

My life, my care home

The experiences of people living with dementia in care homes
in Scotland



HAPPY TO TRANSLATE



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1. Introduction



Many thousands of people in Scotland live with dementia, or they have relatives and loved ones with a diagnosis of dementia. It is possible to live well with dementia, and care services play a crucial role in supporting people to do so.

In order to understand the extent to which the Standards of Care for Dementia are having an impact on the lives of people in care homes, we undertook a study in 145 care homes for older people from June 2016 to March 2017. As well as carrying out regular, unannounced inspections to assure ourselves about the general quality of care being provided, we carried out intensive scrutiny activities to try to understand what life is like for people with dementia living in care homes.

The most important source of evidence for this was to speak with residents, relatives and staff in care homes to hear their perspective.

Coupled with evidence from examining personal plans and directly observing practice, these powerful testimonies helped to identify what works well and where improvement is needed.

As part of our inspections, we seek to involve people who have direct experience of care. Inspection volunteers accompany the inspector to the care home and use their personal experiences to talk with residents and relatives. In some of the inspections, we involved inspection volunteers who themselves have a personal diagnosis of dementia. This ground-breaking approach to involvement provided many insights and motivators for small but powerful changes within care homes. For example, as a result of the observations and perspectives of these inspection volunteers, one care home made changes to the lighting in corridors, another manager bought new soft furnishings to create a more homely environment and another care home made changes to the mealtime experience to make this more dementia-friendly. I would like to thank everyone who helped in producing this piece of work, but I would particularly like to thank our inspection volunteers who gave their time so willingly. It made a huge difference.

The scrutiny evidence presented here shows examples of excellent care being experienced by people with a diagnosis of dementia, across all parts of Scotland, as well as areas for development and improvement. There are a small number of care homes where the quality of care was not satisfactory when we inspected. For those that are not providing the care and support that we would like to see, the Care Inspectorate requires speedy improvement and can provide direct support to ensure the quality of care improves. We are committed to ensuring that quality of life for people is not limited due to lack of expectations of what it means to be an older person living with dementia in a care home.

We hope that including examples and illustrations of effective practice will help stimulate self-reflection and improvement planning in all care services supporting people with dementia and other long-term conditions. We have highlighted areas for improvement which are drawn from the evidence

here. We expect these to stimulate self-evaluation and reflection in care homes and local partnerships as they plan to deliver care which reflects the person-led, rights-based approaches which underpin the new Health and Social Care Standards.

I would like to thank residents and their families and friends for the feedback we have received during our inspections. The views of people experiencing care are vital in assessing its quality, and these views add depth and richness to other scrutiny findings. We appreciate and recognise the important and valuable work that staff in care homes do every day and we hope that they will find this report a useful and practical resource. I would also like to thank our inspectors for their exemplary hard work, commitment, dedication and passion to improve the quality of life for people living in Scotland's care homes.

A handwritten signature in black ink that reads "Karen Reid". The signature is written in a cursive, slightly slanted style.

Karen Reid
Chief Executive

Executive summary

Care homes can support people living with dementia to live with meaning and purpose, fulfilling a human rights-based¹ approach to dementia care. The Standards of Care for Dementia in Scotland were developed to meet three principle aims: help people with dementia and their carers to understand and protect their rights, indicate to care providers what is expected of them and improve the quality of dementia care homes.

This report presents the findings of focused inspection work from the Care Inspectorate over a one-year period. It examines the quality of care in care homes against the extent to which the standards are being met for people with dementia. Overall, we have found that the majority of care homes contribute, sometimes very well, to meeting five of the six Standards of Care for Dementia², which we graded. We did not grade the standard relating to diagnosis and post-diagnostic support as this falls outwith the remit of care homes, although we did look at issues associated with this.

The standards are:

- I have the right to diagnosis.
- I have the right to be regarded as a unique individual and to be treated with dignity and respect.
- I have the right to access a range of treatment, care and supports.
- I have the right to be as independent as possible and to be included in my community.
- I have the right to carers who are well supported and educated about dementia.
- I have the right to end of life care that respects my wishes.

This report presents a number of findings:

- We found that over half of care homes were performing at a Good or better level, however there remain improvements to be made in ensuring that quality of life for people is not limited due to lack of expectations of what it means to be an older person living with dementia in a care home.
- Our evidence suggests that there was inconsistent and variable post-diagnostic support for people and their families, when someone in a care homes is diagnosed with dementia. While we recognise that the number of people receiving a diagnosis at this point in their life may be relatively low, we expect people living in care homes to have the same access to diagnostic and support services as people living in the community.
- We asked if people had access to independent advocacy services and if the manager and senior staff knew how to access these. We found that in 35% of care homes no-one had access to independent advocacy.

¹ https://www.alzscot.org/campaigning/rights_based_approach

² <http://www.gov.scot/resource/doc/350188/0117212.pdf>

- People living with dementia must have opportunities to be active and engage in activities that are meaningful to them. We found that 55% of care homes had provision for ongoing organised activities every day of the week. However, 10% of care homes did not provide any opportunities for people to keep active and engaged.
- In order to have positive outcomes for people who experience care, it is important for them, their families and staff to have up to date and accurate information in personal plans about the care and support they need. We found that the general quality of personal plans was mixed, with more than half (57%) of care homes having personal plans that did not fully reflect the past, present and future wishes, values and beliefs of all their residents. In 57% of care homes, only some staff knew about and used the personal information that had been gathered about residents. While this is an improvement since Remember I'm Still Me³ the key information needs to be known by all staff and used to enhance wellbeing of people living with dementia.
- Inspectors found strengths in the implementation of the enablement approach in 59% of care homes. This approach supports people experiencing care to achieve their personal outcomes, engage and participate meaningfully in their environment and regain a sense of self through contribution. Strengths were built through the integration of the care home with the community and understanding the importance of supporting personal care. We would like to see this approach in more care homes and tailored to meet the needs of all people in every stage of their dementia experience.
- In the majority of care homes inspectors found that only some of the people were supported to keep connected to their community in a meaningful way. In an extremely small number of care homes it was discovered that no residents were connected to their community. We expect people living with dementia to experience the help they need to make sure they have equal access to all of the leisure, recreational and cultural activities within the care home and community.
- We found that in 55% of care homes staff reported that staffing levels rarely or never prevented people from accessing the community at least once a week. However, in 45% of care homes staff reported that staffing levels frequently prevented people from accessing the community at least once a week.
- The majority of care homes now have secure gardens. However, over a third of care home gardens cannot be accessed independently and require staff to be available if a person wants to go out into the garden.
- From observations we completed using the Short Observational Framework for Inspection, it was clear that the staff in many homes are developing warm and genuine relationships with people. There is now the potential to develop these relationships to enable the person to use their existing strengths and skills to enhancing wellbeing. We expect care homes to move from task -

³ Remember I am Still Me was a thematic piece of research on dementia in care homes published by the then Care Commission and the Mental Welfare Commission in 2009

http://hub.careinspectorate.com/media/106931/remember_im_still_me_-_may_09.pdf

focused interactions between staff and the people they are supporting and to use each interaction as an opportunity to engage positively with people.

- Since Remember I'm Still Me, we have seen an improving picture in using non-pharmacological strategies instead of using medication as the first response for people experiencing stress and distress. There needs to be continued development of staff skills and knowledge in this area to understand stress and distress alongside support to care homes from specialist teams when required.
- Care homes have been developing their environments to meet the needs of people. However, the one area that stood out in need of further improvement was in relation to promoting continence and personal hygiene. A total of 47% of care homes had a grade of Adequate or lower for the principle as described by the EHE King's Fund tool. This finding when put in context with the culture of managing incontinence rather than promoting continence, highlights an area for on-going improvement.
- Improvement is needed in respect of meeting the "I have the right to end of life care that respects my wishes" standard, with 42% of care homes found to be Adequate or lower. We expect to see staff who are confident and skilled in understanding their roles and responsibilities in palliative and end of life care.
- We found that where care home staff knew and understood the overall aims and objectives of the care home they were better able to meet the needs of people living with dementia across all of the dementia standards.
- We found that in almost all care home services (97%) some or all staff had learning and development opportunities to enhance dementia practice. However, we did not always see this learning and development being aligned to the Promoting Excellence Framework or put into practice in a way that made a difference in the lives of people living in the care home. There is also a need for all staff to receive appropriate levels of supervision so that they can continue to develop their practice.

1. Purpose of report, background and context

There are 90,000 people in Scotland with a diagnosis of dementia, and for a proportion of these people a care home is where they will live out the final years of their lives. Older people living with a diagnosis of dementia are the focus of this report. Although they retain the same rights as anyone else in society, the nature of their illness means that some older people living with dementia have greater difficulty in protecting their own rights.

This report examines the quality and themes which arose from the Care Inspectorate's review of registered care homes which primarily support older people, including those with a diagnosis of dementia, specifically in relation to:

- the understanding and implementation of the national Standards of Care for Dementia
- and/or how well these standards have been applied in practice and changed the lived experience of people living with a diagnosis of dementia.

This report outlines the Care Inspectorate's approach to scrutinising care home services which support older people who are living with dementia between 2016 and 2017. The report examines the findings in relation to outcomes, experiences and rights of people who use these care homes, aligning them to the six Standards of Care for Dementia. While the report recognises examples of innovation and good practice, it also identifies areas of improvement and, based on the evidence presented, recommendations for further improvement. This document is for people who experience care, work in care, provide care, and for commissioners. We hope it will be of relevance for a wide range of practitioners and policy makers.

1.1 Scotland's Dementia Strategies 2010–2020

Scotland's first National Dementia Strategy⁴ was published in 2010 and focused on improving the quality of dementia services through more timely diagnosis and on better care and treatment, particularly in hospital settings. It began the process of the transformation of care across all sectors in anticipation of the growing number of people with dementia.

The second National Dementia Strategy⁵ covered the period 2013–2016 and outlined key outcomes which emerged from the National Dementia Dialogues. These dialogues took the form of a series of focus groups across the country with a wide range of stakeholders that established the key strategic priorities including more people with dementia living a good quality life at home for longer; and establishing dementia-enabled and dementia-friendly local communities that contribute greater awareness of dementia and reduce stigma.

The latest National Dementia Strategy⁶ published in 2017 builds on previous progress and sets out 21 commitments around work on diagnosis, including post-diagnostic support, care co-ordination, end of

⁴ <http://www.gov.scot/Resource/Doc/324377/0104420.pdf>

⁵ <http://www.gov.scot/Resource/0042/00423472.pdf>

⁶ <http://www.gov.scot/Resource/0052/00521773.pdf>

life and palliative care, workforce development and capability, data and information, and research. It seeks to concentrate the focus on enhancing palliative and end of life care for people with dementia, with the overall aim that by 2021 everyone with dementia has access to high-quality palliative and end of life care, based on the principles of early planning and joint-working between services. This strategy will operate until 2020.

1.2 The Standards of Care for Dementia

The Standards of Care for Dementia, published in 2011, were developed to support the change programme within the first national dementia strategy by helping people with dementia to understand their rights, and how these rights can help make sure that they receive the support they need to stay well, safe and listened to.

