Dorset HealthCare University
NHS Foundation Trust

Quality Matters

Issue 47 – June/July 2017

Introduction from Fiona Haughey

Director – Nursing & Quality

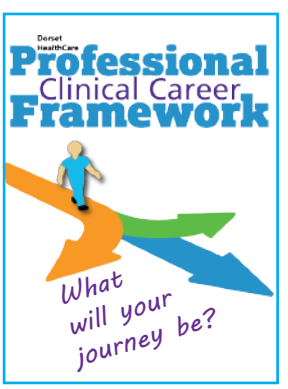
During May we launched our Professional Clinical Career Framework.

The framework has been designed to help you consider your development, providing a career pathway to advanced practice, flagging the education, learning and skills required.

Managers can use the framework in discussions with you to structure development around competencies and assist with identifying learning needs in line with service need and career goals.

Over a 100 staff from Nursing and Allied Health Professionals (AHP) joined the Quality and Nursing Team at an inspiring event in Wareham for the launch. We heard a variety of personal career stories starting with our guest speaker, Dr. Michele Board, Principal Academic Nursing Older People from Bournemouth University on her journey from student to Nurse Academic.

In the afternoon many staff stayed on to join in a Celebration of Nursing lead by Cara Southgate, Deputy Director of Nursing and Quality, creating a 'Proud to be a Nurse / AHP' wall.



At the end of April we held our first dementia conference in partnership with Bournemouth University, a fantastic event, attended by dementia champions from across the Trust. Our Clinical Effectiveness Quality Priority for 2017/18 focuses on dementia, supporting staff with assessment, treatment and management of patients with dementia; the event was a very inspiring and positive start.

This edition of Quality Matters focuses on caring for people with dementia. When reading the reflections I thought it would be useful to have a few dementia facts to put into context this disease.

Dementia facts

- Around 676,000 people have dementia in England.
- Dementia mainly affects older people, after the age of 65, the likelihood of developing dementia roughly doubles every five years.
- There are around 540,000 carers of people with dementia in England.
- It is estimated 1 in 3 people will care for a person with dementia in their lifetime.
- It is estimated 66,000 people have cut their working hours to care for a family member, whilst 50,000 people have left work altogether.
- The cost associated with dementia is estimated at £23 billion a year, which is predicted to triple by 2040.

During 2016/17 the Trust focused on how it engaged with patients, families and carer's in their care plan and treatment. We want to continue this year with the momentum already generated around John's Campaign (http://johnscampaign.org.uk/#/) and the Carers Passport, by ensuring we offer all carers of inpatients with a diagnosis of dementia a Carers Passport.

As a partner agency we have adopted the pan Dorset Carers Strategy (https://www.bournemouth.gov.uk/AdultSocialCare/Carers/Carers-Documents/valuing-carers-in-dorset-brochure.pdf) and will be rolling out the 'Triangle of Care (https://professionals.carers.org/working-men-tal-health-carers/triangle-care-mental-health), across our community mental health teams to ensure we put the patient and their carers at the centre of what we do for 2017/18.

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Professional Clinical Career Framework Useful links

The Professional Clinical Career Framework – competencies and templates
https://doris.dhc.nhs.uk/learning-and-development/advancing-clinical-practic

Generic Clinical Job Descriptions
https://doris.dhc.nhs.uk/hr/toolkit/job-matching

Learning and Development Prospectus
https://doris.dhc.nhs.uk/learning-and-development/Bulletin-Prospectus

External links
https://hee.nhs.uk/

Health Education England (Wessex)
https://hee.nhs.uk/hee-your-area/wessex

Career Cafés

- Are you thinking about your next career move in Dorset HealthCare?
- Are you happy where you are, but want to keep on learning?
- Perhaps you are thinking about professional training? Or moving from one service to another?
- Not sure what to do next?

Then come along to a Career Café and have a chat with someone who can help!

The next Career Café is taking place on **Tuesday 11th July** in the Blue Meeting Room at Westminster Memorial Hospital from 10am–3pm.
For more information, please click here.

Joint Dorset HealthCare and Bournemouth University Dementia Conference


Cliff Kilgore

On the 24th April we had the privilege of staging Dorset HealthCare's first dementia conference. This was a culmination of many weeks of hard work and incredible commitment from practitioners and managers across the Trust and greatly directed in partnership between Dorset HealthCare's dementia steering group and Bournemouth University. The conference ran with the title 'Seeing the person not the diagnoses' which enabled us to concentrate on a person centred approach to dementia education. We had dual key speakers with the wonderful Veronica Devas talking about the carer's perspective as she cares for her husband Christopher who lives with dementia as well as Dawne Garrett, the Dementia lead for the Royal College of Nursing.

