Working in Partnership with Patients and Families on a Dementia Assessment Unit to Improve Care

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Summary of project
The relocation of the dementia unit and the merging of two wards from two separate hospitals provided an opportunity for the project team to review the service they provide when caring for a patient with dementia and their family.

Feedback from relatives and carers previously received had identified that care given was not always person centred, information was not always readily available and communication with staff could be improved. A workshop was held with staff which identified a common vision for care provision. Core aspects are having knowledge and understanding of the patient as a person who has a history, life experiences and a family, working in partnership with the patient and their family/carers. The workshop led to the formation of an action plan and the creation of interest groups that focused on specific areas that had been identified as important in the provision of person centred care. Work carried out within those groups sought to improve the mealtime experience for patients; contributed to the development of an information leaflet about the service on the unit and enhanced staffs’ knowledge of life story work. Work is ongoing to improve the physical environment of the unit. Through this work the team believe they can better identify, understand and work towards the provision of care that responds to relatives’ concerns and acknowledges patients as individuals with unique lifestyle needs.
Background
Following a review of public administration (RPA), eighteen Health and Social Care Trusts in Northern Ireland reduced to five. On the 1st April 2007 Down Lisburn Trust and the Ulster Community and Hospital Trust amalgamated to form the South Eastern Health and Social Care Trust (SET). At this time dementia assessment and treatment was provided in Ward 11 at Lagan Valley Hospital and Wards 32 (male) and 34 (female) at Downshire Psychiatric Hospital. The latter also provided long stay beds. The Bamford Review (DHSSPSNI, 2006) recommended people with dementia should be cared for, where possible, in the community and assessment units should be sited within general hospitals to facilitate accessibility to diagnostic investigations and treatment. This strategic vision was integrated into the SET corporate plan culminating in the phased closure of Wards 32 and 34. Initially Ward 34 closed with Ward 32 incorporating some of these patients but most moved, along with the staff to a purpose built unit in the newly built Downe Hospital which opened in June 2009. There then followed a relocation project to ensure the long stay patients were placed in the community in a purpose built facility. Some nine months after the new unit opened Ward 32 closed and the remaining staff joined their colleagues in the Downe Dementia Assessment and Treatment Unit.

Experience and challenges with the opening of the new Dementia Unit
The old culture of dementia care (Kitwood, 1995) was concerned primarily with providing a safe environment and meeting a person’s physical needs. There was little consideration given to a person’s psychological or emotional needs because the subjective experience of dementia was ignored (Cheston and Bender, 2000). The focus was predominantly on the medical model (Stokes, 2000) which Kitwood (1997) described as the ‘standard paradigm’. Here the emphasis centred on pathology and signs and symptoms and embraced the reductionist principle that the symptoms of disease can be fully accounted for by deviations from the norm of measurable, biological variables (Bond, 1992). Within this paradigm care was chiefly task orientated, paternalistic and risk averse. Some of these aspects characterised the two old wards and transferred to the new unit. This was apparent in the way patients had set bath days and were changed into night attire to accommodate staffing needs.

The concept of the new culture of care (Kitwood, 1995) acknowledges the person with dementia as an active agent and seeks to see the person first and the condition second. Kitwood (1993) argued that the clinical presentation of dementia was not simply a manifestation of the neuropathological impairment or a damaged brain. Rather he suggested the impact of the social environment surrounding the person often constituted a ‘malignant social psychology’ which was detrimental to the well being of the person. This was foreign to many of the staff who had not worked anywhere else since qualifying. It was therefore important that they understood that contrary to the belief that
dementia is ‘...a death that leaves the body behind’ (Kitwood, 1997; p.69) it is viewed nowadays as an intellectual disability. As with any disability an enabling environment is essential to promote independence, maintain existing skills and prevent de-skilling through the creation of excess disability (Brody et al., 1971). This is crucial in any care setting but is particularly important in an assessment unit as patients may return to their own home and skills can be lost very quickly if staff ‘take over’ or outpace the person (Loughlin et al., 2002).

In keeping with best practice in relation to environmental design for patients with dementia (Marshall, 2001) the new unit provided single en suite bedrooms and small sitting rooms. This change from the Florence Nightingale dormitory style presented both opportunities and challenges. Being unable to observe patients was a source of anxiety for staff. Their solution to this problem was to lock the bedroom doors in the morning once the patients were up and dressed which is a throwback to the old culture where control and containment dominated and patients were ‘warehoused’ (Cheston and Bender, 2000). There was a lack of understanding by some staff that this contravened the human rights of patients (Department of Health, 1998) and challenging this was met with resistance by some staff. If relatives expressed concern that belongings had gone astray because other patients were at liberty to enter their loved one’s bedroom, rather than explain why bedrooms couldn’t be locked some encouraged relatives to complain. Overall the unit appeared clinical and staff felt it lacked a homely atmosphere.

During the phased closure of the two olds wards some patients from Ward 34 along with the staff moved into the new unit in the Downe Hospital. The modernisation and reform agenda within the strategic direction of the Bamford Review (DHSSPSNI, 2006) meant long stay patients were to be relocated into community placements. This change of profile for the service with an emphasis on assessment and treatment effectively increased the turnover of patients which contrasted greatly with what the staff had been used to. The skill mix of two registered nurses and three nursing auxiliaries however had remained unchanged and this presented additional pressures for the nurses who combined supervising the nursing auxiliaries’ work, attendance at the team assessment meetings, completion of admissions and discharges as well as the routine work of administering medications, liaising with doctors and other allied health professionals (AHP). However, there was optimism that once the second ward closed and the remaining staff transferred things would improve. Unfortunately, during this time the challenges of the current staffing levels and skill mix, staff sickness and the environmental design of the new unit reduced staff morale. Downsizing from the two old wards to the new unit meant there was only one ward manager post so the process of interviewing both highly competent individuals brought its own uncertainties. Staff loyalties were tested when the ward manager, who had overseen the opening of the new unit, and who had worked there for nine months was not appointed and suspicions grew that the ‘newcomers’,
including the ward manager was going to ‘take over’. The yearning for the day when the staff from both wards would all be together was marred by this which took many staff by surprise. However, it is not unusual for a group to go through a storming stage before they bond and begin to work effectively (Tuckman, 1965). It was against this backdrop that the project team sought to support the staff and navigate them through this change process to facilitate delivering the Trust’s core values of providing accessible, safe and effective high quality person-centred care in collaboration with relatives.

Regular staff meetings were introduced to listen to the issues of concern. One particular area that was singled out for attention was the interface between staff and relatives. Some of the problems encountered such as lost belongings and complaints about bedrooms being too accessible to other patients could be addressed by developing an information leaflet setting out the philosophy of the unit. There was consensus that this would help to explain the nature of the unit and to support and manage the expectations of all.

**Aim of the project**
The aim of the project was to work in partnership with patients, families and staff to enable the development of a person centred approach to care.

