Framework for Health and Social Services Staff Working with People with Dementia, their Families and Carers was developed in response to Scotland's national dementia strategy (2010). NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC) developed Promoting Excellence to support delivery of the aspirations and change actions outlined in the strategy.

Focus on all staff having dementia-specific knowledge and skills at the most appropriate level in line with the Promoting Excellence framework

Like many other clinical areas in Scotland, the DOME has been using Promoting Excellence as a framework to ensure that staff delivering care have the required knowledge and skills to best meet their patients’ needs. As well as using the resources developed by NES and the SSSC – available on the Promoting Excellence website hosted on The Knowledge Network and the local NHS Grampian learning platform – additional training activities have been taking place at a local level.
Staff with enhanced level dementia knowledge and skills

Staff within the unit recognised the importance of having an enhanced level of dementia knowledge within the team to best meet the needs of their patients. At the time of publication, all the Nurse Managers in the DOME have undertaken ‘enhanced level’ training either as Dementia Champions or as a Best Practice in Dementia Care Nurse. There are also an additional eight Best Practice in Dementia Care Nurses within the unit. As well as the Dementia Champions who are nurses, there is a physiotherapist who is also a Dementia Champion. The Best Practice in Dementia Care Learning Programme is an accredited programme delivered by the Dementia Services Development Centre (DSDC) in Stirling University. The Dementia Champions programme is being delivered on behalf of NES and SSSC by the University of the West of Scotland in partnership with Alzheimer Scotland. Dementia Champions are trained to enhanced level of the Promoting Excellence framework. This commitment to having a critical mass of staff who are Dementia Champions ensures that this knowledge and skills can be cascaded to other staff through formal and informal training opportunities. It also means that Dementia Champions can support the leadership structure, as described in Care Action 1, to act as change agents in improving the experience, care, treatment and outcomes for people with dementia, their family and carers. Staff members with enhanced dementia knowledge have been made identifiable to those visiting the ward, and to other staff members, by using posters displayed on the wards (Figure 11).

Figure 11: Use of Dementia Champions and Best Practice in Dementia Care staff poster
Access to local subject expert knowledge to increase staff knowledge and skills

As part of the education and training for staff in Aberdeen Royal Infirmary, training sessions were held to increase staff knowledge and skill in relation to new Adults with Incapacity (Scotland) Act 2000 documentation and the 4AT cognitive and delirium screening tool. Over 185 clinical staff attended face to face sessions. Podcasts on these topics were developed by Dr Lynn Shields, Geriatrician in DOME and Dr Laura McKee, Consultant Psychiatrist, and made available on the NHS board’s learning platform highlighting the collaborative approach between the Older Adults Mental Health Liaison Team and DOME colleagues.

The Dementia in the Acute Hospital study day was developed and delivered by the Alzheimer Scotland Dementia Nurse Consultant and the Carer Information Strategy Programme Manager. Presentations were delivered by colleagues from the DOME, Older Adults Mental Health Liaison Team, Older Adults Mental Health Lead Occupational Therapist and Acute Sector Lead Dietician. Training sessions were designed around the quality improvement priorities previously identified and used the expert knowledge in the team. Feedback from the sessions was extremely positive (Figure 12).

**Figure 12:** Feedback from Dementia in the Acute Hospital study day

- Something I take away: Adults with Incapacity protocol, Getting to Know Me and family input is more important than I realised
- Best study day I’ve been to in a long time
- Know more about delirium and 4ATs. Also the incapacity form. Never really looked at it in detail
- Something I take away: Taking more time to read the Getting to Know Me Documents and use the information in practice
## Care Action 3

### Plan and prepare for admission and discharge

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<th>Co-ordinated discharge planning and follow-up</th>
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There is evidence that people who are delayed more than 72 hours have worse outcomes than those who go home sooner, therefore reducing delayed discharge is a national priority for health and social care

### Why?

#### Co-ordinated discharge planning and follow-up

**Discharge Coordinators for complex discharges to liaise with families and community teams to facilitate timely discharge**

In 2012, the DOME recognised that transitions in and out of the ward could be a traumatic time for people with dementia and their carers. A review of complaints data identified that a high proportion of complaints were associated with the discharge process. As a result of this, a discharge coordinator role was introduced to the DOME wards. This registered nurse role has proven to be invaluable for staff based in the ward and is now recognised as an essential part of the team. The discharge coordinators liaise with the patient and their family and carers on admission to act as a key point of contact to ensure that discharge arrangements are communicated clearly and families are fully engaged in the process. The coordinators provide an advocacy role for carers, liaise with the other members of the multidisciplinary team, and signpost and refer to services as required. They liaise closely with social work and community colleagues to ensure the appropriate services and equipment is in place in time for discharge. Having this dedicated role enables and supports nursing staff on the ward to concentrate on their day to day nursing duties (Figure 13).
"After an X-ray she was admitted to Ward 304 in ARI overnight. We were very keen for her to be discharged home as quickly as possible which meant liaising to ensure that increased care would be available to her at home.