The six measurable Standards of Care for Dementia are underpinned by the Charter of Rights for People with Dementia and their Carers⁷. They strongly align to the new Health and Social Care Standards⁸, published in June 2017. They are:

- **I have the right to diagnosis:** people with dementia and their carers will receive a timely and accurate diagnosis; receive the information and support they need; and be involved in decisions that are important to them.
- **I have the right to be regarded as a unique individual and to be treated with dignity and respect:** people with dementia will be valued and treated at all times as a person; be listened to, feel included and treated fairly; receive information and the necessary support they need to continue to participate in decisions; and will not experience inhuman or degrading treatment.
- **I have the right to access a range of treatment, care and supports:** people with dementia feel listened to, participate in decision making and have a say in how support and treatment is provided; receive the support and treatment they need; and will not experience inhuman or degrading treatment.
- **I have the right to be as independent as possible and to be included in my community:** people with dementia will feel safe, secure and live as independently as possible; preserve the relationships important to them; and feel involved and included in their community wherever they live.
- **I have the right to carers who are well supported and educated about dementia:** carers will feel valued and properly supported in their role and will know where to get help if needed; and health and social care staff will know how to promote the interests of people with dementia.
- **I have the right to end of life care that respects my wishes:** people with dementia will have access to the full range of palliative care services and quality compassionate care towards the end of life; receive the support they need to die with dignity and in the place of their choosing wherever possible; receive care towards the end of life that respects their previously expressed wishes.

⁷ https://www.alzscot.org/assets/0000/2678/Charter_of_Rights.pdf

⁸ <http://www.gov.scot/Resource/0052/00520693.pdf>

The Care Inspectorate has a statutory duty to share good practice and support improvement in the provision of care. We play a significant role in building care homes' capacity to implement the standards and recommendations from this report, in order to continue to support a better quality of life for people with a diagnosis of dementia in care homes. We are committed to working in partnership with all stakeholders to see positive changes.



2. The Care Inspectorate's role in the scrutiny and improvement of care

The Care Inspectorate is the independent scrutiny and improvement body for social care and social work in Scotland. This means we provide public assurance about the quality of care, highlighting excellent practice where we see it and identifying improvements where necessary. Our responsibilities cover both regulated care services and the strategic co-ordination and provision of care across local partnership.

Our inspections are risk-based and intelligence-led. This means we use information from a wide range of sources to schedule and plan scrutiny, concentrating resources where we have the greatest concerns. All care homes and care at home services are inspected once a year, usually unannounced, by a specialist inspector. Often, the inspector is accompanied by an inspection volunteer – someone who has a personal experience of care.

Our inspections are informed by the national care standards, knowledge of best practice in each sector and a quality framework. Depending on the risk attached to a care service, we look at up to four themes. These are:

- the quality of care and support
- the quality of the environment
- the quality of staffing
- the quality of management and leadership.

We evaluate these care services on a scale of:

6. Excellent
5. Very Good
4. Good
3. Adequate
2. Weak
1. Unsatisfactory

Where we believe changes should be made that would benefit the people using a care service, we make recommendations. These may be made in a report following an inspection or if a complaint has been investigated and upheld.

After each inspection, we publish a report showing what we have found in detail. These reports are available on the [Care Inspectorate website](#).

Where a service is not operating to the standards we expect, we may make a requirement. Again, this may be made at an inspection or after a complaint has been upheld. We will set a timescale for the requirement to be met, which may be days, weeks or months depending on its nature and the speed with which it could be reasonably done. When requirements have been made, we expect care services to draw up an action plan for change. At subsequent inspections, we will check to see whether requirements have been met.

The Care Inspectorate also investigates complaints about care services from anyone, including complaints made anonymously.

Where an inspection or complaint investigation suggests that the quality of care is not good enough, we support improvement in a variety of ways. Inspectors play a major role in demonstrating effective practice, encouraging managers and staff to reflect on their own practice, and signposting to improvement support that is available. The Care Inspectorate also has an Improvement Support Team of improvement advisers who can provide support. If improvement is not demonstrated and people are at risk, we have extensive enforcement powers to require improvement. These are exercised rarely, because we always seek to support improvement first. However, we will take enforcement action in specific circumstances, such as where there is immediate serious risk to the wellbeing of individuals.

Remember I'm Still Me

In 2009, the Care Commission and Mental Welfare Commission published Remember I'm Still Me. That report focused on the findings from joint inspections from 30 care homes exploring 10 key areas relating to dementia care and support.

This current report is not a replication of Remember I'm Still Me as the inspection methodology is different. However, several of the recommendations from that report can be aligned with the Standards of Care for Dementia including:

- It is important to know the person as an individual, understand their life history, their likes and dislikes and how they like to live their life in order to provide the right care to meet their needs. People should be involved in their personal planning and reviews as much as possible.
- Activities and getting out must be an integral part of a person's life in a care home and not an optional extra.
- Care homes must strive to provide the right environment to ensure that people can enjoy safe, comfortable, dementia-friendly surroundings.
- Medication to manage challenging behaviour should be a last, not a first, resort. Personal plans should address the causes and outline a range of interventions to be used to manage challenging behaviour.
- People's freedom should be respected as far as possible. Care homes must look at environments, practices and cultures that could be overly restrictive. Care homes also need to understand the rights of people with dementia and the laws and safeguards that exist to protect them.
- People should receive medical treatment that is in line with the law. Where people don't have capacity to consent to their own treatment, the law should be used properly to safeguard them.
- People with dementia should be cared for by staff who have the skills, knowledge and training to provide effective care.

3. Care Inspectorate Inspection Focus Area 2016-2017

3.1. How we conducted the focused scrutiny activity

To gain a national picture of how the dementia standards have been applied in practice, we carried out 145 dementia-focused inspections across Scotland in care homes for older people in 2016-2017. This was in addition to our work in inspecting all care homes. The sample was representative in relation to size of care home, geographical location, grading and provider type.

In addition to carrying out an unannounced inspection of the quality of care provided, we developed scrutiny approaches that were designed to allow inspectors to evaluate the quality of implementation of the dementia standards. The Short Observational Framework for Inspection (SOFI 2) was used to support the person-centred approach to dementia care and support, and to evaluate the implementation of dementia learning and development within the everyday interactions between residents and staff.

These care homes were located across Scotland as shown in the illustration below.



3.2 The King's Fund Environmental Healing Assessment Tool

Inspectors completed the King's Fund tool, Is Your Care Home Dementia Friendly? EHE Environment Assessment⁹ in those care homes inspected within the inspection focus area.

The design principles focus on promoting wellbeing and independence rather than providing detailed room by room guidance. They have been developed as a result of the Enhancing the Healing Environment (EHE) programme and bring together best practice in creating more supportive care environments for people with cognitive problems and dementia.

The principles are drawn from a number of sources, including research evidence and the learning gained from changes tested in a range of care environments.

Each of the five sections contains a list of design elements that are known to support, encourage and enable people with dementia in care settings. It is unlikely that all the elements can be addressed at the same time unless a new build or comprehensive refurbishment is being planned. However, many of the principles are simple, can be introduced with very little financial outlay and are known to be helpful in creating a more supportive physical environment for people with dementia and those who care for them.

The EHE has been informed by research evidence, best practice and over 300 survey responses from those who have used the tools in practice. Each of the sections draws on this evidence to develop a rationale for effecting change in care environments. These rationales also address the visuospatial problems often associated with dementia. For further details, go to the King's Fund website.

Scoring

The EHE uses a 1-5 scale (1=barely met, 5=totally met). We used this five-point scale and aligned it to the Care Inspectorate's grading scale in this way:

EHE scale	Care Inspectorate grading
Totally met	Excellent
	Very Good
	Good
Barely met	Adequate
	Weak
	Unsatisfactory

⁹ <http://hub.careinspectorate.com/media/302736/is-your-care-home-dementia-friendly-ehe-tool-kingsfund-mar13.pdf>

3.3 SOFI 2: Short Observational Framework for Inspection

SOFI 2 is an evidence-based, internationally recognised tool for regulators. The Care Inspectorate introduced SOFI 2 for inspection of older people's services in 2014. It provides a framework to enhance the observations about people's wellbeing and staff interactions with them that we already make on inspection. It is underpinned by the theory and values of person-centred care.

'Person-centred' is used to describe a value base for care. This is about valuing people and enabling them to live their life to the full. Person-centred approaches have four essential elements¹⁰:

1. Valuing the lives of people and those who care for them, promoting their citizenship rights and entitlements regardless of age or cognitive ability.
2. Treating people as individuals, appreciating that everyone has a unique history and personality, physical and mental health, and social and economic resources.
3. Looking at the world from the perspective of the person experiencing the service and listening to their voice.
4. Recognising that all human life is grounded in relationships, and that people with communication and cognitive impairments need an enriched social environment to help them form and maintain these relationships.

SOFI 2 is one of the components of an inspector's toolkit, designed to be one source of evidence which can help corroborate other findings. The observations do not replace talking to people who experience care but can help an inspector get a clearer picture.

Inspectors observe the mood and engagement of people using the care homes and the quality of staff interactions. They also make notes on other aspects of care practice during their observations. Feedback on SOFI 2 observations to staff and managers in the care service also enables them to become more reflective practitioners and supports practice improvement.

Overall grading for the Dementia Standards

Following each inspection of the 145 care homes, we published an inspection report setting out the key findings, areas for improvement, and the grades for the four quality themes that we inspect. However we also asked the inspectors to grade five of the six dementia standards using our six-point grading scale. We did not grade the standard "I have a right to a diagnosis" as the care homes are not directly involved in this process, although we did look at important issues around this.

¹⁰ What is person-centred care in dementia? Reviews in Clinical Gerontology (2003) D Brooker

I have the right to be regarded as a unique individual and to be treated with dignity and respect		I have the right to access a range of treatment, care and supports		I have the right to be as independent as possible and to be included in my community		I have the right to carers who are well supported and educated about dementia		I have the right to end of life care that respects my wishes	
Adequate or lower	Good or higher	Adequate or lower	Good or higher	Adequate or lower	Good or higher	Adequate or lower	Good or higher	Adequate or lower	Good or higher
26.2%	73.8%	28.3%	71.7%	40.0%	60.0%	38.6%	61.4%	42.1%	57.9%

Of the standards we graded, 60% of care homes provided care which inspectors found to be Good, Very Good or Excellent, with the exception of end of life care. Care homes performed best in regarding a person with dementia as a unique individual, treating them with dignity and respect – 74% of care homes were graded as Good, Very Good or Excellent against this standard.



4. Key Findings: How well do care homes meet the individual Dementia Standards?

4.1 Standard: “I have the right to a diagnosis.”

We did not grade the standard about diagnosis and post-diagnostic support as this falls outwith the remit of care homes, although we did look at issues associated with this.

Background to the Standard

The Scottish Government has sought to ensure that everyone diagnosed with dementia from April 2013 is entitled to a minimum of one year’s worth of post-diagnostic support, coordinated by a link worker. Alzheimer Scotland states that there is clear evidence that high quality post-diagnostic support, provided over an extended period, is essential in order to equip people with dementia, their families and carers with the tools, connections, resources and plans they need to live as well as possible with dementia and prepare for the future.¹¹

There are five key pillars which are recognised as essential to supporting people after their diagnosis, outlined in the diagram below.



© Alzheimer Scotland 2011

¹¹ https://www.alzscot.org/campaigning/five_pillars

What we expect to see

We expect that people living in a care home receive a timely and accurate diagnosis and are provided with the information they need about their condition, treatments and support. This means that the person receiving the diagnosis and their carers are given the right information at the right time to live well and be involved in decisions that are important to them now and in the future. Where a person lives should not make any difference to access to a diagnosis and support.

Where a person receives a diagnosis of dementia while they are using a care service, we expect care services to play a role in supporting them and their families to understand how that diagnosis will inform their care. In order to do this, staff need to be skilled and knowledgeable about dementia care.

