

South East Clinical & Delivery Networks Dementia and Care Homes

10 December 2020



Clinical Leads

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Quality Improvement leads: Jo Gavins, Rachel Chappell

NHS England and NHS Improvement



Agenda

- Welcome
- Interfacing with care homes
- Supporting care home staff to be dementia champions
- Oral health in dementia care
- We Check Dementia Care
- Close

Housekeeping

- ❖ Please put yourself on mute and turn your camera off unless presenting
- ❖ Use the Chat function to ask questions or make a comment
- ❖ Meeting is being recorded
- ❖ Recording and slides will be circulated

Interfacing with care homes

Dr Katy Lee

Clinical Lead for the SABP Care Home Pathway
& Consultant Clinical Psychologist

December 2020

Older People's Mental
Health Services

Care home sector: Key facts

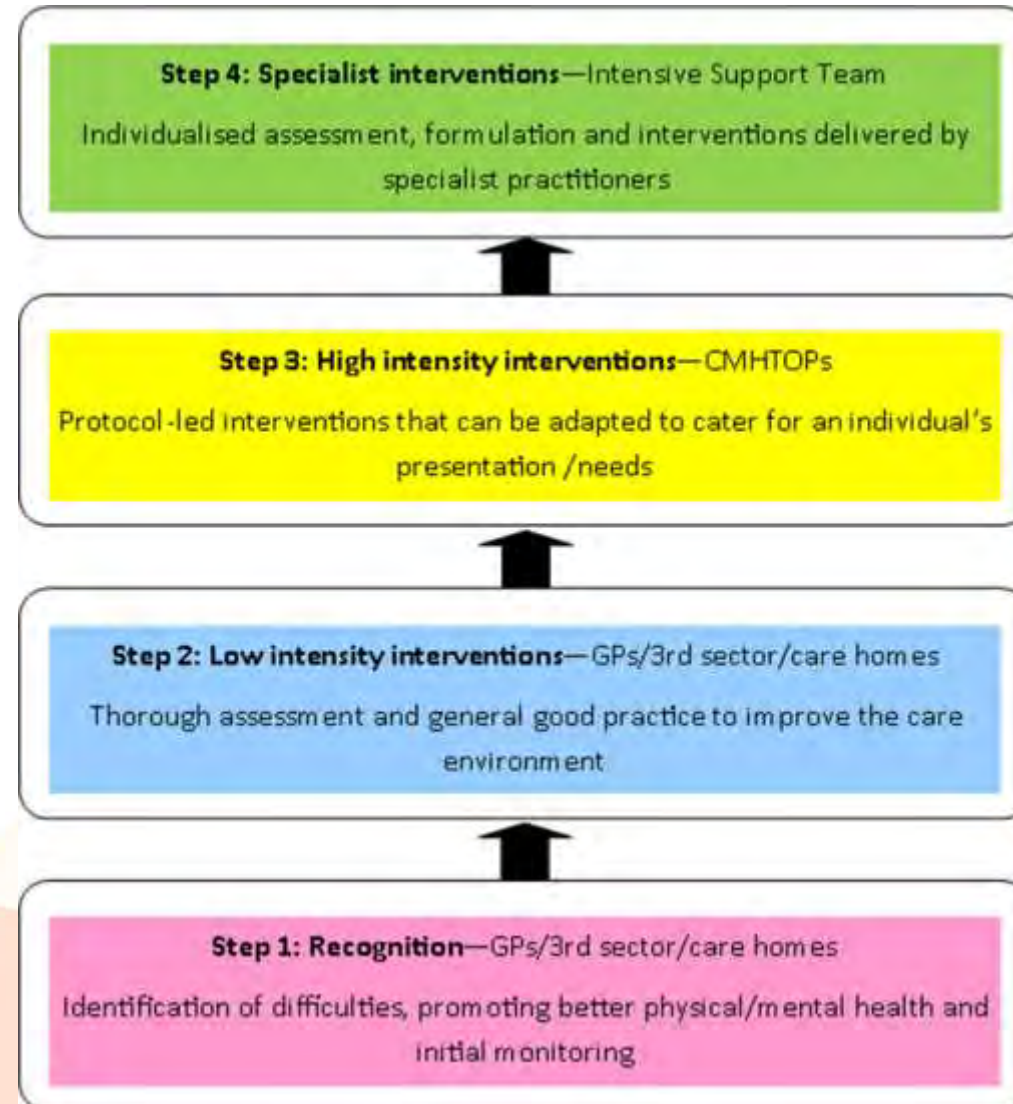
- ▶ **Prince et al. (2014):** Approximately 850,000 people with dementia in the UK and 39% reside in care homes. 65% receive some form of public funding support (Jarrett, 2007).
- ▶ **King's Fund (2017):** People living in care homes often have complex needs (mental and physical co-morbidities) and lack equitable access to services. EHCH is looking to target inequalities and streamline care.
- ▶ **Fossey et al. (2014):** **40-60%** of individuals living in residential care facilities display BtC and unnecessary admissions/ placement moves place a huge strain on the health & social care system.

Compliance with national policies/guidelines

- **Updated NICE guidelines for dementia (2018):** Emphasis on psychosocial interventions and reducing antipsychotics.
- **NICE quality standards (2019):** Recommends a holistic, therapeutically-informed assessment of BtC and focus on meaningful activities/occupation.
- **Positive and Safe** agenda (Department of Health, 2014).



National stepped care model for BtC in dementia



**British
Psychological
Society, 2013**

Surrey and NE Hants: Care home landscape

- Approximately **270 care homes** for older people in our region, of which only nine are LA owned.
- In March 2020, it was estimated that **445 admissions** to our general hospitals were from care homes (**cost of circa £2 million**).



Surrey and NE Hants: Care Home Pathway journey

Our journey to dedicated Care Home Pathway services

- **2014:** set up a supervision group of approximately **10 'challenging behaviour' champions** in each CMHTOP: monthly meetings and CPD (OT and psychology co-facilitation).
- **2015:** Significant Trust engagement with the **Positive & Safe agenda:** embedding Positive Behaviour Support plans across the system.



Surrey and NE Hants: Care Home Pathway journey

Our journey to dedicated Care Home Pathway services

- ▶ **2016:** Closure of a CHC ward led to commissioners requesting a new, community-oriented service (Intensive Support Team) for people with BtC in dementia experiencing the most complex needs. **17 clinicians** working within 3 sectors in Surrey & NE Hants. Step 4 service: 'Newcastle model' approach with PBS plans.
- ▶ **2018:** 80% of the IST resource moved into CMHTOP (step 3) to establish a more localised and proactive offer to people living in care homes. Supervision and consultation from b7/8 psychology and OT in each of the six CMHTOPs across the Trust.