We are lucky that we already have a very good care team from Paramount care supporting Mum at home but more support was needed. I found Sheila, who is a staff nurse and the discharge co-ordinator, very helpful indeed in making arrangements. She was also cheerful and showed warmth and humour in her dealings with me and my Mum. Other members of the team, including the OT and the pharmacist were also very helpful. Mum is home again - thank you."

– Feedback from patient’s relative from www.careopinion.org.uk

Co-ordinated follow-up after discharge for complex discharges

The department take a whole multidisciplinary approach to supporting discharge by planning for discharge from the time of admission. Given the complex needs of some discharges, the Older Adult Mental Health Liaison Team can play an essential role with community colleagues to support admission and discharge, ensuring a plan of care is in place. The department also uses the Community Link Team that offers advice and support to patients and families in their own homes.

Taking a quality improvement approach to review and improve discharge processes

It is recognised that services supporting discharge can be limited due to geography and staff availability, therefore the department has made efforts to improve the discharge process internally through their quality improvement collaborative. This has included the development of a discharge checklist co-designed by the multidisciplinary team (Figure 14).
Multidisciplinary team focus on discharge planning from admission

The pharmacy service plays an integral role to support discharges and has introduced a number of improvements to the discharge process.

- Ensuring that all changes to medication are highlighted in the “Changes to Admission” section of the discharge letter. This provides valuable support not only to GP surgeries but also for patients and carers who look after their own medication.

- Identifying patients on Medicine Administration Record (MAR) charts and ensuring that any changes to medication are highlighted on an electronic discharge letter and Emergency Care Summary (ECS).

- Liaising with the ward staff to ensure that all discharges are highlighted to pharmacy before the multidisciplinary meeting in the morning to ensure all medication can be requested from pharmacy dispensary by 1pm; 95% of discharges are now notified before the meeting as opposed to 50-70% before this system was in place.

These changes have lead to improved communication and safety with primary care teams, patients and carers.
Person-centred care is delivered when health and social care professionals work together with people who use services, tailoring them to the needs of the individual and what matters to them. It enables individuals to effectively make informed decisions and be involved in their own health and care. It ensures that care is personalised, co-ordinated and enabling so that people can make choices, manage their own health and live independent lives, where possible.

Use of person-centred approaches and documentation to inform care planning

The DOME staff feel that much of their success in achieving positive outcomes for people with dementia is due to their focus on person-centred care, rather than focusing on the person’s diagnosis of dementia. There are a number of tools and approaches which can facilitate person-centred care, many of which support high quality conversations to identify factors such as what matters to the individual, their wishes and their preferences. DOME staff have used a number of initiatives to improve care around person-centred assessment and care planning, particularly around the use of the Getting to Know Me (GTKM) document. The department has used PDSA cycles to improve the use of the document and data to track compliance (Figure 15). It can be seen that compliance, especially initially, was variable due to issues such as time, staffing levels, who should fill it in, patient and family participation and understanding how the tool works. Compliance has now increased through analysis of the data and team discussion.
The staff have reported that the Getting to Know Me document is an invaluable communication tool which has improved their delivery of person-centred care.
Getting to Know Me examples

A patient admitted to the ward was very unsettled and was walking unaided, moving other patients’ tables, other patients’ items and the nurses paperwork. Once a GTKM had been completed, the staff found out the patient used to be a banker. The staff sourced paper money and encouraged the patient to sit with them at the nurses base where the patient was happily contented sorting and counting the money and making notes. The patient promoted themselves and used the Senior Charge Nurses office to do his work which as this was on the ward the patient remained safe and contented. The patient’s family was amazed at how settled their loved one had become.

A patient admitted to the ward spoke no English and their family spoke little English, so the GTKM was used to break down the barrier of verbal communication. In this patient’s GTKM, useful everyday words were written down so that as a team we could communicate with the patient in their own language. They were written in a way that was easy for staff to pronounce. As a team we learnt more about this patient’s culture and needs from the GTKM.