The provider of a care service should prepare a written personal plan after consultation with the person and where appropriate their representative. This plan is a live document and should lead how care and support is delivered to the person. This should set out how the person's health, welfare and safety needs should be met. These personal plans should be reviewed with the person at least every six months or more frequently if a change is required. These plans should include the person's wishes and choices, personal preferences, interests, communication needs and details about any necessary equipment or adaptations as well as when relatives should be contacted and who should be contacted if the person wants to raise a complaint or concern.

What we looked at

We wanted to know out of the 145 care homes that we inspected how many people in the past year received their diagnosis of dementia while they were a resident. We also wanted to know what that experience was like, who gave them their diagnosis and what support was offered to them and their families. We recognise, of course, that many people may have received a diagnosis prior to moving into a care home.

What we found

In 27 care homes (19% of all care homes), we identified people who had been given their diagnosis of dementia in the past year. For most people, the diagnosis was made by the consultant psychiatrist (44% of these 27 care homes), followed by the GP (33%) and clinical psychologists (11%). Just under a quarter of these 27 care homes (22%) were not clear who had made the diagnosis for the person. In the majority of these 27 care homes, staff were unsure of how the diagnosis was communicated to the person and their family.

Once a diagnosis of dementia was made for someone living in a care home, we would expect to see this reflected in the person's personal plan. In the majority of cases (70% of care homes), updates to the personal plans were made to reflect support in light of the new diagnosis. In five care homes (19% of these 27 care homes) there were no changes to the personal plan.

Inspectors found that in 68% of care homes the updated personal plans following diagnosis were found to be Good or better.

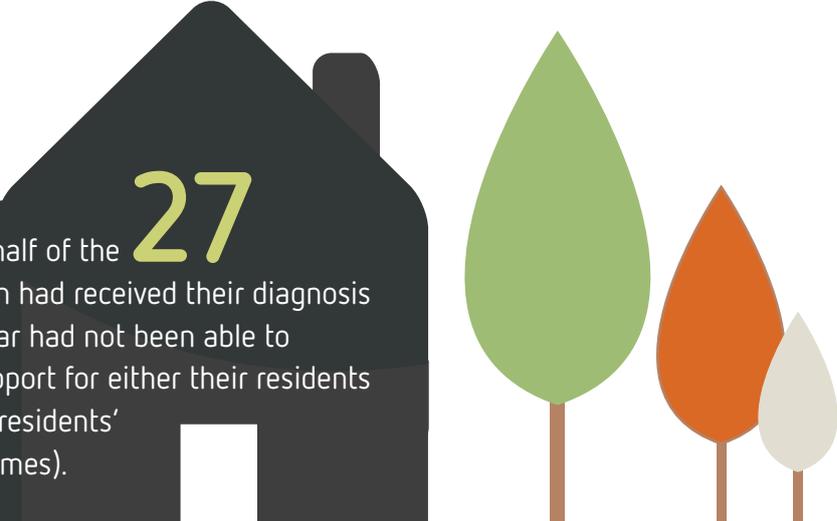
When this standard was written there was an aspiration that people would receive their diagnosis in the earlier to moderate stages of their dementia and that they would still be living in the community where access to post-diagnostic support may be more available. People getting a diagnosis in a care home are often in a later stage of their dementia and have not always had the opportunity to access post-diagnostic support.

We found that more than half of the 27 care homes where a person had received their diagnosis of dementia in the past year had not been able to access post-diagnostic support for either their residents (56% – 15 care homes) or residents' families (67% – 18 care homes). Community psychiatric nurses provided the most post-diagnostic support to both residents (83%) and families (67%) when some level of support has been provided by a service. Alzheimer Scotland provided support to families in four care homes.

We anticipated that the numbers of people receiving a new diagnosis of dementia in a care home setting would be low so we asked about people experiencing cognitive impairment. We were interested to see if a person experienced changes in their cognitive abilities whether the service would explore this further, including referral to outside support.

We found that 38% of care homes (55 care homes) had residents who have not been formally diagnosed with dementia but are living with cognitive impairment and whose presentation has changed over recent months.

A total of 80% of these 55 care homes (44 care homes) had the care and treatment needs of all residents reviewed by a professional out with the service following a change in presentation. Most commonly this review was carried out by the GP (72% – 34 care homes), community psychiatric nurse (30% – 14 care homes) and consultant psychiatrist (30% – 14 care homes).



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We found that more than half of the care homes where a person had received their diagnosis of dementia in the past year had not been able to access post-diagnostic support for either their residents (56% – 15 care homes) or residents' families (67% – 18 care homes).

Staff responded to changes in a person’s presentation by updating the personal plan in 69% of these care homes (38 care homes). As a person’s presentation changes they can experience more stress and distress and staff need to adjust their support to meet this new need. From the personal plans that were reviewed by inspectors, they rated the quality of these changes to be Good or higher in 64% of care homes.

Areas for improvement

Receiving a diagnosis of dementia can be a challenging experience for both the person and their family. Recent work with post-diagnostic support as outlined in the five pillars model from Alzheimer Scotland has indicated that the right support at the right time can make a significant difference for all affected.

We recognise that many people receiving their diagnosis while in a care home setting may be at a more advanced stage of their dementia experience and the support may need to be tailored to meet these different needs. We expect to see closer relationships between community support and care homes to address this unmet need.

We also expect to see closer working between community post-diagnostic support and care homes. There are many care homes that would be able to provide excellent post-diagnostic support to residents and families, however issues of capacity and joint working need to be carefully considered by integration authorities.

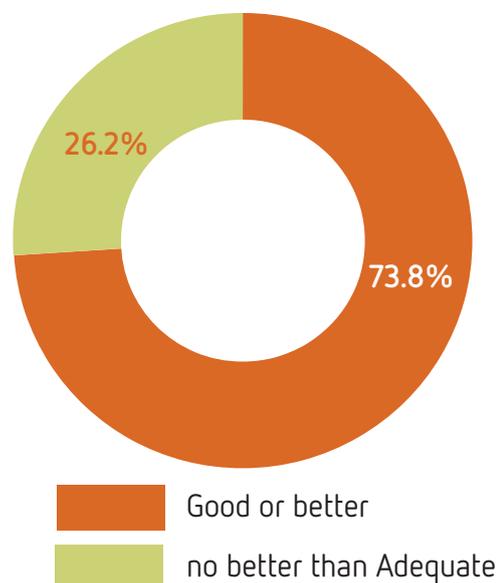
We would like to see clear and easy access for people in care homes to be assessed for a possible dementia diagnosis and to receive post-diagnostic support where appropriate. This ensures that people living in care homes receive the same access to care and treatment as those living in the community.

4.2 Standard: “I have the right to be regarded as a unique individual and to be treated with dignity and respect.”

Overview

73.8% of care homes were found to be Good or better in respect of this standard, with 26.2% of care homes found to be no better than Adequate.

The Standards of Care for Dementia in Scotland tell us that people should expect to be treated as individuals and accepted for the person they are. This means people with dementia should have the things that are important to them considered by those who care for them so they can live as fulfilling a life as possible.



The standards also tell us that people with dementia have the right to be treated with dignity and respect at all times and be free from any kind of discrimination or harm.

What we expect to see

We expect that people with dementia are treated with dignity and respect, with their individual needs, preferences and aspirations being met. We expect that they are listened to, feel included and are treated fairly. They should receive information and the necessary support to continue to participate in decisions which affect them now and in the future.

Care homes should prepare a written plan after consultation with the person and where appropriate their representative. This should set out how the person's health and wellbeing should be met. The personal plan must be a living document which supports and directs the care in a very person-centred and practical way. These personal plans should be reviewed with the resident at least every six months or more frequently if their needs change. They should include the resident's wishes and choices, personal preferences, interests, communication needs and details about any necessary equipment or adaptations as well as when relatives should be contacted and who should be contacted if the resident wants to raise a complaint or concern.

We expect to see that people living with dementia and their carers have access to independent advocacy should they want it. We also expect care and treatment that people living in a care home receive is provided following best practice and takes account of relevant legislation.

What we looked at

We evaluated how care homes found out about each person's past, present and future wishes, values and beliefs, and how this was used to make a positive difference in their life.

We asked if people had access to independent advocacy in care homes, and if so, had they been accessed in the past 12 months. We also asked if the manager and senior staff knew how to access independent advocacy.

We looked to see if the service had a register of Power of Attorney and Guardianship orders (Adults with Incapacity (Scotland) Act 2000).¹²

We looked to see (from the sample of personal plans selected) if any of the people had Section 47 consent to treatment certificates (Adults with Incapacity (Scotland) Act 2000) in place. We asked if care homes experienced any difficulties in obtaining these certificates, and if they did we queried the steps they took to resolve them.

Finally, we looked to see if Section 47 certificates specified treatments to be covered and again if there were any difficulties experienced with this.

¹² <http://www.gov.scot/Publications/2008/03/25120154/1>

What we found

Personal plans

- All care homes had personal plans for some of their residents that reflected the needs and aspirations of the residents.
- 43% of care homes had personal plans that reflected the needs and aspirations of all residents.
- We found that the quality of plans was mixed, with more than half (57%) of care homes having personal plans that did not fully reflect the past, present and future wishes, values and beliefs of all their residents.
- In 57% of care homes, only some staff knew about and used the personal information that had been gathered about residents.

Inspectors reported:

"We continued to find there was a lack of information relating to people's health needs as well as a lack of detail around how people were supported to maintain their independence, reduce levels of stress and distress as well as supporting people with memory issues. The service needs to address this to ensure that staff have clear information on how to support people's care needs in a consistent and effective manner."

"We looked at some very good examples of life history work. The resident's past life was told using old photographs showing them on holiday, at school or with members of their family. These photographs are a good way for staff to encourage the resident to reminiscence and chat."

"We saw some very good examples of person-centred personal plans which linked into the Getting to Know Me. However, we noted that although changes in individuals' presentation and care needs had been recorded in the review record these changes were not always being reflected in personal plans."

"The level of detail in these [plans] clearly described how the individual wished their care to be provided. We could see that care was being delivered as agreed with the person and/or their families."

- A third of care homes (32%) used personal information to make a difference to the quality of life of all the residents in their care.
- In seven care homes (5%) personal plans were not used to make a positive difference for any of the people in the home.

The most popular methods for recording personal information about residents were through personal plans (84% of care homes), life story books (59% of care homes) and one-page profiles (48% of care homes). We found that some care homes were using more than one method, including photograph albums and memory boards.

Advocacy

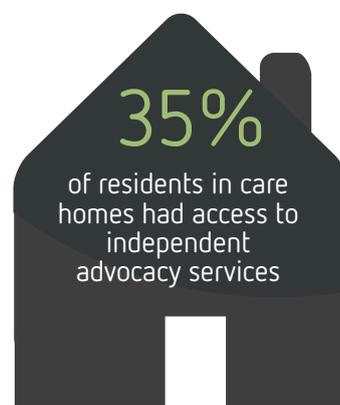
We expect that if a person needs access to independent advocacy it should be available, as having access to independent advocacy is considered good practice.¹³

The Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the importance of independent advocacy in supporting people to be appropriately engaged in the decisions made about their health and wellbeing and for their voice to be heard.¹⁴ This principle is reinforced in related legislation via the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007¹⁵.

This is important, as the Standards of Care for Dementia set out that people living with dementia should have equitable access to services as any other person but may lack capacity to make decisions about their own welfare, money and property.¹⁶

What we found

- In 35% of care homes inspected, no residents had access to independent advocacy.
- In 30% of care homes only some residents had access to independent advocacy services and had accessed this in the previous 12 months.
- We found that in 35% of care homes all residents had access to independent advocacy services and some had accessed this in the previous 12 months.
- In 69% of care homes managers and senior staff did know how to access independent advocacy.
- In 30% of care homes only some of the management and senior staff knew how to do so.
- In 1% of care homes none of the management or senior staff knew how to do so.