Surrey and NE Hants: Care Home Pathway journey

Our journey to dedicated Care Home Pathway services

- ▶ **2020:** Additional CMHT investment in the Care Home Pathway means that we now have **29 clinicians** dedicated to this work across the Trust. Dedicated CPD programme and skills workshops for the group. Improved links with physical health.
- ▶ Our Care Home Pathway team won the **Royal College of Psychiatrists Team of the Year award 2020!**



Expectations before GP or re-referral

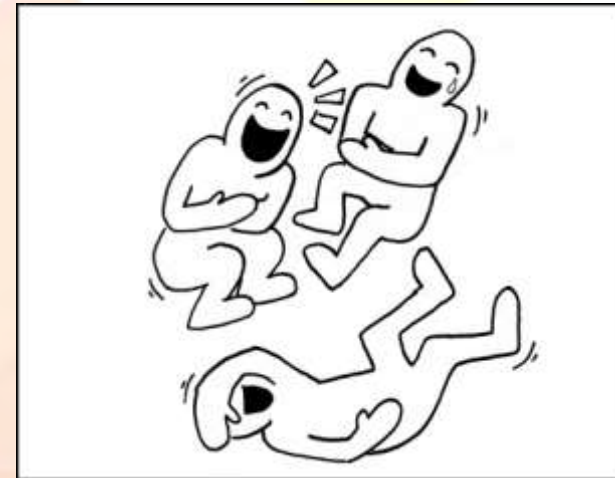
- **Physical health MOT:** Rule out and treat any underlying health problems (delirium, UTIs, infections, constipation etc.)
- Consider **pain** as an issue and treat where relevant.
- Bear in mind the need for an **adjustment period** if recently moved (significant life event).
- Keep **ABC charts** for 1-2 weeks and review patterns.



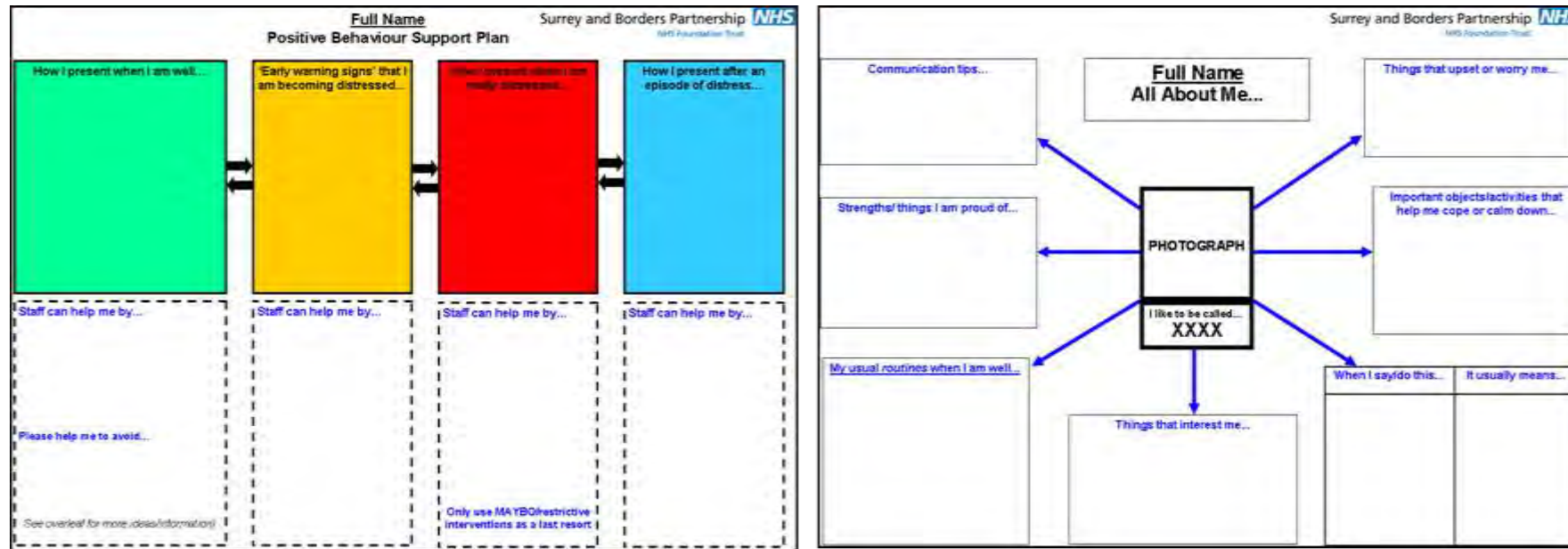
Behavior Example: Yelling/screaming (be as specific as possible)		
BEFORE	BEHAVIOR	AFTER
Date/Time/Location Who was there? What was happening?	What did my loved one do?	What did I do/say? What did my loved one do/say? What did others do/say?

Unmet needs: Professor Ian James

- **Physical comfort**/freedom from pain
- **Perception of safety** (self/others)
- **Intimate touch**
- **Love/belonging**
- **Esteem** (feeling valued and treated with dignity/respect)
- **Control over environment & possessions**
- **Fun** (pleasure, play, laughter etc)
- **Occupation/exploration**



Positive Behaviour Support planning



All behaviour happens for a reason!
 In PBS, the emphasis is always on the **green zone**
 and maximising the person's wellbeing



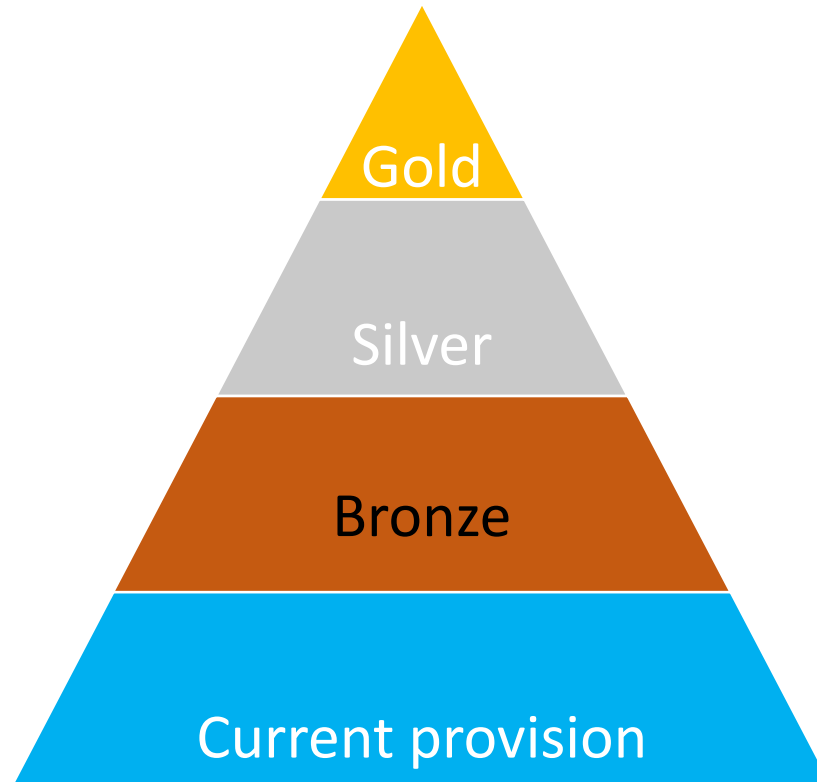
Challenges faced in supporting care homes

- If care home pathways are insufficiently resourced, CMHTOPs often spend too much time focusing on step 2 work, when the emphasis should be on steps 3 & 4.
- Can create a bias towards **crises or prescribing medication**.
- When care homes do not get the support they need, this can lead to **unnecessary admissions or placement changes**.

