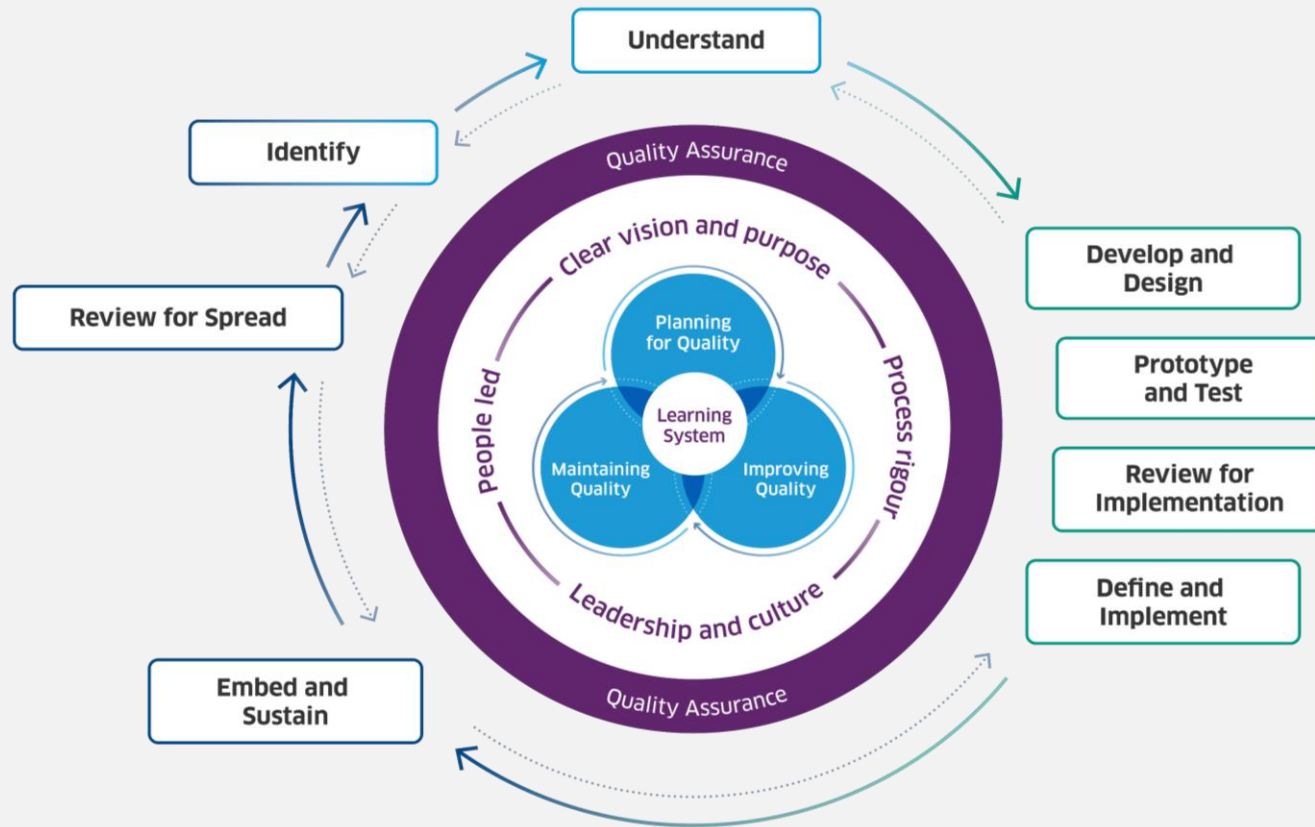


Scottish Approach to Change

Case Study: Reducing Psychoactive
Medication – “Find the Why” Project

November 2025

The Scottish Approach to Change



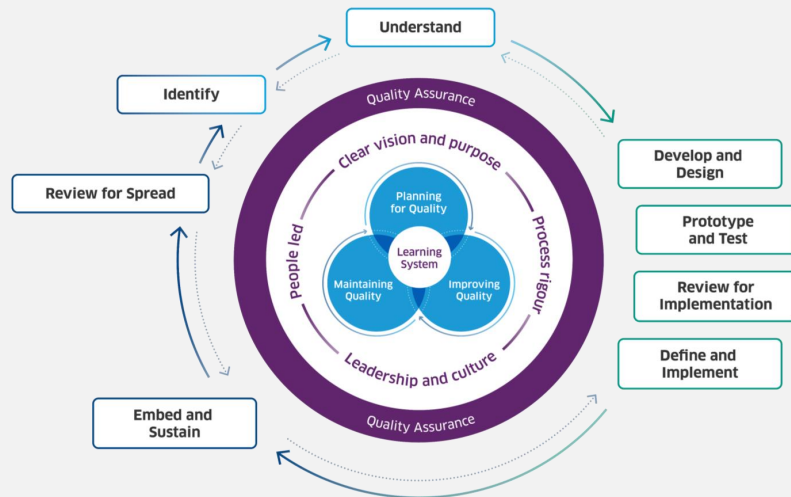
The Scottish Approach to Change includes two aspects:

- the **Steps of Change** – which outline the process that should be undertaken when delivering change
- the **Enablers for Change** – the other aspects that are essential to enabling successful change