Inspectors reported:

¹³ Mental Welfare Commission (2017), Working With Independent Advocates http://www.mwscot.org.uk/media/240668/working_with_independent_advocates.pdf

¹⁴ <http://www.legislation.gov.uk/asp/2003/13/contents>

¹⁵ <http://www.gov.scot/Publications/2008/03/25120154/1> and <http://www.legislation.gov.uk/asp/2007/10/contents>

"People are involved in developing their personal plans with the help of their families if appropriate. This information is central to the person's care. The value of decision making is understood and advocacy is available if needed."

Legislation – Section 47

A Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000 should be in place where an individual has been assessed as not having capacity to make decisions relating to care and treatment for themselves.

What we found

- In 62% of care homes there was a register of legal measure in place under the Adults with Incapacity legislation.
- In 38% of care homes there was no register in place.
- In a small number of care homes we found out of date certificates.¹⁷
- Nearly all care homes (97% of care homes) had Section 47 consent to treatment certificates in place for at least some of their residents.

Inspectors reported:

"The service maintained a register with this information along with other relevant information such as who had powers to act on the behalf of individual residents and in what circumstances. This was reviewed and updated on a regular basis. The staff we spoke with had an awareness of issues of capacity and consent to treatment and how this may affect the care and support given to residents."

- In 45 care homes (31% of all homes) there were difficulties in obtaining these certificates for at least some of the residents.
- In the 45 care homes where there were difficulties, the most common step taken to resolve this was for the service to make repeated requests to the GP (80%).
- We found that in 39% of all care homes the treatments covered were specified for all residents, 47% of care homes had the treatments covered specified in the certificates of some residents.

¹⁷ Care Inspectorate, (2015) Records that all registered care care homes (except childminding) must keep and guidance on notification reporting <http://hub.careinspectorate.com/media/481042/records-that-all-registered-care-care-homes-must-keep-and-guidance-on-notification-reporting.pdf>

- In 15% of all care homes (21) the certificates did not specify the treatments covered by the certificate.
- We found that in 50% of care homes there were no difficulties in getting the person completing the certificate to specify the treatments covered for all residents who required this.
- 39% of care homes had experienced difficulties for some of their residents and 10% had experienced difficulties for all of their residents.

The Mental Welfare Commission in its publication Working with Adult Incapacity Act states: “If the person lacks capacity to decide about his/her medical treatment, a certificate under the AWI Section 47(1) is required in order to authorise treatment. This is the case regardless of whether there is a guardian or a power of attorney with powers relating to medical decisions. The GP, or other authorised health care professional, should complete this treatment certificate. It is recommended that a copy of this is kept close to where the adult is receiving their everyday treatment.”

Areas for improvement

- All care homes must record the past, present and future aspirations of people living in the care home and use this information to direct care and support for people.
- People living in care homes should have access to independent advocacy and staff should know how to access services in their area.
- Section 47 certificates must detail the treatment they cover in line with best practice and legislation.
- We would like to see improved partnership working between GPs and care homes to develop treatment plans to support people living with dementia.

The Short Observational Framework for Inspection (SOFI 2)

In 89 inspections SOFI 2 was used to look at the lived experience of 307 residents with dementia. This tool is especially useful when residents are not able to verbally give a voice to their experiences. Inspectors observed people in a communal area, often a lounge or dining room, and between one to four people were observed for up to an hour.

SOFI 2 records each observation in five-minute timeframes for each person observed.

SOFI 2 Observations: Mood

Observations capture the person’s mood, this includes if they are in a good, neutral or poor mood state. We appreciate that not all people living with dementia will experience a good mood at all times. However we know that long periods in a neutral mood state can often lead to poor outcomes for the individual. These observations also give us information as to how people are supported by staff when they are in a poor mood state.

What we found

- People were in a positive and relaxed mood for just over half of the timeframes observed.
- Just under 40% of the timeframes people experienced a neutral mood state, meaning that the inspector could see no signs of either wellbeing or distress.
- Less than 5% of people who were observed showed that they were experiencing stress and distress.

Engagement

SOFI 2 observes what people are doing and who they are interacting with. Person-centred and person-led care should provide opportunities for people to engage with the world around them in a way that supports their identity and gives meaning and value to life.

What we found

- In 53% of the observed timeframes people were engaged in a task.
- During the observations we recorded in 46% of timeframes people were interacting with staff.
- People interacted with those they lived with for 17% of the timeframes observed.
- People spent 10% of the observed timeframes asleep.
- 4% of the timeframes recorded people in a withdrawn state.

Quality of staff interactions

We know that how a person is interacted with can have a huge impact on their wellbeing. Staff can often be unaware of the effect of their behaviour and communication on the person living with dementia. There are also times when opportunities are missed to make the most of an interaction. We evaluated the communication between residents and staff members, as to whether it was good, neutral or poor.

What we found

- 56% of residents (171 residents) experienced a good staff interaction in over 75% of their interactions with staff.
- A total of 58 residents (19%) experienced a good staff interaction in 10% or less of their interactions with staff.
- 9% of residents (27) experienced a neutral staff interaction in over 75% of their interactions with staff.
- A total of 187 residents (61%) experienced a neutral staff interaction in 10% or less of their interactions with staff.
- Six residents (2%) experienced a poor staff interaction in over 75% of their interactions with staff.

SOFI 2 Observations

Poor interactions

A resident was assisted back into the room where they had previously been sitting and their seat was taken by another person. The staff member did not enter into any discussion with the person or ask them where they would like to sit.

On another occasion a staff member came into a room and while acknowledging the person in the wheelchair moved them out of the room without any explanation of where they were going.

Neutral interaction

Four residents sitting at the table after lunch, when a staff member interacts with them it is neutral and task-focused, saying "Come on I'm taking you to your room".

Good interactions

A staff member comes into the room smiles and waves to a resident who is just waking up. She then goes over and gives reassurance, which is kind and caring with genuine warmth.

A staff member is checking in with residents, smiling, a joke and chat here and there, residents faces light up.

Staff encouraging a conversation with a group of residents, reminiscing about boyfriends and where they had lived. Staff really listening and sharing memories. Residents then share with each other after staff had left, but they had skilfully facilitated this.

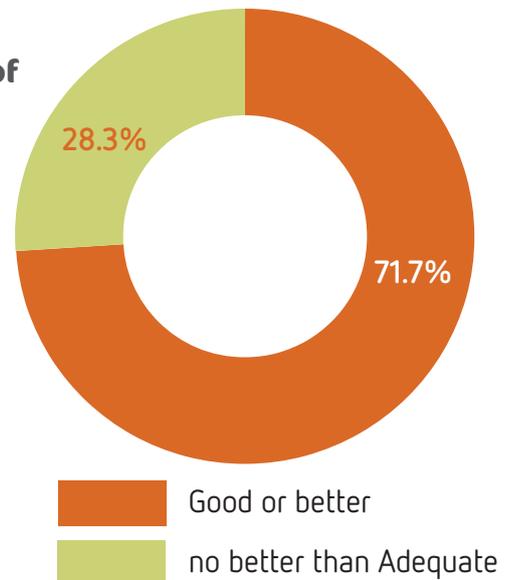
Areas for improvement highlighted by SOFI 2

- We expect staff to interact with people living in care homes in a way that supports and promotes their wellbeing.
- We expect care homes to move from task-focused interactions between staff and the people they are supporting and use each interaction as an opportunity to engage positively with people.
- We expect to see the importance of relationships and positive interactions as a core area of staff induction.
- We expect staff to act as good role models for other staff and to challenge and report poor practice.
- Care homes must support people to make and maintain meaningful relationships with people whom they live with. This would combat some of the loneliness and isolation that can be experienced, even in a communal setting.
- We expect all care homes to regularly use observation as part of their ongoing quality assurance. This is an important way to see if learning and development is making a positive impact in practice and to ensure staff are confident in supporting residents to experience compassion, dignity and respect.

4.3 Standard: “I have the right to access a range of treatment, care and supports.”

Overview

71.7% of care homes were found to be Good or better in respect of this standard, with 28.3% of care homes found to be no better than Adequate.



The Standards of Care for People with Dementia in Scotland set out that people with dementia and their carers have the right to full participation in care needs assessment, planning, deciding and arranging care, support and treatment. People with dementia have the right to access appropriate levels of care providing protection, rehabilitation and encouragement and the right to the highest attainable standard of physical and mental health.

What we expect to see

We expect to see that people with dementia receive good quality, timely and integrated assessment and treatment and that they experience a person-centred approach to support and care.

We expect that they receive the right treatment at the right time, including a range of non-drug based treatments if they experience stress and distress.

Older people living in care homes are at higher risk of oral health problems and related conditions because of high levels of dependency and dementia. Caring for Smiles¹⁸ is Scotland’s national oral health promotion, training and support programme, which aims to improve the oral health of older people, particularly those living in care homes.

Promoting continence is a vital component of health and wellbeing and for a person living with dementia can underpin a positive sense of self.

What we looked at

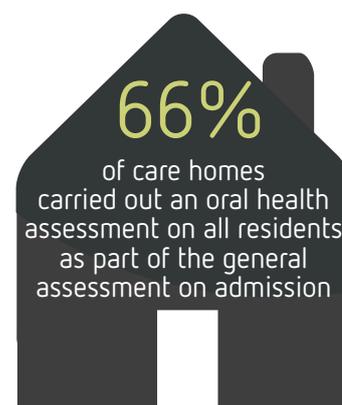
For the purposes of this inspection focus area we looked specifically at how care homes supported residents with oral health, medication management in relation to stress and distress and promoting continence. We spoke with staff and reviewed support plans to gather this information as well as using SOFI 2 to assess residents’ experience in the care service.

¹⁸ <http://www.nes.scot.nhs.uk/education-and-training/by-discipline/dentistry/areas-of-education/priority-groups/oral-health-improvement-caring-for-smiles.aspx>

What we found

Oral care

- 99% of care homes had at least some residents that required assistance to maintain good oral health.
- Most homes (83%) had some residents who found oral health care to be stressful.
- We found that 88% of care homes had or would contact the community dentist or oral health team if a resident consistently refused oral care.
- We found that 80% of care homes were participating in the NHS Education for Scotland (NES) Caring for Smiles (CFS) programme.
- Our findings showed that staff in better performing care homes had greater awareness of where a person experiences a change in appetite or periods of stress, oral pain may be a possible factor.
- In 67% of care homes, with grades of Good or higher on the dementia standard "I have the right to access a range of treatment, care and support", all staff were aware of the effect of oral pain on the individual.
- Just over half of all care homes (55%) had an oral health champion in place. Trainers for Caring for Smiles encourage care homes to consider having an oral health champion to sustain the good practice once the initial training has been completed.
- 66% of care homes carried out an oral health assessment on all residents as part of the general assessment on admission.
- 29% of care homes carried out an oral health assessment on some of the residents on admission.
- 5% of care homes did not carry out an oral health assessment as part of the general assessment on admission.
- In 57% of care homes the assessment informed a personal plan, if required, for all people.
- In 13% of care homes the assessment did not inform a personal plan for any of the people.



Inspectors reported:

"Staff were aware of the importance of good oral care. If a person was distressed by oral health, staff were able to describe approaches to reduce distress, or knew where they could seek additional support."

"Staff had been trained to provide oral health care and the service had good links with the dentist and community oral health practitioners."