NICE

National Institute for
Health and Care Excellence

A model for improving services for people in care homes?



Access to all the interventions described below, plus bespoke training and coaching for care home managers.

Multi-disciplinary (physical and mental health) commissioning, with holistic clinics to support care home residents in a more thoughtful way.
Provision of specialist training: topics offered on a package basis, covering a range of physical/mental health concerns.

Streamlining the provision for care homes across areas: dedicated Care Home Pathway function with links to Dementia Link Practitioners, Geriatricians, Matrons and frailty/ageing well teams etc.
Fostering good links/connectivity in each area between these clinicians and local Care Home Pathway teams.

Lots of clinicians delivering input and support into care homes: often with extreme skill and passion, but at risk of silo working.

Thank you for listening



Any questions?



Dementia champions

Integrated Care Home Support Team



Jennifer Hall

Brief aims of the team

- 3 teams across the West of Berkshire (Reading, Wokingham and Newbury)
- Each locality is covered by:
 - a proactive team - RGNs, RMNs, OT's, physio and speech and language therapist – focus is education, upskilling, clinical support
 - reactive team consisting of Advanced Nurse Practitioners, a Geriatrician and pharmacists. Preventing hospital admissions by treating residents with acute illness.
- Set up initially with just the proactive team in 2013 with the Prime ministers Dementia Fund then in 2017 the reactive team joined to form the Integrated care Home support team.

Dementia Champions

Prime ministers challenge in 2015 – to ensure people with dementia have meaningful lives and care according to the NICE guidelines CG42.

Why champions:

- Train the trainer model. High turnover of staff
 - Acknowledgment of skilled workers
 - Role models
 - Single point of information sharing
-

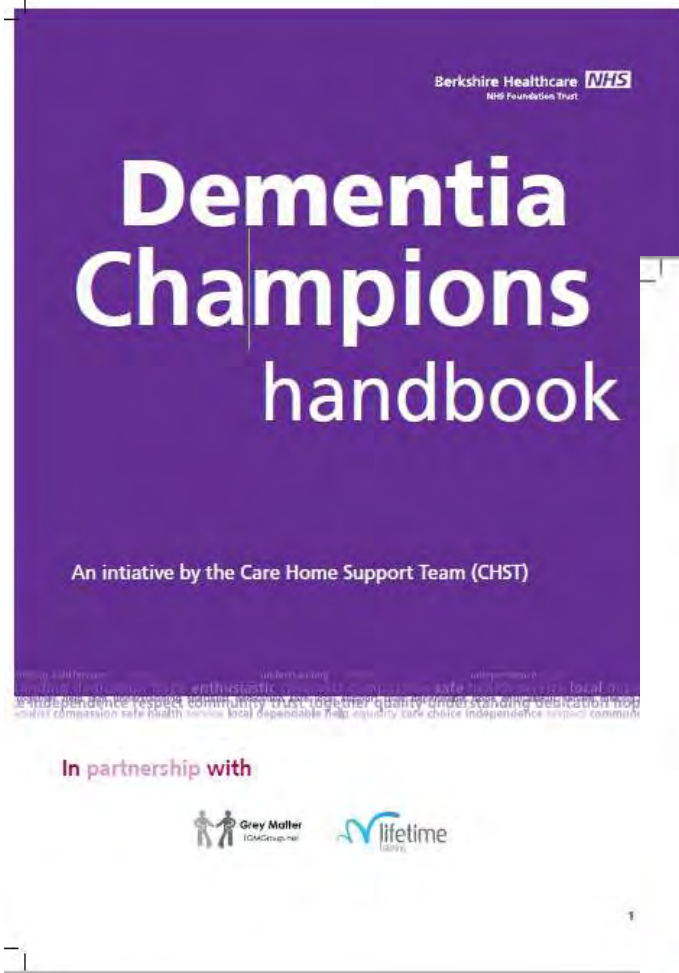
Training

We decided to use the Tier 1 training devised by the Dementia Academic Action Group (DAAG) –commissioned by Health Education Thames Valley to meet the NHS mandate that all staff be trained at a level appropriate to their role in dementia.

- The Oxford Brookes University
- University of Bedfordshire
- University of Northampton
- University of West London

This 2 hour training session was in line with Tier 1 Alzheimer's society training and was accredited by them so trainees would qualify for a Dementia friends badge.

Dementia Champions



Dementia Champions pathway

We are working on developing Dementia Champions across the 1 we currently support within the West of Berkshire. The aim is to the Dementia Champions pathway across all areas that support p Dementia.

There are existing government initiatives such as:

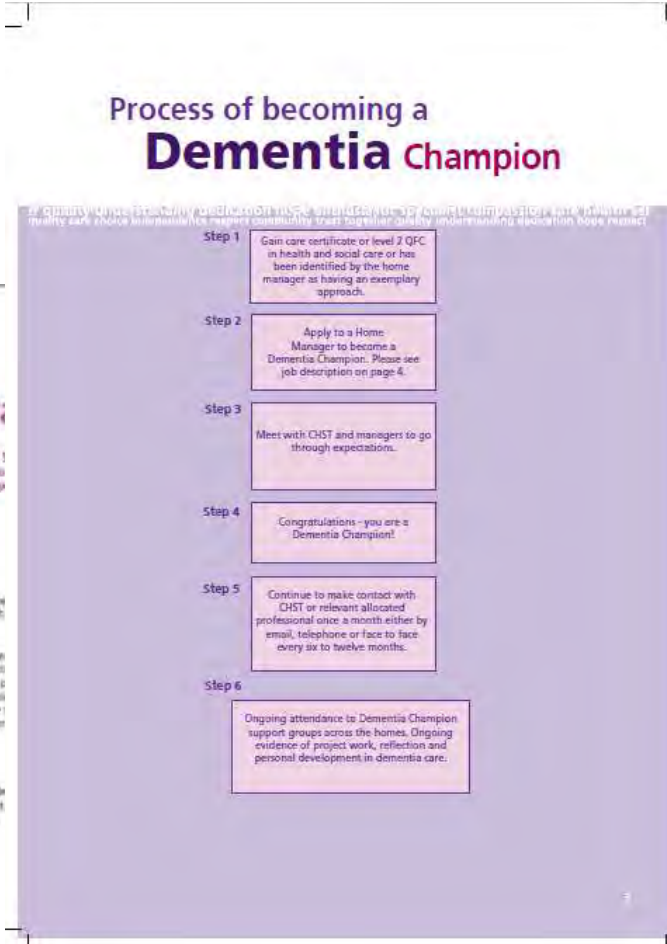
- the Dementia Strategy (2009)
- the prime minister challenge (2015)
- care according to the best guidelines (2012).

There is also the need for Dementia Champions in care homes. In 2013, more of people in care homes have dementia or some cognitive impairment, which importance of skilled workers within these roles.