The Scottish Approach to Change is integrated with the HIS Quality Management System Framework. It explains how to use a quality management system approach through a change process.

Reducing Psychoactive Medication “Find the Why” Project

This Case Study provides an example of the Scottish Approach to Change, showing how the steps of change and the enablers of change can be used in practice to deliver change.

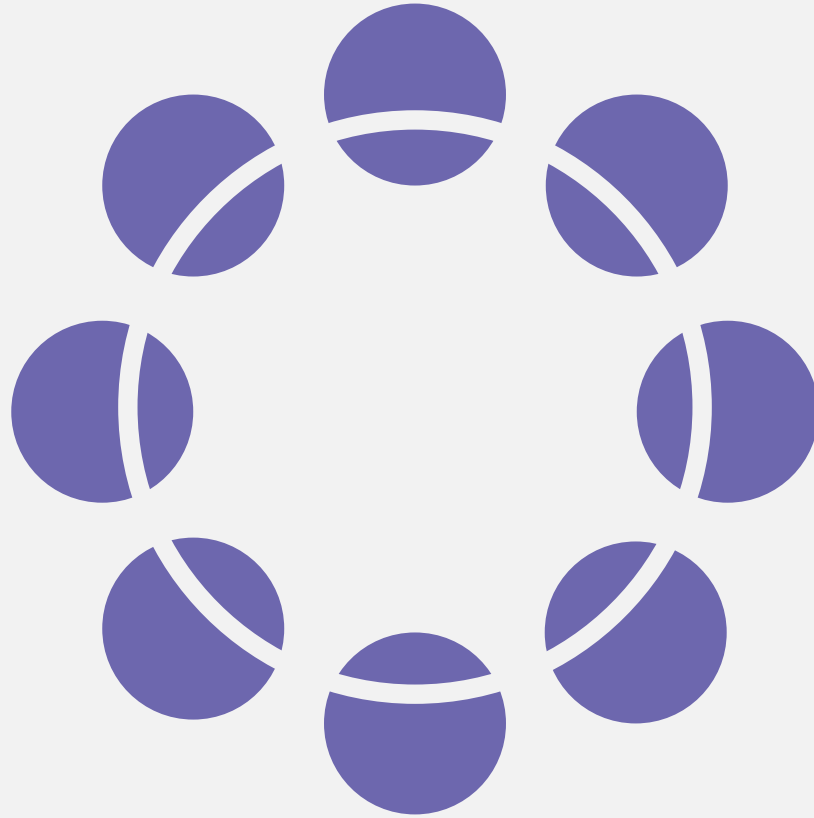


The **Reducing Psychoactive Medication – “Find the Why” project** was led by the Care Inspectorate in partnership with HC One Care Homes.

