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Preface

I am very pleased to introduce the latest of Skills for Care's products which focuses on developing the skills of the social care workforce who support people living with dementia who also live with other conditions. This product has been commissioned by the Department of Health.

It is specifically aimed at leaders and managers working in services for people with dementia, and will help colleagues to develop their teams who are supporting people living with dementia when they also live with other conditions such as a disability or a sensory impairment.

The resource is a case study-based guide and has been compiled by Skills for Care working closely with social care employers across England. Developed for our sector, by our sector, we are confident that the information, advice and guidance contained within this guide will support the development of your team.

Using qualifications to develop your workforce and supporting staff working with people with learning disabilities who also live with dementia are just two examples from this informative guide which covers a wide range of relevant areas.

We hope that by using this information it will support your organisation to further develop your workforce to more effectively support people living with dementia who also live with other conditions.

We welcome your feedback and comments on this guide so please feel free to get in touch with Skills for Care staff or contact us via email at info@skillsforcare.org.uk.



Chief Executive Officer
Skills for Care



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Sensory impairment and dementia Vista Blind

Established in 1858, Vista is a local charity working with almost 6,000 children and adults with sight loss, living in Leicester, Leicestershire and Rutland. The organisation:

- promotes eye health to prevent sight loss
- reduces the impact of sight loss
- provides support and care for people with sight loss

Vista offers a wide range of community services for people of any age. They operate four specialist residential care homes in the local area, including two for older people with sight loss and dementia, and two for adults with learning dif culties and sight loss.

Five top tips

1. Optimise a person's visual ability
2. Create a sight loss and dementia-friendly environment
3. Equip staff with knowledge and skills in dementia and sight loss
4. Reduce loneliness and isolation
5. Develop comprehensive support plans

The combination of sight loss and dementia can be an overwhelming experience for an individual, their family and carers. The overall disorientation a person experiences leads to loss of independence, feelings of isolation and having to face multiple losses which challenge both the person and the care service.

Dif culties in the detection and diagnosis of sight loss can be further compounded by dementia as one condition may mask or be mistaken for another. Some types of sight loss can cause visual hallucinations which can be mistaken for dementia symptoms. That is why it is so important to understand a person's sight loss.

In practice

Wycliffe Home offers care for up to 48 older people who all have a visual impairment. The home is also registered to provide care for people who have a dual impairment i.e. people who have a sensory impairment and dementia.

The home currently employs 72 staff members. All of the staff have received specialist training to help them meet the unique needs of older people with sight loss and dementia.

Ensuring staff have the knowledge and skills to be able to support people appropriately.

More than 12% of people over 75 years of age have some sight loss and in the over 80s vision is reduced by 35%. In care homes, studies indicate a higher proportion of people with both sight loss and dementia. The organisation recognises the importance of adapting its core training to include supporting individuals with multiple conditions, in addition to their sight loss. It is recommended that in residential settings, in addition to having training

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Sensory impairment and dementia

Alternative Futures Group

Alternative Futures Group are one of the UK's largest health and social care charities, currently supporting around 1,200 people across the UK and employing over 2,500 staff. They work locally in the community and through their treatment and recovery centres to provide a wide range of innovative and bespoke care services delivering life-enhancing person centred support to people with a diverse range of care needs.

Five top tips

1. Be clear that we cannot deliver personalised support if we don't know what matters to people and how best to support them from their perspective, therefore a one-page profile is the foundation of personalisation.
2. Recognise that delivering personalised support requires a huge cultural shift in many areas. It's a different way to work together and think about what is going to work for the person being supported.
3. One-page profiles needs to be developed over time.
4. As soon as there is enough information about someone recorded in a one-page profile, we need to ensure we share it with the right people. One-page profiles should be a living document that evolves over time. Five top tips for developing one-page profiles

Arthur is terrified of being 'put in a home' so his family and carers are doing their best to help him stay in his own home. He has support from home care workers four times per day to prepare his meals for him. In addition to his sensory impairments, Arthur must have his walking stick within reach as he has quite an unsteady gait. He finds his way around his flat quite easily but his furniture should never be moved around or it could cause confusion and he shouldn't go out alone.