The Dementia Champions pathway will ensure that staff who work are trade standard, supported in personal development and part of a training system to colleagues are supported. Those who become Champions will be the career is for support, knowledge and skills. They will become the voice for those people and improve care, the environment and well-being. These Champions will be the Home Manager, their training provider and the Care Home Support Team relevant professional.

Aim

The aim is to ensure every home has a Dementia Champion to every 20 people and of 2020. The projects will have the approval of Health Education England, Alzheimer's Society, Berkshire Healthcare NHS Foundation Trust and Age UK.



Pathway

step 1 – Gain care certificate or level 2 QFC in health and social care or has been identified by the home manager as having an exemplary approach.

Step 2 - Apply to a Home Manager to become a Dementia Champion. Please see job description on page 4.

Step 3 – meet with CHST RMN for 2 hour training. Using the DAAG training

Step 4 – make monthly contact with CHST RMN and face to face supervision/support/education every 3-6 months

Step 5 – ongoing self reflection, evidence of self development and project work in the home.

Dementia Champions

Job description and application

Dementia Champions are staff who have a personal interest in understanding dementia, improving dementia care and become a go to resource staff.

Dementia Champions will be expected to:

- ▶ engage in reflective practice
- ▶ work alongside the CHST
- ▶ engage in project work in the home to improve practices
- ▶ play an active part in trying out new care approaches to help manage challenging behaviours
- ▶ help with person centred care planning for good quality interventions
- ▶ assist with mentoring new staff

Describe why you think you would be a good Dementia Champion?

Once completed please give this form to your manager for consideration.

4

Added a sense of formality

- Commitment to engage in the process
- Assisted with mentoring new staff
- Allowed time to be set aside
- Permission to liaise with RMN in the Care home support team.

Dementia Champions

Monthly supervisor reflection template

Example questions

How do you feel your month has gone overall?

Were there any incidents that were good or bad?

What could you have done differently?

Project work

Dementia Champions will be expected to manage projects in th help improve the environment or quality of life.

The project work should be done in line with SMART (specific, measure realistic and timely) goals and agreed with their Manager.

Below is a list of some example projects.

Environment

Creating friendly social areas
Individualising rooms

Well being

Being mindful of religious beliefs
Encouraging physical exercise

Activities

Providing a music workshop
Facilitating activities that can involve patients families

Progress sheet summary

Date	Diary entry	Date achieved
e.g. 25.3.26	Care certificate	20.6.16

Identity

Style: BHBB5
32mm x 32mm



Roll out barriers

The aim was 1 Dementia champion per 20 residents

But

- ❖ Not all homes wanted champions
- ❖ Bupa homes had their own champions
- ❖ Staff turnover
- ❖ Difficulty in securing 1-2 monthly supervision
- ❖ Manager absent so not supported
- ❖ Manager not on board

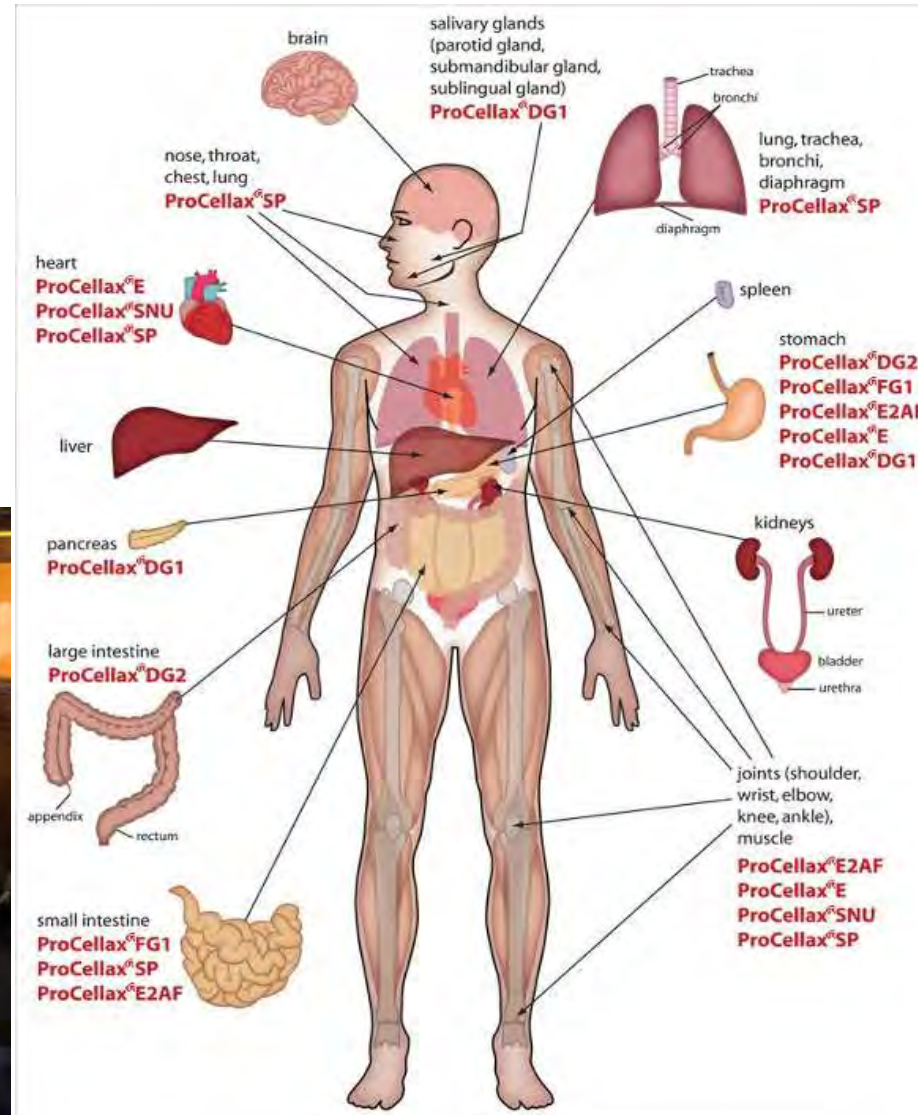
Ongoing contact aims

- ❖ Monthly email with latest research, ideas for activity and occupation, interesting reads etc...
- ❖ Every 1-2 months booked time to spend with champion/s in the home for support and education on a subject they are interested in.
- ❖ once a year holding a Dementia Champions Forum
- ❖ Keeping Champions in touch with each other to share ideas and support

Champions Forum

So far we have held 3 Forums

1. Was a full day in a room in a large care home – celebration of achievements, oral health, nutrition and hydration, looking at confidence at talking to people about how to achieve change, challenges in the homes people face and planning for the future.
2. Was held in an upstairs room in a pub, was a full day and looked at advancing dementia, biology and brain changes and intensive interaction.
3. Was held again in the same pub as it was so successful and we focused on physical health, personality and social aspects of the person and the social environment



Current statistics

Out of the 52 homes in the West of Berkshire we currently have 48 Champions to 2520 beds.

- Making the ratio 1:52 a long way short of 1:20
- out of the 52 homes 31 of the homes have dementia champions

During COVID

The aim has been to try to maintain contact and offer support in whatever way we can.