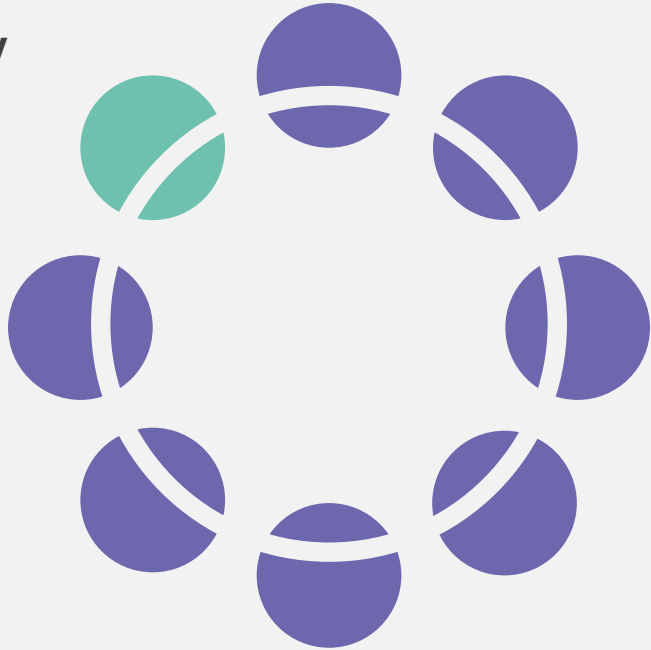
The project aimed to empower frontline staff to find solutions to **improve dementia care** relevant to their local context and **reduce inappropriate use of psychoactive medicines** for people with dementia.

The Steps of Change

How did they make the change?



Identify



The Reducing Psychoactive Medication – “Find the Why” project identified the problem.

- There was a **high level of prescribing sedating psychoactive medications** (e.g. antipsychotics, anxiolytics) for people with dementia in care homes, often used as a first-line response to stress and distress.
- **Reviews of these medications were often delayed or inconsistent**, particularly during, and after, the COVID-19 pandemic.

