Healthcare Improvement Scotland

NHS Education for Scotland

care inspectorate

Self-evaluation tool for reducing stress and distress for people living with dementia guidance

A quality improvement framework

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Introduction

This tool sets out what is expected from high-quality, person-centred care to enable good outcomes for people living with dementia and their unpaid carers[1]. It enables staff, managers and leaders in care home and hospital services to identify areas of good practice and areas for improvement. This includes specialist dementia units, acute and community hospitals, and care homes, given the high numbers of people living with dementia in these settings at any one time[2]. It summarises what we know about how person-centred approaches can prevent and support stress and distress for people living with dementia.

Improving experience and outcomes for people living with dementia in hospitals and care home settings through the development of high-quality, person-centred care remains a priority of the dementia strategy for Scotland. This tool supports teams to evidence implementation of relevant standards and guidelines, such as SIGN guideline on dementia, Ageing and Frailty Standards and Health and social care standards: my support, my life and aligns with the Care Inspectorate approach to Self-evaluation for improvement. The tool works within the principles of the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003.

Healthcare Improvement Scotland, Care Inspectorate and Mental Welfare Commission for Scotland continue to highlight the need for support to improve person-centred planning across health and social care settings and the engagement of unpaid carers. Providing person-centred approaches that prevent and support stress and distress can lead to better outcomes for people. It can also help to avoid admission or readmission to hospital, enable timely discharge and effective transitions of care between hospital, home or care home settings.

This tool is intended to support teams to reflect on their current practice to support people living with dementia and identify how to build on what they are currently doing well and what areas they should consider as a focus for improvement.

Background

We have captured learning through working with teams across Scotland to support improvement in the provision of high-quality care for people living with dementia. Key documents relevant to dementia care have been incorporated into this tool. We also gathered views and feedback from people with lived experience and their unpaid carers and experts with clinical and professional expertise.

[1] 'unpaid carers' are defined as those who provide care and support to family members, friends, and neighbours.
[2] While this tool was primarily designed and tested in hospital and care home settings, it can be adapted for other health and social care settings where people living with dementia are supported.

Why do we need this tool?

It is estimated that around 25% of people in acute hospitals and 62% of care home residents have dementia[3]. We know that people living with dementia often experience longer hospital stays, delays in leaving hospital and reduced independent living. Up to 90% of people living with dementia will experience stress and distress and this can be exacerbated when in unfamiliar environments, which include hospitals and care homes[4]. Distress can also lead to increased safety issues, such as falls. Many people who do not have a diagnosis of dementia, will also experience distress due to cognitive impairment, delirium, or other factors.

Staff require high levels of confidence and skill to best support people with symptoms of stress or distress. While there are some examples of good practice, it is an area of significant challenge. There can be a reliance on pharmacological solutions, the side effects of which may exacerbate impairments in cognitive functioning and lead to wider safety issues, such as increased risk of falls. Traditional one-to-one observation may be used in other cases. These approaches are costly when person-centred preventative strategies would have been more appropriate. These findings are consistent with Mental Welfare Commission for Scotland reports on specialist dementia units, Care Inspectorate assurance visits to care homes and Healthcare Improvement Scotland quality assurance visits to acute general hospitals.

Principles of a person-centred approach to stress or distress

This tool focuses on the prevention, early recognition and response to stress and distress using person-centred approaches. The principles for this approach have been developed based on key guidance such as Health and Social Care Standards, SIGN guidelines and Promoting Excellence Framework and include the following.

- Understanding the lived experience of people living with dementia and their unpaid carers and engaging their participation, consent and choice about treatment and care.
- Creating dementia friendly physical environments that are fit for purpose, therapeutic and hazard free.
- Creating a culture that values anticipation, early recognition of deterioration and triggers for stress.
- Consideration of factors that may lead to or worsen the person living with dementia's distress, such as pain, constipation, infection or medication.
- Embedding a human rights-based approach to care including the Charter of Rights for people living with dementia and their unpaid carers.
- Introducing education, training and supervision for staff to ensure they have the knowledge and skills to deliver high-quality care.