"Oral health assessment was in place but not fully linked to a personal plan and sometimes there was no personal plan. It was often not recorded clearly what

method of oral care was being used, for example tooth brushing or denture cleaning. Some units had oral care records. Others had not introduced these yet. Some records showed frequent refusal of oral care but there were no strategies in place of how this was to be managed. A formal agreement to ensure a dentist was available for the care home was still being worked on. This meant a number of people had not been reviewed and may not be receiving regular oral care."

Areas for improvement

- It is important that all older people in care homes have their oral health assessed when they first come into a care home and then regular on-going assessments are carried out. This helps establish a baseline of their oral health on admission to the home. Care homes should ensure that oral health assessments form part of the welcoming process when a new resident moves in.
- Arrangements must be in place to ensure that all people living in a care home have access to dental care. Care homes should support them to keep their own dentist if preferred and practicable.
- Personal plans should describe clearly the support that people need to maintain good oral health which includes teeth, dentures and gum care.
- Care homes need to ensure that people who require assistance with oral health receive this regularly as recommended by their dental health team.
- Consideration should be given to seeking additional support, as well as a dentist when needed, to support oral care. This could include working with the person's family, GP or linking with community mental health team/community psychiatric nursing teams.
- Staff need to be trained and skilled to support people to maintain good oral health and to be able to identify potential issues.
- Care homes should consider having oral health champions within each home to help keep staff up to date with the latest best practice guidance and to monitor oral health care provision in the home.

Medication management

We sampled medication records and personal plans with a focus on medication review and the use of medication for people experiencing stress and distress.

What we found

- We found that all medication was reviewed in care homes.
- 52% of care homes demonstrated that medicines were regularly reviewed (annually or every six months).
- We found that 81% of care homes tried non-pharmacological methods to support all or some people with dementia before administering psychoactive medications.



- In 77% of care homes all or some residents' care plans stated "as required" (prn) medication was being used for stress and distress and detailed its use.

Inspectors reported:

"We saw good examples of care plans for distressed behaviour. Other ways to help someone get calmer were identified in the care plan and tried before antipsychotic drugs were given. The methods for calming someone were person-centred and specific to that individual."

Areas for improvement

There has been an improvement in the use of non-pharmacological interventions rather than medication as the first line response to stress and distress since Remember I'm Still Me in 2009. However there remain areas for development which will have a positive impact on both the people being supported and the staff.

- We expect all care homes to engage with NHS Education for Scotland and Scottish Social Services Council to develop staff in understanding stress and distress in people living with dementia.
- We expect care homes to have appropriate links and relationships with community mental health teams and/or care home liaison teams to put into practice formulation-led interventions.
- Care homes need to further develop their role in monitoring medication and the condition it is prescribed for including knowledge of the side effects of medications prescribed.
- Staff need to be knowledgeable and confident in their skills to ensure that the medication that is prescribed is enhancing quality of life and doing what it is intended to do.
- We expect care homes to have in place good collaborative working with GPs and pharmacists. Strategies and methods to support people experiencing stress and distress must be clearly developed, noted in the personal plan and known to all staff.
- Where "as required" (prn) medication is prescribed for stress and distress, we expect to see this detailed in personal plans, with clear conditions for its use and expected outcomes, with a record of whether these outcomes were actually met.
- We expect that staff understand and know their residents well enough to use non-pharmacological interventions in the first instance thus reducing the need for "as required" (prn) medication.

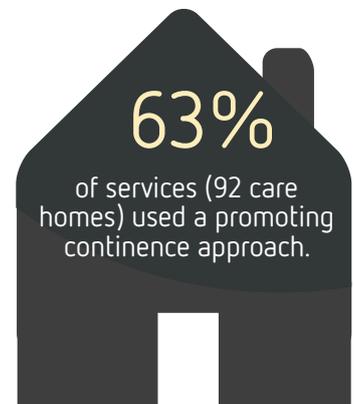
2. Continence

For this report, incontinence is defined as a loss of bladder or bowel control leading to the involuntary or inappropriate passing of urine and/or faeces.

We expect care homes to promote continence for individuals rather than managing incontinence. Promoting continence can be achieved in a variety of ways and needs to be understood as an important factor in a person's wellbeing.

What we found

- 63% of services (92 care homes) used a promoting continence approach.
- 37% of services (53 care homes) that used a managing incontinence approach.
- 47% of services (68 care homes) supported all residents to use lower absorbency products and to visit the toilet as needed.
- 47% of services (68 care homes) supported some residents to use lower absorbency products and to visit the toilet as needed.
- 6% of services (9 care homes) did not support any residents to use lower absorbency products and to visit the toilet as needed.
- In 88% of care homes at least some staff had attended education/training related to bowel and bladder health, and this was having a positive impact on people experiencing care.



In 45% of care homes with grades of Good or higher on the Dementia Standard "I have the right to access a range of treatment, care and supports", all staff had received training to promote continence. This compares to just 7% of care homes with grades of Adequate or lower for this Dementia Standard.

Inspectors reported:

"Staff described a culture of promoting continence rather than managing incontinence. We signposted the service to the Care Inspectorate's Promoting Continence resource to build on practice in this area."

King's Fund tool: The environment promotes continence and personal hygiene

If a person is not able to find the toilet this provokes anxiety. Using the same signs and door colours to denote all toilets will help people find them more easily. Ensuring good colour contrast on sanitary fittings will make toilets and basins easier to see and use. Traditional and familiar designs will help ease anxiety and promote self-care. Being plunged into darkness if sensor lights go out can be very frightening.

What we found

Table 5: Overall statistics on whether the service environment promotes continence and personal hygiene

	% share of services	Number of services
Excellent	3.1%	4
Very good	16.4%	21
Good	33.6%	43
Adequate	38.3%	49
Weak/unsatisfactory	8.6%	11

Areas for improvement

Nationally and locally, further work is needed to raise the profile around the overall health and wellbeing benefits that is linked to actively promoting continence for all older people who present with a bowel and/or bladder care needs.

Promoting continence is a vital component of health and wellbeing and for a person living with dementia it can underpin a positive sense of self. Promoting continence should not be seen as a task, but as an opportunity to engage with a person in a meaningful way. For example, as a person is accompanied to the toilet the member of staff can be assessing mobility, have a chat which can give information about mood and wellbeing, as well as assisting the person to go to the toilet. This can impact on quality of life as well as contributing to physical wellbeing. Although we recognise that incontinence may affect a person with dementia at the latter stages of their experience, it should not stop staff from seeing the potential in a person to maintain or possibly regain continence.

- We expect people living in care homes to have a continence assessment.
- We expect care homes to provide a physical environment which enables people to use the toilet independently where possible.
- We want to see staff who are confident in using a range of strategies that promote continence. This includes exploring alternatives to the use of products.
- We expect care home staff to engage with the resources that are available to them to help them actively promote, maintain and/or improve continence care outcomes for people living in care homes.
- We encourage care homes to use the Care Inspectorate's continence resources to support them on their improvement journey.¹⁹

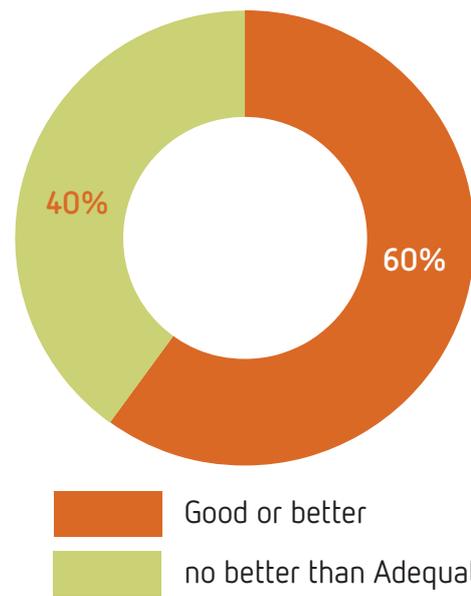
¹⁹ <http://hub.careinspectorate.com/improvement/spotlight-on-bowel-and-bladder/>

4.4 Standard: “I have the right to be as independent as possible and to be included in my community.”

Overview

60% of care homes were found to be Good or better in respect of this standard, with 40% of care homes found to be no better than Adequate.

The Standards of Care for Dementia in Scotland set out that people should have the same opportunity as everyone else to live as full a life as possible within their community. They should expect to be able to keep up relationships with the people who are important to them and be able to do the things they enjoy. This means people with dementia should be given the help they need to make sure they have equal access to all of the leisure, recreational and cultural activities within and beyond their own local community.



What we expect to see

We expect to see residents being given opportunities to remain as independent as possible and, where possible, regain skills that they may have lost but with support of 24-hour residential care can once more be achieved.

Relationships are vital for the wellbeing of people with dementia and we expect care homes to support families and friends to remain connected to their loved ones.

Moving into a care home should not mean the loss of community connections. We expect care homes to be part of their community.

What we looked at

We assessed if care homes used an enablement approach to promote the independence of their residents and whether this was part of the philosophy of the care home. We evaluated how this approach was delivered to either maintain or improve a person’s level of independence.

Inspectors used the King’s Fund environmental tool under this section to determine whether care home environments promoted orientation, mobility, wellbeing, meaningful interaction and purposeful activity between people who live in the home, their families and staff.

We looked at how care homes supported people to keep connected to their community and if the home was part of the community. We also asked care homes what methods were being used to help

people keep in touch with relatives and friends and if there were opportunities to keep active and engage in meaningful activities of everyday life.

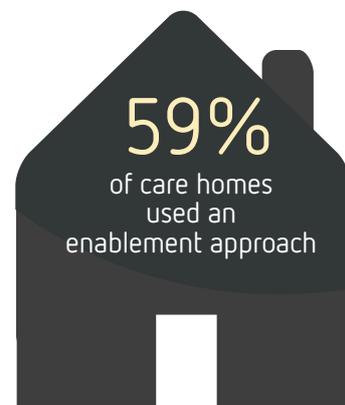
We checked if care homes had access to their own transport and/or used community transport links to facilitate access to their local community.

We also looked at whether there were appropriate opportunities for people to go outside of the care home and the extent of these opportunities. As staffing levels can affect the possibilities for people to leave the care home, we asked if and how often staffing levels prevented people from accessing the community at least once a week.

What we found

Enablement

- 10% of care homes did not provide any opportunities to keep the people living in the home active and engaged.
- 55% of care homes had provision for on-going organised activities every day of the week.
- 40% of care homes had this provision for on-going organised activities for weekdays only.
- 6% of care homes had no provision for these on-going organised types of activities – in other words they did not have a regular schedule of activities.
- 59% of care homes (85 care homes) used an enablement approach.
- Of those 85 care homes using an enablement approach we found that 71% (60 care homes) delivered this to all residents.
- In the remaining 25 care homes (29%) the enablement approach was only used with residents considered by care staff to have the potential to improve.



92% of care homes using an enablement approach were able to demonstrate where this approach had either maintained or improved a person's level of independence.

Inspectors reported:

"Overall, individuals were supported, including with the use of mobility aids and equipment, to attend to their own personal care (to eat, drink and wash independently) and take part in physical activities. Enablement also extended to assisting residents to arrange holidays and days out."

"In one service, one resident had a befriender with whom he went swimming. In another care home, one resident rarely left their room and was very isolated, which was having a negative effect on this person's wellbeing. Staff encouraged and supported this resident to leave their room and access a nearby sitting room with the hope that they would gain confidence to eventually restart visiting the ground floor and main shared areas of the home, including the dining area."

"In one care home, a woman who previously enjoyed horse riding expressed an interest in returning to the sport. Staff explored this with the assistance and support of the local Riding for the Disabled Association. After discussions and assessment of her physical abilities the woman was supported to ride in a carriage. She felt that she was physically unable to ride a horse but was delighted with the modified version of horse riding."