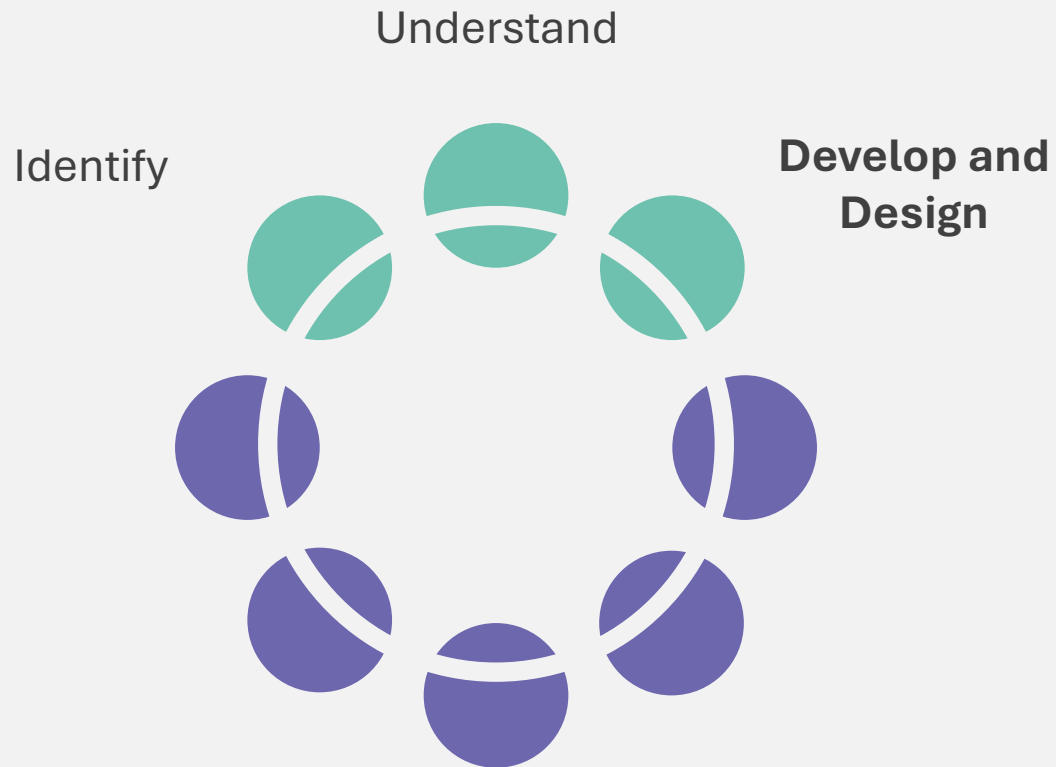
Understand

Identify



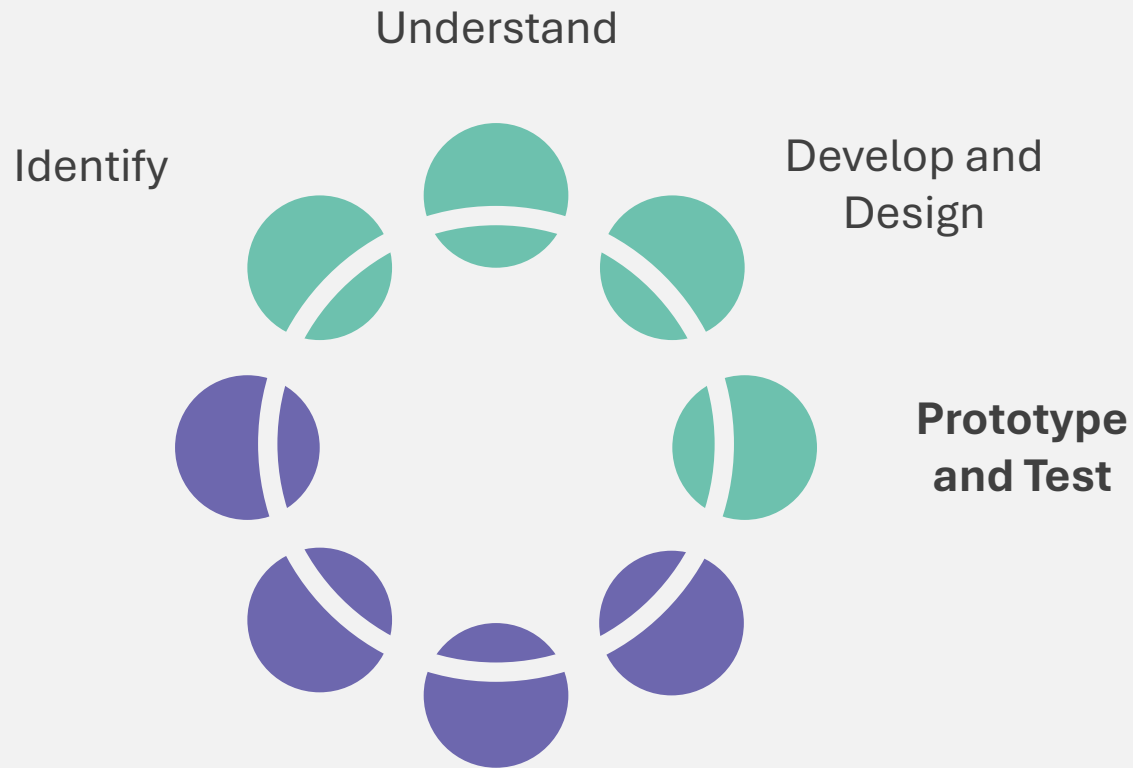
To further understand the problem an evidence review and needs assessment were completed.

- Concerns were raised by care home staff and regulatory bodies (e.g. Care Inspectorate) about the **overuse, and lack of timely review, of psychoactive medications**.
- Staff often lacked confidence or support to **explore non-pharmacological alternatives**.
- The project team recognised the need to **empower frontline staff to understand the root causes** (“the why”) of behaviours of concern.



