

Cross Party Group on Dementia

Meeting – 25/6/2014

Meeting Start Time: 12pm

Present: Sue Northrop (Dementia Friendly East Lothian); Amy Dalrymple (Alzheimer Scotland); Anna Buchanan (Life Changes Trust); Alison Thomson (Mental Welfare Commission of Scotland); Heather Edwards (Care Inspectorate); Hazel Marsden (Care Inspectorate); Sarah McDermott (Health and Social Care Alliance); Brian Johnstone (Home Instead Senior Care); Swaran Rakhra (Scottish Care); Susanne Cameron-Nielsen; Dr Richard Simpson (MSP); Lynne Stevenson (Nutricia); Mary Scanlon (MSP); Roderick Campbell (MSP); Dr Nanette Milne (MSP); Shirley Law (DSDC); Jilly Polson (DSDC); Archie Noone (SDNG); Dorothy McElroy; Professor Stephen Bell (Heriott-Watt); Irene MacKinnon (attending on behalf of Maureen Watt) and Eilidh Lean (in-house secretariat).

Apologies: Myra Lamont, Sally Hughes, Gaby Stewart, Fiona McLeod.

Roderick welcomed and introduced Shirley Law and Jilly Polson. He explained that they were giving short presentations on the training of care home staff and on the importance of care home design.

Presentation from Shirley Law:

Shirley Law explained how there are a number of challenges for care home staff as people are supported at home for longer which means that they are coming into the care home at a later stage and have more complex needs. Care homes are also dealing with staff shortages and an unskilled workforce and this can lead to a poor culture of care.

To illustrate the problems surrounding staff shortages, SL explained that in a small town with a number of care homes, you could be disciplined in one care home and walk into a job in another home – such is the problem with staff shortages. The costs involved in staff training to ensure that staff are brought up to an appropriate level can also be quite costly. Both of these can lead to a poor culture.

SL explained that it is possible for a person with dementia to live in a care home for a long time but people are still being admitted to acute care facility when dying. She explained that there is both appropriate and inappropriate admissions to care facilities and this can have an effect on an individual. She indicated that care home staff should still have a role when a resident is admitted to hospital.

She explained that the DSDC's Best Practice in Dementia Care Learning Programme has now been accredited by the RCN and City & Guilds. She also indicated that this course covers a huge number of things. She explained the course is facilitator led and takes 6 months to complete involving 2 hours of study per week and a group discussion with the facilitator on alternative weeks. Everyone on the course learns from each other and the training takes place in workplace and is suitable for anyone at any level, they don't want to scare anyone away.

She indicated that the learning outcomes allow those taking the course to have a better understanding of dementia and the impact it has on individuals. It also allows individuals to take part in reflective evaluation of interventions and change practice accordingly, as well as recognising a person-centred approach to care. The course also demonstrates that a more expansive use of communication skills when interacting the needs of people with dementia and recognises the role of the carer/family, their needs and support networks. The course is also evaluated by students and facilitators both pre-test and post-test, reflective exercises are completed by students and online post-test service manager surveys.

She explained that the results are fantastic as 90% of participants reported improved understanding of dementia and its impact on the person; 95% reported an improvement in person practice; 90% felt that changes in practice had a positive impact on the ways they are able to care for and support people with dementia and their families.

Q&A Session following Shirley's presentation

Shirley was asked by Amy Dalrymple about the take-up and SL explained that there are 320 trained facilitators in care homes and 2,500 staff have went through the programme. 100 domestic care facilitators are also up and running, 2,500 hospital staff have also went through the programme. Shirley explained that she is currently working with A&E staff and that Perth Royal Infirmary and Ninewells Hospital recently piloted the A&E programme.

Hazel Marsden asked if the uptake was spread across the country and SL said that it has been spread across the country, Councils in Shetland and Orkney love it. They target both rural and urban areas.

Swaran Rakhra asked if the ball was rolling in the private sector, which is poorly funded and under a lot of pressure. SL explained that DSDC trustees will match fund and the DSDC has found funding for independent care homes. Money from the Scottish Government for hospital staff and the good thing is the training is sustainable and cost-effective.

Sue Northrup said that the course is a great vehicle for opening up for staff. Alison Thomson said that recommendations that the MWC made about staff are in the course.

SR asked about Big Lottery Funding and Shirley explained that they weren't sure of the position. SR

asked if the Care Inspectorate were aware and Heather Edwards said they are going in and asking about training, they ask about education. She is aware that there are tensions for providers vis-à-vis money. SR said that NHS Education for Scotland really need to step up to the plate, education is really important for care homes.

