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Royal Cornwall Hospitals NHS Trust

POLICY UNDER REVIEW

Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Information Category	Detailed Information
Document Title:	Dementia Care Policy V3.0
This document replaces (exact title of previous version):	RCHT Dementia Care Policy V2.0
Date Issued/Approved:	1st August 2019
Date Valid From:	August 2019
Date Valid To:	November 2022
Directorate / Department responsible (author/owner):	Frazer Underwood, Consultant Nurse / Associate Nurse Director and Clinical Lead for Dementia Care
Contact details:	01872 255043
Brief summary of contents:	This policy exists to translate national strategy into local policy to benefit the population with living with dementia and mild cognitive impairment, their carers and families, that use our services today and into the future.
Suggested Keywords:	Dementia, Dementia Care, Mild Cognitive Impairment, Carers, Mental Capacity,
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Medical Director
Approval route for consultation and ratification:	RCHT Dementia Action Group
General Manager confirming approval processes:	Jo Floyd

Information Category	Detailed Information
Name of Governance Lead confirming approval by specialty and care group management meetings:	Paul Evangelista
Links to key external standards:	CQC Outcome Framework NICE Clinical Guideline – Dementia (CG 97) NICC Quality Standard – Dementia (QS1) NICE Pathway – Dementia Mental Capacity Act Mental Health Act The Care Act
Related Documents:	RCHT Mental Capacity Act Policy RCHT Adult Discharge and Transfer Policy NICE Clinical Guideline - Delirium (CG 103) RCHT Guideline for Dementia Care RCHT Enhanced Care Policy RCHT Carers Policy PAINAD Chart (CHA 3106) Clinically Related Challenging Behaviour Care Plan (CHA 2913) Dementia / Mild Cognitive Impairment Care Plan (CHA 3009) Best interest decision record form (CHA 2912) 'When Will I Go Home' (RCHT1006) Information for Carer leaflet (RCHT 1235) Carer's Passport
Training Need Identified?	Yes
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
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This document is only valid on the day of printing

Controlled Document

Dementia Care Policy

V3.0

August 2019

Table of Contents

1. Introduction

1.1. Dementia and the challenges of mild cognitive impairment will impact on the vast majority of our services directly and/or indirectly. Nationally, close to 850 000 people live with a dementia and this is set to double over the next 30 years. It is the most feared disease for over 55 year olds. The prevalence of the disease is anticipated to increase as the demographic changes across our society witnesses a significant growth in the older age population. It is estimated that 25 per cent of hospital beds alone and 75% of care home residents are currently occupied by people with dementia.

1.2. This policy exists to translate National strategy and guidelines into pragmatic means to support staff and to benefit the population with living with dementia and mild cognitive impairment that use our hospitals' services today and into the future.

1.3. The current National strategy for dementia care is set out in the 2015 document: Prime Minister's Challenge on Dementia 2020. This sets out a programme of work to transform the care, support and research into dementia care by 2020. Additionally, the Five Year Forward View highlights the importance of dementia care. With ambitions to tackle unwarranted variation in meeting the triple aims of better outcomes, better experience and better use of resources.

1.4. This National document and many others contain National Dementia Declarations for England, these are rights are enshrined in the Equality Act, mental capacity legislation, health and care legislation and international human rights law. Updated in 2017, they are the ever present voice of people living with dementia and their carers:

- **Independence/Interdependence/Dependence**
  We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.
- **Community/Isolation**
  We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.
- **Carers**
  We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.
- **Care**
  We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.
- **Research**
  We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.

1.5. By 2020 the Prime Minister's Challenge on Dementia wishes to see all hospitals meeting agreed criteria to becoming a dementia friendly health and care setting.

1.6. The National Dementia Action Alliance Dementia Friendly Hospital Charter was refreshed in 2018 to include a volunteering element. The Trust has used this framework in the past to shape its annual improvement plan. The areas the charter focus' on are:

- Staffing
- Partnership
- Assessments
- Care
- Environment
- Governance and
- Volunteering

1.7. In June 2018 The National Institute for Health and Care Excellence (NICE) updated their guidelines on 'Dementia: assessment, management and support for peoples living with dementia and their carers' (NICE Guideline 97)

1.8. NICE Guideline 97 identifies several risk to individuals living with dementia during hospital admission:

1.8.1. Increased risk of delirium in people living with dementia who are admitted to hospital. See the NICE and Trust guideline on delirium for interventions to prevent and treat delirium.

1.8.2. Additional harms they may face in hospital, are:

- disorientation
- a longer length of stay
- increased mortality
- increased morbidity on discharge
- delirium
- The effects of being in an impersonal or institutional environment.