**Objectives of the project**
- develop a shared vision for working in partnership with patients and their relatives
- develop an information leaflet for relatives
- introduce principles of the ‘New Culture of Dementia Care’

**Methods and approaches**
A number of approaches were used to facilitate and evaluate the changes in practice.
- Culture workshops with all staff
- Creation of interest groups as a means to develop and improve care
- Observation of practice/environment

These approaches will be discussed in more detail below.

**Culture workshops with all staff**
Culture has been described as ‘the way things are done around here’ (Drenan, 1992) which may not necessarily reflect the corporate mission statement. According to Schein (2010), it is characterised by observed behaviour, espoused beliefs and values and basic underlying assumptions.
Most of the staff working in dementia care within the old psychiatric hospital had done so for many years and practice predominantly focused on completing tasks. The lack of investment in their professional development was evident in the care delivered which, while delivered in a caring manner lacked the implementation of innovative psycho-social interventions such as doll therapy (Moore, 2001; James et al., 2005). To bring about a change in current practice and thinking and move towards a transformational culture (Manley, 2004) the project team decided to facilitate a workshop that would enable the staff to explore both the concept of workplace culture and the context in which they provide dementia care as well as how this impacts on the delivery of person-centred philosophy.

To ensure that all staff had the opportunity to attend, two workshops were held. These took place away from the work environment which provided ‘protected time out’ for staff and enabled them to reflect on their espoused views of what good dementia care was and illuminate what was actually happening in practice. This consciousness raising (Habermas, 1972) is the first step in recognising that change is needed. As workplace culture is influenced by everyone in the workplace and is the first thing noticed by staff and visitors who come into contact with patients (Department of Health, 2008), it was important that everyone was included and that staff from both the Downe Hospital and the Lagan Valley Hospital had the chance to mix. This was vital as the project team sought to foster shared values and challenge any preconceived beliefs about the ‘difficulties’ each locality faced such as staffing levels and observational/environmental concerns.

The workshops were very well attended from a nursing, AHP and domestic support perspective. In total twenty (87%) nurses, sixteen (94%) nursing auxiliaries, two (100%) occupational therapists and five domestics attended. The medical staff were also invited but disappointingly although there are four consultant psychiatrists, two staff grade doctors and three senior house officers, only one consultant psychiatrist attended and he had to slip out from time to time to take phone calls. The clinical director was enthusiastic and supportive of what the project team were trying to achieve but vying with pressing workloads did impact on his ability to attend. The project team were fortunate that representatives of the pharmaceutical companies Easia and Napp kindly agreed to provide lunch and refreshments.

It was felt by the project team, that to be successful the workshop needed to be led by someone with expertise in practice development and facilitation. Although the background of one of the project team was in practice development, she was a newly appointed nurse consultant with managerial responsibility for the service, and therefore had concerns that staff would be uncomfortable with this and that it may inhibit them from engaging in honest dialogue. The RCN
were approached and asked if they would facilitate the workshop as this would provide the neutrality the project team were striving to achieve. Having secured their agreement a programme (Appendix, 1) was developed which was designed to:

- To explore staffs’ roles and responsibilities in relation to improving care for older people
- To identify the values staff hold about caring for older people
- To create a vision for how staff work in partnership with our patients in the future
- To identify how close staff are to reaching our vision
- To explore staffs’ perceptions of ageing and how it influences the care we deliver to our patients
- To agree a set of actions that will help staff to live out our values in practice
- To identify what success will look like for the patient and staff

For the majority of staff this was the first time they had been exposed to practice development methods. The tools they were introduced to included a Value Clarification Exercise (Warfield and Manley, 1990) and Claims, Concerns and Issues (Guba and Lincoln, 1989). The former was chosen to enable staff to make explicit the values and beliefs they held about what good dementia care would look and feel like. From this exercise each group developed similar vision statements. These were amalgamated to produce a vision statement that everyone was able to take ownership of:

*We believe that patients in our ward/unit should receive a high standard of evidence based, safe and effective individualised care which is dignified and respectful and is delivered with kindness and compassion. It should be delivered within a culture that promotes positive risk management and in partnership with the patient and their family*.

Staff believed they could achieve this by:

*Working together as a team with a shared vision, communicating effectively and treating each other with dignity and respect and addressing any issues in a constructive and supportive way. Through the creation of a culture which supports evidence-based practice, challenges poor practice, maintains a high level of knowledge and skill and always puts the needs of the patient first.*

The Claims, Concerns and Issues tool was developed to enable stakeholders to express their experiences, circumstances and values relating to a particular issue (McCormack and Manley, 2004). This approach was used at the workshop to enable staff to articulate the things they were proud of and would like to develop further while at the same time identifying things that could be
done better or that were not done and should be. Furthermore, this tool helped them to explore what enablers and barriers existed. This helped them to tease out what needed to be addressed in order to achieve their vision and what questions they could ask or strategies they could implement that would enable them to do this. The enthusiasm with which they embraced these exercises and the action plans they developed demonstrated how enlightening and empowering staff found this way of working. Feedback from the Claims, Concern and Issues was analysed and themed and staff were able to articulate:

- The care they believed patients should receive
- How this could be achieved
- What their personal contribution to this could be
- What would help them achieve this
- What might stop them from achieving this

The workshops concluded with staff devising action plans to turn their ideas into a reality. These were subsequently refined at team meetings to reflect prioritisation of the most pressing concerns and are presented in Table 1 below.

Table 1. Action plans arising from staff workshops

<table>
<thead>
<tr>
<th>Issue</th>
<th>Improving communication and information sharing between the staff, patients and relatives</th>
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| Actions | 1. Make better use of clinical supervision sessions  
2. Investigate the use of ward meetings to communicate aspects of care that need to change/are changing  
3. Investigate the possibility of implementing the ‘Patient Status at a Glance’ ‘whiteboard to ensure all staff can access changes for patients  
4. Ask relatives to identify what information they would like to know when their relative is admitted to hospital and when they are being discharged  
5. Develop a Carers Support Group |
| By whom | Ward managers; MDT; staff; patients; relatives; |
| When? | By November 2010 |
| How will we | Staff feel better informed |

1 Releasing Time to Care: The Productive Ward NHS Institute for Innovation and Improvement (2011)
**Implementing the action plan**

Following the workshops a team meeting was held and consideration was given to how these initiatives should be prioritised and implemented. There was consensus that improving

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communication and sharing information was the most pressing concern so the ‘Patient Status at a Glance’ board was the first change to be introduced. The format of the board meant that relevant information was easily available to staff without compromising patient confidentiality as the board was located at the nurses’ station and could be closed over following the handover. We invested in signage as a means of providing information to patients and to orientate to surroundings including relevant areas such as bedrooms and communal rooms (Appendix 2). To further enhance orientation to individual bedrooms we purchased memory boxes. These wooden boxes have a Perspex front and are placed on the wall beside the bedroom door. Relatives are encouraged to bring in small items such as photos or ornaments which are placed behind the Perspex. This enables the person to ‘see’ what is in the box. The rationale is that as the contents belong to the person this acts as an aide memoir helping the person to recognise their own bedroom (Appendix 3). An activities board was purchased and strategically positioned so everyone could readily see it. We chose a board that had pictures of various activities around the edges which was eye catching and had the advantage of drawing attention to anyone passing by (Appendix 4). In addition this had the facility to write specific activities and the times available. To complement this two orientation boards (Appendix 5) were also acquired. As well as detailing the date, month, year and weather they also had a large face clock.