[3] Public Health Scotland. Care home census for adults in Scotland - Statistics for 2012 – 2022 [online]. 2022.
[4] St John K, Koffman J. Introducing Namaste Care to the hospital environment: a pilot study [online]. 2017

Observation practice

This tool includes criteria for one-to-one observation practice, also known as enhanced observation. One-to-one observation is the scaling up of contact provided by staff supporting and caring for the person living with dementia. It may be required if the person cannot be safely left on their own for short periods of time. Observation practice is a form of restrictive practice and should be used for the shortest time possible and following team discussion and approval. In some areas there is a move towards a more person-centred, flexible and therapeutic approach to observation practice and the terminology 'continuous intervention' is used. When one-to-one observation is required, staff should continue to follow, or adapt, the person's individualised care plan. This will ensure that their health and wider care needs are responded to. Staff should adhere to the approaches outlined in Mental Welfare Commission's Rights, Risks and Limits to Freedom Good Practice Guide to ensure the least restrictive approach is taken, that does not stop the person making choices, moving around or undertaking the activities they want.

Transitions of care

Moving between different settings (transitions of care) such as home, hospitals and care homes* are critical because they often occur during periods of vulnerability and can significantly impact on stress and distress behaviour for people living with dementia and their unpaid carers. Transitions between settings may result in a temporary loss of independence and autonomy for the person living with dementia and can contribute to increased stress or distress if not managed appropriately. Fragmentation during transitions of care often arises when teams approach the process solely from the viewpoint of their own service area. Teams should systematically consider and review the handover and planning processes involved when receiving an individual, as well as their responsibilities when transferring a person to another care environment. Safe and effective transitions require proactive coordination, clear and consistent communication, and shared accountability between both the sending and receiving teams. Teams should adopt structured transition processes that prioritise communication, consistency and shared decision-making to ensure that the person living with dementia remains central to all planning and that their rights, preferences and wellbeing are upheld throughout the transition process.

**Different settings include community, between hospital wards or care home units and transfers between ambulances and hospital, home or care home.*

How to use the self-evaluation tool

The self-evaluation tool can be used by teams to self-assess their service against a set of seven quality criteria. The criteria are based on what we have learned is important in the prevention and management of stress and distress based on person-centred approaches.

This can be completed as a service development activity and can be an internal process or facilitated by someone who is not normally part of the team. It should involve all key professions involved in the delivery of care including care home staff, nurses, allied health professionals, managers and doctors. It is recommended to involve people with dementia and unpaid carers in the self-evaluation process.

The self-evaluation tool can be printed and completed by hand or an editable version has been created to allow completion using a computer or tablet. To download the relevant version of the tool use the links below:

- Reducing Stress and Distress Self-Evaluation tool: printable version
- Reducing Stress and Distress Self-Evaluation tool: editable version

Each criterion has been divided into a number of sub-criteria. There is a column against each sub-criterion to rate current practice on a scale from 1-6.

1. Unsatisfactory: urgent remedial action required
2. Weak: priority action required
3. Adequate: strengths just outweigh weaknesses
4. Good: important strengths, with some areas for improvement
5. Very Good: major strengths
6. Excellent: outstanding or sector leading

Additional columns are provided to capture details about your current processes and supporting evidence. Examples of evidence sources for each sub-criteria can be found in Appendix 1. Not all evidence examples will be relevant to your workplace and it is expected that teams will identify their own sources of evidence. Evidence should demonstrate that the views of staff, people living with dementia and unpaid carers have been included. Appendix 2 includes an example of a completed section of the self-evaluation tool. A list of tools and resources to support teams as they complete the self-evaluation can be found in Appendix 3.

Following completion of the self-evaluation, an improvement plan identifying the top three priorities can be developed (see Appendix 4 for an improvement plan template).

Reducing stress and distress self-evaluation tool

The table below is for information only. To complete the tool use the links on page 5.