1.8.3. When thinking about admission to hospital for a person living with dementia, take into account:

- any advance care and support plans
- The value of keeping them in a familiar environment.

1.9. In addition, NICE Guideline 97 sets out a range of recommendations pertinent to the acute hospital environment. These are reflected in the practice standards below.

1.10. The National Institute for Health and Care Excellence (NICE) set Quality Standards for Dementia Care. Quality, Standard 1 (QS1). These have had minor update to reflect the latest NICE Guideline (97).

1.11. Locally the Trust is contracted to continue to meet the Commissioning for Quality and Innovation (CQUIN) for dementia set in 2012/13. The goal of the Dementia CQUIN was to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions and to prompt appropriate referral and follow up after they leave hospital.

1.12. With so many documents included in the dementia care agenda, this policy sets the pragmatic path through them all. The ten 'statement' of quality that is set for health and care providers to achieve QS1) is how this policy's practice

standards are framed. Pertinent elements of other documents are introduced when necessary to deliver the overarching aim for the Trust – to be a brilliant place for the care of people living with dementia, their carers and families when they need it.

1.13. This version supersedes any previous versions of this document.

1.14. Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can't rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team rch-tr.infogov@nhs.net

2. Purpose of this Policy

2.1. The overarching aim of this policy is to deliver the best possible care to people living with dementia, their carers and families when they need it.

2.2. Its purpose is to ensure the Trust meets its strategic commitments to the National dementia care agenda.

2.3. In addition, this policy will guide staff to the highest best practice clinical care and treatment standards across all of its services.

3. Scope

This policy applies to all Trust staff who are directly or indirectly involved in the care of people with dementia or mild cognitive impairment, their carers and families.

4. Definitions / Glossary

4.1. **Dementia:** The term 'dementia' is used to describe the progressive loss of cognitive function that occurs when the brain is affected by specific diseases and conditions. These include Alzheimer's disease, vascular dementia, dementia with Lewy bodies and sometimes as a result of multiple strokes.

4.2. **Mild cognitive impairment (MCI):** is a relatively recent term, used to describe people who have some problems with their memory but do not actually have dementia. It is a descriptive term rather than a specific medical condition or disease. It describes memory loss apparent to the individual, and those around them.

(Definitions taken from Alzheimer's Society On-line Fact Sheet 400 and 470 respectively)

4.3. In the context of this policy 'Dementia' from now on will include MCI, unless separation is warranted.

5. Ownership and Responsibilities

5.1. The Chief Executive Officer and wider Trust Board

The Chief Executive Officer and wider Trust Board have key roles and responsibilities to ensure the Trust meets requirements set out by statutory and regulatory authorities (for example: the NHS England/NHS Improvement, Commissioners and the Care Quality Commission). These responsibilities are delegated to an Executive Lead with supportive structure to ensure and assure standards and expectations are met. These are described below.

5.2. Role of the Executive Lead

The Chief Nurse is the nominated Executive Lead and will be responsible for ensuring structures and processes are in place to assure delivery of the dementia care agenda. The Executive Lead will report to Trust Board on progress as required.

5.3. Clinical Lead for Dementia Care

Reporting to the Executive Lead and responsible for the leadership and deliver of the national dementia care agenda within the Trust. The Clinical Lead will network local with statutory and voluntary partners and with regional and national colleagues to maximise the opportunities for delivering the best possible care to those with dementia, their carers and their families in the hospital. They will chair the RCHT Dementia Care Action Group

5.4. Dementia and Delirium Improvement Practitioner

This post holder is based within the Corporate Nursing, Midwifery and AHP Team. Reporting to the Lead Nurse / Practitioner for Clinical Safety and Quality Improvement, they will provide the practical support to the Clinical Lead for Dementia Care to lead the development and day-to-day delivery of the Trust's dementia and delirium improvement work in line with the reported improvement plan. They will work alongside multidisciplinary teams to support them with expert dementia and delirium care to reduce harm and improve experience. Additionally they will contribute to strategic planning and ensure collaborative working in conjunction with key partners,
Monitor dementia and delirium data (i.e. Incidents) and support reporting of dementia and delirium performance data from Ward to Board.

5.5. Role of the RCHT Dementia Care Action Group and its Members

5.5.1. The Action Group is responsible for delivering the corporate and clinical requirements linked to the National dementia care agenda, including quality standards for dementia care. The Action Group will develop and lead the implementation a local improvement plan, which is updated and monitored quarterly, is key assurance measure of progressive quality improvements for this patient group. In addition the Action Group will oversee a set of mandatory and quality metrics to evaluate performance and identify areas for further action.