"We were aware that the activities coordinator was not always able to commit to allocated hours due to being asked to provide care and support to residents during staff shortages. Residents told us there was a lack of varied activities taking place and they would like to get out and about more. Care plan activities records contained little detailed information about residents' likes and dislikes, hobbies and skills. Although staff completed activity records routinely they contained summarised information about how residents spent their days which consisted mainly of watching television, family visits and listening to music. Activity records did not record residents' responses and abilities with activities undertaken."

Care home gardens

We are aware from research that it is possible to promote the wellbeing of older people living in care homes by providing them with opportunities to visit outdoor green environments.²⁰ Being outdoors offers physical health benefits as well as emotional and psychological benefits.

We recommend that people should be able to choose to spend extended periods of time outdoors. The building guidance for care homes notes the powerful effect that being outdoors can have on a person's wellbeing. For example, it can help rekindle past interests and hobbies, it can support physical activity and exposure to sunlight is necessary for the absorption of Vitamin D.

What we found

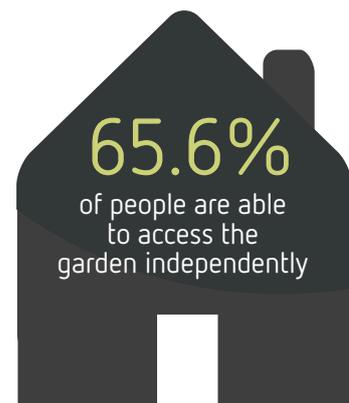
We found that in the majority of care homes where residents could access the care home garden, this garden is secure. However the number of people who could access a secure garden independently was much lower in comparison.

Overall numbers on whether care home gardens are secure

	% share of services	Number of services
Garden secure	86.0%	113
Garden not secure	14.0%	19

Overall numbers on whether people are able to access the garden independently

	% share of services	Number of services
Access independently	65.6%	87
Cannot access independently	34.4%	44



Inspectors reported:

"A particular strength was the provision of outdoor space on both levels of the home which people were able to access independently. Residents were encouraged to get involved in the garden growing fruit and vegetables which were used in food preparation within the home. The home had also achieved success at the Ayr Flower Show."

²⁰ Visiting outdoor green environments positively impacts self-rated health among older people in long term care (2006) Rappe, Kivella and Rita (2006) <http://horttech.ashspublications.org/content/16/1/55.full.pdf>

"We witnessed some good practice with a resident who is a keen gardener. They were involved with growing vegetables for the home in the greenhouse and also spent time chopping and preparing vegetables for some of the home's meals."

"There was a garden at the front of the home which was colourful and well maintained, although this was not enclosed and could not be accessed easily or independently. There were concrete steps from the conservatory which were quite steep or ramp access could be used via an alarmed fire escape or through the support service at the other side of the building. There was a pathway in part of the garden. However, a large section was grass or stone chips which a lot of people would have found difficult to walk on with walking aids or if their balance was poor. One person we spoke with had interpreted the stone chipped area as water."

"Very few residents are able to access the outside independently. The garden has become overgrown and the paths are not easily recognisable due to weeds. There was some broken fencing and the garden is not totally secure. The summer house was being used to store garden items and was not as pleasant as at previous visits."

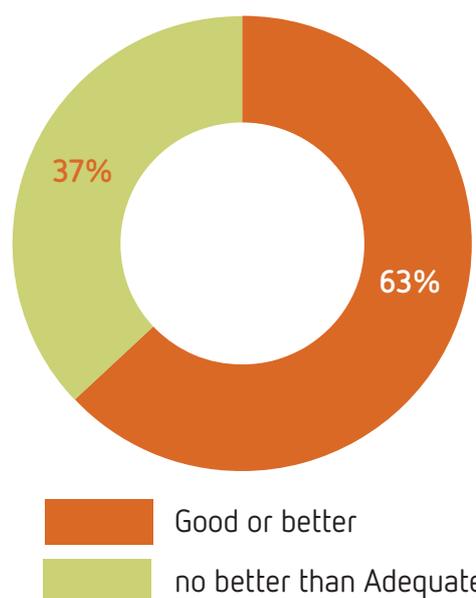
King's Fund tool

The environment promotes mobility

63% of care homes were found to be Good or better in respect of this principle, with 37% of care homes found to be no better than Adequate.

What we expect to see

We expect to see residents given every opportunity to walk independently in the care home. We look for safety to be enhanced by providing handrails and small seating areas where people can rest in corridors and gardens. Attention needs to be paid to flooring as people with dementia may interpret



shiny floors as being wet and or slippery and changes in flooring colour as something to step over, patterned flooring can also be confusing. Access to the outdoors throughout the year is essential for wellbeing.

What we found

In the majority of care homes, mobility and independence were encouraged, although this encouragement was in some cases directly related to the residents' abilities, with those who were more able having more opportunities. The most common tool used by most care homes to facilitate mobility was internal and external handrails. We also saw care homes engaging with more formal exercise promotion. For example, one service worked closely with the physiotherapists to implement suggested exercise programmes that were recommended to ensure residents' mobility remained at the optimum level.

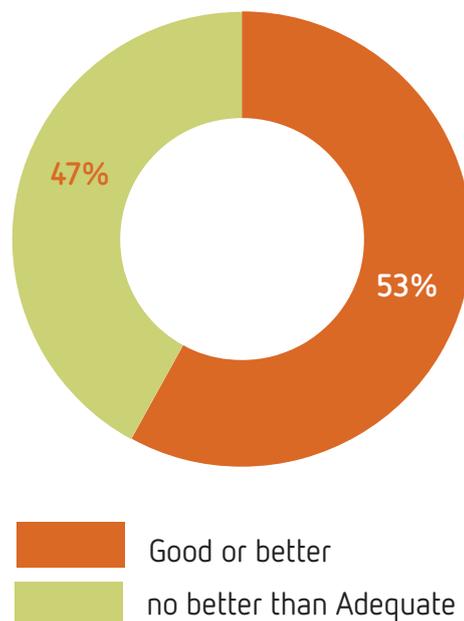
There were a small number of care homes who did not promote mobility to an effective level. In these cases, either the garden was not accessible or secure, spaces need to be improved to facilitate mobility, trip hazards were visible, or residents did not have enough opportunities to be active.

The environment promotes orientation

53% of care homes were found to be Good or better in respect of this principle, with 47% of care homes found to be no better than Adequate.

What we expect to see

We expect to see orientation being promoted with the use of visual clues and prompts, including accent colours and artworks, personalising bedrooms and providing clocks and calendars. Signs using both pictures and text placed at a height where they can easily be seen, along with careful attention to the placement of mirrors will decrease disorientation.



What we found

Inspectors found many positive examples in the provision of personalised bedrooms. Most bedrooms were personalised with photographs, objects and furniture. Personal objects, including self-care items were generally kept in appropriate places.

However, there was also a significant number of care homes that either did not have or had to improve dementia-friendly signage. These examples are indicative of a wider trend.

The use of calendars and clocks may help with orientation. However, the lack or inadequate provision of each of these in homes was noted by several inspectors.

Inspectors reported:

"Large clocks and calendars are not in use within communal areas, and not all bedrooms have one."

The environment promotes meaningful interaction and purposeful activity between people who live in the care home, their families and staff

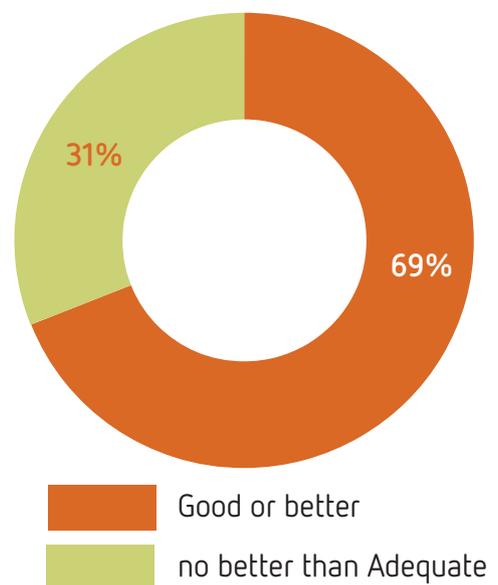
69% of care homes were found to be Good or better in respect of this principle, with 31% of care homes found to be no better than Adequate.

What we expect to see

We expect to see living spaces that are welcoming for both residents and their families. We expect the furniture and decor to give clues to the use of the space, with a choice of seating, including chairs with arms and sofas. Arranging chairs in clusters will encourage conversation. Residents should also have access to quiet seating areas. The environment needs to be able to accommodate a range of possible activities.

What we found

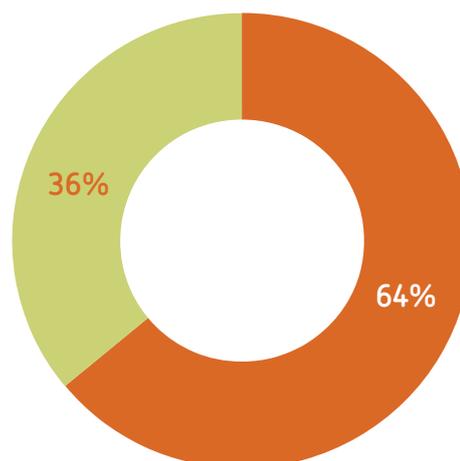
Meaningful interaction within the environment was promoted usually through the promotion of wellbeing by encouraging independence in daily, personal activities such as eating, drinking, continence and personal hygiene. Family and friends were welcomed into care homes in most services.



The environment promotes wellbeing

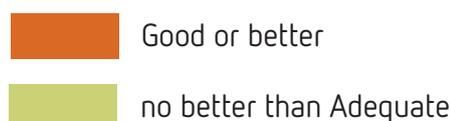
Analysis

64% of care homes were found to be Good or better in respect of this principle, with 36% of care homes found to be no better than Adequate.



What we expect to see

The King's Fund Tool and research from the Dementia Services Development Centre in Stirling have drawn attention to older people's need for higher light levels. Some people with dementia may interpret shadows or dark areas on the floor as holes and try to step over them. Stripes on flooring can also be confusing and disorientating. Appropriate light levels can help promote normal patterns of waking and sleeping, as well as independence at mealtimes. Views and access to the outside are essential for wellbeing.



What we found

We found some care homes with good levels of natural lighting which were appropriate for people. One care home manager has used new technology by introducing an app that could check the levels of lighting at the home. Another service was found to have used advice from the Dementia Services Development Centre at Stirling University to improve the lighting within the home. One care home improved lighting by installing new LED lighting and reported that it had made a difference to residents, with more light and accessibility.

Many care homes were identified as having poorer light levels in bedrooms. The lighting level was low to encourage rest and if a resident woke in the night. However, it also meant that people could not, for example, retrieve the items in their wardrobes during the day.

Keeping in touch with family, friends and the community

Encouraging connections with volunteering, local community groups, schools and colleges to support the care environment can be mutually beneficial for all. We defined keeping connected to the community as either opportunities for the community to come into the care home or for the residents to leave the care home and access the community. In 35% of care homes all residents were supported to keep in touch with their community, either by means of the community coming into the home or by the resident visiting the community. In 64% of care homes only some of the residents were supported to keep connected to their community. In two care homes, no residents were supported to keep connected to their community.

We found that the majority of care homes (84%) described themselves as part of the community.

We found that 91% of care homes used the telephone to help people keep in touch with families and friends, 53% used letters, 50% used email, 41% used video calls and 26% used other forms of communication.