Challenges in moving the action plan forward
The project team quickly realised that they would have to implement the action plan within their existing time resources and that was extremely challenging. After a shaky start the project team re-grouped and considered how this could be achieved. While the volume and diversity of the work initially seemed daunting they found that developing interest groups was an effective means of managing this appropriately.

Interest groups and observations of practice
The four interest groups were:
1. Developing an information leaflet/Carer’s Support Group
2. Life story work training
3. Enhancing meal time experience ‘Come dine with me’
4. Making the environment more welcoming/person-centred

The activity undertaken by these groups will be outlined below.

Group 1: Developing an information leaflet/Carer’s Support Group
Admission to a Dementia Assessment and Treatment Unit can be a stressful event for all concerned. For the person with dementia, the environment and the people, both staff and other
patients are unfamiliar. The progressive deterioration in cognitive, affective and functional abilities that accompany the condition renders the person susceptible to a lowered stress threshold (Hall and Buckwalter, 1987). This may compromise their ability to receive, process and respond to environmental stimuli. Minor irritations may provoke catastrophic responses which are indications of the heightened levels of distress the person feels. The ability to draw on pre-morbid coping strategies to deal with adversities diminishes with the progression of the disease. With the inability to negotiate as they once did conflict may lead to verbal or physical aggression.

Relatives who were used to visiting their loved one in a care home facility where the ambience may have been more homely and relaxed found the unpredictable nature of the unit disturbing; particularly if this was their first experience of an admission to a Dementia Assessment Unit there was the added uncertainty of what the future holds. Concerns expressed ranged from apprehension if they observed an aggressive outburst, bedrooms being accessed by other patients and belongings that were missing were particular areas of contention. Staff do not wear name badges on their uniform, rather they have an identification card which is calibrated to allow access to the unit by means of swiping across a magnetic strip. This clips onto the pocket of the tunic which makes it impossible for anyone to read the name of the nurse. This was frustrating for relatives who were unsure of who they were speaking to. Furthermore, trying to absorb the volume of information in relation to investigations and various tests that were being carried out can be difficult at a time of heightened uncertainty. Consequently, the staff felt that the need to provide relatives with relevant, timely and practical information was essential. The most obvious solution to achieve this was to develop an information leaflet. It was anticipated that this would complement the verbal information given at the time of admission. It would explain the assessment process, describe the function of the unit and help with managing expectations. While professionals may have thoughts on what should be included it was important to ask relatives what they considered to be salient information.

Focus groups are a popular method of assessing health education messages and examining public understanding of illness and of health behaviours (Eldridge and Kitzinger, 1993). Participants are encouraged to talk to each other, asking questions, exchanging anecdotes and commenting on each other’s’ experiences and points of view (Kitzinger, 1994). This method is considered to be an effective means of bringing together a homogeneous group of people to gain an in-depth understanding of a common experience. As one of the project team had prior experience of facilitating a focus group (Scott et al., 2005) it was agreed that this format would be ideal to glean the information that was required to develop an information leaflet. However, a poster inviting relatives to participate in a focus group (Appendix 6) had a poor response with no-one indicating a wish to attend, although one person did provide some thoughts in writing. To ensure that staff engaged fully with family members, an open day was planned for September 2010 in the Downe
Dementia Unit and relatives and the local Alzheimer’s Support Worker were cordially invited by placing a poster (Appendix 7) at the entrance to the unit and by opportunistically speaking to relatives during visiting times.

Although attendance at a focus group was met with little enthusiasm, within the relaxed and less formal atmosphere of the open day relatives offered their opinion on what an information leaflet should include. This was further augmented by ideas put forward by an established Carer’s Group who had experience of a family member being admitted to Ward 11. The wealth of information received was collated by the interest group and emerging themes such as ‘what happens after the assessment is over’ and concerns about clothing informed the leaflet. It also enabled staff to highlight the philosophy of the unit and educate on areas of importance such as visiting and meal times. When the leaflet (Appendix 8) was printed it was shared with those relatives whose input was appreciated. One relative commented:

‘It is more wordy than I had anticipated, yet all the information is relevant’.

One concern that a family shared with us was the need to be able to identify staff. As previously stated the staff’s identification card is designed to clip onto the tunic pocket. From a health and safety perspective this was intended to reduce the possibility of a patient being injured from the pin of a badge during personal care; however, it makes it difficult to see the person’s name. In addition to making reference to this in the leaflet it was also acted upon by introducing a board with photos and names of the team to facilitate identification of staff. To further facilitate information sharing a Relative’s Notice Board was installed and a leaflet rack with a plethora of relevant information on a variety of topics such as advocacy services, nursing homes, and our information leaflet and a ‘Personal Story’ leaflet (Appendix 9) that was also developed.

The inclusion of the Alzheimer’s Support Worker at the Open Day proved popular and relatives took advantage by browsing through the various pamphlets she had brought with her. During informal discussions the idea of a Carers Support Group on the unit was mooted by staff. This was to gauge if this would be welcomed, particularly if this was a family’s first experience of an admission to an assessment unit. Linking in with the local Alzheimer’s Support Worker would also facilitate the transition to a local Carer’s Support Group on discharge. As the event was attended by relatives with a variety of experience of both admission and attendance at a Carer’s Support Group the response was mixed. Some already attended a support group; others felt when they had precious time to themselves they would prefer to ‘get away from dementia’, but there was a feeling that being able to talk to others who could relate to their issues would be beneficial. It was decided to implement a monthly support group. An afternoon session was thought to be most appropriate time.
when people would be visiting on the unit. However, this would be flexible to suit the needs of the group and if evenings were more popular this could be arranged. Again the local Alzheimer’s Support Worker would be involved as a co-facilitator with a staff member. It was envisaged the membership would consist of relatives of inpatients. On discharge those who wanted ongoing support would be signposted to the Alzheimer’s Carer’s Support Group operating in their locality. There would be no problem with someone continuing to attend the unit group following discharge of their relative but it was felt this was unlikely to happen. In reality it was anticipated the purpose of this group was to meet the needs of carers during their relative’s admission to the unit. Therefore, the membership would fluctuate. The date and time of the group is advertised on the relative’s notice board and the family of newly admitted patients are given the information leaflet which also contains information about the group. The inaugural meeting which took place in October 2010 attracted two relatives whose husbands had been admitted for the first time to a Dementia Assessment Unit. Over tea and biscuits the women were able to relate their experience of the caring role leading up to the admission and drew strength from each other. Although by the next month both men had been discharged the women were aware of how to access their local support group and the Alzheimer’s Support Worker had arranged to visit one of the women at her home to discuss pertinent issues with her. Although the attendance was small nevertheless the session was productive.