A patient was admitted from another area very anxious and scared. The patient had dementia and was being supervised in the previous ward due to mobility issues and was very unsettled. There was no GTKM in place, so we asked their family to complete one and explained the reason for this was to ensure that care was given to their loved one in a way that they would like to be cared for. The patient had a large family and was very much the matriarch of the family and liked to be in control and make the decisions. Due to her declining dementia, the patient was not always aware that family was updating her with their news and would often get upset with the family. After completing the GTKM and finding this out, the staff and family decided to keep the patient updated by writing in a book what was happening and adding the date. This enabled the patient to continue to feel that she was still very much the head of her family, helping them to make the right decisions and the family felt happier as their loved one was less anxious, scared and enjoyed being part of a new family within the ward.
The physiotherapy staff came up with a very novel way of increasing awareness of both the Getting to Know Me document and Playlist for Life. All of the physiotherapy staff were asked to complete their own GTKM document and a Playlist for Life. These were then incorporated into their staff Christmas lunch, where their playlists were played and the information from their GTKM documents was used as part of a quiz (Figure 16).

Use of quality improvement methodology to review and improve assessment and care planning processes

Another initiative the department has been using to improve person-centred care is having “What Matters to You?” conversations with their patients and their carers. This is part of a shift that has been developing from a “What’s the matter with you?” to “What matters to you?” culture. White boards at each bedside and What Matters to Me Trees have been introduced to allow key information from the “What matters to you?” conversations to be recorded, enabling all staff to have a better understanding of their patients’ likes, dislikes, needs and goals (figures 17 and 18). Data collection was used to monitor and support compliance until use was embedded in practice (Figure 19).
The Physiotherapists and Occupational Therapists used PDSA cycles and collected data to improve communication in the multidisciplinary team to promote person-centred care. Using the Trakcare system, therapists provided daily updates with relevant information on patient treatment plans, progress and information about discharge planning. This enabled other members of the team to access information quickly to assist in person-centred care planning, avoiding duplication and delay. Data from their PDSA cycles can be found below (Figure 20).

**Figure 19:** Example of data of “What Matters to Me?” conversation compliance

The percentage of patients who had two sections of "What Matters To Me" within 48 hours

Source: NHS Grampian local data

**Figure 20:** Physiotherapy and Occupational Therapy Trakcare data

Compliance with Trackcare Updating

Source: NHS Grampian local data
Multidisciplinary approach to care planning, including the use of shared documentation

Pharmacists within the unit have also adopted a person-centred care approach by including a review of every patient’s social circumstances, including support services and carer support. By including this information in every review, the pharmacist has a better understanding of a patient’s home lifestyle which can influence the timing and format of medications prescribed, especially if the patient requires assistance taking their medication. For example, if a patient who requires assistance to take their medication has three times daily care at breakfast, lunch and teatime, issues would arise if medication was prescribed outwith these times. These circumstances are now taken into account, whereas previously it may not have been a focus.

One of the improvement ideas adopted successfully is the use of shared notes which has improved communication between the multidisciplinary team, saved time and avoided unnecessary duplication, and in doing so facilitated improved person-centred care. It facilitated improved communication with patients and family members by ensuring that all of the multidisciplinary information is close to hand.

This has frequently led to much more efficient and safer discharge planning, with a more consistent message given to patients, families and carers about their health status and what their options are.

– Dr Roy Soiza, Consultant Physician

The shared notes have made it so much easier to find out what has been happening with the patient. It used to be really frustrating trying to find information from nursing notes, occupational therapy notes and physiotherapy notes, but now it is all easily accessible. I feel that it has greatly improved our team's communication.

– Dr Catherine Butchart, Consultant Physician
A rights-based approach is about making people aware of their rights, whilst increasing the accountability of individuals and institutions that are responsible for respecting, protecting and fulfilling rights. It is based on principles such as respect, dignity, autonomy, inclusion, participation and non-discrimination. In Scotland, the Charter of Rights for People with Dementia and their Carers in Scotland was developed to empower people with dementia and their carers and to ensure that those who provide services respect their rights, therefore ensuring the highest quality of service provision. A rights-based approach has also underpinned Scotland’s national dementia strategies.