We recognised some innovative examples of using technology to support connections between residents and other people. Some care homes had set up internet cafes to enable residents to use Skype to connect with family who lived abroad. Local school children supported the initiative by assisting the residents to use the computers and learn more about computing in general, supporting intergenerational living. We found an innovative example of using Google Earth to help a care home encourage connections with the places from the past. One woman was able to virtually revisit the town of her birth and see her parents' house. Another man virtually revisited a pigeon loft he had built and thought he would never see again. Although these examples are virtual connections, it was an important reconnection with their past and we identified that this had a positive impact on people. In almost all of the care homes at least some of the residents had appropriate opportunities to go outside of the home. For 39% of care homes, these opportunities were for all residents and in 57% of care homes these were available for only some of the residents. In 4% of care homes no residents had appropriate opportunities to go outside of the care home. This limits a person's ability to be part of a local community and experience a wide range of things they may enjoy.

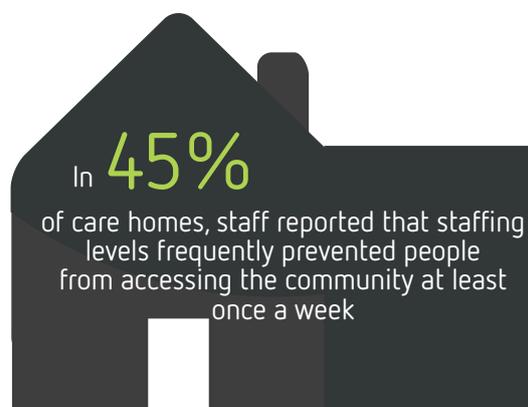
Of the care homes where there were opportunities for residents to go outdoors, 91% of these care homes' residents could visit the care home garden and in 87% of these care homes they could visit their local community.

Residents who were being supported to go into the local community visited shops, cafes, theatres, museums, the local pub, singing groups, hairdressers and local nurseries to help maintain their garden. Some care homes supported their residents to partake in sailing and canal trips.

We found that in 55% of care homes staff reported that staffing levels rarely or never prevented people from accessing the community at least once a week. However, in 45% of care homes, staff reported that staffing levels frequently prevented people from accessing the community at least once a week.

Inspectors reported:

"Outside for 5 is an initiative to enable residents to get outside for a short walk. Appropriate outdoor clothing enabled the residents to get out no matter what the weather. The five-minute sessions enabled the person receiving care to experience the wind in their hair, hear the birds in the trees, the crunch of the leaves, the



children playing, a dog barking and a cat walking along a fence. Even short periods of time like this are powerful in supporting improved experiences and outcomes for people. Even if the specific memory is forgotten, the happiness and sense of achievement often remains and contributes to people's wellbeing."

Transport can make the difference in having links with the community and therefore affect the wellbeing of people within the service. Overall, findings were mixed on this topic. Some care homes had their own transport, usually a minibus, and some had either very limited access, depending on staff availability, volunteer drivers or public transport, or no private transport at all.

Access to transport was broken down as:

- 45% had access to transport every day of the week
- 17% had access only on weekdays
- 38% had no private transport at all

However, we found that most care homes (78%) used taxis to help residents get into the community, 30% used buses and 15% did not use any community transport.

Examples

One care home had a dedicated minibus, this allowed residents to attend groups out with the home at Alzheimer Scotland as well as tea dances and singing sessions. Activity preferences are recorded and are individualised and person-centred to meet the choice and wishes, which include the use of local venues such as the pub where the staff have also been trained as Dementia Friends, as well as excursions or visiting entertainers.

Inspectors reported:

"Residents were supported to maintain connections with the local and wider community such as shopping, tea dances, going to the swimming pool and meeting residents from other local homes. The home had its own vehicle to support this. The community was also welcomed into the home. Visits by pupils from a few local primary and secondary schools supported intergenerational engagement, and residents were invited for afternoon tea and festive parties at some schools. Pupils from a secondary school took part in group work with residents, and a few senior pupils became volunteers."

Areas for improvement

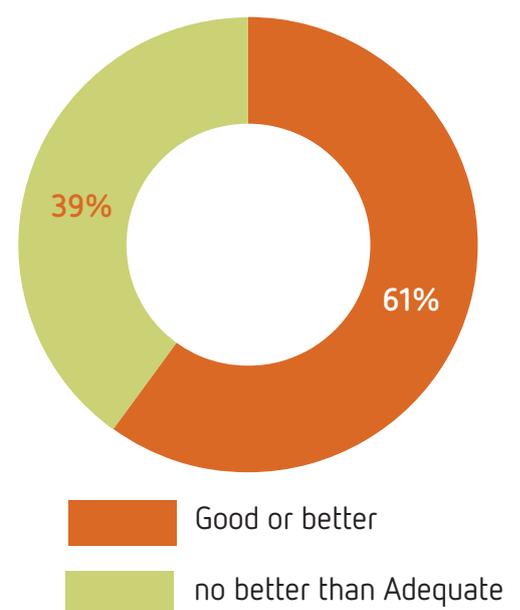
- We expect care homes to use the information they have about people to offer meaningful activities for all individuals.
- We expect care homes to support residents to keep connected with their community.
- We expect people to have increased opportunities for activities at weekends and evenings.
- We expect all staff to understand the importance of meaningful activities for people and to take an active role in this.
- We expect care homes to support people to maintain relationships with family and friends.
- We expect all care homes to identify the potential in every individual and support the remaining strengths of the individual to promote wellbeing.
- We expect enablement to be a core part of staff induction and to receive on-going learning and development
- We expect care homes to have secure gardens that can be accessed independently by people including those with physical disabilities.
- Access to gardens needs to be available for all and not only those living on the ground floor.
- We expect in determining appropriate staffing levels that care homes take into account people having access to outdoor /and the community and the support people need to maintain relationships.
- We expect to see care homes quality assuring their environments to meet the needs of people living with dementia. We expect environments to promote wellbeing and not to be a barrier to independence.

4.5 Standard: “I have the right to carers who are well supported and educated about dementia.”

Overview

61% of care homes were found to be Good or better in respect of this principle, with 38% of care homes found to be no better than Adequate.

The Standards of Care for Dementia in Scotland set out that people should expect to be supported by social care services provided by professionals and staff who have had appropriate training/learning and development in dementia and human rights to ensure the highest quality of care. This is supported by the Promoting Excellence²¹ framework which explains the essential knowledge and skills that staff need to support people with dementia, making sure that they achieve positive outcomes.



²¹ <http://www.sssc.uk.com/workforce-development/supporting-your-development/promoting-excellence-in-dementia-care>

It is aspirational with a philosophy based on continuous learning, as is expected in the Scottish Social Services Council Codes of Practice for Social Service Workers.²²

What we expect to see

We expect to see that care staff have the knowledge and skills they need in relation to their role in supporting people with dementia and that they receive appropriate learning and development, levels of supervision, and opportunities to reflect on their practice. We expect family members and friends to be recognised and valued as partners in care and to be supported in their role. This should include invitations to contribute to staff development.

We expect care homes that support people living with dementia to have a skilled and knowledgeable workforce who provide care and support to meet each individual's unique needs.

We also expect staff to know the overall aim or vision of the care home and to appreciate how their learning and development fits in with this aim to give residents the best quality of life as possible.

What we looked at

During our inspection focus area, we examined key enablers of these expectations, including whether staff had learning and development opportunities to enhance their dementia skills and knowledge, as well as if care homes had engaged with the Promoting Excellence Framework.

We spoke with managers of care homes to see if they had an understanding of the skills and knowledge that staff need in order to meet the needs of residents living with dementia.

We also asked if care homes had a Dementia Ambassador, this is an initiative supported by the Care Inspectorate and Scottish Social Services Council.

Finally, we asked if staff knew the aims/objectives or vision of the care home. This helps examine whether staff are clear about what they are trying to achieve for residents.

What we found

- 97% of care homes provided some or all staff the opportunity for learning and development to enhance their dementia practice.
- There was a clear correlation between care homes with grades of Good or above for the dementia standard "I have the right to access a range of treatment, care and supports" and higher rates of staff trained in dementia care.
- 55% of care homes with grades of Good or above had learning and development opportunities for all staff compared with 12% of care homes with grades of Adequate or lower.

²² <http://www.sssc.uk.com/about-the-sssc/codes-of-practice/what-are-the-codes-of-practice>

Inspectors reported:

"We heard how staff had received training in dementia and how this helps them to understand the condition and recognise and manage stress and distress situations. This enabled residents to be cared for and supported in a way which met their individual needs."

- In four care homes (3%) no dementia learning was offered to staff and this impacted negatively on the care provided to people in these care homes.
- In 73% of care homes the roles and responsibilities of all or some staff had been fully aligned to the Promoting Excellence Framework.
- Care homes using the framework were generally found to be providing better quality care than those who did not use the framework.
- 47% of care homes with grades of Good or above had aligned all their staff roles to the framework compared with just 9% of care homes with grades of Adequate or lower.

Inspectors reported:

"We saw there was good practice in dementia care in the home. Staff demonstrated a good understanding of the condition in the way in which they responded and interacted with residents. Training in dementia care was tailored to the job role of staff. The manager was aware that training needed to be aligned to the Promoting Excellence Framework for Dementia Care."

- In 66% of care home managers demonstrated a full understanding of the required skills and knowledge of staff to meet the needs of people living with dementia.
- In 84% of care homes with grades of Good or above, managers demonstrated a full understanding of required skills compared with 34% of care homes with grades of Adequate or lower.
- In nine care homes (6%) managers demonstrated no understanding of the skills and knowledge required by staff to provide good dementia care.
- 60% of care homes provided regular planned supervision for all staff.
- 36% of care homes provided some level of supervision.
- 4% of care homes had no supervision available.
- We found that where staff received regular, planned supervision that the service was more likely to be a better performing service with better outcomes for people.
- In 46% of care homes there was a dementia ambassador for the home.
- In 53% of care homes with grades of Good or above there was a dementia ambassador compared with 33% of care homes with grades of Adequate or lower for this standard.



Inspectors reported:

"The manager is a dementia ambassador and along with her excellent leadership and motivational skills, ensured staff provided the highest standards of dementia care to residents and their families. A very positive ethos and culture of respect and dignity was clearly evident and ingrained in practice in the home. There was a focus on a 'can do' approach. A number of best practice champions promoted excellent standards of care in areas such as dementia, oral health care and continence promotion. This all provided a solid foundation that linked positively to every aspect of the service provided."

- In 34% of care homes (48 care homes) all members of staff knew the principles, aims and objectives of the service.
- Of these 48 homes, 43 had grades of Good or higher on the dementia standard "I have the right to have carers who are well supported and educated about dementia". The other five homes were graded as Adequate or lower for this standard.
- In 10% of care homes (14 care homes) no member of staff knew the principles, aims and objectives of the service.

Areas for improvement

- We expect staff to know and understand the aims of the care home and how their role supports meeting these aims.
- We expect care homes to have staff who understand the importance of person-centred care through learning and development, and are able to put this into practice by moving away from task-driven care to care and support that meets the needs of each individual resident.
- We expect care homes to align staff roles and responsibilities to the Promoting Excellence Framework and to develop staff so that they have the skills and knowledge outlined at each level of the framework.
- Care homes should ensure that all staff receive learning and development opportunities in dementia practice appropriate to their role, and are confident and competent in applying that learning in order to improve experiences and outcomes for people living there.
- We expect care homes to provide supervision and development opportunities to staff in order to support staff wellbeing and resilience.
- We expect care homes to make use of Scottish Social Services Council²³ and NHS Education for Scotland²⁴ resources in dementia practice and supervision.