**Group 2: Life Story work training**

The culture workshop emphasised the importance of person-centred care and focused the staff’s attention on this vital area. The cornerstone of person-centred care is knowledge of the individual, therefore, although it was not identified as an action plan; developing life story work was considered paramount. Whilst this was an area the nursing auxiliaries could take forward it was thought this would be empowering for them as transformational leadership advocates everyone can be a leader at something (Manley, 2004). It would also provide an opportunity for developing deeper relationships with the patients they were caring for (Ibid). McKeown et al. (2006) argued that life story work is a complex activity and should not be implemented without a well thought out strategy. Furthermore, although the staff were enthusiastic, they were apprehensive due to their lack of experience, knowledge and skills in this area. For these reasons the project team commissioned the Reminiscence Network to provide three half day workshops for sixteen nursing auxiliaries. To facilitate the involvement of the nursing auxiliaries without impacting on the unit, the training was delivered in small groups. This format enabled them to engage in the life story work and bring the learning to the next session where it could be shared and any issues discussed. The workshops were evaluated through feedback which indicated that the nursing auxiliaries found them useful, specific comments were captured and are highlighted below:
One person described a ‘eureka’ moment when he exclaimed:

‘It just makes more sense to get to know the person’.

He was able to relate some behaviours displayed by patients with links to their past. Being able to make these links was enlightening.

Another enthused:

‘I am very excited about carrying out this work’.

Life story work made identifying with the person more meaningful as one nursing auxiliaries testified:

‘It was interesting to find out he owned a butchers shop that he worked in with his brother. I was talking to him about cuts of meat and he was advising me on what to buy’.

On a more cautious note:

‘When will I have time to meet with the patient as the ward is very busy?’

was highlighted but making the time was clearly rewarding:

‘It was great getting the family involved and seeing all the photographs of their life’.

Formats were mooted to collate life story information including a memory box, before deciding on a scrap book with sections on favourite places, happiest memories etc. (Appendix 10). The template was placed onto the unit computer and the information collated can be tailored to the individual. This means the book can be as detailed and comprehensive or as superficial as the person wishes. A camera was purchased to enable the inclusion of a photograph which personalised the record and a ‘Personal Story’ leaflet to inform relatives of this vital work was produced as outlined earlier.

**Group 3: Enhancing the mealtime experience - ‘Come dine with me’**

The controversy surrounding the nutritional needs of older people in hospitals has been well rehearsed in the media (Martin, 2010; 2008) and highlighted in reports (Burke, 1997). Within our dementia service all staff are available at meal times to assist patients. Despite this the group involved with taking this initiative forward unanimously agreed mealtimes could be enhanced and
the experience made more enjoyable. To provide a baseline measure an observational tool (Appendix 11) was devised using the philosophy of Dementia Care Mapping (Kitwood and Bredin, 1994). This seeks to capture the experience from the perspective of the person with dementia. Choice, independence, dignity, noise, smells, sights, pace and the social ambiance were scrutinised. Two staff from this interest group undertook a baseline observation over a lunchtime period. As the objective was a service improvement ethical approval was not required. All staff present were made aware of the exercise but were not privy to the components of the tool. This was to minimise the hawthorne effect (Landsberger, 1958) which occurs when individuals react to being observed by modifying their behaviour. In keeping with the way a Dementia Care Map would be conducted the observers explained their presence to the patients by saying they were doing a survey. There was also agreement that should a patient be curious about the tool this would be shown to them; however, this wasn’t an issue. Following the observation the two staff compared their individual results which tested the internal reliability of the tool. For the purposes of this exercise agreement of 70% would be acceptable and this was exceeded. Any discrepancies were discussed before consensus was reached. The exercise demonstrated that although the care was good there was little to ‘cue’ the person into recognising it was mealtime which may be achieved through smells, sight or sounds. The nature of the service means meals arrive pre cooked from the central kitchen. This reduces the aromas that would naturally emanate during the cooking procedure and offers little opportunity for enticing odours to prompt or stimulate the palate. However, the staff were able to purchase posters to provide a visual cue of mealtime (Appendix 12). To accommodate visual or perceptual deficits as well as enhancing the attractive presentation of food we invested in contrasting crockery (Appendix 13). This makes it easier to distinguish the food and aids the overall presentation (Appendix 14). Indeed a meal consisting for example of white fish, potatoes and cauliflower against the background of a white plate would make discerning what the food was difficult and would be unappealing which may impact upon whether the meal was eaten. This would not be helpful for someone with visual problems or a poor appetite. To minimise distractions that may impede patients completing meals protected mealtimes3 was introduced and this was highlighted in the information leaflet.

The exercise also flagged up that cutlery and condiments were not on the table when patients entered the dining room and prompted reflection that these would also act as a visual prompt. Rather they were brought over by staff once everyone was seated. The rationale behind this practice was the dining room was often used outside of meal times for other purposes such as during visiting. Having cutlery and condiments on the table raised the possibility they may be removed by patients who had free access to the dining room. This is often cited as a reason for

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3 www.npsa.nhs.uk/nutrition
adopting a paternalistic approach which is contrary to normalising the experience. To overcome this
the domestic staff agreed to set the tables in the dining room shortly before the meals are served.
This collaborative approach confirmed evidence of a change in work practices following the learning
from the culture workshop.

The FoNS Facilitator had suggested undertaking an observation of practice along with a member of
staff on her next visit. As it was tea time when she arrived on the unit the observation focused on
the mealtime experience (Appendix 15). Evaluation of the data gathered revealed there was a
shared approach with the nursing staff sitting with the patients which created a calm and relaxed
atmosphere. It also revealed how crowded the dining room could be and prompted the staff to
consider using the smaller dining room simultaneously for the more dependent patients.

**Group 4: Making the environment more welcoming/person-centred**

As previously stated dementia is viewed nowadays as an intellectual disability. As with any disability
it is crucial the surroundings orientate the person and enables them to maintain their independence.
Balancing this philosophy against what is essentially a hospital is a challenge. Obviously there are
competing agendas to consider such as infection control and ligature points. In practice this has
meant that while the design included single en suite bedrooms, complying with regulations meant
sinks taps and toilet cisterns were operated by sensors. This compromised the opportunity to retain
independence as this technology is naturally alien to what the patients were used given the mean
age of this cohort is 70. Some of the environmental issues have addressed through appropriate use
of signage; however, the unit appeared clinical and devoid of a homely feeling.