- TEAMS meetings and support
- Use of TEAMS for training in Tier 1 for new champions and staff
- Development of the Advancing Dementia course on TEAMS (initially rolled out to relatives) for established champions and other staff. Looking at the brain biology, communication, sensory and the environment, behaviours that challenge and End of Life
- Development of a Delirium TEAMS presentation
- Care planning support either virtually and face to face with Champions to manage those residents unable to conform to social distancing or isolation
- Verification of Expected Death training for senior Dementia Champions

Thank you
questions...

Oral Health

Katy Kerr MSc BDS DDPH RCS(Eng) PGCertCE
Level 7 Award in Leadership Coaching and Mentoring
Regional Dental Adviser HEE Thames Valley / Wessex

Chair of the Dementia Friendly Dentistry Group

Member of the Dementia Workforce Advisory Group

**Member of the CQC Oral Health in Care Homes
External Advisory Group**

Member of Dental Flexible Commissioning Group

Member of Oral Health in Care Homes Working Group

**Project lead for The dementia awareness video,
'The Appointment.'**



Developing people
for health and
healthcare

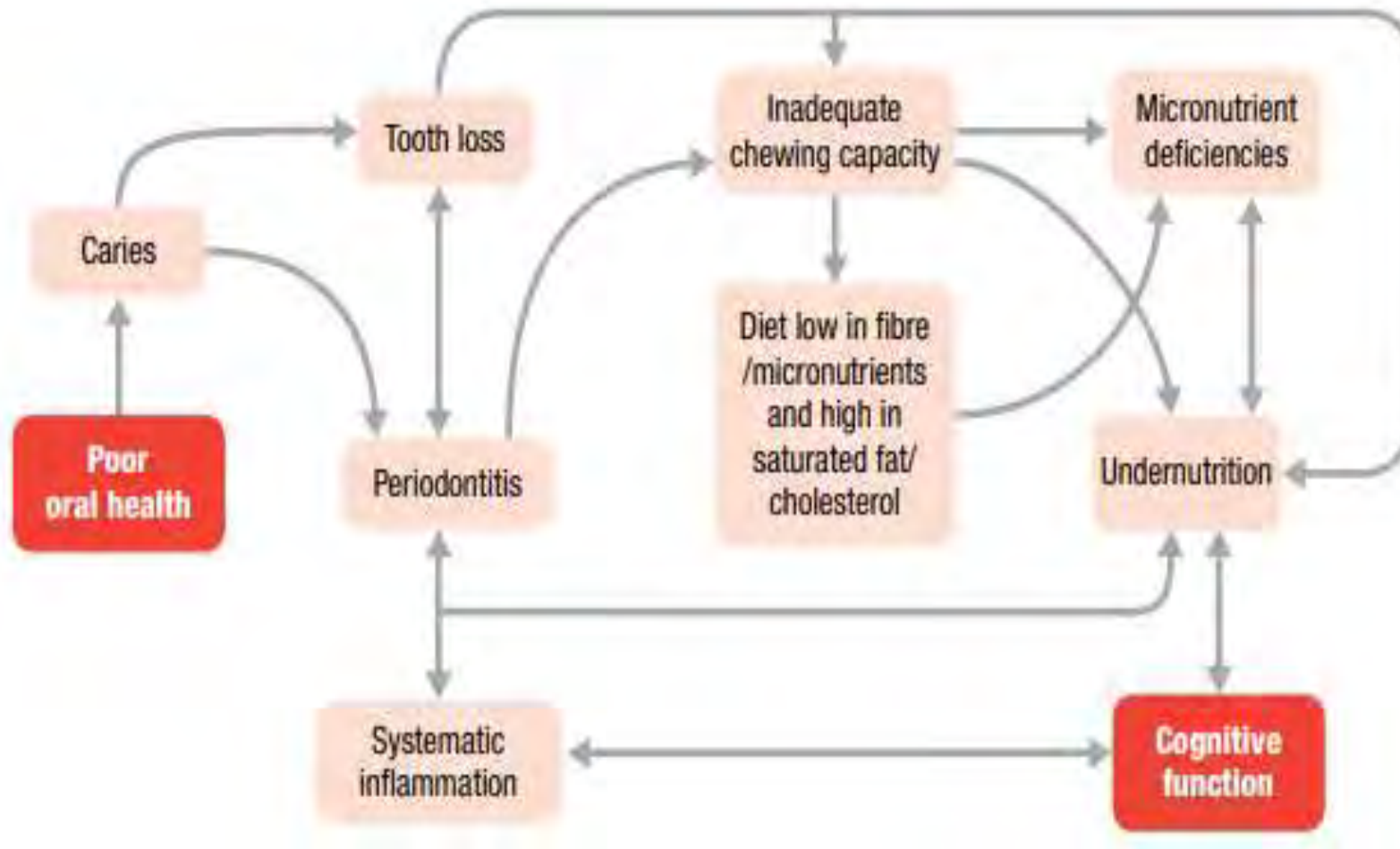
www.hee.nhs.uk

Poor oral health in dementia

- People with dementia are more likely to be unable to perform oral hygiene
- Tend to have worse oral health, greater treatment need, yet access care less frequently than general population
- Significant impact on general health and wellbeing, impacts upon quality of life, diet and nutrition, and life-expectancy in the longer term
 - The build up of bacteria in the mouth is implicated in aspiration pneumonia
 - Both pain and infection can decrease cognitive function



Poor oral health and nutrition



Dental disease

- Gum (periodontal) disease



- Tooth decay (caries)



- Tooth wear
(erosion/abrasion)



**Dental
diseases are
preventable**

**Oral hygiene
and diet**



Public Health England

ORAL HEALTH is very important in DEMENTIA

Think Teeth!

Ask: Do you have a dentist?

Mouth problems can be prevented by acting early

Limit sugary foods and drinks to main meals

Try a powered toothbrush

Use a high fluoride toothpaste

Brush teeth and gums twice daily

Do not rinse after brushing

Medicines can cause oral side-effects

Consider sugar-free

A healthy mouth helps with eating, drinking, speaking and socialising with dignity and without pain

A painful or infected mouth, loose teeth, poor diet and dehydration can all impact on mood, behaviour, wellbeing and general health

Ask the dentist about labelling dentures

AT LEAST 1350PPM FLUORIDE

A. SMITH

Mouth care for people with Covid-19

- When providing mouthcare wear personal protective equipment (PPE) to prevent contact and droplet transmission.
- They are more likely to cough when performing mouth care, be gentle, stand to the side or behind them, take breaks to allow the resident to rest and swallow
- If possible, sit the person upright, do not use an electric toothbrush as this may cause droplets and splash
- If the mouth is dry, encourage sips of fluid and use a dry mouth product
- if a person is confused, refuses, or resists care, stop and try again later.