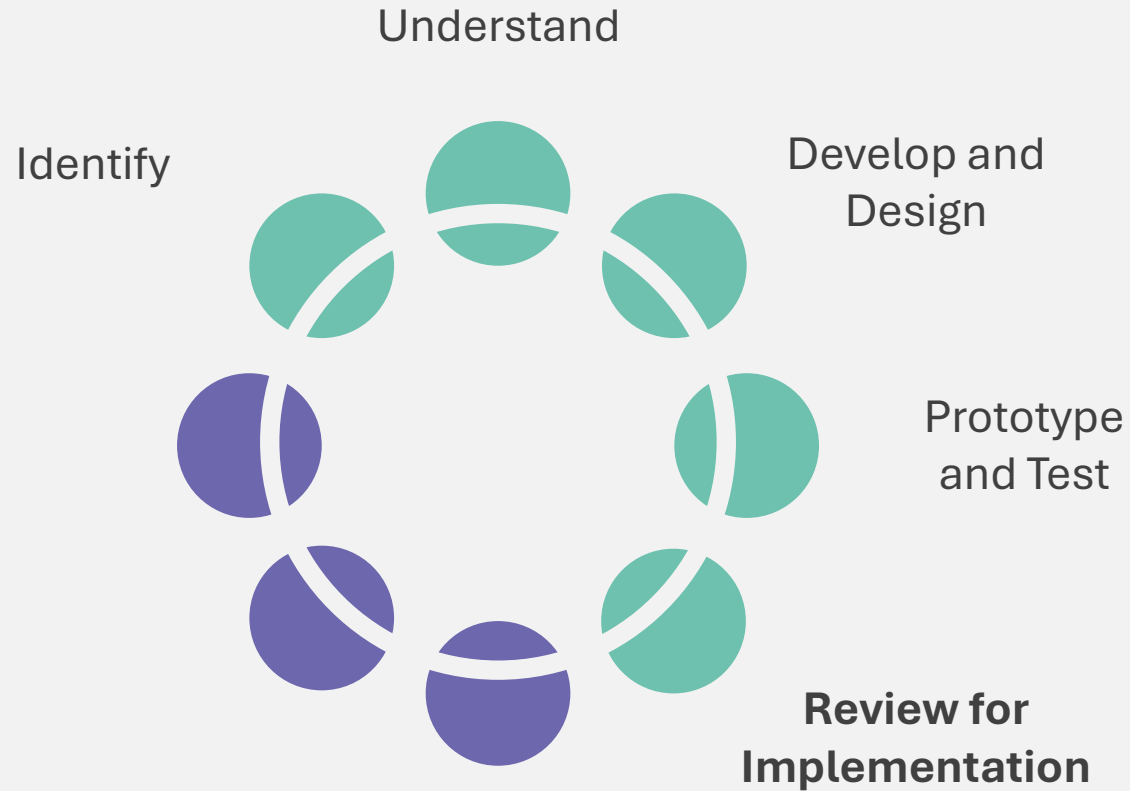
The Reducing Psychoactive Medication – “Find the Why” project used service design approaches to develop and design a solution.

- **A quality improvement (QI) programme was co-designed** with eight HC-One care homes in Scotland.
- The programme was voluntary and based on three principles:
 1. **All teach; all learn** – shared learning across all participants.
 2. **Voluntary participation** – care homes self-referred.
 3. **Empowering frontline staff** – psychological safety to test and refine ideas.