The occupational therapist was a member of the interest group that was attempting to improve the
appearance of the unit to make it more welcoming and less austere. One activity patients were
engaged in was making wall hangings of their hand prints. These were very colourful and eye
catching and worthy of adorning the walls in the day rooms and in the corridors (Appendix 16). This
group also revelled in choosing furniture and curtains for the day rooms and planned seating areas
in alcoves dispersed throughout the unit. It is acknowledged that the decor of a nursing home
cannot be replicated within an assessment unit. Nevertheless, plans are afoot to visit facilities within
the independent sector and decide what can be incorporated from the PEARL project (Baker, 2008)
to stimulate, invite inquisitiveness, reduce boredom and orientate. Even with the introduction of
comfortable furniture the day rooms are under-utilised. Patients naturally gravitate towards the
nurses’ station which tends to be a hub of activity. In contrast the day rooms are situated at the
opposite end of the unit in what is a much quieter area. Attachment theory and Parent Fixation
(Miesen,1993) may explain this need to seek out the company of others and perhaps there is a
sense of abandonment in the solitude of the day rooms compared to a sense of security when able
to see other people. This may explain the attraction of one area over another. To encourage someone with dementia into an area it needs to be attractive to the person. To maximise the use of these rooms a trainee clinical psychologist is undertaking a literature review on this topic and she and the occupational therapist plan to visit other units to garner ideas.

Discussion
The culture workshop was an excellent platform for bringing the staff together and having time out from the work environment proved to be productive in enabling everyone to focus their attention on their values and beliefs. Being able to articulate the kind of care that staff wanted to deliver was the starting point in agreeing a vision statement that everyone felt comfortable with. The tools used supported the staff to move beyond talking about 'problems' to accepting they had the power to make changes to their practice. This empowerment was an enlightening experience and the catalyst in shifting the mindset from believing it was the responsibility of others to bring about change. For the nursing auxiliaries this was particularly true as previously they had never been encouraged to read care plans. From their perspective being responsible for taking forward the life story work enhanced their job satisfaction and made them feel their contribution was valued.

However, enthusiasm and willingness alone was not enough to implement the action plans that had been devised. Balancing team assessment meetings with three consultant psychiatrists, accommodating family meetings, admissions, transfers of physically unwell patients to medical wards and discharges absorbed much of the staff’s time and their energies. Achieving the project objectives while ensuring mandatory training was not compromised was compounded by staff shortages. The metaphor of the biblical parable of the sower and the different grounds aptly describes how the cares of the unit grew up and strangled the new shoots of change and stifled growth and resulted in some of the initial momentum being lost. In November 2010, the project team discussed this with the FoNS facilitators who arranged to visit to see how they could help the project team to regain this and get back on track. Interestingly, this illuminated that the project leads were trying to do this alone. Once the project team re-focused on the underlying philosophy that practice development is owned and driven by the staff the project was able to move forward. To ensure everyone was involved the project team met with the staff and re-visited the action plans from the workshops and refined these to prioritise into four areas. The staff agreed to develop interest groups based on these with membership by self selection. This meant everyone was involved and the responsibility for taking forward the project was shared. More importantly the staff felt in control as they could chose which group they wished to be involved in. There was consensus about the difficulties encountered with getting protected time. By thinking creatively about ways of implementing the action plans within the constraints of a busy unit, staff agreed that utilising natural meetings such as handovers for discussions would be the most effective and productive use of
time. Involving all the staff generated the ideal of developing interest groups. Group members also communicated with each other by phoning, e mailing and leaving notes. This method of sharing the work meant the overall objectives seemed less daunting and made the project manageable.

With everyone playing their part it wasn’t long before progress was made. The ‘Patient at a Glance’ board improved communication and was a source staff could rely on for up to date information about the patients. There is a correlation between improved communication, reduced misidentification of bedrooms due to signage and a reduction in complaints which have decreased by 60%. Furthermore, there is an increase in family satisfaction with the care provided which is evidenced in the complements received. These have taken the form of letters, cards, fruit, chocolates and two families gave £100 and £260 respectively with a request it is to be spent on staff. However, the aspirations of a vibrant Carer’s Support Group have not been realised. Despite advertising this on the relative’s notice board and highlighting in the information leaflet there does not appear to be the eagerness that had been anticipated. Staff plan to circulate a questionnaire to ask families what support they would like and to enquire if regular speakers at a Carer’s Support Group would be welcomed and if so what topics would be of interest.

A Dementia Assessment Unit does not enjoy the luxury of the relaxed pace that is afforded to a long stay facility. Effectively this meant that ensuring the smooth running of the clinical procedures coupled with respecting the pressure the central kitchen were under prohibited altering the mealtimes. Nevertheless, protecting mealtimes and the improvements that have been made to make this a more enjoyable experience for the patients have resulted in a quieter, relaxed and more pleasant atmosphere. The observational activities were particularly insightful in prompting staff to stand back and use all of their senses to absorb and discern the culture which can be overlooked in the bustle of a busy unit.

Planning the improvement of the environment was perhaps the most challenging activity of all. Balancing the constraints of complying with regulations and making the surroundings welcoming, homelike, enabling and person-centred demanded a pragmatic yet creative approach. The purchasing of contemporary comfortable chairs and sofas combined with positioning these in alcoves throughout the unit have been effective in reducing patients pacing. They provide dignity and respect by offering choice of where to sit and encourage social interaction. Incorporating the patients’ artwork into the decor demonstrated working together and valuing their contribution. Seeing their work displayed on the walls also gave staff a tremendous sense of satisfaction.

Conclusion
The project has enabled the staff on the Dementia Assessment Unit to explore the workplace culture, examine their values and beliefs about person-centred care and improve practice. Although the project itself has concluded, practice development is a continuous process towards increased effectiveness in patient centred care (Garbett and McCormack, 2002) and as such the work will continue.

References


Marshall, M. (2001) Environment: how it helps to see dementia as a disability in Care Homes and Dementia (ed S. Benson) *The Journal of Dementia Care*

Loveday, B; Kitwood, T; Bowe, B (1998) Improving Dementia Care: A Resource

Martin, D. (2008) Number of elderly patients starving in NHS wards doubles to 30,000 in two years. Daily Mail, 30\textsuperscript{th} July.


Appendix 1. Workshop Programme

Creating a Vision for the Care of Older People in the South Eastern Trust
Wednesday 5th May 2010

Programme Objectives

- To explore our roles and responsibilities in relation to improving care for older people
- To identify the values we hold about caring for older people
- To create a vision for how we work in partnership with our patients in the future
- To identify how close we are to reaching our vision
- To explore our perceptions of ageing and how it influences the care we deliver to our patients
- To agree a set of actions that will help us to live out our values in practice
- To identify what success will look like for the patient and staff

9.00-9.30am        Welcome and introductions
9.30–9.45am        What do I need to get from today to make it worthwhile for me?
10-10.30am         Value clarifications exercise (solo)
10.30–10.30am     Value clarifications exercise (groups)
10.30-10.45am     Coffee
10.45-11.45am     Feedback and discussion
11.45-12.30pm     How far are we from our Vision? Claims, Concerns and Issues
12.30–1.30pm      Lunch
1.30– 3.00pm        Exploring our perceptions of aging (collage and art work)
3.00– 4.15pm       What needs to happen to help us achieve our vision?
4.15–4.30pm       Evaluation and close
Appendix 2. Signage to orientate patients to surroundings