There were so many fantastic examples of learning with great speakers from our own organisation and Bournemouth University and we were certainly inspired by the attendance of 140 people, which was oversubscribed and required a waiting list for cancelled places. However, what I was most excited about was the genuine interest from the audience who showed rapt attention to the speakers and participated in the break out discussions with great commitment. We know as healthcare professionals that we have much to do to make dementia care the best it can be but if the staff that attended the conference are anything to go by we are going in the right direction!

Cliff Kilgore, Consultant Nurse Intermediate Care/Older People

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A quote from Veronica, the patient/ carer who presented; 'the sea of YOUNG faces that greeted us was a joy, "to be telling the young professionals of today of our experiences and hoping that what we helped them understand dementia more, made the day very worthwhile"

Reflections from Dementia Virtual Tour Training

I attended, along with a Memory Nurse and my mentor, a Dementia Virtual Tour ran by the Train2care.

The training2care website describes the following:

"The Virtual Dementia Tour was invented 20 years ago in America by world renowned professional PK Beville who owns the non-profit company Second Wind Dreams owners of the VDT. The Virtual Dementia Tour is medically and scientifically proven to be the closest that we can give a person with a healthy brain an experience of what dementia might be like. By understanding dementia from the person's point of view we can change practice, reduce issues and improve their lives."

Upon arriving at the care home hosting the event, we met our fellow trainees who consisted of some sixth form students, NHS nurses working in dementia care, independent dementia specialists and myself, a student mental health nurse.

The lady running the event was not welcoming and did not introduce herself but gave some equipment to three people and said to follow her for the tour leaving behind the rest of us with no instructions or context. Several of us tutted at her lack of professionalism and became a bit irritated thinking if she was going to run the session like this, we had better things to do!

After about 15 minutes she returned to collect the next three including myself. She gave me spiked insoles to simulate poor circulation, bulky gloves with some fingers sewn together to simulate arthritic hands with lost sensations, sunglasses with patches blocked out to simulate sight restrictions and a set of headphones playing very loud "white noise" (this turned out to be specially designed noise to represent how some older adults experience the sounds around them).

I was then led into a darkened room with darting lights and could see the event runner in front of me saying something but I could not hear a thing. I was already irritated from the lack of introduction and context she had provided and then thought she had put my headphones too loud and that the event was not ran well. I could see the other two who were doing the virtual tour with me, moving about the room seemingly following the same instructions I had not heard so I thought I said, but turned out shouted "What am I meant to be doing, I couldn't hear you". After some time she gave me the instruction "do something useful" into my ear so I could hear it. I then found some clothes to fold although it was very difficult with the simulated impairments.

After what felt like a long time but was in fact just 8 minutes, we stopped and the lights were turned on. We were offered the opportunity to watch the next three and this is where it really became enlightening. The three young adults professionally trained in dementia care, when deprived of their senses, behaved in a way very recognisable to the people with later stages of dementia in the secured hospital units! Some behaviour that particularly stood out was standing with the back to the wall for security and when one lady was told to "fold the towels" which were on the bed kept trying to open the bathroom door from which she was quickly stopped and returned to the main room without being given a reason why she wasn't allowed through that door.

When all the participants had finished the tour, we all met up again and discussed the experience. It was at this point that the lady running the event explained the lack of introduction; she had been portraying a poor support worker in a care home. We discussed some of the individual behaviours we had exhibited, many of which we had not been aware of. We talked about why some behaviour may seem odd to us whilst the person doing the "odd" thing thinks it makes sense. One example was when a lady was rummaging through an empty draw and when watching her, it looked like she was perhaps having delusions, but she told us afterwards that she was looking for a comb and with the sight restrictions could not see if the draw was empty or not. At the end of the discussion we came up with the phrase, "There is no challenging behaviour, just behaviour that challenges us to be better".

Despite having experienced professionals in the room, everyone was in agreement as to the extreme level of empathy this experience had helped us to achieve. I personally have taken away a new approach to working with people with dementia and a new understanding of what their capabilities are despite any restrictions. Even after visiting the Deprivation of Liberty's (DOLs) team and speaking with a mental health advocate, I have not had such awareness of the level of capacity that may be there, covered by a diagnosis and symptoms.

I truly believe this training should be provided to all staff that have contact with dementia care and I will be bringing this training to the curriculum review at my university.