Dorothy McIlory asked how much was taken up by NHS domestic staff – is there a gap? Shirley explained that primary care is usually council staff, NHS is hospitals and community. JP explained that she does the marking and often small changes reflect deep learning. Dorothy said that this is a big area that needs to be addressed. SL noted that domestic care was touched upon at 2011 have to work to ensure all aware that staff need this level of training.

Amy D said that commissioning and the way care is commissioned is important – is local government aware of how to govern quality care. SL said that one of their teams is training family carers through the programme and they're getting the right people for the position.

Amy N asked if local authorities were taken up the training budget, Robertson Trust offers some funding. Shirley explained that the Robertson Trust was a small part and the DSDC trustees will match fund.

Roderick welcomed Nanette Milne and Mary Scanlon to the meeting; prior meeting had overrun.

Presentation from Jilly Polson:

Jilly Polson's presentation focussed on why design is important in dementia care and explained why it is important part of the care that we give to people with dementia. She explained that design can create

opportunities or barriers. JP asked us to imagine ourselves in a strange airport and just how confusing this would be, she explained that the everyday situation and environment can be just as confusing for the person with dementia.

JP indicated that it is often not the illness itself but how we respond, our attitudes and environments that disable people with dementia. JP explained that the characteristics of person with dementia: older, striving for independence and autonomy, personal identity, working hard to make sense of the environment and staying engaged. Older people with dementia all have the impairments that are common in late life, they often have additional conditions and they may not understand that they have these impairments so optimal health is really important. JP stressed the importance of keeping people out of hospitals and that design can combat delirium

She explained that benefits of good design: optimises function; reduces excess disability; enables people to adapt; facilitates staff roles and responsibilities; supports positive engagement; reinforces personal identity and enhances self-esteem; orientates and understandable; welcomes relatives and the community; controls and balances stimuli.

JP explained that costs of getting it wrong: slips, trips and falls; stress and distress, behaviour which may be perceived as “challenging” to others; death by boredom; reduction in quality of life and wellbeing.

JP also stressed that design is only one part of care – good design does not always mean good care and vice versa. Good design can reduce stress and distress for someone with dementia without affecting others. She explained that we need to take into account people’s needs and consider the environment and their dignity. She explained that we need to compensate for deterioration in sight, hearing and cognitive impairment. The environment should take all of these into account – information should be clear, acoustics are important and traditional design is key.

JP stressed the importance of the outdoors – people need to be allowed outdoors. She also indicated that the DSDC offers lots of design services and can audit buildings so that care homes know what is needed – places can look lovely but not designed with needs in mind.

RC had to leave the meeting during JP presentation, Mary Scanlon apologised for his departure and convened the rest of the meeting.

MS indicated that she had heard about red toilet seats; circular gardens; linoleum that looks like water – these aren't costly. She explained that there's been a focus on SDS – people with dementia could be getting reassessed every 6 months with SDS. She also spoke of her concerns about respite care in the Highlands.

JP said that sometimes the training is great, but it isn't translated into practice – we need to translate things to practice. Shirley explained that the DSDC do take calls from individuals who are at their wits end and there is always something out there. Problem with respite when in community care – respite care is important.

AT said we are lucky to have the DSDC and that best practice is not always reflected in our hospitals. Experts are ignored, although people are aware of good design but are throttled by red tape.

JP said that this causing major issues for patients on the ward and it goes to illustrate how you should be trying to get it right from the start. Good design is gathering more pace. We need to understand why training and design are important. Things aren't insurmountable but need will in the first place.

Lynne Stevenson spoke about the well-designed care home that her father is in. She explained that his

room has back door and he has had really positive experience. JP said there is lots of good practice. Picking up on the space point HE said that difficulty to access to outdoor space they see homes on multiple levels. Hazel Marsden indicated that the Care Inspectorate see new builds as great opportunities- direct them to dementia services. Small things that they can do. MS asked whether the CI is looking at training and design. HE said that training is already being looked at, though people can be ensure of where they can go. MS asked if design will be there and HE explained that environment is always there and recommendations made there and they can always signpost.

Both JP and SL said that small changes are important and with the hospital trial at PRI and Ninewells, staff are already suggesting design changes. MS noted that inexpensive changes can be made and asked if any final questions. Amy D indicated that there's so much they've heard about and they need to coordinate.

MS indicated that she was happy that the CPG was back on track and explained that no date was set for the next meeting and suggestions were welcome for next meeting and the group can lead the way on dementia.

The meeting was then brought to a close and finished at approximately 13.35.