### Care Action 5
Promote a rights-based and anti-discriminatory culture

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**Why?**

**Increasing awareness and understanding of dementia and reducing stigma**

The DOME has been striving to raise awareness and reduce the stigma associated with dementia by facilitating Dementia Friends sessions for staff and visitors to the department. They are using these sessions to support individuals to learn more about what it is like to live with dementia and turn that understanding into action by signing up to be a Dementia Friend and making a pledge by putting their name on the Dementia Friends Tree. This includes sessions for staff in the wards, visitors and even a subcontractor coming to the ward to carry out work. This new Dementia Friend said he was going back to his workplace to talk to his colleagues about what he had learned. One ward has successfully signed up 80 Dementia Friends on their tree (Figure 21).
Many of the Dementia Friends sessions have taken place during Dementia Awareness Week. Ward 306 ran sessions during this week, enticing potential friends with not just a badge and a certificate but with a sunflower or forget-me-not pot plant. The ward also holds a tea party every year to help further raise awareness. Members of the public have commented on how this has increased their awareness of dementia and will make them be more patient and understanding when interacting with members of the public who have dementia.

A son-in-law visiting his mother-in-law, who did not have dementia, reported to the charge nurse that he had been watching the staff interact with the other ladies in the ward who had dementia. He said he was very impressed and had picked up some real tips from watching the staff on how to interact and communicate with someone with dementia. He said he was going to take these tips on board as his own mother had dementia and on reflection he felt he could have handled some of their interactions better.
Promoting a non-discriminatory culture within a ward environment

The department has trained staff and promoted the use of the Adults with Incapacity (Scotland) Act 2000 principles and documentation, ensuring it benefits the person, restricts the person’s freedom as little as possible, takes into account their wishes past and present, takes into account views of relevant others and encourages the person to use existing abilities and to develop new skills.

The department has also used the Caring Behaviours Assurance System (CBAS) approach to promote a rights-based and anti-discriminatory culture. CBAS is an evidence-based system for enabling and assuring the delivery of person-centred care which is delivered with compassion and kindness. It addresses caring for patients and caring for staff in equal measure. The charge nurses who had received CBAS training used the Ward Level Walk Round Care Assurance Tool to make the environment more pleasant and enabling for patients and staff, including dementia-friendly design such as bright decoration and quiet spaces. CBAS was also used to ensure that care is provided in an environment free from stigma and discrimination for patients, visitors and staff alike by managing any indications of stigma or discrimination through open and honest conversations. The staff have reported that the process has made them more aware of different cultures.

A lady was admitted to the ward who did not speak English. She was very stressed and distressed, especially with personal care. The ward staff contacted the family to learn more about some of the factors which contributed to her feelings and preferences about who should provide personal care. They worked with the daughter to support personal care activities and all of the staff learned some words of the lady’s own language, which helped greatly.
Modern acute hospitals are busy, noisy places which can be very frightening and disorientating for people with dementia. The environment can either be over or under stimulating, difficult to understand and easy to misinterpret. This can have an adverse impact on experiences and outcomes such as stress and distress, falls, reduced function, poor hydration/nutrition and incontinence, and can increase the risk of delirium.

**Improving the physical environment using audit and dementia-friendly design**

Recognising the importance of a safe and therapeutic environment, the DOME has made massive steps to improve the environment for their patients, carers, visitors and staff. They have used methodology such as the Ward Level Walk Round Care Assurance Tool, the Last 9 Yards Meal Service Audit and the Kings Fund Audit. They have also used SoundEar Noise Warning Sign technology to monitor and encourage appropriate noise levels.

Changes have included moving furniture so that patients have a better view of the outside, themed dayrooms where patients and their families can come together to have a coffee and chat away from the bedside, bright décor with art and murals to add interest, and clear signage to improve orientation and independence. There are also reminiscence pods in three of the wards, which are pop-up reminiscence rooms. Most patients responding to our questionnaires were very positive about the ward, particularly around how welcoming and clean they were; 100% of relatives who responded to the questionnaire found the facilities as a visitor ‘good’. Staff areas have also been improved by decluttering and providing simple additions such as adequate kettles and crockery for staff rest breaks (Figure 22).
Figure 22: Examples of environmental design changes

Therapeutic activities recognised as an essential part of day to day life and not an add on

The physical environment can also be enhanced by the therapeutic activities which take place within it. Staff acknowledge that spending quality time with their patients can be challenging given the turnover of patients and general time constraints. However, they recognise this is an area that should be prioritised to improve patient outcomes. As well as the benefits of traditional rehabilitation activities, such as physiotherapy and occupational therapy that take place within the wards, there has been a real drive in the department to increase meaningful activity opportunities for the patients, and visitors.
I looked at ways to introduce more activities and one to one interactions with patients. This helped patients with dementia and delirium to be more relaxed and less distressed. Some of the activities that were introduced to the ward were:

- an activity box – which had a range of activities from memory cards, dominoes, reminiscence objects, paint by water, board games
- afternoon tea rounds
- one to one activities designed from using the Getting to Know Me document such as a movie day, reading, gardening or just chatting
- musical memories
- wellbeing time such as applying makeup, hand massage, hair
- Therapet, and
- chair-based exercise.