1. Person-centred care plans are developed and used to inform care **Person-centred care plan may be called a care plan or personal plan depending on setting*			
a	**Staff use best practice guidance in person-centred care planning.**		
	Rate 1-6	**Process**	**Evidence**
b	**Information written in care plan reflects the approach and delivery of person-centred care.**		
	Rate 1-6	**Process**	**Evidence**
c	**All team members can easily see and use up-to-date information in the care plan.** **The team includes the broad range of professions involved in care and will be dependent on care setting and the needs of the individual.*		
	Rate 1-6	**Process**	**Evidence**
d	**Care plans are used to inform and guide the delivery of care.**		
	Rate 1-6	**Process**	**Evidence**
e	**There is a team approach to person-centred care planning and delivery.**		
	Rate 1-6	**Process**	**Evidence**
Initial improvement ideas (optional)			

2. Meaningful activity and/or connections are provided to prevent and support stress and distress **Meaningful activity is one that has been identified by the person living with dementia and/or their unpaid carers rather than one that is routinely provided to all patients/residents*			
a	**Meaningful activity is identified and offered in line with the care plan.**		
	Rate 1-6	**Process**	**Evidence**
b	**The whole team are aware of the importance of meaningful activities and connections identified for individuals and know how to support.**		
	Rate 1-6	**Process**	**Evidence**
c.	**Meaningful activities are adapted as health and individual needs change for the person living with dementia. An example would be where the person enjoyed taking daily outdoor walks but is no longer able to do so and a discovery box filled with outdoor items that hold personal significance is offered as an alternative.**		
	Rate 1-6	**Process**	**Evidence**
d	**The environment is dementia friendly, therapeutic, and as far as possible, hazard free.**		
	Rate 1-6	**Process**	**Evidence**
e.	**Evidence that the environment supports the delivery of a range of activity to support stress and distress. (old 2d)**		
	Rate 1-6	Process	Evidence
Initial improvement ideas (optional)			

3. There are effective processes for the early recognition and assessment of stress and distress			
a	Staff follow a structured, holistic and multidisciplinary approach when identifying stress and distressed behaviours in people living with dementia.		
	Rate 1-6	Process	Evidence
b.	Regular multidisciplinary team reviews that support early recognition to stress and distress behaviour to prevent escalation.		
	Rate 1-6	Process	Evidence
c.	Multidisciplinary staff are clear in their roles and responsibilities when developing person-centred assessment and care planning for people living with dementia who are experiencing stress and distress.		
	Rate 1-6	Process	Evidence
d.	Written and verbal communication methods (such as safety briefings and shift huddles) facilitate rapid communication about people living with dementia who are experiencing stress and distress.		
	Rate 1-6	Process	Evidence
Initial improvement ideas (optional)			

4. Periods of one-to-one observation/continuous intervention are implemented in line with best practice guidance **may be required when the person cannot be safely left on their own for short periods of time*			
a	**Any proposed one-to-one observation follows a period of more frequent interaction and builds on the person's existing care plan to evidence therapeutic benefits and outcomes expected during this period of care.**		
	Rate 1-6	**Process**	**Evidence**
b	**One-to-one observation is restrictive practice* and must be trauma-informed and minimised. Any restriction should be considered in line with Mental Welfare Commission Use of restraint guidance and documented based on assessment of immediate or significant risk of harm.**		
	Rate 1-6	**Process**	**Evidence**
c.	**There is a review process for people living with dementia requiring one-to-one observation – the purpose and nature are reviewed every 8-12 hours (minimum) by the team.**		
	Rate 1-6	**Process**	**Evidence**
d.	**There is evidence of meaningful activity and connection being planned and offered during periods of one-to-one observation.**		
	Rate 1-6	**Process**	**Evidence**
e.	**Meaningful activities are directly linked to the person's care plan and tailored to their individual health and care needs during one-to-one observation.**		
	Rate 1-6	**Process**	**Evidence**
Initial improvement ideas (optional)			

5. There is an effective and person-centred approach during transitions of care* for people living with dementia **Transitions of care refer to when a person moves between settings.*			
a.	**There is a process in place to support and prevent multiple transitions of care (future planning).**		
	Rate 1-6	**Process**	**Evidence**
b.	**People living with dementia and unpaid carers are involved in and provided with appropriate information during decision-making when moving between settings and their wishes, values and clinical needs are consistently upheld across all settings.**		
	Rate 1-6	**Process**	**Evidence**
c.	**There is a structured and person-centred individual plan for when a person moves between settings.**		
	Rate 1-6	**Process**	**Evidence**
d.	**A multidisciplinary team is identified and involved in early planning, structured communication and co-ordination between settings.**		
	Rate 1-6	**Process**	**Evidence**
e.	**There are effective processes for information sharing from both the sending and receiving teams when moving between settings.**		
	Rate 1-6	**Process**	**Evidence**
f.	**Unpaid carers and families are involved, kept informed and supported when a person moves between settings.**		