Appendix 3. Memory boxes

Appendix 4. Activities board
Appendix 5. Orientations board
RELATIVES

We are seeking to improve our services by developing a Ward Information Leaflet. We would value your support as you can tell us the type of information that you would find useful on admission. If you would be willing to work with a small group of staff and contribute your thoughts and ideas please give your name to the Ward Manager.
RELATIVES AND FRIENDS
YOU ARE CORDIALLY INVITED TO JOIN WITH US IN OUR

OPEN DAY

2 – 4PM Thursday 9th Sept 2010
Enjoy light refreshments and an afternoon of music and craic
Appendix 8. Relative information leaflet

Meal times
Please inform staff of your relative’s food preferences and dietary requirements and we will endeavour to accommodate these. We operate protected meal times and actively discourage unnecessary disruptions at these times because it is important older people maintain their nutritional status. Therefore we would ask you to respect these times and not visit the ward. Meal times are breakfast at 8.30am, lunch at 12 noon and tea at 5.00pm. A selection of beverages are available throughout the day. Sometimes patients require assistance with eating and may eat better for family than they would for staff. In these circumstances your support would be appreciated and may be negotiated with the nursing staff. For health & safety reasons please do not leave perishable food in your relative’s room.

Valuables
It is inadvisable to have anything of a valuable nature in the ward as the Trust and staff cannot take responsibility for these. Personal items need to be clearly labelled and easily identifiable. Due to the nature of dementia it is not unusual for the person to remove or misplace personal items. Neither is it unusual for another patient to take an item that does not belong to them in the erroneous belief it is their property. We cannot lock patients’ bedrooms as they must have the freedom to come and go freely. Therefore, we strongly recommend you take home any items of a valuable or sentimental nature. Photographs are particularly helpful with orienting people with dementia to their own room. As these are irreplaceable it may be a good idea to use photocopies rather than originals.

Medication
While it is helpful to bring your relative’s medication with them at the time of admission for the medical and nursing staff to check, these need to be taken home as we cannot store patients’ medication on the ward.

Advocacy Services
MindWise provide an independent advocacy service. They are based in English Street, Downpatrick, telephone (028) 4461 7964.

Comments/Complaints
We welcome any comments in relation to your relative’s care and would encourage you to approach staff if you have any concerns or problems. This allows us an opportunity to resolve any problems as soon as possible. We are continuously trying to improve the quality of the care we provide and your comments and/or suggestions can help us to identify ways to do so. If we are unable to resolve any issues you have the right to make a formal complaint and the Nurse in Charge will advise you how to do this.

Regulation Quality Improvement Authority
The Regulation and Quality Improvement Authority is an independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland. They can be contacted at:-
9th Floor Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT
Telephone: (028) 9051 7500

Downe Dementia Assessment & Treatment Unit
Tel: (028) 4483 8304

Carer Information

Designed by Communications Department
Appendix 9. Personal story leaflet

If you decide you do not want Personal Story

Staff and patients share care, support and company within a varied choice of pastimes and activities aimed at promotion of individual well-being. Alternatives to Personal Story will be available.

If you decide you do not want Personal Story

It should be of benefit and pleasure to yourself and others close to you to have his or her Personal Story known or documented.

The choice to start is yours. The choice of content is yours. The choice to stop is yours.

Other Information

Personal story work is designed to be friendly and informal, helpful in numerous ways and to create a record of the owner as a very individual person.

Further information can be gained from other Personal Story owners and any staff member.

Downe Dementia Unit

‘Personal Story’

(A person-centred approach to care)
**What is Personal Story?**

It is a person’s own thoughts and memories and knowledge pertaining to his or her present and past life.

The collective information may take the form of a box, booklet or album.

**Why is Personal Story used?**

It is used to improve or maintain well-being for someone who may have a faulty memory, feel muddled at times or would simply like to have his or her Personal Story known or documented.

It is a method of self help or shared help.

**Who uses Personal Story?**

It is used by the person who owns it and anyone with whom the owner wishes to share it.

**How is Personal Story used?**

It is started by the owner and perhaps his or her relative and/or a staff member discussing what would be helpful to form Personal Story.

Past and present important information, photographs, tapes, memorabilia and other objects can be collated and kept together.

Aspects of use are varied to include enablement of personal recognition and recall, promotion of discussion and humour, help to deal with present matters by relating to the past and identification with others.

The owner can use it continuously with contents changed to suit his or her needs and wishes.

**Where and when is Personal Story used?**

It can be used anywhere. The owner may wish the collective material to accompany him/her to any future placement.

It can be used alone, with staff, with friends and relatives at home or within small discussion and reminiscence groups on the ward.

It can be helpful to the owner if he or she goes into a new residence.
Appendix 10. Life story book

My Life Story Book

NAME:
Life Story Work

Life Story Work is about finding out, recording and making use of information on personally relevant aspects — past and present of the individual’s life. Information and materials that can contribute to life story work include photographs, postcards, certificates or newspaper clippings collected together in some way such as a file, memory box or notice board. This involves looking back on the past usually on a one-one basis. It can be beneficial to the person with dementia, the family and any care workers. It aims to capture the experience of whom the person was, what was significant to them and what they achieved in life.

Life Story Work
• Is based on what is relevant to the individual
• Should be seen as part of normal routine
• Does not need to be comprehensive
• Need not involve a lot of writing
• Should not be seen just as a product but as a process

Benefits of Life Story Work for carers and staff
• Reinforces the whole person
• Promotes communication
• Includes the family
• Provides valuable information about the person
• Helps with planning and delivery of individual care
• Informs new staff
• Offers explanations from the past for present day behaviours

Every person with dementia has a unique life history, set of relationships, personality, habits and preferences. Understanding these can often help determine the context of challenging behaviour and the messages that lie behind them.

Life Story Work begins with the assessment form and assessment interview when an individual with dementia first comes into contact with you. At that point a variety of “background” information is collected. Most people benefit from triggers and cues when asked to discuss the past therefore photographic material and memorabilia are essential to the life story work.