The team supporting Arthur at home began to use person-centred practices - practical tools to help health and social care professionals understand what makes a person tick and which create action for change.

Arthur, his family and a team member sat down and developed his one-page profile through conversation. From those conversations they summarised together what was important to him and how best to support him, and also what others appreciated about Arthur. There was a focus on the positive, valued characteristics of Arthur – his important relationships and connections, passions, hobbies and interests – in so much detail that you know which newspaper he liked.

Much of this could have been overlooked – such as the fact that he wanted his food served very hot and he must always have a £10 note in his top pocket. But when he shared these small details with staff they were able to act on them. The manager worked with all the staff team to make sure that as well as being healthy and safe, what mattered to Arthur was put at the forefront of his care. The staff learned that if he was in bed they should never approach him as he would think it was a burglar and hit out with his walking stick. Calling his name from the bedroom door worked best – but due to his poor hearing, staff needed to ensure he acknowledged them before approaching him.

Arthur always wears his wool bob hat and said he is sick and tired of people telling him to take it off – his view is "this is my flat and if I want to wear my hat I will wear it". He has lived in his flat for 35 years. He lost his wife Madge 20 years ago and treasures her wedding ring which he wears on his little finger. Arthur loves talking to people and is an amazing storyteller.

They learnt that Stephen is Arthur's nephew who Arthur loves dearly. Stephen phones Arthur every day at 5pm which he really looks forward to. Stephen also visits on Tuesdays and Saturdays and takes Arthur to his house for tea every Friday where Arthur loves chatting to Sally (Stephen's wife) and their teenage children Jo, Ollie and Darren. This is the highlight of Arthur's week.

Arthur makes sense of his days by sticking to his routines; anything out of the ordinary will totally disorientate him, leaving him confused and likely to go outdoors in search of help. He always has a £10 note in his top pocket "in case he needs it". If he loses it, he will struggle on his hands and knees for hours looking for it. If something out of the ordinary is happening, such as a hospital appointment, staff explain clearly to him about this a week beforehand and remind him daily.

From those conversations there was enough information to learn some of the things that really mattered to Arthur and how best to support him from his perspective. Asking different questions led to different conversations, giving a thorough understanding about what matters to Arthur and how he wants to be supported. This is the information that was needed to ensure his support is tailored to his needs and aspirations.

One-page profiles are fundamental to the planning process and Arthur's profile has become the job description for those providing his support. This helps to ensure these things are present and that Arthur is consistently supported in a way that makes sense to him. This enhances his choice and control on a day-to-day basis. Staff cannot decide on outcomes to be achieved without doing it in the context of what is important to people and knowing how best to support the person from their perspective.

One-page profiles are also a person-centred thinking tool that support the transition from people living with dementia being passive recipients of care, to them being recognised as equal valued members of society. They also herald a new progression, as services aspire to move beyond personhood towards citizenship and personalisation, with a view to enhancing the amount of choice and control people have.

Useful resources

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Sensory impairment and dementia Carers Trust 4all

Carers Trust 4all provides care and support to people with care needs and their carers. The organisation delivers a wide range of services that are tailored to the individual and all care packages are different. Carers Trust 4all has an excellent learning and development programme which effectively supports its workforce to deliver high-quality care in people's own homes.

Five top tips

1. Make sure your staff team has the tools to do their job – a well-trained workforce that knows what to expect when supporting people with dementia can make such a difference to the quality of care being provided and the ability to be responsive.
2. Good ongoing communication with the training provider (in the case of Carers Trust 4all, this was their training manager) to ensure that training needs are met, especially where a client's needs were changing quickly.
3. Thorough training for the full team around mental capacity, especially around working with the five key principles at the forefront of everything.
4. Develop a process for 'whole family' assessment from the very start when working with someone with a dementia diagnosis and the added complexity of a physical disability.
5. Good sharing methods for the carer support team – regular debriefings worked very well and gave the team a chance to overload and reflect.