The Action Group reports quarterly to the RCHT Trust's Quality Assurance Committee. The Action Group will produce an Annual Report.

5.5.2. The Action Group is made up of three distinct participative groups: subject specialist, Care Group representatives and importantly service users, carers and representatives of people with dementia.

- **Subject specialist:** bring expertise of the subject from clinical, managerial volunteering, and commissioning perspectives
- **Care Group representative:** are fundamental to ensure work flows from the action group to clinical teams and that a feedback mechanism is established back to the action group
- **Service users, carers and representatives of people with dementia:** bring reality and challenge to the action group, supported by the Alzheimer's Society.

5.6. Role of the RCHT Quality Assurance Committee

The RCHT Quality Assurance Committee will hold to account the work and actions of the RCHT Dementia Care Action Group. It will receive and scrutinise progress in delivering the local improvement plan and Annual Report on behalf of the Trust Board.

5.7. Role of the RCHT Forget-Me-Not Champions (FMN Champions)

5.7.1. FMN Champions are volunteer staff members from across all the Trust's wards and department who have a passion for dementia care and a commitment to promote and share knowledge and best practice standards.

5.7.2. A RCHT FMN Champion Networks exists to enable clinical champions in each clinical area to champion excellence in dementia care at a local clinical team level and to develop and implement practice changes with the aim to improve the care of people with dementia, their carers and families.

5.7.3. FMN Champions are empowered to deliver the ambition of the organisation to provide excellent care for such people across its whole service. Their role responsibilities are set out in Appendix 3; this role has Trust Board endorsement.

5.8. Role of Care Group Triumvirates

Care Group Triumvirates (Clinical Directors, General Managers and Heads of Nursing/Midwifery/AHPs) are responsible for ensuring their Care Group representative and local network of FMN Champions are pulling together to achieve and maintain high standards of care. Effective communication and dissemination of information to all clinical teams must be assured.

5.9. Role of Ward and Department Leaders (and other and Line-Managers)

Line-managers are responsible for identifying and supporting their local FMN Champions in effecting change and to ensure effective communication channels exist to the Care Group representative, encouraging dissemination of information and actions across the wider health and care team.