Edward Parker, Student Nurse, Memory Assessment Service, Alderney Hospital

For details http://www.training2care.co.uk/virtual-dementia-tour.htm

Seeing the person not the diagnosis – a reflection on a patient assessment

My belief is that all aspects of any consultation are potentially educational. It is a dialogue through which I expect the patient to educate me in terms of their lifestyle choices, symptoms, hopes for treatment and fears surrounding potential failure. Experience suggests that their expectation is that I will, in turn, educate them in how these hopes and fears can be managed. Education is a process of facilitating skills, values or knowledge acquisition. It is about challenging or confirming beliefs and demonstrating that this need not be threatening but is supportive. Clinical education of patients often occurs opportunistically and therefore identifying these opportunities as well as acting on them is crucial in health promotion.

I reviewed this 85 year old, ex professional footballer (J) to confirm the diagnosis of cellulitis made out of hours over the weekend. The diagnosis was made via a telephone conversation with his wife. The concern was that it may have been a flare up of his gout. My mentor was present in order to assess my communication skills and ability to recognise patient education opportunities regarding self-management of his diagnosis.

Patient centred issues:

1. Dementia – ability to retain information
2. Ability to self-manage
3. Support network
4. Correct diagnosis.

Educational opportunities discussed:

1. Foot hygiene to prevent infection – antifungal powder prescribed
2. Fluids to prevent gout
3. To elevate legs when seated to prevent accumulation of fluid, skin breakdown and further portal for infection.

J was co-operative with his clinical examination and interested in discussing his symptoms and preventative options. He was supported throughout by his wife who helped to remind him of his symptoms, confirmed the history when he was uncertain, and managed his medication and treatment. She provided him with physical and emotional support, was his main carer, managed his medication and activities of daily living, encouraged and clearly loved him. Holding the consultation without her presence would have prevented J's case from being adequately presented, affecting the outcome of the consultation.

Although clinically J's case was very straightforward: Examination confirmed cellulitis in his right foot with a potential entry point from a fungal infection between his toes, in terms of patient / clinician interaction managing a consultation with someone with memory impairment requires patience and the willingness to be repetitive. I was aware that each time I discussed the potential reasons for the cellulitis he was hearing this for the first time. So even though his wife tutted with impatience at one point in acknowledgement of his forgetfulness I felt that it was important to J that I treat each statement as if it had never been spoken. Therefore I am conscious of tone of voice, not sounding impatient or judgemental in order to retain a relationship of warmth with both J and his embarrassed wife (who was, I feel conscious that he may have been prolonging the intervention). Time spent, in order to build a rapport is not wasted and we cannot predict what an individual with memory impairment will take away from a consultation. Therefore in terms of communication repetition may provide a basis which his wife can repeat and build on. In terms of reassurance, J may not remember the content but he may remember the feeling it inspired, and I would prefer to leave him a happy man.

My mentor discussed the strengths of this interaction as being my communication skills, knowledge, compassion and professionalism. We specifically discussed my ability to repeatedly impart the same information without appearing critical. I feel that in working with patients with dementia this is an important skill. My mentor had no developmental suggestions.

Patient Feedback / Compliments

"To all at the pain clinic, I feel compelled to write and say a big thank you to the clinic which I attend (January/February 2017).

At the beginning I didn't know what to expect, but as the weeks went by I found myself really looking forward to the sessions.

The mix of physio and O.T suggestions were invaluable, plus being able to share information with the group. Most of all the psychology together with the amazing way the brain functions – as explained by the pain nurse – is something I will treasure.

All this has enabled me to fully understand pain. I now feel more confident and 'restful'. It's like being given a gift, all wrapped up, that I can refer to whenever I feel the need.

Dorset Community Pain Service

http://www.dorsetpain.org.uk/

Welcome to the team

After nearly 20 years working around the country in various roles, I am delighted to have been appointed as the Head of Patient Safety and Risk for Dorset HealthCare. I have a clinical background in Retail and Hospital Pharmacy, but most recently I have been working in Patient Safety for Oxfordshire Clinical Commissioning Group.

This means relocating my family back to Dorset from Oxfordshire and I can't wait to get stuck in! Having left the commissioning side of the NHS, I am really pleased to be back working with staff that are so passionate about our patients and working together to make our systems and processes better so that we continually strive to provide high quality care for our patients.

I'm based in Sentinel House, but I am trying to get out as much as possible to meet our fantastic teams across the county. What I realise every day is how diverse our services are and how dedicated everyone is to doing a really good job. Thank you to everyone I've met so far for being so welcoming and helping me to find my way around (whether it's the printer or the building!). I look forward to meeting as many of you as possible over the coming weeks and months.

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Rachael Maiben (L) joins fellow apprentices, Matthew Cheetham, Kirstie Hancock (R) and Jack Cullen

Kirstie joined the Clinical Effectiveness team based at Sentinel House in January. "My team is great and I am really enjoying my apprenticeship so far. I have built lots of confidence, got to know new people and learnt new skills in such a short space of time. I am looking forward to being able to further develop my skills throughout the rest of my apprenticeship."