While on-going research, discussion and debate is taking place with regards to dementia, it is important not to overlook the small things we can do to support people living with dementia to live good lives.

In practice

This case study is about Mr and Mrs L who lived in the family home. Mr L was 95 years of age and had been diagnosed with clinical depression with auditory hallucinations. He had very poor mobility and spent a large portion of the day in bed. Mrs L cared for her husband and provided a great deal of emotional support to him. She had a diagnosis of Alzheimer's and was registered blind.

Mrs L was displaying signs of memory loss, in particular with short-term memory. She was struggling with remembering if she had taken her medication and if she had helped her husband take his. Mrs L's husband was unaware of her diagnosis as she didn't want to worry him and she had full capacity to make her decision. Mr and Mrs L's family lived 150 miles away but visited every other weekend and were very supportive and involved.

Several weeks after the diagnosis, Mrs L suffered a serious fall at home causing a broken leg

It was quite some time before the extent of this was recognised. It was through the carer support workers giving their care coordinator clear and regular feedback, and in turn the care coordinator regularly talking to the family, that it became clear that the care package was no longer enough.

A number of reviews were held where social workers looked at how safe both Mr and Mrs L were in their home. It was agreed that because of their unwillingness to accept more than minimal help and support, that they would not be able to stay in their own home. Carers Trust 4all supported Mr and Mrs L to make their wishes to stay together known and a small one-bedroom flat was found with a 24-hour warden.

The case study highlights the complexities of supporting someone with a sensory impairment and dementia. It also highlights the need for a whole family assessment as at the start, Carers Trust 4all were informed that it was just Mr L with support needs, when in fact both Mr and Mrs L needed support.

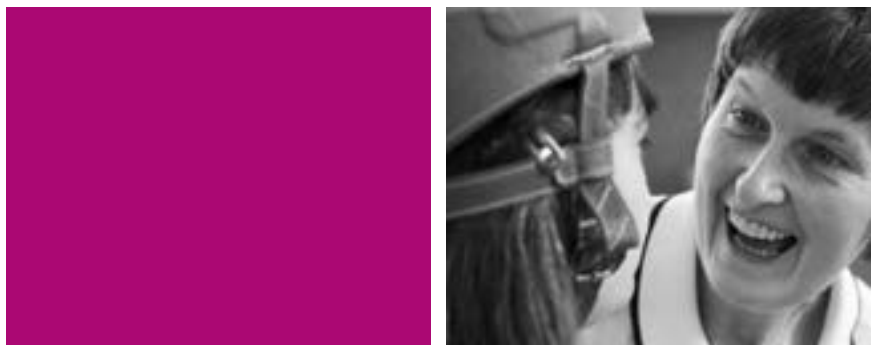
The organisation did feel that there was a lack of understanding of supporting someone with dementia who was a carer in the wider social care community. This could be addressed with some good awareness raising sessions delivered to a much wider audience such as the Dementia Friends initiative offered by the Alzheimer's Society.

Useful resources

Alzheimer's Society factsheets – for carer support workers to use as a reference tool
www.alzheimers.org.uk/factsheets

Skills for Care – Common Core Principles for supporting people with dementia
www.skillsforcare.org.uk/dementia

Mental Capacity Act – Easy read guide
www.alzheimers.org.uk



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Holistic care for people with dementia and other conditions

Angelica Place, Manor Court Care

Angelica Place has a goal to provide a high-quality, flexible seven-hour therapeutic day-care service for those individuals who currently live within the community.

Angelica promotes individual's independence at all times. The service is staffed seven hours a day by specialist trained staff who use therapeutic activities with the primary goal of supporting self-expression and communication among the people using the service. Angelica Place provides an enjoyable and sociable day out from home. It provides an opportunity for individuals and staff to make new friends and enjoy regular social interaction.