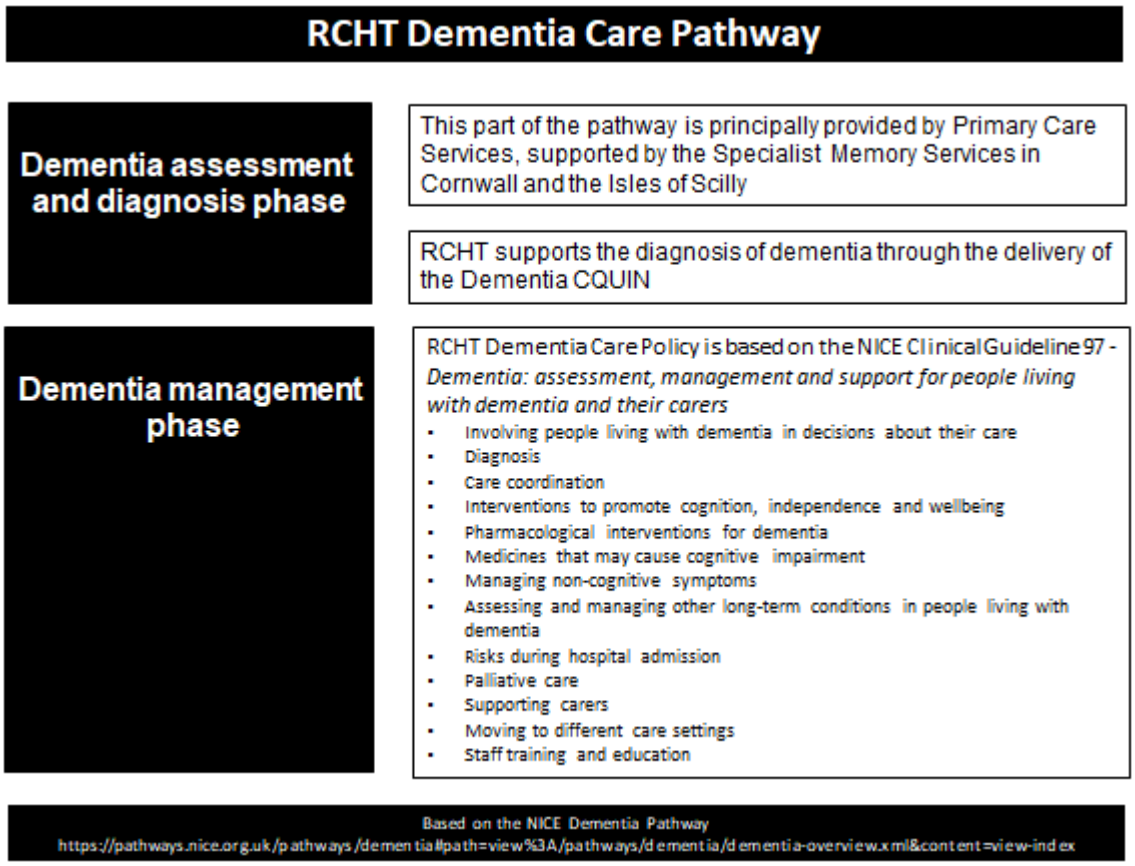
5.10. Role of Individual Staff

All staff members are responsible to ensure they comply with Trust policy regarding the care of people with dementia (including MCI *(see Definitions)*). They must meet requirements set out regarding learning and development for their level of involvement with people with dementia and should ensure they know who their local FMN Champion or Care Group representative is, to enable communication and sharing of information.

6. Standards and Practice

6.1. RCHT Dementia Pathway

6.1.1. The RCHT Dementia Care Pathway (see illustration below) is based on the NICE Dementia Pathway.



6.1.2. Local dementia care standards and practice are drawn from the complex range of strategies, directives and guidance set out in the introduction. For simplicity the latest NICE Clinical Guideline 97 - *Dementia: assessment, management and support for people living with dementia and their carers,* is used here to set these out. The Clinical Guideline is made up of thirteen recommendations. These are:

- Involving people living with dementia in decisions about their care
- Diagnosis
- Care coordination
- Interventions to promote cognition, independence and wellbeing
- Pharmacological interventions for dementia
- Medicines that may cause cognitive impairment

- Managing non-cognitive symptoms
- Assessing and managing other long-term conditions in people living with dementia
- Risks during hospital admission
- Palliative care
- Supporting carers
- Moving to different care settings
- Staff training and education

Each recommendation is detailed below, giving local context for delivery of the recommendation.

6.2. Involving people living with dementia in decisions about their care

This recommendation covers the importance of involving people in the care and treatment decision; providing information and Advance Care Planning.

6.2.1. Staff should encourage and enable people living with dementia to give their own views and opinions about their needs and their care.

6.2.2. In RCHT we promote the use of "This is me" document to support better information sharing and communication between the person living with dementia, their carers, care home and hospital staff. The standard for practice is that all people with frailty or cognitive impairment should have a "This is me" completed and visibly available at their bedside to support personalised care.

6.2.3. A growing range of leaflets are being made available to support bespoke information for people living with dementia and their carers. These include:

- Information of dementia and delirium in hospital
- Eating and drinking in the later stages of dementia
- Information on medicines used for delirium in hospital
- Carers information leaflet

6.2.4. The NICE recommendation covers details required at the time of diagnosis. If patients living with a diagnosis of dementia and their carers require information of these specifics, they should be signposted back to community supporting services via their GP-practice based Dementia Care Practitioner.

6.2.5. Advance Care Planning should be considered at each contact with hospital services. We have a duty to start conversations about planning ahead and signposting patients living with dementia back to their GP for more detailed discussion on making advance statements about their wishes and preference regarding future care. GP's should be informed that conversations have started in hospital where appropriate.

6.3. Diagnosis

6.3.1. In Cornwall land the Isles of Scilly dementia diagnosis is a GP-led activity, supported by specialist memory services.

6.3.2. RCHT has a commissioned role to support the identification of potential patients living with dementia. The 2012/13 Dementia CQUIN was introduced to support this.

6.3.3. The dementia CQUIN algorithm is embedded within the Maxims electronic system and requires within 72 hour of acute admission a screening for dementia and delirium to be carried out. The system uses the Confusion Assessment Method (CAM score) and the Abbreviated Mental Test Score (AMT score) results entered in to the dementia module within Maxims to generate a bespoke patient alert (if appropriate) in to the patients electronic discharge summary letter to their GP.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215049/dh_133859.pdf

6.3.4. It is important that any person with suspected dementia be fully assessed (history and collateral history, physical examination, appropriate blood tests, urine tests and brain imaging to rule out reversible causes, characterise the dementia and cognitive testing captured). Findings should be reported to GPs in the patents' discharge summaries.