- Emma Davidson, Band 3 Senior HCSW - Ward 304

The department has embraced music as a social and therapeutic intervention using initiatives such as Playlist for Life (www.playlistforlife.org.uk) and Music in Hospitals Scotland (www.musicinhospitalsscotland.org.uk). Playlist for Life encourages families and caregivers to create a playlist of personally meaningful music on an iPod for people with dementia. This helps support communication and social interaction. Music in Hospitals Scotland aims to enhance the lives of people of all ages in hospitals, care homes, hospices, day centres and special schools across Scotland through the provision of live music.

This was a great event, the patients loved it and so did the staff! We are a care of the elderly ward and some of the patients can be frail, have a dementia or are just withdrawn. The music brought them to life with smiles, singing and joy. One patient was poorly all morning but heard the music and wanted to come through. She sang, clapped and smiled; this patient had a great time.

- Feedback from Ward 306 to Music in Hospitals (supported by TOTAL E&P UK)
A holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people’s health has been demonstrated to be associated with improved outcomes. Many people with dementia are admitted to an acute hospital as a result of a co-morbid condition and not their dementia. It is essential for positive outcomes for frail older adults in hospital that they receive comprehensive geriatric assessment to identify areas where they are likely to be at risk. This includes delirium and falls.

### Care Action 7

**Use evidence-based screening and assessment tools for diagnosis**

| Critical success factor | Focus on comprehensive holistic assessment and care planning using validated screening and assessment tools and best practice interventions |

The department has strived to make improvements in their holistic and comprehensive assessment and care planning. Use of the Single Question in Delirium (SQiD) was one of the first quality improvement projects undertaken. Figure 23 demonstrates how they used data to monitor their progress. As they had reported 100% compliance for a sustained period of time, ongoing measurement was discontinued.

**Figure 23: Data collection on SQiD use**

Source: NHS Grampian local data
Use of quality improvement methodology to drive improvements

The use of PDSA cycles has improved compliance with the 4AT Delirium bundles and use of the Think Delirium leaflets (Figure 24). These are now widely used in practice.

**Figure 24:** Data collection on 4AT compliance

Falls prevention work remains a priority area, with a falls subgroup established as part of the quality improvement collaborative. The group plans to use quality improvement methodology to look at elements such as falls data collection, care plans, lying/standing blood pressures and post-fall protocols. Figure 25 shows falls bundle data and visual data of days with and without falls.

**Figure 25:** Examples of falls data collection

Source: NHS Grampian local data
The Scottish Government has recognised the importance of supporting carers through policy and strategy such as the Carers Strategy for Scotland\textsuperscript{19}, The Quality Strategy\textsuperscript{20} as well as dementia specific policy, including The Standards of Care\textsuperscript{4}, The Charter of Rights\textsuperscript{6} and through Scotland’s national dementia strategies.

Families, friends and carers are welcomed as active partners in the delivery of person-centred care

### Person-centred visiting

The department strives to make families, friends and carers very welcome and regards them as an integral part of the patient’s care. This is partly achieved by developing person-centred visiting and a welcoming ward (Figure 26). Not only are visitors welcome but they can be involved in the care of their loved one. This can be beneficial to the patient who may be distressed when receiving personal care or help with mealtimes from a stranger. Carers can often feel helpless at the time of admission. This allows them to feel involved and supported to carry out their caring role if they wish to do so. It is also very useful for the staff to help them better understand a patient’s likes, dislike and preferences. This has been very well received by families, friends and carers. Of the relatives who responded to the inquiry questionnaire, 100% reported they valued the person-centred visiting and reported that staff in the ward made visiting as positive as possible. Staff have commented that it is nice to see families interacting with their relatives at mealtimes, making it more of a social occasion. Staff have also found they have more time to discuss patients with their carer, family or friends, as visitors come in more often throughout the day. Of the relatives who responded to our questionnaire, 100% stated that they were given options and were well informed.
Environment designed to be welcoming

Efforts have been made to make the environment as welcoming as possible for visitors. The dayrooms are open to families, friends and carers to create a welcoming, calm atmosphere. The dayrooms have tea and coffee making facilities and support literature on conditions such as delirium, as well as third sector organisations (Figure 27).