Mouthcare is an important part of the overall care provided

**Person exhibits care-related
stress/distress
Someone can refuse verbally or
non-verbally**

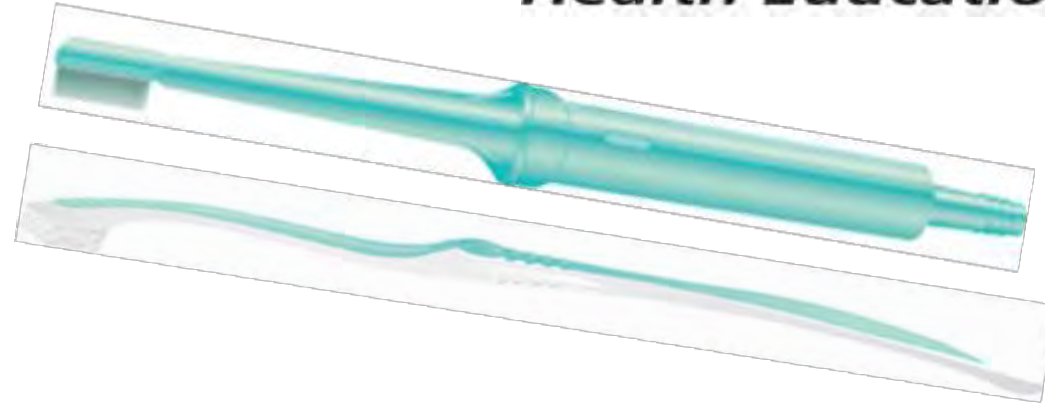
**If they lack capacity, then investigate why they are
refusing, then:**

- Look for any signs of soreness, infection, broken teeth etc. which could make mouth care uncomfortable
- Come back and try later (try another time of day when the person is calmer and more receptive)
- Try another carer with whom the person is more familiar
- Explain carefully what you are going to do and why you are going to do it
- Be patient, take your time and be reassuring

Document and report if a someone persistently refuses mouth care

Late Stage Dementia

- Likely to have swallowing problems
- Mouth care carried out more often (minimum 4 times a day)
- Keep hydrated and use oral gel as likely to have dry mouth
- Check for infection daily



- Low foaming toothpaste
- Dry brush with small amount of toothpaste imbedded in the bristles

NICE guidance June 2016

All adults in care homes (older people and learning disability) should receive good oral care by **skilled** staff.

Care homes need:

- Policies on oral health and providing residents with support to access dental services
- Oral health assessment and mouth care plans
- Daily mouth care and keeping records
- To update care staff knowledge and skills



Dental practitioners:

- Provide residents in care homes with routine or specialist preventive care and treatment as necessary, in line with local arrangements
- Ensure dentures appropriately marked with name

Smiling Matters: CQC probe – findings:

Among the homes visited:

- Most had no policy to promote and protect people's oral health (52%)
- Nearly half were not training staff to support daily oral healthcare (47%)
- 73% of care plans reviewed only partly covered or did not cover oral health
- It could be difficult for residents to access dental care
- 10% of homes had no way to access emergency dental treatment for residents

Recommendations

A cross-sector approach including:

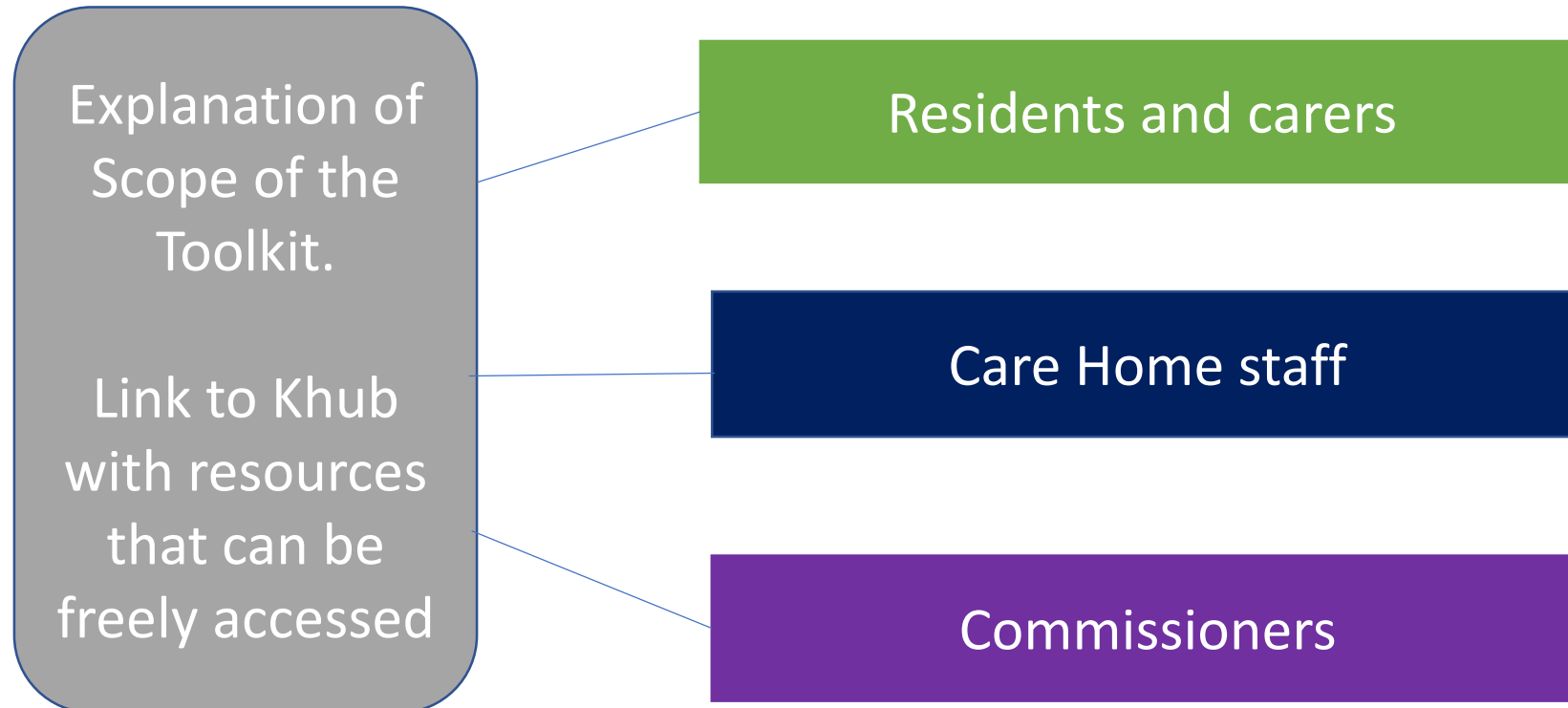
- Sharing best practice and raising awareness (AOHOG)
- Repeating and reinforcing the guidance for care homes to implement NICE guidance
- Mandatory staff training in oral health
- Oral health check-ups for all residents moving into a care home
- Improved guidance to the dental profession on how to care for people in care homes, including advice on charging
- Improve access to NHS dental services, both routine and urgent
- NICE guidance used more in regulatory and commissioning assessments