	Rate 1-6	**Process**	**Evidence**
g.	**Transferable documentation (for example, Power of Attorney, Anticipatory Care Plan, Getting to Know Me, Herbert Protocol or End of Life) that records the needs of people living with dementia is updated and available when moving between settings.**		
	Rate 1-6	**Process**	**Evidence**
Initial improvement ideas (optional)			

6. Unpaid carers* are identified, involved and their needs are supported within approaches to reduce and support stress and distress

**unpaid carers are defined as those who provide care and support to family members, friends, and neighbours*

a	**Unpaid carers are consistently identified, and information recorded.**		
	Rate 1-6	**Process**	**Evidence**
b	**Unpaid carers are involved meaningfully in assessment, care planning and review processes as partners in care.**		
	Rate 1-6	**Process**	**Evidence**
c	**Unpaid carers are supported to identify and support stress and distress.**		
	Rate 1-6	**Process**	**Evidence**
d.	**The wider needs of unpaid carers are identified and supported to enable the caring role to be maintained and support the transition of care.**		
	Rate 1-6	**Process**	**Evidence**
Initial improvement ideas (optional)			

7. All staff feel confident, competent, and supported to use person-centred approaches			
a.	**The team is able to show evidence of applied knowledge and skills to deliver person-centred care as outlined in the Promoting Excellence framework. This should be at the levels appropriate for their role and nature of contact with people living with dementia.**		
	Rate 1-6	**Process**	**Evidence**
b.	**The team have the knowledge and skills to respond appropriately to stress and distress as outlined in the Promoting Excellence Framework This should be at the levels appropriate for their role and nature of contact with people living with dementia.**		
	Rate 1-6	**Process**	**Evidence**
c.	The team have the knowledge and skills to deliver trauma-informed care* as outlined in the Transforming Psychological Trauma Knowledge and Skills Framework. This should be at the levels appropriate for their role and nature of contact with people living with dementia. **Trauma-informed care is defined as the knowledge and skills needed by everyone in the Scottish workforce to be able to recognise where an individual may be affected by trauma and to adapt their practice accordingly in order to minimise distress and support recovery through a safe and compassionate response.*		
	Rate 1-6	**Process**	**Evidence**
d.	**There are effective line management and clinical supervision in place to support staff who work with people living with dementia who experience stress and distress.**		
	Rate 1-6	**Process**	**Evidence**
e.	**Local dementia experts and other leaders support staff development activities and sharing of learning about dementia care in practice.**		
	Rate 1-6	**Process**	**Evidence**
f.	**Staff are supported to identify, test and implement improvements.**		

	Rate 1-6	Process	Evidence
Initial improvement ideas (optional)			

Appendix 1: Examples of suggested evidence

1. Person-centred care plans are developed and used to inform care	
a.	1. Evidence that staff have been trained in best practice on person-centred care planning such as Mental Welfare Commission guide on person-centred care plans or Care Inspectorate Guide for Providers on Personal Planning. 2. Evidence in care plans that staff have applied their knowledge and skills (from training aligned to Promoting Excellence Framework or Trauma Informed and Responsive Practice in Dementia Care) to deliver person-centred care. 3. Evidence that staff are aware and confident in communicating with individuals in their preferred communication format. 4. Evidence that the care/personal plan has been implemented.
b.	1. Evidence that information about the person's life history is captured from documents such as 'Getting to Know Me' and care partners to inform the care plan.
c.	1. Person-centred information is shared and accessible to all members of the team, for example, recorded on bedside posters where appropriate or in shared notes. 2. Evidence that staff are aware of and know where to access the personal/ care plans for people in their care.
d.	1. Evidence of regular review, evaluation or personal/care plans to ensure appropriate support and identify if further action is required.
e.	1. Clear roles and responsibilities for developing and maintaining personal/care plans are recorded, such as a standard operating/ operational procedure. 2. Processes are in place for escalation to other relevant professionals, such as care home liaison, psychiatry or psychology.
2. Meaningful activity and/or connections are provided to prevent and support stress and distress	
a.	1. Evidence in care plan of meaningful activity being identified through documents such as 'Getting to Know Me', conversations with person with dementia and their unpaid carers. 2. Evidence that identified activity has been offered. 3. The impact of participating in meaningful activities is documented and there is evidence that staff have reviewed and ensured continuation of these activities when they have proven effective. 4. Evidence that the meaningful connections the self-evaluation tool has been used to enhance staff practice.
b.	1. Information in individual records about activities and connections are meaningful for each person living with dementia and how that can be supported by all members of the team, for example, use of an activity planner to lay this out.