Figure 26: Person-centred visiting signage

“Knowing I can visit at any time shows the ward has nothing to hide.”

“I was in the corridor waiting to visit my mother and I heard her being rude and awkward, I heard nothing but patience, compassion and professionalism from the staff who were trying to provide care to my mother. The staff were unaware that I was outside the door listening.”

“Makes visiting my dad so much easier, as I can fit this around my work and caring for my children.”

“I can visit my husband earlier in the day as I don’t like driving in the dark.”

“I like to come in and help my family member with her meals.”

– Feedback from relatives, friends and carers on person-centred visiting

Figure 27: Examples of support literature available in the wards
Support for carers is also facilitated by Heather Tennant, NHS Grampian Programme Manager – Carer Information Strategy. Heather provides education, support and a liaison role.

In my role as Programme Manager – Carer Information Strategy, I have been supporting the quality improvement work within the department. The MDT has embraced improvement work to support family members and carers and are regularly considering further ways to enhance this.

It's great to see how the work has been embedded and how it links to key drivers, including the national Equal Partners in Care (EPIc) core principles, Commitment 8 of the 10 Dementia Care Actions in Hospital and the promotion of person-centred conversations ‘What matters and who matters to you? I look forward to working with the MDT as we roll out the provisions of the Carers (Scotland) Act 2016 next year.

- Heather Tennant, NHS Grampian Programme Manager – Carer Information Strategy

Family, friend and carer feedback actively sought and welcomed

Families, friends and carers are also actively encouraged to inform and contribute to improvement in the ward by using initiatives such as improvement trees where ideas for improving the ward can be placed (Figure 28), NHS Grampian feedback cards and the website www.careopinion.org.uk.

Figure 28: Improvement tree example
There are many causes of stress and distress for people with dementia, including biological, psychological, social and environmental factors. There has been a shift from managing stress and distress using antipsychotic medication to prevention and management using non-pharmacological means whenever possible. This has been reflected in commitments 12 and 13 of Scotland’s national dementia strategy which commits to reduce the use of inappropriate psychoactive medication.

### Person-centred, meaningful and therapeutic activities in an enabling environment

Many of the initiatives featured in this publication undoubtedly help minimise and respond to stress and distress. The team has supported and introduced a range of improvements to the environment, including improved décor, management of noise levels, bright, well-signposted wards and quiet areas to allow patients and their relatives to find time away from the main ward.

### Person-centred care – getting to know patients and their carers

Using Getting to Know Me documents and What Matters to Me have all helped to minimise stress and distress, as have attempts to keep people meaningfully occupied and engaged during their hospital staff.

I did not expect to have such a big impact on the improvement of patients being distressed on an acute medical ward by introducing small personal activities that could be used at any time of day and for short or long periods.

- Emma Davidson, Band 3 Senior HCSW - Ward 304
The adoption of person-centred visiting means that families, friends and carers can visit at any time, particularly at times when the patient may be at more risk of stress and distress, for example times when personal care is required or mealtimes.

**Meaningful and therapeutic activities**

The Occupational Therapy Department has also developed twice weekly Active Recovery sessions in the step down wards which they deliver with the physiotherapy staff. The sessions contain cognitive stimulation therapy (CST), reminiscence, memory and orientation therapeutic activities. They have reported that patients are “more animated, orientated and content” following the sessions.

**Specific knowledge and skills in responding to stress and distress for people with dementia**

The investment in specialist dementia training for staff has provided them with the knowledge and skills to prevent, minimise and respond to stress and distress.

They also benefit from a supportive infrastructure of dementia expertise. As well as the local Alzheimer Scotland Dementia Nurse Consultant, they are also supported by the Older Adult Mental Health Liaison Team that takes referrals from the wards if a patient has complex mental health needs, including stress and distress. This seeks to reduce the number of patients being prescribed antipsychotic medication or to be transferred to a specialist site. They will also assist in the diagnosis of dementia, give advice on Adults with Incapacity issues and support transitions.