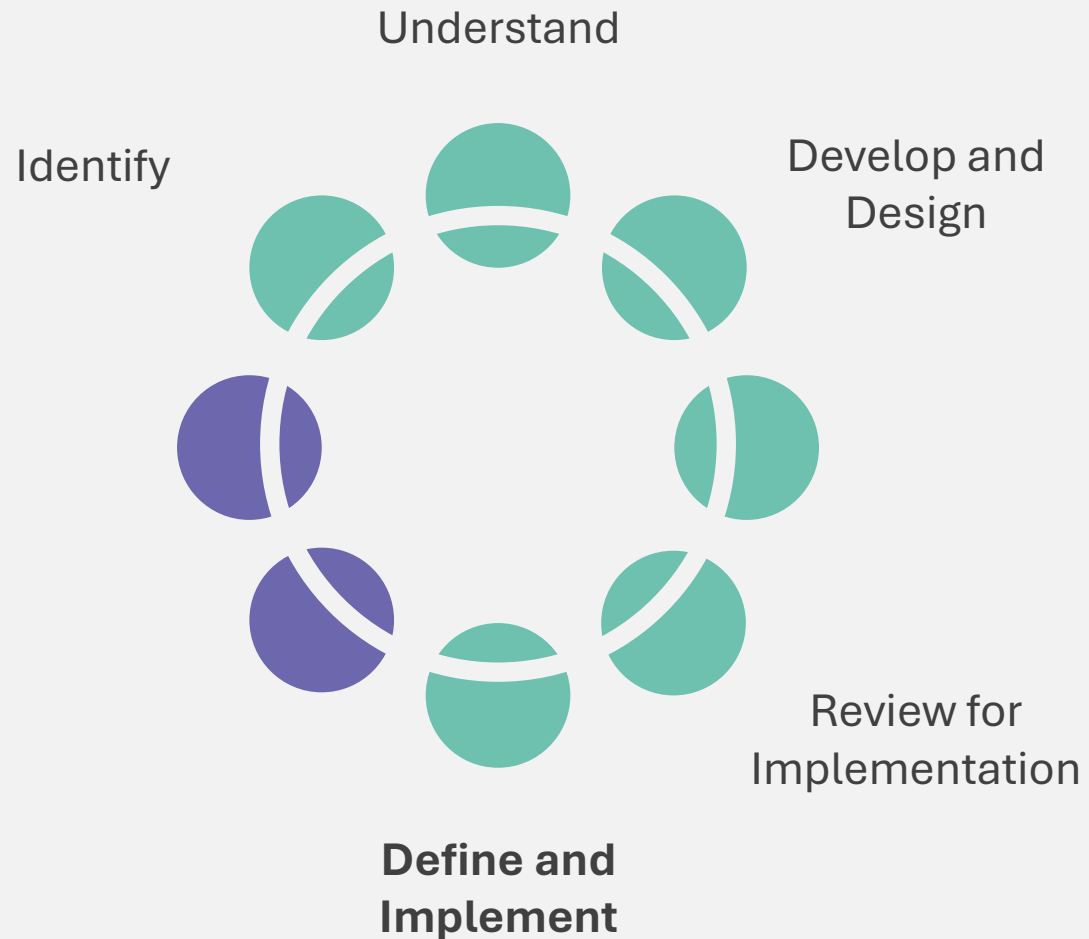
Change ideas were prototyped and tested.

- Care homes **tested small-scale interventions** with 1-2 residents initially.
- Change ideas focused on five themes:
 1. **Environment** – e.g. reducing visual triggers, creating calming spaces.
 2. **Personal care** – e.g. identifying triggers like staff height or gender.
 3. **Activity and wellbeing** – e.g. meaningful roles and routines.
 4. **Medication reviews** – e.g. structured review forms, GP engagement.
 5. **Staff practice** – e.g. ABC charts, peer review of medication use.



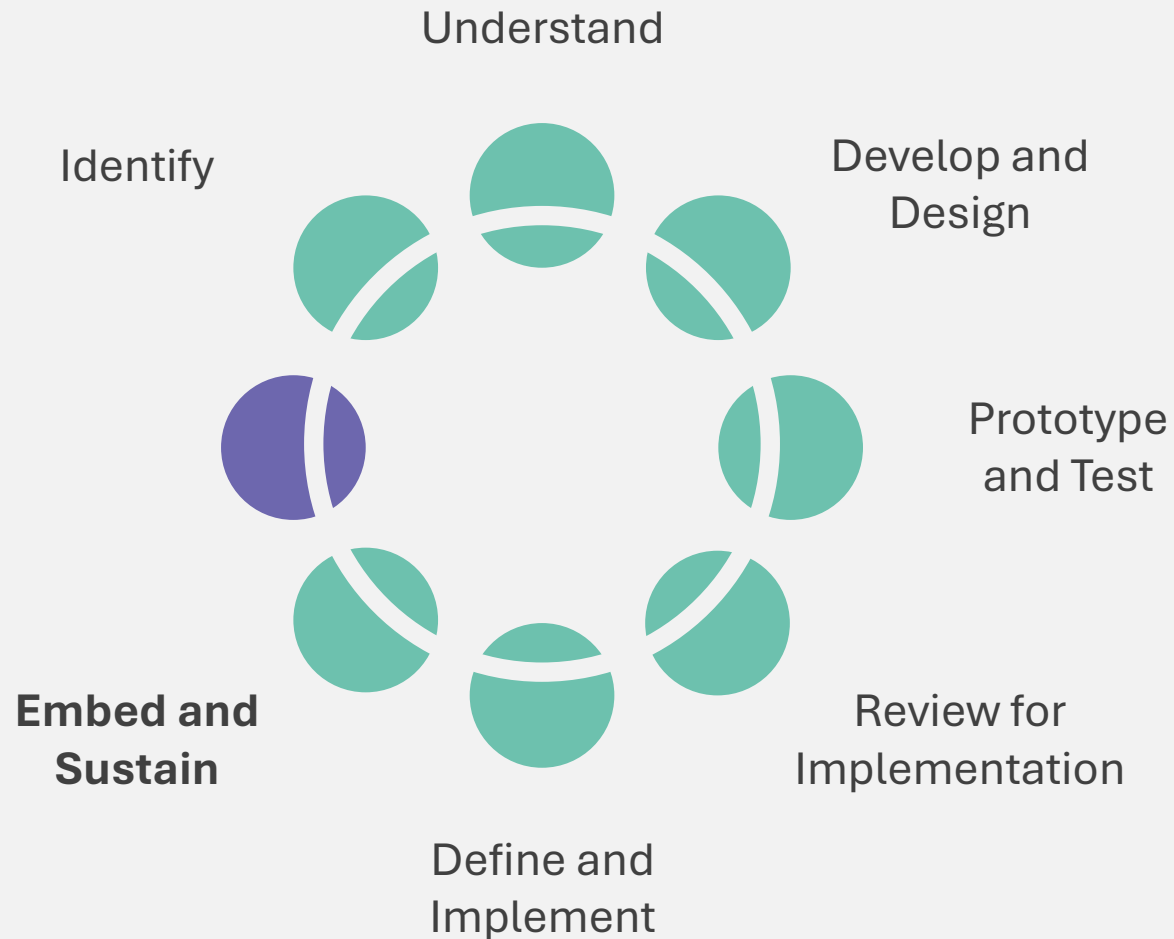
The changes were reviewed for impact.