6.4. Care coordination

6.4.1. The NICE recommended that each person with dementia should have a single named health or social care professional responsible for co-ordinating their care. This single point of contact in Cornwall and the Isles of Scilly is usually the GP practice Dementia Care Practitioner. These practitioners are often useful point of contact for transferring information into and out of our hospital services.

6.4.2. The Trust has a duty to provide services that are accessible to people with cognitive impairment. Staff plays an important advocacy role in ensuring the Trust delivers this duty. Consideration for those without carers or with caring responsibilities themselves; and of other disabilities or impairments they may have, should be considered and provided for where appropriate.

6.5. Interventions to promote cognition, independence and wellbeing

6.5.1. The Trust must provide a range of activities to promote well-being that is tailored to the person's preferences. The use of this is Me supports the delivery of this recommendation.

6.5.2. The Trust promotes *24 Hours of Rehabilitation*, to prevent deconditioning and maintain activity and independence.

6.6. Pharmacological interventions for dementia

6.6.1. For hospitalised patients with dementia or MCI, a detailed medication history is needed and review required. Please refer to the Cornwall Formulary and the NICE Technology appraisal guidance for use and changes to any acetylcholinesterase (AChE) inhibitors.

6.6.2. For covert medicine administration considerations please refer to guidance in the Trust's Medicine Policy.

6.7. Medicines that may cause cognitive impairment

Be aware of medicines that are associated with increased sedation, psychoactive side effects and anticholinergic burden and their effect on cognitive impairment.

6.8. Managing non-cognitive symptoms

6.8.1. For any **agitation, aggression, distress or psychosis** a structured assessment should be conducted before starting non-pharmacological or pharmacological treatment. Antipsychotics should only be used for people living with dementia who are either: at risk of harming themselves or others or who is experiencing agitation, hallucinations or delusions that are causing them severe distress. Remember to use the lowest effective dose and use them for the shortest possible time. Stop treatment with antipsychotics if the person is not getting a clear ongoing benefit from taking them. Be aware that for people with dementia with Lewy bodies or Parkinson's disease dementia, antipsychotics can worsen the motor features of the condition, and in some cases cause severe antipsychotic sensitivity reactions.

6.8.2. For **depression and anxiety** consider psychological treatments. Do not routinely offer antidepressants to manage mild to moderate depression in people living with mild to moderate dementia, unless they are indicated for a pre-existing severe mental health problem.

6.8.3. For **sleep problems** consider a personalised multicomponent sleep management approach that includes sleep hygiene education, exposure to daylight, exercise and personalised activities.

6.8.4. For guidance on managing **Parkinson's disease symptoms** in people with Parkinson's disease dementia or dementia with Lewy bodies, see the NICE guideline on Parkinson's disease.

6.9. Assessing and managing other long-term conditions in people living with dementia

Four recommendations are set out for this section. Importantly all co-morbidities along with dementia must be appropriately managed.

6.9.1. **Pain** must be assessed using the PAINAD Chart (CHA 3106), especially as verbal communication becomes unreliable (temporary or permanently).

6.9.2. **Falls risk** in people with dementia is often higher than in people without. Use of the multifactorial falls risk assessment tool is essential to personalising a falls prevention programme for the patient whilst in hospital.

6.9.3. Diabetes, NICE recommend relaxing the target HbA1c on a case-by-case basis for adults with type 2 diabetes where cognitive impairment may affect awareness of hypoglycaemia.

6.9.4. Urinary and Faecal Incontinence must to appropriately assessed and treated.

6.9.5. Sensory impairment, appropriate prescriptions and correctly fitting glasses and hearing aids should be used to maximise communication opportunities for people living with dementia.

6.10. Risks during hospital admission

6.10.1. People living with dementia or MCI are at increased risk of delirium when admitted to hospital. Please refer to the Trust guideline in delirium assessment and management.

6.10.2. Additional risk due to hospitalisation include:

- Longer length of stay
- Increased morbidity and mortality
- Impersonal care

To overcome these comprehensive assessment of needs are required for all patients living with dementia. The Dementia / MCI Care Plan (CHA 3009) prompts personalised care, the prevention of deconditioning, and the involvement of the person and carers in discharge planning. The encouragement of carers, family and friends are important. The Carers Passport should be made available.