Five top tips

1. Believe in the therapeutic activity you are preparing to deliver; it might not work for everyone initially, but you will recognise that small parts of an activity make big differences.
2. Create a workforce culture which sees the person first and the dementia second. An effective way of developing this culture is to use your dementia champion as an 'on-the-spot' trainer alongside the in-house training.
3. Remember that honest and heartfelt self-expression is unexpectedly powerful in building relationships with others.
4. Empower the staff to recognise that self-expression requires freedom – freedom to communicate and act in a relaxed environment without restrictions laid upon individuals.
5. Ensure there is an ongoing commitment to communicate with staff, relatives and carers to create an atmosphere of holistic care which is acceptable to all.

While on-going research, discussion and debate is taking place with regards to dementia, it is important not to overlook the small things we can do to support people living with dementia to live good lives.

In practice

Angelica Place has four main priority areas in ensuring the correct delivery of therapeutic

Each individual has their own identity and this is recognised by the staff team at Angelica Place

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Learning disabilities and dementia Hull City Council

Nicholson House in Hull currently provides specialist care for both permanent and respite individuals. Their primary focus is supporting people living with advanced complex needs due to diagnosis of dementia. They also support a small number of individuals with a learning disability.

Five top tips

1. Improving wellbeing can improve health.
2. Support the whole person rather than treating the illness.
3. Consistent person-centred approaches build relationships and trust.
4. One act that achieves a smile is an isolated incident, shared, it can become a daily occurrence.
5. A meaningful goal is only achievable with the right attitude.

Care plans are living documents that are changed and added to according to the choices and changing needs of the person, regardless of the diagnosis. Identifying the onset of dementia in a person living with a learning disability can be difficult without medical intervention.

In practice - Joan

Joan lives with a dual diagnosis of a learning disability and dementia. She has lived in residential care for 51 years. She was diagnosed with a learning disability and lived alone with her aging mother. When her mother required full-time care it was felt it would be appropriate for Joan to accompany her. Joan was 37 years old; she is now 88. In her later years Joan began to show signs and symptoms of early dementia, although many of these actions mirrored Joan's habits and routines of earlier life, making a diagnosis uncertain.

Through the Dementia Academy, staff received sensory training enabling them to provide people with a personal journey using the five senses of sight, sound, touch, feel and taste. By implementing the training they immediately observed overwhelming positive changes and reactions from the people they care for.

The Dementia Academy works alongside carers to help improve the quality of life for people living with dementia. A process called 'dementia care mapping' is used and this involves observing a person with dementia over a set period of time and then documenting their experience of approach, interaction and care. Following analysis and the interpretation of the information gathered, the organisation is able to work together to promote and achieve change and improvement in our collective approach to an individual's personalised care.

The staff at Nicholson House then set out to create this throughout the whole of their environment. They start the journey by looking at meaningful activities for each individual, receiving information from life story work undertaken with family and friends and also information and knowledge they have collected over the years. With this information they produce individualised plans of care. These include an individual activity profile, in which they blend the personalised information received and the psychological needs of individuals, such as comfort, attachment, occupation inclusion and identity, to achieve and enhance wellbeing.

Staff work from 'individual profiles'. These break down each section of care using collated information and life story work to provide a step-by-step tailored explanation of how to best approach and achieve the task ahead. Person-centred profiles encourage a consistent approach to individualised care.

Throughout the building there are themed areas, all of which are designed to create and stimulate the senses. These areas are accessible and were created to encourage participation through conversation, reminiscence and occupational tasks.

At Nicholson House, staff and relatives feel lucky and excited to have recently been chosen to pilot the Namaste programme in the Hull area. The word 'Namaste' means 'the spirit within' and the programme focuses on sensory experiences for people who are most disabled by dementia. They have created a room within the care home which is exclusively dedicated to Namaste care and which hopes to improve wellbeing further.

Useful resources

Dementia Academy www.dementiaacademy.co.uk

Namaste Care www.namastecare.com



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Long-term pain management and dementia Making Space

Making Space is a national charity and provider of adult health and social care services. It has been helping adults with care and support needs, and their carers, to lead independent and fulfilling lives for more than 30 years.