Benefits of Life Story Work for the person with dementia
• Failure free activity
• Enhances enjoyment
• Improves self-esteem
• Reinforces long term memory
• Promotes communication
• Builds relationships
• Reinforces sense of identity
• Reinforces social skills
Murphy (1995)

Charter for Good Practice in Life Story Work

- **DO** tell the individual with dementia what you are proposing to do and ask for permission to do it
- **DO** think about what preconceptions you might bring to the situation, for example, doubt rather than belief
- **DO** try to understand what it might feel like to have such information recorded
- **DO NOT** feel that you need to record everything
- **DO NOT** let pressure for accuracy overshadow the need to understand the underlying feelings and emotions
- **DO** be aware of the variety of ways in which the life story book may be used; by staff, by family carers and by the person with dementia
- **DO NOT** see a life story book as a task to be completed
- **DO** see the life story book as an organic activity
- **DO NOT** be constrained that photographs are the only way to illustrate a life story book
- **DO** acknowledge sadness and grief, when these emotions are expressed
- **DO NOT** see the life story work as a separate activity; it feeds into and from other work such as reminiscence groups, outings and care planning
- **DO** use triggers when doing life story work and be aware that all five senses have the potential to be stimulated
- **DO NOT** leave the individual with dementia trapped in the past after a session of life story work
- **DO** offer and environment relatively free of distractions when doing life story work
- **DO** include current material as well as historical details on the individual with dementia
- **DO** leave life story books in a accessible place, subjects to the constraints of confidentiality
- **DO** remember who “owns” the book
Personal Details

Name:________________________  Known as:____________________

Address:______________________ ____________________________

__________________________________________________________

Telephone no:_________________  DOB:__________________

Marital status:_______________  Religion:__________________

Members of household:____________________

__________________________________________________________

Next of Kin:____________________

Address:______________________ ____________________________

__________________________________________________________

Telephone no:__________________

GP:____________________________

__________________________________________________________

Telephone no:__________________

Emergency contacts:____________________

__________________________________________________________
Family tree of important people
Any other important information which maybe required quickly: allergies, illness, medication, significant people, etc
Important dates/events to remember

January  
February  
March  
April  
May  
June  
July  
August  
September  
October  
November  
December
My memories up to twenty

Home: __________________________________________
______________________________________________
______________________________________________

School: _________________________________________
______________________________________________
______________________________________________

Pet: _____________________________________________
______________________________________________
______________________________________________

Family: _________________________________________
______________________________________________
______________________________________________

Love: __________________________________________
______________________________________________
______________________________________________

Dance: _________________________________________
______________________________________________
______________________________________________

Sports: _________________________________________
______________________________________________
______________________________________________

Cars: _________________________________________
______________________________________________
______________________________________________
My memories from twenty to sixty

Love: __________________________________________
_________________________________________;
_________________________________________

Partners: ______________________________________
__________________________________________
__________________________________________

: ___________________________________________

Marriage: ___________________________________
__________________________________________
__________________________________________

Children: ___________________________________
__________________________________________
__________________________________________

Jobs: _______________________________________
__________________________________________
My memories from twenty to sixty

Homes:____________________________________________________
____________________________________________________

Pets:____________________________________________________
____________________________________________________

Cars:____________________________________________________
____________________________________________________

Hobbies:________________________________________________
____________________________________________________
____________________________________________________

Holidays:________________________________________________
____________________________________________________

Health:________________________________________________
____________________________________________________

Grandchildren:__________________________________________
____________________________________________________
Memories from sixty to present day

Family: ____________________________________________
________________________________________________
________________________________________________

Friends: _________________________________________
________________________________________________
________________________________________________

Hobbies: _________________________________________
________________________________________________
________________________________________________

Activities: _______________________________________
________________________________________________
________________________________________________

Holidays: ________________________________________
________________________________________________
________________________________________________

Health: _________________________________________
________________________________________________
________________________________________________
<table>
<thead>
<tr>
<th><strong>Best ever favourites</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Christmas</strong></td>
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<tr>
<td><img src="image" alt="Christmas" /></td>
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<tr>
<td><strong>Holiday</strong></td>
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<td><img src="image" alt="Holiday" /></td>
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<tr>
<td><strong>Place</strong></td>
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<td><img src="image" alt="Place" /></td>
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<tr>
<td><strong>Birthday</strong></td>
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<td><strong>Times</strong></td>
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<tr>
<td><strong>Anniversary</strong></td>
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<td><img src="image" alt="Anniversary" /></td>
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<tr>
<td><strong>Achievements</strong></td>
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<td><img src="image" alt="Achievements" /></td>
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<tr>
<td><strong>Skills</strong></td>
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<tr>
<td><img src="image" alt="Skills" /></td>
</tr>
</tbody>
</table>
Plans and ambitions for the future
✓ Tick the words that best describe you

Decisive Intellectual Traveller
Homebird Worrier
Warm Positive
Lonely
Independent Reader
Indecisive Artistic
Sociable Witty Sarcastic
Angry Busy
Bored
Stubborn Easy going
Energetic Quick tempered
Musical Colourful
Irritable Argumentative
Sporty
Pet lover Indoor Patient Creative Shy
Loud Quiet
Placid A thinker
Organised
Disorganised Outdoor
Cautious Leader
A follower Outgoing
Determined Relaxed
Communication

Aids required e.g. Hearing aids: __________________________

Usual words used to describe everyday things i.e. toilet or lavatory: __________________________

Companionship i.e. prefers mate company (include pets): __________________________

Conversation i.e. Topics
• Likes: __________________________

• Dislikes: __________________________

Touch i.e. massage, hair brushing
• Likes: __________________________

• Dislikes: __________________________

Languages i.e. sign language, lip reading, Chinese, French: __________________________

__________________________
Mobility/Exercise

Ability to walk:

Aids required/assistance needed:

Usual exercise/activity:

Preferred footwear:

Preferred Seating:

Access to transport:
# Clothing

<table>
<thead>
<tr>
<th>Clothes</th>
<th>Size</th>
<th>Length</th>
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<tbody>
<tr>
<td>Trousers</td>
<td></td>
<td></td>
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<tr>
<td>Skirt</td>
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<tr>
<td>Blouse/Shirt</td>
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<tr>
<td>Cardi/Jumper</td>
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<tr>
<td>Underwear</td>
<td></td>
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</tr>
<tr>
<td>Bra</td>
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<tr>
<td>Socks/Tights</td>
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<tr>
<td>Slippers/Shoes</td>
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</table>

**Preferred Styles/Usual Dress:**


Favourite Colours:

Fastenings (i.e. Belts, braces, buttons)

Dislikes:

Usual Laundering methods/products:
Food

Preferred times and places for eating: ________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Quantities, usual diet, likes, dislikes for:
Breakfast: ________________________________________________________

_________________________________________________________________

_________________________________________________________________

Lunch: ____________________________

_________________________________________________________________

_________________________________________________________________

Tea/Dinner: _______________________

_________________________________________________________________

_________________________________________________________________

Supper: __________________________

_________________________________________________________________

_________________________________________________________________
Preferred drinks (alcoholic and non-alcoholic): __________
____________________________________________________
____________________________________________________
____________________________________________________

Special dietary requirements: ____________________________
____________________________________________________
____________________________________________________
____________________________________________________

Any aids/assistance required: ____________________________
____________________________________________________
____________________________________________________
____________________________________________________

Favourite restaurants/meals: ____________________________
____________________________________________________
____________________________________________________
____________________________________________________
Nails –
Usual length: ________________________________

Chiropody: ________________________________

Teeth –
Usual products: ________________________________

Toileting –
Aids/Appliances used: ________________________________

Other information –
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

Spiritual

Religion/Beliefs

Usual service attended

Name and contact for Priest /Minister

Requests/Wishes in relation to dying i.e. donor card
Medical History

Past ill health/hospitalisation:

Current/ongoing medical condition:

Current medication:
Home Information

Where are things?