6.10.3. Please refer to the RCHT Adult Discharge and Transfer Policy to support best practice when discharge planning. Consider:

- 'When Will I Go Home' (RCHT1006) can support discharge planning whilst in hospital.
- Best interest decision should be documented on the record form (available on the Trust's forms to print webpage CHA 2912) and used in conjunction with the Trust's Mental Capacity Act Policy

6.11. Palliative care

6.11.1. Dementia unpredictable progression, therefore consideration of palliative care needs can occur at any time. Please refer to the Trust's End of Life Care Policy. Assessment and considerations to physical and mental health needs, including emotional and spiritual wellbeing are required.

6.11.2. Specific consideration should be given to eating and drinking safety. Speech and Language Therapist involvement is essential.

6.11.3. When mental capacity for decision making is not present, the Trust's Mental Capacity Act Policy and best interest decision paperwork should be used (CHA 2912).

6.12. Supporting carers

6.12.1. The Trust provides a range of support services for carers. Please refer to the Trust's Carers Policy for more details.

6.13. Moving to different care settings

6.13.1. Please refer to the RCHT Adult Discharge and Transfer Policy to support best practice when discharge planning

6.13.2. Restrictions to the out-of-hours transfers in hospital and from hospital of people living with dementia - restricted between 8pm and 8am.

6.13.3. Reassessment of the person's needs and wishes is essential after every transition.

6.14. Staff training and education

6.14.1. The Trust is committed to the using the Dementia Training Standards Framework from Skills for Health. The Trust uses the National three tier framework (Tier's 1, 2 and 3).

6.14.2. Tier 1 - dementia awareness training for all staff exists in staff induction and annual mandatory training programmes. These support all staff in the recognition of dementia (and delirium) and the promotion of good early engagement and communication with the person, their carers and families.

6.14.3. Tier 2 - knowledge, skills and attitudes for roles that have regular contact with people living with dementia. Training comprises of a programme what included a series of e-learning modules concluded with a face-to-face session (see Appendix 4). For more detail contact the Learning and Development Department.

6.14.4. Tier 3 - enhancing the knowledge, skills and attitudes for experts working with people living with dementia is a more bespoke education programme where specialist modules and training exists. Please contact the Learning and Development Department for more information.

6.14.5. Training in the Mental Capacity Act and the Mental Health Act (including Safeguarding) are available at various levels. For more detail contact the Adult Safeguarding Team.

7. Dissemination and Implementation

7.1. This policy will be cascaded by the RCHT Dementia Care Action Group to Care Group representatives and to the RCHT Forget-me-not Champions Network for communicating and sharing at a local clinical level, making all resources available to all relevant staff.

7.2. This policy's implementation will be through the delivery of the improvement plan for dementia care, championed by the Action Group. This promotes training and educational opportunities and makes sure local recourses are available via the dementia link worker network

8. Monitoring compliance and effectiveness

Element to be monitored	National benchmarking through National Audit participation Local self-assessment against the National Dementia Action Alliance Dementia Friendly Hospital Charter
Lead(s)	The Trust's Clinical Lead for Dementia Care takes responsibility for monitoring the Trust's clinical performance in meeting the Nationally set standards of care and service delivery for dementia care and the operational and strategic performance against nationally set standards.
Tool	The Trust is committed to participating in the National Dementia Care Audit, conducted by the Department of Health and facilitated by the Royal College of Psychiatry. This template is Nationally negotiated and published. In addition, The Trust undertakes an annual self-assessment based on the National Dementia Action Alliance Dementia Friendly Hospital Charter
Frequency	The Trust's clinical care performance is benchmarked with National results (often annually, but not always) Annually the Trust undertakes an annual assessment against the National Dementia Action Alliance Dementia Friendly Hospital Charter.
Reporting arrangements	The Trust's performance report, local response and improvement plan are presented through the RCHT Dementia Care Action Group to the RCHT Clinical Effectiveness Committee.
Acting on recommendations and Lead(s)	The RCHT Dementia Care Action Group leads on service improvement for dementia care in the organization.
Change in practice and lessons to be shared	Improvement and change in service delivery is documented in the notes and minutes of the Dementia Care Action group.

9. Updating and Review

The policy will be kept under review by the authors and RCHT Dementia Care Action Group in line with Trust strategic and operational developments and clinical practice changes. The minimum review period will be in three years' time in line with Trust policy. Revision activity is recorded in the version control table at the beginning of this document.