Making Space provides high-quality, person-centred services and accommodation, and supports adults of all ages, with a diverse range of needs including mental health conditions, learning disabilities, dementia and older people with age-related conditions.

Mr A had full responsibility for managing Mrs A's pain on a day-to-day basis, without education or a non-pharmacological intervention. That role became a burden to him and he struggled to cope, impacting their quality of life as a family.

To address these two key needs, the Admiral Nurse reviewed the Assessment of Pain in Advanced Dementia tools to determine the most appropriate to use for the family. This was to ascertain Mrs A's level and intensity of pain on a daily basis. Her level of cognitive impairment was an additional complication, with little communication and some adaptive behaviour. This lack of ability to communicate is a substantial barrier to pain assessment.

In this lady's case it was important to find a tool that differentiated between physical pain and emotional distress. The Disability Distress Assessment Tool (DisDAT) was chosen following the review of what was available. The DisDAT tool identifies distress as the primary factor, with pain being a single part of the whole picture of distress. Other distress factors being identified as environmental and poor perception of situations. In the case of Mrs A, the distress tool would be of more relevance as she shows signs of agitation and emotional distress on a regular basis. Being able to differentiate between these would be inherent in the future management and treatment plan.

Information taken from this assessment was then used as evidence in the multi-disciplinary review process to inform the family-centred pain management plan.

In addition to this, the Admiral Nurse explored the emotional impact of chronic pain on her son in his caregiving role and whether his hypervigilance (preventing her from standing) and fear avoidance behaviours (not going out of house) were causing unnecessary limitations to their lives. This provided the basis for an activity and education plan to reduce his burden and introduce non-pharmacological treatments into her care.

Evidence available around this area suggests that Mr A has developed new strategies for preventing recurring injury. Unless this is addressed with a plan to expose them to new situations, under skilled and careful support from professionals, they will continue to live with a poor quality of life and constant fear. A plan to work with the carer to expose the family to situations that they have previously avoided should help him to build confidence in their abilities to explore the outside world, restoring their connection to others.

A plan was put in place with support from the multi-disciplinary group involved in Mrs A's care and over a six-month period, there was a reduction in her pain levels (this was evident in the repeat use of the assessment tool at two weeks, one month and three months). Her carer reported improved confidence in carrying out daily activities but also in getting her out of the home for recreational and support group activities.

Initially, a minimal pharmacological plan was in place. The updated plan aims to draw professionals together to manage Mrs A's care with the Admiral Nurse taking the lead in co-coordinating this. The Admiral Nurse wanted to build the confidence of Mr A so that something can be done and that he has reliable parties involved that will both enable him to make decisions and support him in those. Following the period of intensive work with the family, he stated: "I know we can trust people now and that I can try to take on board what others say. We are not destined for failure"

This case study highlights how important it is for the families of those with dementia to be supported in coping with pain. There are many things that can be done to alleviate distress for the family if consideration is given to the biopsychosocial model, while also including spiritual pain such as coping mechanisms and addressing the needs of carers. This can be achieved through advice, support and education as part of an integrated plan to improve their quality of life as a family.

Useful resources

The National Council for Palliative Care (2012) *How to help someone with dementia who is in pain or distress* publication explains how to help someone with dementia who is in pain or distress and is available from www.ncpc.org.uk

National Institute for Health and Clinical Excellence (2006) *Dementia: Service user and carer views* (CG42) [online] London: SCIE available at: www.nice.org.uk/nicemedia/pdf/CG042NICEGuideline.pdf

Royal College of Physicians, British Geriatrics Society and British Pain Society. *Guidelines for the management of pain in older people*. Concise guidance to good practice series, No 8. [online] London: RCP, 2007 Available from: www.britishpainsociety.org



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Parkinson's and dementia Cardinal Healthcare Group

Cardinal Healthcare Group delivers a personalised range of services at their residential care homes in Suffolk. The group comprises of two care homes and also offers care in the home through Primary Homecare. The care homes offer residential and nursing home care in Suffolk, as well as specialising in day care, short-term rehabilitation, convalescence, respite and dementia care.