- All care homes demonstrated improvements, including:
 - **reductions in regular and PRN psychoactive medication use**
 - **improved resident wellbeing and quality of life**
 - **increased staff confidence and job satisfaction.**
- **Data was tracked over time** to assess effectiveness and guide adjustments.



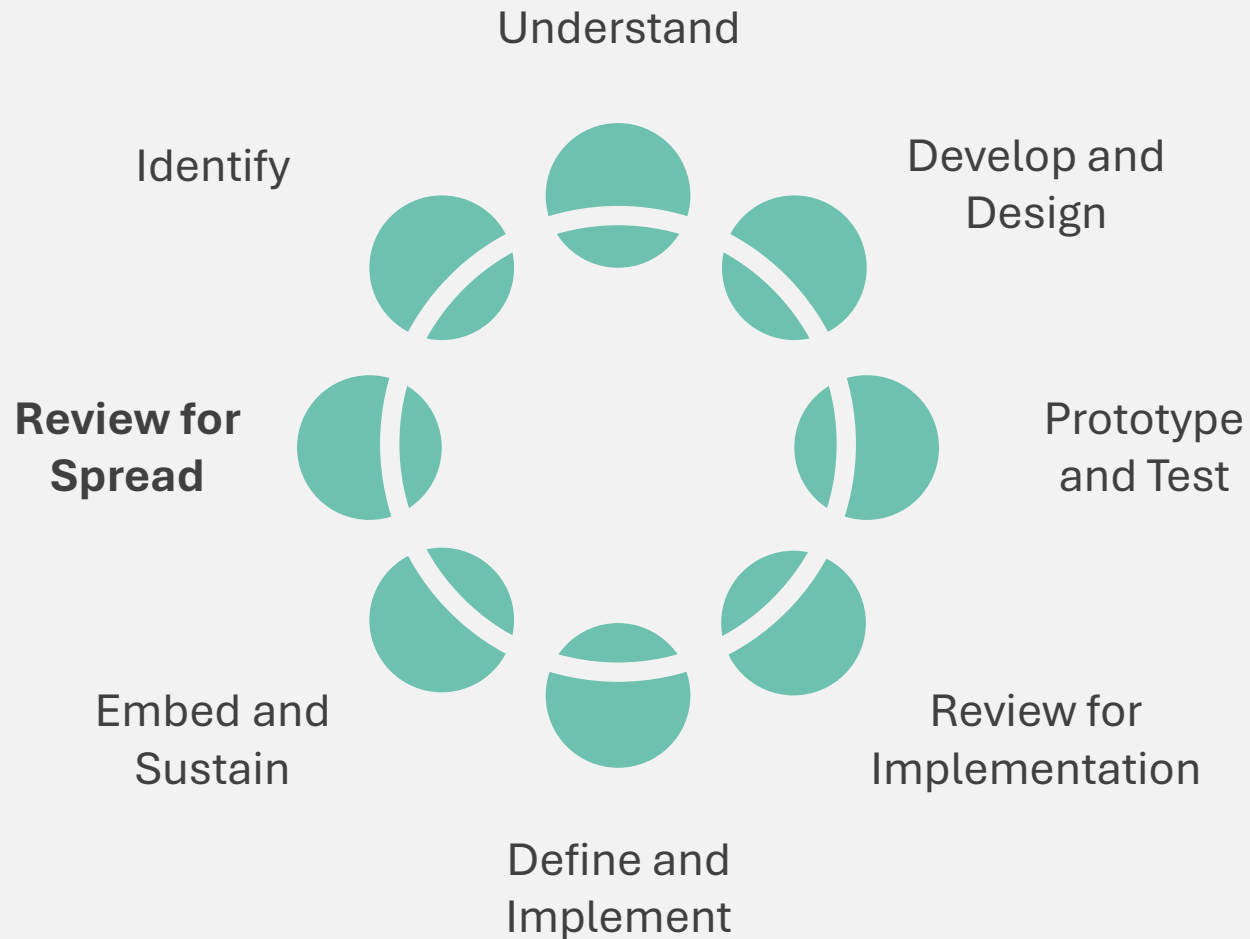
An iterative approach to implementation was adopted.