One of the wards referred a lady to the Older Adult Mental Health Liaison Team. It looked likely that this lady would require to be moved to a specialist mental health bed in another hospital. With the support of the team, the ward staff were delighted that were able to meet her complex needs in the DOME.

A lady was nearing the end of her life. She was very distressed that her dogs were not with her. The staff arranged for them to visit her in the ward. She exclaimed: “Look my friends are here!” She passed away a few days later.
Evaluating patient experience and outcomes are recommended as part of Scotland’s person-centred quality ambition, one of the ambitions of The Quality Strategy. Quality improvement is a proven approach to support developments using a variety of tools and methodologies. It supports better understanding of systems and processes, the identification of areas for improvement, and provides the tools to evaluate the impact of change. There is a focus on the use of data to support and drive improvements.

Use of improvement methodology to monitor and improve patient outcomes and experience

Quantitative data, such as length of stay and institutionalisation, have previously been collected and analysed in the department. A previous evaluation of the Geriatric Assessment Unit found a 7-day reduction in length of stay and a 1.5% reduction in institutionalisation, when compared to the unit’s previous location in Woodend Hospital, Aberdeen, over two separate 12-month periods. This was achieved despite a 124.2% increase in admissions (L MacLeod, Bachelor of Sciences (medical sciences) student at University of Aberdeen. Personal Communication. 30 Jan 2015). Data obtained from ISD Scotland from 2011-2016 shows the department has the lowest mean length of stay of any NHS board, both for emergencies and overall, 7 days lower than the Scottish Geriatric Medicine average. Figure 29 shows data from 2015-2016 presented as a funnel plot. A funnel plot is a way of comparing areas of different sizes to understand variation. This shows that NHS Grampian has a lower than average length of stay.

These outcomes were attributed by the staff to their focus on comprehensive geriatric assessment and co-ordinated multidisciplinary care, which they felt led to better assessment, better co-ordination of care and better person-centred decision making. Whilst these are important in terms of patient outcomes, the department felt that patient experience of care and discharge was also critical to improved outcomes and as such would provide invaluable data to focus any improvement work.
The department has been using improvement methodology to achieve demonstratable improvements in patient experience through better person-centred care. They found that existing data was not fit for purpose so they developed their own tool based on the NHS Institute for Innovations and Improvement recommendations. The results from the questionnaire are used by the collaborative to help prioritise and drive improvements across the unit (figures 30 and 31).

**Figure 29: ISD Length of Stay data**

**Figure 30: Patient Questionnaire Tool and Scorecard example**
Staff reported that the development and introduction of a meaningful measurement framework helped to drive improvements in practice, even before they came up with specific change ideas. The staff also regularly review the comments of any feedback letters, including complaints and thank you cards, to gather intelligence about the performance of the department (Figure 32).

Figure 31: Examples of run charts of Patient Experience Questionnaire results

Figure 32: Thank you cards
“Your care was amazing, sensitive, intelligent and compassionate – I will never forget it. I also found it to be a very warm and well-organised dementia-friendly place.”

“I was very impressed with the level of nursing care. All of the nurses were caring, competent, professional and really showed a level of compassion that went above and beyond what might have been expected. The cleaners were very thorough. The porters were also very competent. The food – given the numbers being catered for – was good. I cannot fault your staff. If people complain, they do not realize how lucky we are in Grampian.”

“I write to congratulate and compliment the team that work on ward 304 A.R.I. In such challenging and constantly busy environment the Medical, Nursing, Therapy and domestic staff all delivered an exemplary high standard of care. Despite being obviously stretched for time all staff were approachable, friendly and professional. Notes on how Granny liked her tea, favorite meals and significant family members were in place from the day she was admitted, this helped keep her reassured and ensured a great feeling of safety for Granny. Details such as providing warmed wet wipes after meal times to clean hands and face was a particularly nice touch (Granny has developed a total dislike to all things cold). Care was delivered with dignity, patience and such a warm caring compassionate way to every patient in the ward but to friends and relatives too that my family and I wanted to convey our gratitude via this letter.”

– Examples of patient and family feedback
Key learning

The identification of critical success factors associated with positive outcomes for people with dementia, their carers and staff in acute care in the Department of Medicine for the Elderly, Aberdeen Royal Infirmary, was achieved using an appreciative inquiry methodology. Information was captured from a range of sources, including a multidisciplinary workshop, conversations with staff, stakeholder questionnaires, data collection and thematic analysis using the 10 Dementia Care Actions as a framework.