²³ SSSC, Promoting Excellence in dementia care <http://www.sssc.uk.com/workforce-development/supporting-your-development/promoting-excellence-in-dementia-care>

²⁴ NES, The Knowledge Network <http://www.knowledge.scot.nhs.uk/home.aspx>

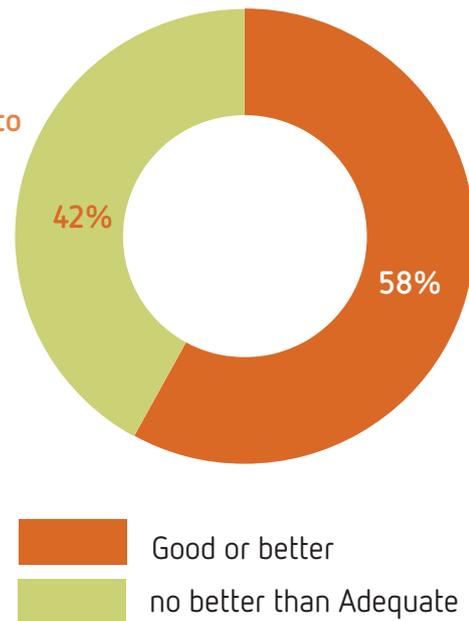
- We encourage care homes to consider the Scottish Social Services Council host an Open Badge²⁵ scheme where people can submit a reflective account of how they have applied their learning. The open badge is awarded in recognition of this learning.
- We expect care homes to have identified staff who are dementia ambassadors or champions. Both Scottish Social Services Council and NHS Education for Scotland offer support to key staff to become dementia ambassadors or champions for care homes.

4.6 Standard: “I have the right to end of life care that respects my wishes.”

Overview

58% of care homes were found to be Good or better in respect of this principle, with 42% of care homes found to be no better than Adequate.

The Standards of Care for People with Dementia in Scotland set out that people should receive the full range of palliative care services and good quality compassionate care towards the end of life. This means that people receive the support they need to die with dignity in the place of their choosing wherever possible and in a way which respects their previously expressed wishes.



What we expect to see

We expect to see residents living well and being supported to plan for a good end of life. We expect to see care homes supporting the physical and emotional needs of the person and their families. We want to see staff who are skilled and confident in their roles, and who know when they need to bring in additional support from the wider health and social care team. We expect care homes to work in partnership with other agencies and professionals to ensure people’s wishes are known and respected, and we expect local partnership to work across health and social care boundaries to promote good anticipatory care planning.

What we looked at

For this standard we chose to look at the use and understanding of anticipatory care planning, which helps people make choices about their future care and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). We also looked at the support that care homes receive from external agencies.

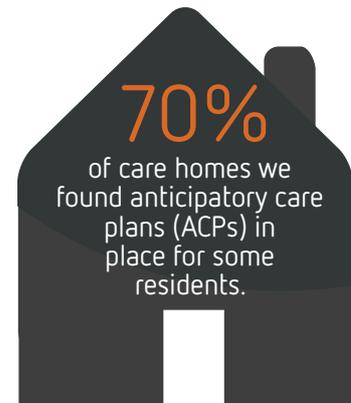
The decision to start an ACP is one that needs to be discussed with the person, their family and the supporting team from health and social care. Some residents may choose not to be part of this

²⁵ <https://www.badges.sssc.uk.com/>

process. However, when ACPs are explained carefully and support is given then people are often keen to have plans in place that enhance their wellbeing even in light of deteriorating health.

What we found

- In 70% of care homes we found anticipatory care plans (ACPs) in place for some residents.
- In 30% of care homes no ACPs were in place for any resident.
- In 68% of care homes at least some residents had appropriate family/representative involvement in the writing of the ACPs.
- In 32% of care homes where ACPs were in place no evidence of appropriate family/representative involvement in writing ACPs was found.
- In 43% of care homes where there were people who lacked capacity to make decisions there was an end of life personal plan reflecting discussion with a power of attorney or guardian.
- In 33% of these care homes there was a record of likely wishes discussed during a review meeting, or some other method detailing the way the resident wanted to be cared for when their condition deteriorates.
- In 27% of care homes, there was no adequate form of planning in place of an ACP.
- In 58% of care homes there was evidence that residents received external support whenever it was needed.
- In 19% of care homes there was evidence that residents received external support but more could be done.
- In 23% of care homes there was evidence that residents did not receive external support if required.



Inspectors reported:

"During the inspection staff dealt with a sensitive matter of end of life care within the home in a professional and dignified way. We observed staff to be both sensitive to the needs of residents and relatives offering appropriate levels of support to each individual. The use of a small memorial tree and book is available in the front foyer for residents/relatives to write any comments in should they wish to do so."

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

What we found

- In 72% of care homes there was a list of residents who had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)²⁶ form in place.
- In the majority of care homes the DNACPR information was kept in the personal plans for residents.
- In five care homes (3%) DNACPR information was not kept in the personal plans, which could lead to confusion for staff at a crucial time and poor outcomes for the resident.
- In the majority of care homes the DNACPR forms were completed correctly for residents although not always consistently.
- In six care homes (4% of care homes) the DNACPR forms had not been completed correctly for any of the sampled support plans. This could mean that decisions and actions around resuscitation are not what have been agreed.
- The quality of DNACPR forms and record-keeping varied.
- The majority of care homes (51%) reviewed forms to meet the needs of residents or at the request of the GP.

Good practice guidance recommends that review may not be needed if the initial decision remains clinically appropriate until end of life. It is also recommended that if a person is transferred from the care home and clinical responsibility changes the DNACPR needs to be reviewed.

Areas for improvement

- We expect care homes to have knowledgeable staff who have the confidence and skills to start conversations about what is important to people at end of life and see this as part of their role along with other professionals.
- We expect care homes to ensure staff understand ACP and DNACPR, how to use these in everyday practice and how to involve families in these conversations. We encourage care homes to use resources such as those published by Healthcare Improvement Scotland (HIS).²⁷
- We expect care homes to be able to access additional support from health and social care partnerships as required. People living in care homes have the same rights of access to health and social care support as people living in the community.
- It is important that care homes engage with the Scottish Government's Strategic Framework for Action on Palliative and End of Life Care²⁸ to both ensure that residents receive the best possible care at end of life and that staff are given learning and development to do this. This framework sets out the approach and shared vision for people in Scotland where by 2021 everyone who needs palliative care will have access to it.

²⁶ Scottish Government resources on DNACPR:

<http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/peolc/DNACPR>

²⁷ <http://ihub.scot/anticipatory-care-planning-toolkit> and http://www.healthcareimprovementscotland.org/our_work/patient_experience/palliative_care/dnacpr_indicator/information_for_dnacpr_leads.aspx

²⁸ <http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/peolc/SFA>

5. Supporting improvement in care

Improvement is a different approach to assuring quality. It goes beyond traditional methods of setting targets, recommendations and requirements in order to see improvement in care quality, where it is appropriate to do so. It brings a systematic approach to realising improvement in the quality of care which focuses on outcomes for people.

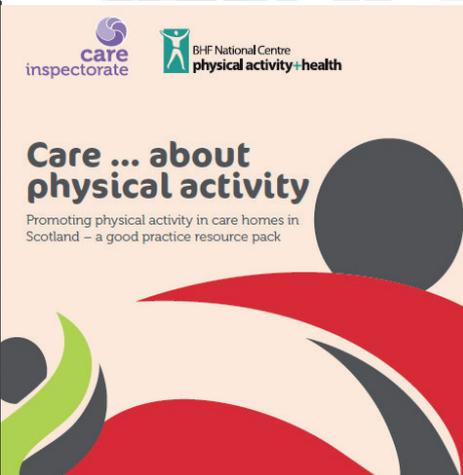
Research tells us that improvement should be done by those closest to the front line in order to make changes that are appropriate, sustainable and truly improve the lives of those experiencing care. The responsibility for improvement rests with those providing and leading services. However, a true improvement approach brings people together to identify, plan and make the changes collaboratively where it has been clearly identified it will make a difference to the lives of individuals such as in this report.

Improvement provides opportunities, generates creativity and innovation, and requires partners to work differently and be united in approach, remaining optimistic and relentless in the drive for excellent care.

Improvement support

- a) Inspectors provide improvement support to services when as a response to, or during scrutiny, it has been identified improvements are required. This can be done in a variety of ways such as providing guidance, signposting to examples of good practice, improvement conversations and giving change ideas.
- b) The Care Inspectorate's improvement support team has a wide range of subject matter expertise in supporting improvement in care and in specialist areas of health and wellbeing including dementia care. The team supports improvement in a myriad of ways, including developing guidance and acting in an advisory role, working with services and providers to focus on specific improvements and with partner organisations to develop educational solutions for the care sector and contribute to strategic improvement activity. The team also has a wide network of partners including the Scottish Care Integration Leads to draw on to support improvement in local areas.
- c) The Care Inspectorate has several improvement alliances and works closely with improvement organisations such as HIS to support providers and services to make sustainable improvements. Where a national programme of work is required to support widespread improvements the Care Inspectorate can design and lead this work.





6. The Health and Social Care Standards

The Health and Social Care Standards were published in July 2017 and the Care Inspectorate expects care services and local partnerships to use these from April 2018 in planning, assessment, commissioning and delivery. Underpinned by wellbeing principles and human rights, they provide a person-led approach to understanding quality in care, which aligns well with effective dementia practice. There is one set of standards across all health and social care services, which describe what people should experience as a result of care. This supersedes an older approach of specifying provider inputs.

This new approach requires care services to reflect carefully on how they contribute to good experiences and outcomes for people experiencing care. In moving away from compliance-based approaches to regulation, it also places greater emphasis on the need for evidence-based learning to be applied in all settings. We strongly encourage care services and partnerships to use the areas for improvement set out in this report as prompts for discussion and evaluation of their performance. The Health and Social Care Standards comprise five principles and a series of more detailed statements. The principles are: dignity and respect, compassion, be included, responsive care and support, and wellbeing. These principles are core to delivering high-quality care for people living with dementia. Although these standards were not published at the time we started our inspection focus area, they have informed the areas for improvement identified in this report. You can read more about the standards at www.newcarestandards.scot.



7. References and further reading

- Charter of Rights for People with Dementia and their Carers in Scotland (2009) Cross-Party Group on Alzheimer's.
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<http://www.gov.scot/resource/doc/350188/0117212.pdf>
- Is your care home dementia friendly? EHE Environment Assessment Tool (2013) King's Fund.
<http://hub.careinspectorate.com/media/302736/is-your-care-home-dementia-friendly-ehe-tool-kingsfund-mar13.pdf>
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- Strategic Framework for Action on Palliative and End of Life Care 2016-2021(2015) Scottish Government.
<http://www.gov.scot/Resource/0049/00491388.pdf>
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- Scotland's National Dementia Strategy 2017-2020 (2017) Scottish Government.
<http://www.gov.scot/Resource/0052/00521773.pdf>
- Health and Social Care Standards: My Support, my life (2017) Scottish Government.
<http://www.gov.scot/Resource/0052/00520693.pdf>
- SSSC, Promoting Excellence in dementia care
<http://www.sssc.uk.com/workforce-development/supporting-your-development/promoting-excellence-in-dementia-care>
- NHS Education for Scotland, Oral Health Improvement – Caring for Smiles: Better Oral Care for Dependent Older People
<http://www.nes.scot.nhs.uk/education-and-training/by-discipline/dentistry/areas-of-education/priority-groups/oral-health-improvement-caring-for-smiles.aspx>

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