10. Equality and Diversity

10.1.This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Dementia Care Policy V3.0			
Date Issued/Approved:	1st August 2019			
Date Valid From:	August 2019			
Date Valid To:	August 2022			
Directorate / Department responsible (author/owner):	Frazer Underwood Consultant Nurse / Associate Nurse Director and Clinical Lead for Dementia Care			
Contact details:	01872 255043			
Brief summary of contents	This policy exists to translate national strategy into local policy to benefit the population with living with dementia and mild cognitive impairment, their carers and families, that use our services today and into the future.			
Suggested Keywords:	Dementia, Dementia Care, Mild Cognitive Impairment, Carers, Mental Capacity,			
Target Audience	RCHT	CFT	KCCG	
	✓			
Executive Director responsible for Policy:	Director of Nursing, Midwifery and Allied Health Professionals			
Date revised:	April 2019			
This document replaces (exact title of previous version):	RCHT Dementia Care Policy V2.0			
Approval route (names of committees)/consultation:	RCHT Dementia Action Group			
Care Group Manager confirming approval processes	Frazer Underwood Consultant Nurse / Associate Nurse Director and Clinical Lead for Dementia Care			
Name and Post Title of additional signatories	None			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Clinical / Integrated Services for Older Peoples / Dementia			

Links to key external standards	CQC Outcome Framework NICE Clinical Guideline – Dementia (CG 97) NICC Quality Standard – Dementia (QS1) NICE Pathway – Dementia Mental Capacity Act Mental Health Act The Care Act
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Training Need Identified?	Yes

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
21/06/2011	v1.0	New document incorporating Trust strategy document and commitment to deliver Southwest Hospital Standards for Dementia Care	Frazer Underwood Consultant Nurse /Associate Director of Nursing
29/12/2014	v2.0	Complete update of the policy	Frazer Underwood Consultant Nurse /Associate Director of Nursing
01-05-2019	v3.0	Complete update of the policy in light of new national policies and guidelines	Frazer Underwood Consultant Nurse / Associate Nurse Director and Clinical Lead for Dementia Care

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Appendix 2. Initial Equality Impact Assessment Form

<table>
<tr><td colspan="3">Name of the strategy / policy /proposal / service function to be assessed

Dementia Care Policy V3.0</td></tr>
<tr><td colspan="2">Directorate and service area:
Corporate Clinical</td><td>New or existing document:
Existing</td></tr>
<tr><td colspan="2">Name of individual completing assessment:
Frazer Underwood</td><td>Telephone:
01872 255043</td></tr>
<tr><td>1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="2">This policy exists to translate national and local strategy into practical means to benefit the population with living with dementia and mild cognitive impairment that use our services today and into the future.</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="2">To translate the multiple dementia relevant strategies, policies and guidance into a meaningful framework to support practice.</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="2">Delivery of NICE Quality Standard and Clinical Guidance</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="2">Self-assessment and
Peer-review (National Audit Programme)</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="2">Patient and Carers</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td colspan="2"><table><tr><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr><tr><td></td><td></td><td></td><td>X</td><td></td></tr></table></td></tr>
<tr><td colspan="2">Please record specific names of groups

Alzheimer’s Society has representation / membership to the RCHT Dementia Action Group (policy approving group), often supporting peoples living with dementia and their carers with participation themselves.

Yes, the Alzheimer’s Society has been consulted with.</td></tr>
<tr><td>What was the outcome of the consultation?</td><td colspan="2">Agreed</td></tr>
</table>

7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		✓		
Sex (male, female, trans-gender / gender reassignment)		✓		
Race / Ethnic communities /groups		✓		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		✓		A positive impact is expected for those with memory and cognitive impairment receiving care in our services e.g. with those living with dementia
Religion / other beliefs		✓		
Marriage and Civil partnership		✓		
Pregnancy and maternity		✓		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		✓		

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	✓

9. If you are **not** recommending a Full Impact assessment please explain why.

Positive consequences are to be realised from adoption of this policy. No negative effects of implementing this policy have been identified.

Date of completion and submission	01-05-2019	Members approving screening assessment	Policy Review Group (PRG) **APPROVED**

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust's web site.

Appendix 3 Forget-Me-Not Champion role description

Forget-Me-Not Champion v3.1

All wards and departments where staff work with patients who have a dementia and staff who work with relatives and carers whose relative has a dementia will identify and support a Forget-Me-Not Champion.

All staff that care for patients with a dementia or mild cognitive impairment should be appropriately trained and therefore it is essential that protected time is given to maintain a knowledge base and to fulfil the duties of this role; this should be negotiated with individual line managers as each area will require different demands on their time.

It is essential that Forget-Me-Not Champions are fully supported and empowered by line managers to carry out these responsibilities.