Matthew has been an apprentice on the Patient Experience and Complaints Team since November 2016. "I have found my time here as part of the Nursing and Quality Directorate incredibly interesting and insightful. My team (and the wider N+Q team) have all been amazing and supportive of my apprenticeship. I am fortunate to be a part of this Trust."

Jack Cullen (not pictured) has been with the Trust for 18 months, based at Shelley Road, Jack is the Clinical Effectiveness teams Clinical Audit, apprentice.

NICE Guidelines Update

Each month we review any new guidance or quality standards issued by the National Institute of Health and Care Excellence (NICE). This section of Quality Matters will be dedicated to keeping you up to date with the key recommendations from the latest relevant publications.

Please review your clinical practice within your teams to assess whether you are meeting these standards.

CG68 STROKE AND TRANSIENT ISCHAEMIC ATTACK IN OVER 16S: DIAGNOSIS & INITIAL MANAGEMENT

- In people with sudden onset of neurological symptoms, hypoglycaemia should be excluded as the cause of these symptoms
- People who have had a suspected TIA (that is, they have no neurological symptoms at the time of assessment [within 24 hours]) should be assessed as soon as possible for their risk of subsequent stroke using a validated scoring system, such as ABCD
- People who have had a suspected TIA who are at high risk of stroke (that is, with an ABCD2 score of 4 or above) should have:
  - aspirin (300 mg daily) started immediately
  - specialist assessment and investigation within 24 hours of onset of symptoms
  - measures for secondary prevention introduced as soon as the diagnosis is confirmed, including discussion of individual risk factors
- People with crescendo TIA (two or more TIAs in a week) should be treated as being at high risk of stroke, even though they may have an ABCD2 score of 3 or below
- People who have had a suspected TIA who are at lower risk of stroke (that is, an ABCD2 score of 3 or below) should have:
  - aspirin (300 mg daily) started immediately
  - specialist assessment and investigation as soon as possible, but definitely within 1 week of onset of symptoms
  - measures for secondary prevention introduced as soon as the diagnosis is confirmed, including discussion of individual risk factors
- Brain imaging should be performed immediately for people with acute stroke if any of the following apply:
  - indications for thrombolysis or early anticoagulation treatment
  - on anticoagulant treatment
  - a known bleeding tendency
  - a depressed level of consciousness (Glasgow Coma Score below 13)
  - unexplained progressive or fluctuating symptoms
  - papilloedema, neck stiffness or fever
  - severe headache at onset of stroke symptoms

For further information contact:
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Reminder – Clinical Supervision

All registered clinical staff within the Trust are required, as per policy to receive and record a minimum of 2 formal clinical supervision sessions within each of the periods 1st April – 30th September and 1st October – 31st March.

The clinical supervision policy can be viewed via this link, Clinical Supervision Policy.

Please follow this link to record supervision sessions on Ulysses, Log your supervision.

A list of current DHUFT Supervisors can be found by following this link, List of DHUFT Supervisors.

Clinical Supervision for Supervisors training can be booked via the Online Booking System. Further details of this training can be found in the Learning & Development Prospectus.

Appraisal Survey – Your chance to tell us about the process, the system and suggestions

Our aim is to capture as much information as possible around your experience of the current appraisal process and use your ideas and suggestions to help improve it. This includes looking at the current recording system used to capture the Appraisal conversation.

If you would like to provide feedback please complete this survey, https://www.surveymonkey.co.uk/r/CX3HJJ5AppraisalProcessReview. Your opinions will be very much appreciated and will help to improve the overall experience for everyone.

Assuring Safer Care: Embracing Human Factors for Improvement – 10 & 31 July 2017

This two day course covers the reasons why information exchange, shared mental models, collaborative decision making and new models of distributive leadership are key to facilitating appropriate prioritisation and delegation of patient care. It would be particularly useful for those who are currently or planning to engage in service development/quality improvement work.

To find out more, please click here.

LSCB Level 3 Training

Please click here to view dates for the Serious Case Review Training taking place in July and September 2017. Please book your place via CPD online system.

For more information on Safeguarding Children Level 3 training please click here.

Delivering Compassionate Care

This course is aimed at all staff.

By the end of the day, it is anticipated that participants will be able to:

- Explore our understanding of what is compassion
- Discuss current thinking around models of compassionate care
- Identify areas of best practice in delivering care with kindness and compassion
- Explore situations, circumstances and environments in which impact on the effect of giving compassionate care
- Discuss ways in which key learning is applied in practice

Please book your place via the Online Booking System. More information on this course can be found in the Learning and Development Prospectus.