We identified 15 different critical success factors under the 10 Dementia Care Actions (Figure 33). This appreciative inquiry found that despite pressures on time due to demand and workforce capacity, the success of the department in improving the quality of person-centred care, experience and outcomes for people with dementia, carers and staff was as a result of their committed use of quality improvement methodology, which was used to review and improve many aspects of their care delivery. This was supported for a time by dedicated improvement advisor support and dementia leadership to identify areas for improvement and to help drive and support those improvements. Their success was due to staff having dementia-specific knowledge and skills, however the importance of holistic person-centred assessment and care was highlighted and found: “If you get it right for people with dementia, you get it right for everyone”.

Whilst not all acute sites are alike, it is hoped that the learning from this work will be of interest to other inpatient sites in NHS Grampian and across Scotland, and staff will use the learning to identify opportunities to improve the care and experience for people and people with dementia in their own areas.
Key learning points:

- **staff delivering care in acute wards should have dementia-specific knowledge and skills in line with the Promoting Excellence framework**
- **investment in developing an infrastructure of dementia leadership in acute care, for example Dementia Champions, Best Practice in Dementia Care Nurses, Nurse and Allied Health Profession Dementia Consultants, and**
- **building quality improvement capacity, capability and infrastructure so that quality improvement becomes part of everyday business, and where possible, supported by dedicated improvement advisor support.**

In response to these key learning points, Focus on Dementia will continue to support services as they implement the acute care commitment of Scotland’s national dementia strategies through:

- **developing and testing improvement and learning resources**
- **providing advice and guidance in relation to quality improvement approaches, and**
- **the continued identification and spread of good practice across Scotland.**
Figure 33: Critical success factors identified

<table>
<thead>
<tr>
<th>Dementia Care Action</th>
<th>Critical success factor</th>
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<tbody>
<tr>
<td><strong>Care Action 1</strong>&lt;br&gt;Identify a leadership structure within NHS Boards to drive and monitor improvements</td>
<td>• Leadership for improvement including senior managers, Alzheimer Scotland Nurse Consultant and Dementia Champions&lt;br&gt;• Quality improvement knowledge, skills and support&lt;br&gt;• Whole team approach to quality improvement</td>
</tr>
<tr>
<td><strong>Care Action 2</strong>&lt;br&gt;Develop the workforce in line with Promoting Excellence</td>
<td>• Focus on all staff having dementia-specific knowledge and skills at the most appropriate level in line with the Promoting Excellence framework</td>
</tr>
<tr>
<td><strong>Care Action 3</strong>&lt;br&gt;Plan and prepare for admission and discharge</td>
<td>• Co-ordinated discharge planning and follow-up</td>
</tr>
<tr>
<td><strong>Care Action 4</strong>&lt;br&gt;Develop and embed person-centred assessment and care planning</td>
<td>• Use of person-centred approaches and documentation to inform care planning</td>
</tr>
<tr>
<td><strong>Care Action 5</strong>&lt;br&gt;Promote a rights-based and anti-discriminatory culture</td>
<td>• Increasing awareness and understanding of dementia and reducing stigma&lt;br&gt;• Promoting a non-discriminatory culture within a ward environment</td>
</tr>
<tr>
<td><strong>Care Action 6</strong>&lt;br&gt;Develop a safe and therapeutic environment</td>
<td>• Improving the physical environment using audit and dementia-friendly design&lt;br&gt;• Therapeutic activities recognised as an essential part of day to day life and not an add on</td>
</tr>
<tr>
<td><strong>Care Action 7</strong>&lt;br&gt;Use evidence-based screening and assessment tools for diagnosis</td>
<td>• Focus on comprehensive holistic assessment and care planning using validated screening and assessment tools and best practice interventions</td>
</tr>
<tr>
<td><strong>Care Action 8</strong>&lt;br&gt;Work as equal partners with families, friends and carers</td>
<td>• Families, friends and carers are welcomed as active partners in the delivery of person-centred care</td>
</tr>
<tr>
<td><strong>Care Action 9</strong>&lt;br&gt;Minimise and respond appropriately to stress and distress</td>
<td>• Person-centred, meaningful and therapeutic activities in an enabling environment&lt;br&gt;• Specific knowledge and skills in responding to stress and distress for people with dementia</td>
</tr>
<tr>
<td><strong>Care Action 10</strong>&lt;br&gt;Evidence the impact of changes against patient experience and outcomes</td>
<td>• Use of improvement methodology to monitor and improve patient outcomes and experience</td>
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References


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