	2. Shared individual records are used to increase communication across the team. 3. Information in individual records that demonstrate different staff are involved in providing meaningful activity and connections.
c.	1. Evidence in documents that record how and why interactions are delivered and adapted based on the person living with dementia's ongoing assessed needs. 2. There is a risk enablement approach to activity.
d.	1. The environment reflects best practice in dementia inclusive design, as evidenced through comparison with recognised dementia environmental audit tools such as use of the University of Worchester's Environmental assessment tools to audit the environment design.
e.	1. Evidence that the person living with dementia is supported to access various areas of the environment and resources to support activities that correlate to the residents' interests or patients' common interests to them that have been proved to be effective, for example discovery boxes, sensory items, relaxing music or activities.
3. There are effective processes for the early recognition and assessment of stress and distress	
a.	1. Evidence of unpaid carer involvement within assessment process. 2. Individual records evidence consistent use of agreed tools for assessment, prevention and management of stress and distress. 3. Recorded information is accessible to multidisciplinary staff of which assessment tools have been agreed for use.
b.	1. Evidence of people living with dementia experiencing stress and distress are identified during multidisciplinary team reviews. 2. During staff handover, there is evidence of an additional care plan that identifies 'triggers' and early indicators.
c.	1. An agreed process by involved professionals for review is in place and recorded in individual'– this may be evidenced in a standard operating/operational procedure.
d.	1. Individual records evidence regular team reviews. 2. Records of safety briefings and huddles show evidence of use of effective communication tools such as SBAR. 3. During staff handover, there is evidence of an additional care plan that is accessible to staff regarding support put in place to respond to stress and distress and any further action required.
4. Periods of one-to-one observation/continuous intervention are implemented in line with best practice guidance	
a.	1. Care planning in place for one-to-one observation is linked to main care plan. 2. An agreed process is in place covering pathway for one-to-one observation – this may be evidenced in a standard operating/operational procedure.

b.	1. Evidence of least restrictive practice. For example, where noise is a cause of stress and distress, the person may be supported in quieter areas of ward or care home and is not automatically kept in their room or without access to outdoor spaces. 2. Staff are aware of potential triggers and these are in one-to-one observation care plan. 3. Individual records have evidence of regular reviews of any restrictive practice. 4. Reviews include detailed information and justification for any restrictive practice.
c.	1. Individual records include evidence of team reviews taking place at minimum 8 to 12-hour periods.
d.	1. Individual records include details of how periods of one-to-one observation have been planned and are adapted in line with the person's existing care plan.
e.	1. Individual records include daily evidence of engagement in meaningful activities in line with the person-centred care plan.
5. There is an effective and person-centred approach during transitions of care for people living with dementia	
a.	1. There is a person-centred process in place for future planning for each resident and it is reviewed as and when the person living with dementia's needs change.
b.	1. Individual records that individuals and unpaid carers are included in discussions when a hospital admission or discharge to care home is being planned and actions are followed through. The information is shared with relevant health professionals and rest of the team.
c.	1. Individual records include an up-to-date, person-centred transfer document (for example Getting to Know Me) that reflects the person's current needs and wishes. 2. Individual records include a settling in transition plan. 3. The person living with dementia is supported to visit the care home or hospital beforehand so that they can meet staff where possible.
d.	1. An agreed process with the hospital ward and care home liaison team is in place to ensure that they are informed of hospital admissions, enabling early liaison with all health and social care staff and unpaid carers in supporting a safe, co-ordinated care and discharge planning. 2. Health and social care professionals for example nurses, care workers or social workers known to the person, along with unpaid carers, are involved in providing support, information and planning throughout the transition process.
e.	1. A standard operational/operating procedure outlines the steps care home staff should take when a resident is admitted to hospital, including establishing an effective communication plan with the hospital ward and identifying a named key contact for updates. It also details how care home