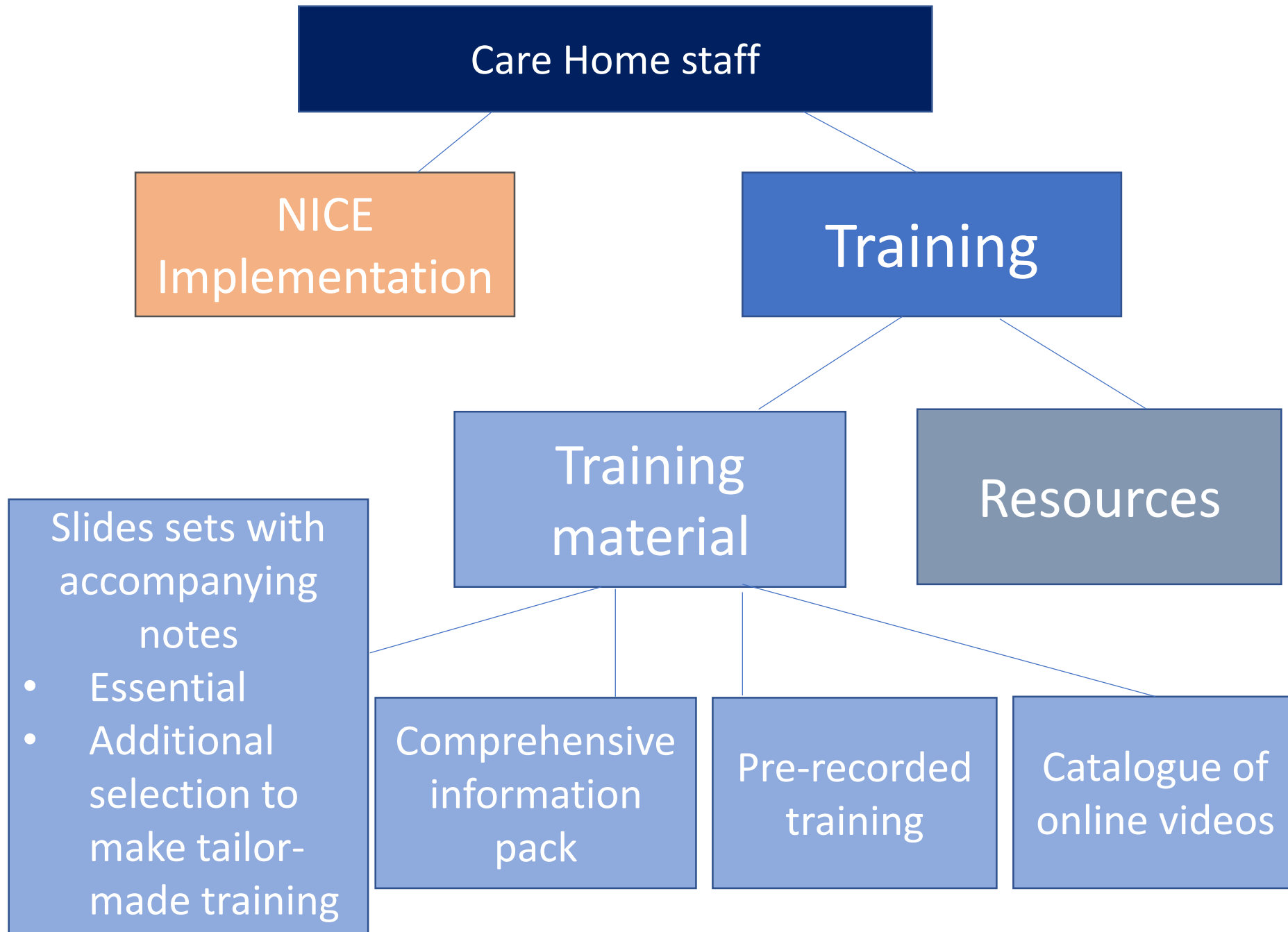
Adult oral health in care homes



PHE.Gov landing page

<https://www.gov.uk/government/publications/adult-oral-health-in-care-homes-toolkit>





Person Centred Care

- Ensuring that people's preferences, needs and values guide decisions, and providing care that is respectful of and responsive to them.
- Every effort should be made to involve the individual in planning their mouth care with support from family or friends who know the person.
- Have a holistic approach, plan for oral health taking into consideration medical conditions, advice from other professionals and hydration and nutrition

Having consistent messaging helps everyone



Have a holistic approach and consider oral health

1. What new skills /knowledge did you gain today?
2. Did this session meet your expectations?
3. Write down one thing that you like to change or implement as a result



for listening and I look forward to working together to improve the oral health of people living with dementia

Katy Kerr Mobile 07825901682

Email Katy.Kerr@HEE.nhs.uk

WE CHECK DeMentia CaRe

Supporting Good Dementia Care in Care Homes



Dr Sian Roberts Clinical Lead Dementia





- This toolkit has been developed to support care home managers and their staff improve the identification of those with dementia, and enable quality dementia care to be provided to their residents.
- Not all residents with dementia have the same need and so it's important that each resident is supported with a personalised care plan approach.

WHY??

- Good dementia care enables people to live well with dementia
- 70% of people living in care homes have dementia.
- Many residents in care homes with dementia or cognitive impairment remain undiagnosed.
- Most care home residents who live with dementia are at the latter stages of the condition and may struggle to communicate their needs and preferences.
- This can result in crisis management and unplanned admissions to hospital that could be avoided if personalised dementia care is provided.

WE CHECK DeMentia CaRe

Know how toolkit for care

This toolkit has been developed by South East Clinical Delivery and Networks to help to care home managers and staff improve the quality of the dementia care that they provide to their residents. The toolkit accompanies the **SECDN WE CHECK DeMentia CaRe self-assessment tool** developed to enable care homes to self-assess the quality of dementia care that they provide. The self-assessment tool and toolkit are based on a set of ten standards informed by national and local best practice and the NHS Enhanced Care Home Framework. Once a self-assessment has been completed the care home can use this toolkit to find the information and resources that can help them to make the improvements in dementia care. The information and resources within this toolkit are organised into ten sections which correlate with the standards in the self-assessment tool. If you click on a section heading below, it will take you to the relevant place in the toolkit.



NHS England and NHS Improvement

The toolkit includes:

- Self-assessment questionnaire
- Digital know how toolkit; care homes resources to support dementia care
- Action plan template

Download from : [We Check Dementia Care Toolkit and Templates](#)

- **The purpose of the toolkit** is to help care homes assess the quality of dementia care provided in relation to a set of standards of what good dementia care in a care home should look like.
- **The standards** are informed by national and local best practice, NICE , CQC and are aligned to the NHS Enhanced Care Home Framework.