- The programme ran over six months with **three learning sessions**:
 1. Introduction to QI and project aims
 2. Sharing and refining change ideas
 3. Celebrating progress and planning for sustainability
- **Staff were supported by the HC-One Dementia Care Team and QI Advisors.**



Sustainability of improvement was supported.

- Staff **ownership of change ideas** promoted long-term adoption.
- Tools like medication review forms and ABC charts became **embedded in practice**.
- **Cohort 1 staff are now mentoring Cohort 2**, supporting spread and continuity.
- **Cultural shifts** included valuing data, psychological safety, and frontline leadership.



Preparation for spread and wider adoption has been undertaken.

- A **structured format** for future cohorts has been developed.
- The approach is being **scaled up with support from mentors and QI frameworks**.
- The model is seen as **replicable and adaptable to other care settings**.

Process rigour

People led

Leadership and culture

Clear vision and purpose

The Enablers for Change

Why did it work?

Process rigour

People led

Leadership and culture

Clear vision and purpose is necessary to provide direction, motivation, and alignment for everyone involved, ensuring efforts are focused and effective.

- Within the project there was a **shared goal** to reduce inappropriate psychoactive medication use.
- The project focused on **person-centred care** and **understanding behaviours as expressions of unmet need**.



Clear vision and purpose

Leadership, culture, and a whole system approach are key to ensuring changes are sustainable.

- Within the project there was a focus on **empowering frontline staff to lead change**.
- The project created a **psychologically safe environment for testing and learning**.
- The project promoted a **culture of curiosity, courage, and continuous improvement**.



A people led approach to change is crucial to ensuring the result of the change is also people led.

- The project took a people led approach by ensuring **residents' needs and preferences** were central to all interventions.
- In addition, **families were involved** in assessments and care planning.
- Within the project **staff were encouraged to “find the why” behind behaviours.**



People led

Leadership and culture

Clear vision and purpose

Process rigour means deliberately and systematically going through a structured process to ensure high-quality and reliable outcomes are achieved.

- In order to ensure a rigorous approach to change the project used **QI methodology (Plan-Do-Study-Act cycles)**.
- **Data was tracked over time** to ensure that impact was measured in a rigorous way.
- The project **developed structured tools** (e.g. review forms, ABC charts) to support consistency.



What outcomes have been achieved?

All care homes involved in the project were able to demonstrate some improvement. The following outcomes were achieved:

- Reductions were noted in the use of when required and/or regular psychoactive medicines.
- Case studies also showed positive quality of life benefits for residents and their families.
- Staff fed back that they felt empowered by the project.
- Staff fed back in some cases that the change ideas reduced administrative work and allowed more quality time with residents.