	staff can share the resident's needs and preferences with hospital teams to support their care during the admission. 2. A clear process is in place for when a patient/resident is admitted to hospital or care home, setting out joint responsibilities and agreed communication pathways. The process includes ongoing two-way communication between the hospital, care home and unpaid carers, sharing updates and any clarification on the person's needs or preferences. 3. Records of unpaid carers and care homes kept informed of key updates and changes are kept in individual's notes for example, catheter status, medication adjustments, referrals or follow-up arrangements. 4. One person is assigned from the care home or hospital to act as a 'buddy' during the transition process.
f.	1. Records of early discussions involving unpaid carers are kept in individual's notes. 2. An agreed plan with unpaid carers for when a person living with dementia is moving from home or hospital to the care home is in place. The plan includes information about likes and dislikes, stressors, background information about the person to familiarise our care home staff in advance. 3. For planned admission to care home or hospital ward, unpaid carers are provided with practical information and emotional support to reduce the stress of transition.
g.	1. There is a standard operating/operational procedure in hospital ward or care homes for updating transferable documentation and making sure they are available to patients when they are discharged to home, hospital or care homes. 2. Updated transfer documentation accompanies the person during transition.
6. Unpaid carers are identified, involved and their needs are supported within approaches to reduce and support stress and distress	
a.	1. Individual records include details of identified unpaid carers. 2. Information related to power of attorney or guardianship is recorded, accessible and staff are aware of its relevance. 3. Staff are aware of the definition of 'unpaid carer' and what this means to their practice. 4. Information for unpaid carers is available, for example, notice boards, leaflets. 5. Staff have completed Equal Partners in Care (EPIC) training.
b.	1. Individual records include details of unpaid carer involvement in assessment, care planning and review processes. 2. There is clear process for involving unpaid carers in completing a Getting to Know Me document for example or other documents used to gather information on a person's life history, is included in the admission process. 3. Evidence in individual records that unpaid carers have been offered choice of how and when to be involved. 4. Evidence in individual records of open and transparent communication with unpaid carers.

	5. The service operates person-centred visiting in line with Ann's Law for care home visiting and there is clear and accessible information about this for all visitors. 6. Unpaid carer feedback indicates they feel their caring role is valued by staff. Can be captured by feedback questionnaires, Care Opinion, comments / complaints, thank you cards.
c.	1. Evidence that information is shared with unpaid carers regarding approaches to support stress and distress. 2. Range of tools and resources available for signposting. 3. Training provided for carers to support their role.
d.	1. Evidence that unpaid carer health and wellbeing needs are identified. 2. A single point of contact is established for unpaid carers. 3. A pathway for referral to local unpaid carer services or unpaid carer support worker is in place.
7. All staff feel confident, competent, and supported to use person-centred approaches	
a.	1. Evidence in care plans/personal plans that staff have applied the knowledge and skills learned to enable early recognition and assessment of stress and distress in the people they are looking after for example use of pain assessment chart. 2. Evidence in care plans/personal plans that staff have applied the knowledge and skills learned to enable a care approach that is outcome focused. 3. All staff have a personal development plan which includes training to the relevant level of the Promoting Excellence Framework and how they use the training in practice. 4. A team or department training and development plan sets out a range of learning and development opportunities. 5. Regular personal development reviews for all staff. 6. Regular observation of staff practice.
b.	1. Evidence that staff have access to NHS Education for Scotland (NES) / Scottish Social Services Council (SSSC) resources as appropriate for example Dementia Standards: Supporting Change Tool or Dementia resources. 2. Staff rotas allow protected time to access training and development activities including self-directed learning opportunities in line with personal development plans.
c.	1. Staff have completed relevant training related to trauma-informed care. 2. Staff can evidence they have applied their trauma-informed knowledge and skills to deliver person-centred care in care plans/personal plans. 3. Evidence in care plans that staff have applied their knowledge and skills (from training aligned to Trauma Informed and Responsive Practice in Dementia Care) to deliver person-centred care.
d.	1. Staff records include evidence of regular supervision for all relevant staff. 2. Evidence of regular clinical supervision delivered by someone who is appropriately trained, such as complex case discussion forum, reflective practice, debrief after a serious incident.