Role Description

The Forget-Me-Not Champion provides support within the organisation by:

- Being a single point of contact for the ward team caring for patients with a dementia, to cascade information from the Trust's Dementia Care Action Group to their own clinical area;
- Providing an essential link between practice areas across the Trust;
- Supporting staff to ensure that patients with a dementia and those with mild cognitive impairment are the focus for consideration even when the primary intervention is with the carers;
- Being vital in supporting the Trust to execute its responsibilities to safeguard vulnerable patients with dementia or mild cognitive impairment;
- Being aware of the named and designated leads for dementia care in the Trust and their division and know how to access them;
- Alerting the Ward Sister / Charge Nurse to any serious or significant incident or concern relating to the welfare of a patient with dementia or mild cognitive impairment;
- Being proactive and informing the Ward Sister / Charge Nurse or Care Group Representative (or deputy) of any gaps identified within the services in their area of work relating to caring for patients with a dementia or mild cognitive impairment;
- Support the Trust's dementia care monitoring programme through audits and evaluations, and implementing actions from these findings;
- Being the local link for dementia volunteering in their area of work, liaising at least annually with the hospital's dementia volunteering co-ordinator and agreeing the levels of volunteering support the area requires.

Responsibilities

The Forget-Me-Not Champion will promote best practice in dementia care within their ward areas by:

- Acting as a resource for staff within their area on issues relating to dementia care and best practice, keeping staff on their ward/department up to date about current dementia issues;

- Supporting staff to deliver patient-centred dementia care;
- Signposting staff and carers to supporting services;
- Providing support and information to staff within their area to access appropriate advice and assistance;
- Seeking advice, support and supervision from their care group action group representative or Dementia Care Action Group itself, if needed;
- Ensuring systems and processes are in place on their wards to deliver the Trust's safeguarding and mental capacity policies;
- Liaising with the dementia volunteering co-ordinator regarding on-going support for their area of work;
- Ensuring processes are in place to share information and findings with the Ward Sister / Charge Nurse and ward staff information from 'Forget-Me-Not Champion Development Sessions';
- Carryout quarterly Key Performance Indicator (KPI) audits in their local area if appropriate;
- If nominated by the Care Group Representative to attend any group, ensure that they do so and actively participate in the event and give timely feedback and advice.

Learning and Development

Forget-Me-Not Champion will be supported and developed to fulfil their role expectations. This includes induction for new link workers, provision of support materials to promote excellence in care and a time commitment to attend local dementia multi-agency training to maintain knowledge and skills.

The Forget-Me-Not Champion will be expected to attend regular Forget-Me-Not Champion Development sessions. These meetings will provide an opportunity to share new developments in dementia care, ensure systems are in place to enable safe and skilled practice, and to disseminate lessons learned from case reviews. The meetings will provide a forum to discuss best practice and share experiences relating to dementia care.

The Forget-Me-Not Champion will responsible for ensuring all new staff within their area of responsibility has dementia care included in their work place induction; Assist with the delivery of on-going training within their area; Act as a resource for staff requiring further training or who have a particular interest in dementia care or mild cognitive impairment; and Identify any additional training needs within their area of responsibility or for individual staff members.

Appendix 4 Tier 2 Dementia care training programme v2

The following modules, available through the electronic staff record (ESR) (updated 30th April 2019), make up the Trust's agreed tire 2 dementia training programme. http://intra.cornwall.nhs.uk/Intranet/AZServices/E/ElectronicStaffRecord/ESR.aspx

The programme is blended; a mix of on-line (HEE e-Learning for Healthcare) and face to face training (RCHT Learning and Development Department).

Tier 2 training is targeted at staff whose roles bring them into regular contact with people living with dementia. The programme is therfore targeted primarily at older peoples ward areas and departments within the Trust and to all Forget-Me-Not Champions.

Requirements

Completing all thirteen on-line modules:

000 Dementia: Dementia Awareness *(as this is referenced in other modules)*
000 Dementia: Communication, interaction and behaviour in dementia care
000 Dementia: Dementia identification, assessment and diagnosis
000 Dementia: Dementia risk, reduction and prevention
000 Dementia: End of life dementia care
000 Dementia: Equality, diversity and and inclusion in dementia care
000 Dementia: Families and carers as partners in dementia care
000 Dementia: Health and well-being in dementia care
000 Dementia: Law, ethics and safeguarding in dementia care
000 Dementia: Leadership in transforming dementia care
000 Dementia: Living well with dementia and promoting independence
000 Dementia: Person-centred dementia care
000 Dementia: Pharmacological interventions in dementia care
000 Dementia: Research and evidence-based practice in dementia

And one face-to-face session

156 Dementia: Communication
156 Dementia: Nutrition and hydration
156 Dementia: Pain and behaviour