Stopcock: ________________________________
Heating system controls: ________________________________
Hot water switch: ________________________________
Clean clothing/bed linen: ________________________________
Meters: ________________________________
Power supply/Torch: ________________________________
Spare fuses/Batteries: ________________________________
Spare light bulbs: ________________________________
Rubbish collection days: ________________________________
How to operate cooker: ________________________________
How to operate washing machine: ________________________________
Contact Number for spare door key: ________________________________
Coal man/Oil man: ________________________________
# Usual weekly/daily events

<table>
<thead>
<tr>
<th>Day</th>
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<tbody>
<tr>
<td>Monday</td>
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<tr>
<td>Tuesday</td>
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<td>Wednesday</td>
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<td>Saturday</td>
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</tr>
<tr>
<td>Sunday</td>
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</table>
Current clinics/specialists attended:

Concerns or worries regarding your health:

Wishes regarding treatment in the future
Services/Contact Numbers

GP: _____________________________
District Nurse: ____________________
Family: __________________________
Neighbours: _______________________
Home Help: ________________________
Sitting Services: ___________________
Carer Group: ______________________
Day Centre: ________________________
Respite Care: ______________________
Social Worker/Nurse: ______________
Minister/Priest: ___________________
Dentist: __________________________
Chiropodist: ______________________
Optician: _________________________
Solicitor: _________________________
Bank/Building Society: _____________
Police Station: ____________________
Spare Key: _________________________
Plumber: __________________________
Electrician: _______________________
Gas Man: _________________________
Corner Shop/Post Office: ___________
Any other numbers
Photographs
### Appendix 11. Observational tool

#### Dementia Meal Time Observation Tool

Do all patients have?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>Choice of meals</td>
<td></td>
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<tr>
<td>Offered handwashing facilities</td>
<td></td>
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<tr>
<td>Assistance if needed</td>
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<th>Yes</th>
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<td>2.</td>
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<tr>
<td>Is independence promoted</td>
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<th></th>
<th>Yes</th>
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<td>3.</td>
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<tr>
<td>Dignity maintained</td>
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<tr>
<td>Offered extra if requested</td>
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<tr>
<td>Alternatives available if 1st choice gone</td>
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<th></th>
<th>Yes</th>
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<td>4.</td>
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<tr>
<td>Meal rushed</td>
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<tr>
<td>Socially enhanced</td>
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<td>Seated by someone you can relate to</td>
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<th>Yes</th>
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<td>5.</td>
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<tr>
<td>Drinks of choice available</td>
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6.

**VAS**

| Noise       | 0-----------------------------10 |
| Sights      | 0-----------------------------10 |
| Sounds      | 0-----------------------------10 |

7.

<table>
<thead>
<tr>
<th>Were food charts completed?</th>
<th>Yes</th>
<th>No</th>
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8.

<table>
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<tr>
<th>Food served by all nursing staff?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
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9. Did all staff wear aprons and hats?

<table>
<thead>
<tr>
<th>Did all staff wear aprons and hats?</th>
<th>Yes</th>
<th>No</th>
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10. Do Patient Experience staff have basic hygiene course?

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<thead>
<tr>
<th>Do Patient Experience staff have basic hygiene course?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

11.

If assistance was required to feed a patient, did the staff do this by:-

<table>
<thead>
<tr>
<th>If assistance was required to feed a patient, did the staff do this by:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td></td>
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</tr>
</tbody>
</table>
12. Was suction machine readily available?  
   In an emergency were all staff aware of how to access it and use it?  

13. Did all staff wash their hands before serving meals?  

14. Those patients unable to sit long enough at a table to complete meals, were their needs met?  

15. Is choice offered to patients?  

16. Are meals nutritionally balanced?  

17. Are all staff available at meal times to assist?  

18. Are patients consulted in an appropriate manner?  

19. Is the dining area overcrowded?  

20. Are meals provided in the same area patients sit in?  

21. If patient requested an extra portion was this provided?
22. If a patient required specialist equipment ie. cup, spoon, fork, slip mat was this available? 

23. Was there provision for patient to add salt, pepper, sauce independently? 

24. Are patients encouraged to choose from the menu?
Appendix 12. Visual mealtime cues
Appendix 13. Crockery

Appendix 14. Presentation of food
Appendix 15. ‘Snap shot’ observation of practice

Active learning 'snap shot' activity; reflection in practice

Observation of practice

Guidance for facilitator

The aim of the activity described below is to enable practitioners to experience looking at their practice through observation as part of a practice development project. The practitioner is supported carrying out the activity with a facilitator. These small activities can be used to build up practitioners' confidence and skill at in learning about practice in their area. They may then move to more complex active learning activities.

The activity can be adapted to suit the context that it is being undertaken in. Consideration also needs to be given to the level of experience of the practitioners and the facilitator undertaking the activity.

Guide:

1. This activity is for a minimum of two people, a lead person (facilitator) who may be from that clinical area or in a role such as practice development facilitator and practitioners from the clinical area. The practitioners could include registered and unregistered staff.
2. All those involved need time firstly, to discuss with the facilitator when and how the activity will be undertaken, minimum of 15 minutes to carry out the observation and 15-30 minutes to reflect and discuss and make notes of what the practitioner observed.
3. There is no need for consent as no names are used and the focus is not on individuals but practice in general in the area. To aid with looking at day to day practice rather than the individual, it is best to observe with different members of the team and at different times of the day.

Process:

1. The whole team in that area need to be aware of why you are observing practice and how this activity is part of the practice development project. This can be through discussion at ward meetings or a poster etc.
2. Discuss the enclosed activity sheet with the practitioners undertaking the observations.
3. Agree with the practitioners the time and place for the activity. To observe, stand by the nurses’ station, or sit in a dayroom or stand in a bay for example. You will have to explain to patients why you are there.
4. Ask the practitioner to stop and look at practice. Ask them to focus on feeling detachment as if it’s their first time there. Ask them to focus on the following questions:
   - What can you hear?
   - What can you smell?
   - How do you feel?
   - What can you see?
   - Are there any surprises?
   - What stood out for them?
5. After the observation, sit with the practitioner(s) and engaged in a reflective conversation on how they found the activity and what they learnt about practice focusing on the questions above.
6. If more than one practitioner took part in the activity then discuss similarities and differences in what they observed.
7. Once various members of the team have carried out this activity meet with them to explore as a group best practice they saw and aspects of practice they feel could improve. See if there are any key themes emerging from about practice in the area such as reducing noise or greeting relatives at the nurses’ station etc.

8. From this information you can either develop an action plan for making changes to practice (as long as enough members of the team have taken part); explore means of sharing the information with the wider team; add it to other information collected such as patient experiences or move on to longer periods of observations.
Appendix 16. Patient hand prints picture