e.	1. Evidence that the area of practice where possible, have engaged with established experts in the field of dementia such as Dementia Consultants and Dementia Specialist Improvement Leads to support dementia education for staff. 2. Dementia Champions/Ambassadors are in place within the area of practice or staff are able to access their support. 3. Dementia Ambassadors are in place and have been trained to the appropriate level as recommended by SSSC. 4. Both the Dementia Champions and Dementia Ambassadors participate in the wider network opportunities available. 5. Dementia Champions/Ambassadors and Dementia Specialist Improvement Leads have protected time to support team development.
f.	1. Evidence of structured quality improvement work and improvement data are recorded and shared. 2. Current quality improvement work is displayed on an improvement noticeboard. 3. Staff information networks that share news about improvement work and development opportunities. 4. Learning events are available and accessible for all team members.

Appendix 2: Example completed section of the self-evaluation tool

1. Person-centred care plans are developed and used to inform care **Person-centred care plan may be called a care plan or personal plan depending on setting*			
a	**Staff use best practice guidance in person-centred care planning.**		
	Rate 1-6	**Process**	**Evidence**
	5	Staff CPD training on person-centred person planning (Care Inspectorate Guide for Providers on Personal Planning) organised on a yearly basis or when there are new staff starts.	Clinical supervision where personal plans are audited 2-weekly to ensure of person-centred personal plans.
b	**Information written in care plan reflects the approach and delivery of person-centred care.**		
	Rate 1-6	**Process**	**Evidence**
	5	Getting to Know Me (GTKM) paper forms and on digital TRAK are available on the ward. Staff are reminded to use GTKM information to inform care plan at handover.	Audit of sample of 10 patients where information from completed GTKM section is used to form part of the care plan.
c	**All team members can easily see and use up-to-date information in the care plan.**		
	Rate 1-6	**Process**	**Evidence**
	1	Person-centred care plans are completed in digital records.	Feedback from multidisciplinary team that person-centred care plans are not consistently updated on digital records.
d	**Care plans are used to inform and guide the delivery of care.**		
	Rate 1-6	**Process**	**Evidence**
	5	Care plans are used when looking after the individual's needs and preferences.	We have regular visual observations that care plans are being translated into practice.

e	There is a team approach to person-centred care planning and delivery.		
	Rate 1-6	**Process**	**Evidence**
	4	Standard operational procedure stating the roles and responsibilities of multidisciplinary staff for recording care plans.	We have a standard operational procedure for recording care plans that is visible in the staff lounge.
Initial improvement ideas (optional)			

Appendix 3: Tools and resources

Resource	Source	What it is and what it is for
Meaningful Connection, Visiting and Ann's Law	Care Inspectorate	An online information and resources for people who live in care homes, families and friends, and care home providers and staff. The aim is to support and promote all forms of meaningful connection for people living in adult and older people's care homes, while helping the sector prepare for the implementation of Anne's Law. Ann's Law is a piece of Scottish legistration that strengthens residents' rights to see and spend time with the people who matter to them—even during infectious disease outbreaks—recognising meaningful contact as essential to their health and wellbeing.
Anticipatory Care Plan	NHS Scotland	A dynamic record developed through ongoing conversa tions between people living with dementia, families, unpaid carers and healthcare providers. It focuses on planning for future health needs for the individual.
Care Opinion	Care Opinion	An online platform for people to share their experiences of health and care to lead to learning and change in a safe and simple approach.
Dementia "A once for Scotland" learning site on TURAS Learn	NHS Education for Scotland	A learning site containing a suite of resources to support the workforce to gain the knowledge and skills within the Promoting Excellence Framework to support people with dementia and their families and carers to have the best quality of life possible.
Dementia Champions Programme	University of West of Scotland (commissioned by NHS Education for Scotland on behalf of the Scottish Government)	This 6 month in-person national programme is currently paused and not being delivered. Its original aim was to support the development of enhanced knowledge, skills, values and attitudes aligned to the Promoting Excellence Framework, to improve the quality of life for people living with dementia and their unpaid carers. Many former participants remain within the health sector in particular and may continue to offer invaluable support in the field of dementia and improvement.
Dementia Resources	Care Inspectorate	An online resource that provides information and guidance to help you in supporting people living with dementia.
Dementia Improvements in	NHS Education for Scotland	This programme is currently paused and not being delivered. The programme was designed to build participants capacity to lead workforce education and