The standards cover 11 key areas:

1. Workforce
2. Environment
3. Care
4. Holistic Care
5. End of Life
6. Co-ordinated care
7. Kindness and dignity
8. Dementia diagnosis
9. Medication
10. Communities
11. Responding to Behaviour



There are three key elements to the **WE CHECK DeMentia CaRe** process:

- Completion of a self-assessment questionnaire



- Reflect and consider areas that can be improved



- Completion of an action plan



WE CHECK DeMentia CaRe Self-Assessment Tool for Care Homes

STANDARD	SPECIFICATION	ASPIRATION	ANSWER (RAG rated)			EVIDENCE
A well-led WORKFORCE <i>The care home provides an effective workforce who are dementia aware and can provide a high standard of care and support to residents with a diagnosis of dementia</i>	1. Does the care home have:					
	a. Staff that are Tier 1 Dementia Awareness Trained (Dementia Standard Framework, Skills for Health and Care)?	All staff are Tier 1 dementia trained	<50%	>50%	100%	
	b. Carers that are Tier 2 Dementia Awareness Trained (Dementia Standard Framework, Skills for Health and Care)?	All carers are Tier 2 trained	<50%	>50%	100%	
	c. A care home manager or nurse that is Tier 3 Dementia Awareness Trained (Dementia Standard Framework, Skills for Health and Care)?	A care home manager or nurse that is Tier 3 dementia trained.	<100%		100%	
	d. Carers trained in Deprivation of Liberty Safeguards (DoLS)?	All carers that are DoLS trained	<75%	>75%	100%	
	e. Carers trained in the Mental Capacity Act (MCA)?	All carers are MCA trained	<75%	>75%	100%	
	f. Carers trained in End of Life (EOL) Care/Palliative Care?	>80% of your carers have undertaken EOL/palliative care training	<50%	>50%	>80%	
	2. Can the care home manager demonstrate that:					
a. There is a named team/shift leader on duty on each shift to ensure there is adequate supervision for care delivery?	There is a named team/shift leader on duty for each shift.	<50%	>50%	100%		

Complete the self-assessment questionnaire against each of the 11 standards.

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NHS England and NHS Improvement

Use the Digital Toolkit to develop an action plan

A Well-Led Workforce

High-quality dementia care requires leadership and education at all levels of the organisation.

[Enhanced Health Care in Care Homes \(EHCH\) Vanguard Learning Guide: High-quality Dementia Care](#)

Online Resources	Guidance
 Effective Supervision in Adult Social Care - Information & Advice On How To Deliver Effective Supervision	 RCN Guidance to Safe Nurse Staffing in the UK
 Dementia Friends Champions & Friends - Information and Guidance	 Delivering Good and Outstanding Care - Safe Staffing
 Mental Capacity Act - Information, Guidance and Accredited Training	 Guide to Developing Your Staff
<h2 data-bbox="792 925 886 968">Tools</h2>	<h2 data-bbox="1671 925 1811 968">Training</h2>
 Establishment Genie - A Safe-staffing, Workforce Planning and Benchmarking Tool	 Tier 1,2,3 Dementia Awareness Training
 Menu of Care Calculator	 End of Life E-learning Programme
 Supervision Learning Plan Template	 Deprivation of Liberty Training



Care is Co-ordinated

Providing Continuity of Care

Care co-ordination is essential to high-quality dementia care. Effective Multi-disciplinary Team (MDT) is key in ensuring continuity of care for people with dementia.

[Enhanced Health Care in Care Homes \(EHCH\) Vanguard Learning Guide: High-quality Dementia Care](#)


The MDT team in a care setting may include:

- Care home staff member
- GP
- Practice nurse
- Community Matron or specialist practitioner
- Social Care Practitioner
- Older Person's Mental Health consultant/nurse
- Geriatrician
- Dementia Advisor
- Social Prescriber
- Palliative Care consultant/nurse
- Pharmacist
- Optician


Red Bag Scheme




Pioneered by Sutton Homes of Care the Red Bag scheme helps to provide a prompt, safe and efficient transfer of clinical care when a resident moves between a care home and other clinical settings.

 [Improving the Effectiveness of Multi-disciplinary Working](#)


 [Quick Guide to Sharing Patient Information](#)

 [NICE Guidance: Transition Between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs](#)

 [Moving Between Hospital and Home Including Care Homes – A Quick Guide for Registered Managers of Care Homes and Home Care](#)

 [Video on how to implement the Red Bag scheme](#)

 [Red Bag Hospital Transfer: Quick Guide](#)





 [Hospital Transfer Pathway Red Bag Pathway](#)



Diagnosis of Dementia

The value of a dementia diagnosis in a care setting is often not recognised as being important. However, a diagnosis can help care home staff understand behaviour and enable the NHS to support the care home effectively.

[Enhanced Health Care in Care Homes \(EHCH\) Vanguard Learning Guide: High-quality Dementia Care](#)

Resources and Guidance	Tools	
 Why Early Diagnosis of Dementia is Important	<p>Make dementia diagnoses via the GP easier by utilising tools such as the DIADeM Tool.</p>	
 Understanding Dementia: Recognising the Signs and Symptoms of Dementia	 DIADeM Tool	 Dear-GP Tool
 Supporting Carers At The Time of Diagnosis of Dementia		
 NICE Quality Standard 184: Dementia	 The Wessex Diagnosis Toolkit - helps care home staff to document some of the steps to supporting a diagnosis and initiate care plans	
 Dementia Quick Guide: Discussing and Planning Support After Diagnosis		




Goal	Actions	Responsible Person	Timeframe
<i>To ensure 80% of staff have had Dementia Awareness training</i>	<ol style="list-style-type: none"> <i>To appoint a Dementia Champion</i> <i>To access Tier 1 Dementia awareness training</i> <i>To ensure all staff annual PDP includes Dementia Awareness Training</i> 	<i>Care Manager - Mrs Black</i>	<i>1 month</i> <i>1 month</i> <i>12 months</i>
<i>To make the Care Home environmentally Dementia Friendly</i>	<ol style="list-style-type: none"> <i>To conduct an Environmental audit</i> <i>To ask Families for opinions on Dementia Friendly initiatives</i> <i>To contact Alzheimer's Society for ideas on being Dementia Friendly</i> <i>Develop a Dementia Friendly Care Home Action Plan</i> 	<i>Deputy Care Manager - Mr Brown</i>	<i>2 months</i> <i>3 months</i> <i>4 months</i> <i>6months</i>
<i>To ensure 100% patients are offered a Flu Vaccination</i>	<ol style="list-style-type: none"> <i>To contact the Surgery to identify when Flu Vaccination are likely to be available</i> <i>Obtain consent from residents or their PoAs in preparation for flu vaccinations</i> 	<i>Senior Nurse - Mrs White</i>	<i>1 month</i> <i>2 months</i>
<i>Ensure Activities include Dementia Friendly and are culturally suitable</i>	<ol style="list-style-type: none"> <i>To review activities programme</i> <i>To contact external dementia services for advice and whether can be offered (eg. Singing for the brain)</i> 	<i>Activities Co-ordinator - Mr Green</i>	<i>1 month</i> <i>6 months</i>




Care Home to develop a action plan with SMART objectives

Tools


Templates




WE CHECK DeMentia Care Toolkit introduction




WE CHECK DeMentia Care in Care Homes Flow chart



WE CHECK DeMentia Care Self-assessment Tool for Care Homes



Action Plan Template



Action Plan completed example

Download the set of five templates from [here](#).



Thank you for joining us today

We will circulate the recording and slides after
the event

If you have any questions please contact Rachel.Chappell2@nhs.net or
Joanna.Gavins@nhs.net