Specialist Dementia Care		training alongside service development, thus strengthening the infrastructures within both the health and social care sectors. The programme was aligned to the expertise level of the Promoting Excellence Framework. A well-attended former participants' network remains in place, and many Dementia Specialist Improvement Leads continue to work in both the health and social care sectors and may provide valuable support in dementia related improvement initiatives.
Dementia resources	Scottish Social Services Council	An online resource to help health and social care professionals implement NHS Education for Scotland Promoting Excellence Framework and the Standards of Care for Dementia in Scotland within their practice.
Dementia Standards: Supporting Change Tool	NHS Education for Scotland	This tool is designed to facilitate change and improvements in services and practice against the Standards of Care for Dementia in Scotland. The tool offers staff an opportunity for self-assessment of their care setting.
Dementia Skilled Improving Practice: Learning Resources	NHS Education for Scotland	Resource for health and social service workers to develop and improve staff knowledge, skills and confidence in the work they are doing to support people with dementia, and their families and carers. This resource will develop understanding about dementia, and support staff to think differently about the people with dementia they work with.
Enhancing the Healing Environment	Worchester University	A range of resources, including assessment tools, to enable hospitals, care homes, primary care premises and specialist housing providers to become more dementia friendly.
Getting to Know Me	Alzheimer Scotland	A downloadable PDF to support hospital staff to gain better understanding of patients with dementia. The document is designed to be completed by a person living with dementia, or a carer or relative.
Guide for Providers on Personal Planning	Care Inspectorate	A document to support staff in services to develop personal plans for adults.
Herbert Protocol	Police Scotland	An information gathering tool where key personal information is completed and maintained by unpaid carers or families for people living with dementia. The Herbal Protocol assists police, emergency and care services to work together to quickly locate missing people with dementia and return them home safely.

Meaningful connection in care homes: Self-evaluation tool	Care Inspectorate	A self-evaluation tool to help evaluate and support meaningful connection for people living in adult and older people's care homes and identify any areas of improvement.
National Trauma Transformation Programme: A Roadmap for Creating Trauma-informed and Responsive Change	Scottish Government	A Roadmap for Creating Trauma-informed and Responsive Change. Guidance for organisations, systems and workforces in Scotland.
Person-centred care plans: Good practice guide	Mental Welfare Commission for Scotland	Guidance on good practice in the development of person-centred care plans for people using mental health, dementia and learning disability services.
Power of Attorney	Office of the Public Guardian	Guidance on the process of creating and register a Power of Attorney (PoA). A PoA is a written document that lets you plan what you want another person to do for you in the future, should you become incapable of making decisions about your own affairs.
Promoting Excellence Framework	Scottish Government / NHS Education for Scotland	Web page-based knowledge and skills framework. The framework is for all health and social services staff working with people living with dementia and carers.
Rights, risks and limits to freedom: Good practice guide	Mental Welfare Commission for Scotland	Guidance on the legal, ethical and practical considerations and how to balance potential risks and benefits for individuals when considering whether someone's freedom of movement may need to be limited.
Right to Treat?	Mental Welfare Commission for Scotland	Guidance on delivering physical healthcare to people who lack capacity and refuse or resist treatment.
Trauma Informed and Responsive Practice in Dementia Care	NHS Education for Scotland	Specific learning resources to help health and social care professionals understand the complex relationship between trauma and dementia and to support routine implementation of trauma informed practice in dementia care.
Use of Restraint Guide	Mental Welfare Commission for Scotland	Guidance on best practice on the consideration and use of restraint in care settings.

Appendix 4: Improvement plan template

Service name				**Date:**	
The top three priorities for improvement	**Quality sub-criteria this priority is linked to**	**Improvement ideas (optional)**	**Lead**	**By when**	**Completed**
Any other improvements			**Lead**	**By when**	**Completed**

Contact us

Get in touch to provide feedback or share your plans for using the Reducing stress and distress self-evaluation Tool. Your query will be directed to the appropriate contact at Healthcare Improvement Scotland, Care Inspectorate or NHS Education for Scotland.

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	NHS Education for Scotland

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Need information in a different format? Contact our Equality, Inclusion and Human Rights Team to discuss your needs. Email his.equality@nhs.scot or call 0141 225 6999. We will consider your request and respond within 20 days.

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