Five top tips

1. There needs to be a whole team commitment to the ethos to 'care for the person before the disease'. The plan of care should be totally unique and detailed so everyone should recognise the person, without looking at the name.
2. Communication - all staff to embrace positive interactions with both resident and relatives. Really listen and observe - remember not all family expectations match.
3. All staff to receive training on empathy and compassion - but equally important is observational supervision to assess the impact of learning and competence on the job.
4. Empower staff to be courageous – to think 'outside the box', to be flexible, to go the extra mile. The whole team must be part of developing a relationship-centred service.
5. Create a sense of possibility and opportunity, even for long-term conditions – everyone needs to contribute to achieving individual goals and aspirations, however small.

Facing the prospect of dementia and a long-term illness is difficult and life changing, even more so when families decide it's no longer possible to continue care at home.

Understanding the emotions at the core of this transition is why Cardinal Healthcare has changed its approach and commitment to families from the initial enquiry. By placing more emphasis on seeing the 'person before the disease', the aim is for people to feel better about their home and their life - their way. This can be achieved by empowering residents and their families to get more involved in the home – for example; by meeting staff, spending time in personalising bedrooms and by creating a memory box. The challenge then is to ensure all staff are on board and share the challenge to maintain that positivity and create opportunities for every person with a long-term illness, incorporating their aspirations, wishes, personal and family goals in their plan of care. Staff are reminded that we all need to feel part of a family.

In practice

This case study is about Mr B, who has a diagnosis of Parkinson's disease and Lewy body

Pictures were hung on the wall and a memory box filled with conversation starters, for example who's who, dates and information – which created important reminiscence tools.

A clothes protector was also supplied. This was a backed shirt front, modified to be just the front and worn over Mr B's clothes so it could be changed easily and didn't stand out as being a clothes protector. Suddenly Mrs B said "going out to eat with her husband would no longer be as embarrassing," as the dignity protector looked "just like a normal shirt".

Staff went on to create opportunities for Mr B to mend old kettles, and supplied wires, old sockets, plugs and even his old boiler suit to wear. A part of his routine became stopping for 'elevenses' with the maintenance team. All the usual risk assessments were put in place, as part of evidencing the duty of care, but by concentrating on looking holistically at the whole family, as well as the healthcare needs of Mr B, suddenly the family dynamics changed. Relationships were repaired as the family were no longer simply stressed carers, but a wife and daughter again.

Mr B and his family added a new dimension to the home and the centre life, really joining in, spending time together. Even if Mr B was asleep the family would stay and join in with team quizzes, supporting other residents and being supported themselves by a wider group of people.

Examples of good practice:

- Create positive social interaction for the whole family and team.

- Stimulate reminiscence with 'pockets of opportunity' that's meaningful to the individual.

- Engagement in everyday life - even if Mr B could no longer do a quiz, joining a team quiz gave the same feeling of participation and inviting his family to make the team was even more positive.

- Key workers spend time with families to build a life story into the care plan and supporting all parties in understanding and improving communication and quality of life and maintaining it in the review meetings.

In understanding that relationships suffer too when someone is chronically unwell and has dementia, and by placing more emphasis on building a 'relationship-centred service', there has been a tangible enhancement on everyone's wellbeing. Improvements can be seen in the individual's sense of possibility, a reduction in antipsychotic medication, the team's morale and the support to both residents and their families and in the contributions to 'home life' that families have made. Families have reported increased confidence and trust in staff and there is an increased desire by everyone to contribute to ideas and suggestions.

Useful resources

UK wide initiative promoting better quality of life in care homes myhomelife.org.uk

A national network of dignity champions www.dignityincare.org.uk

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Mental health and dementia

Rethink Mental Illness

Reconnect is a part of Rethink Mental Illness and is a service which has been offering housing related support since 2002. The service provides high quality client led support and aims to support clients to stay safely in their own homes and live independently for as long as possible.

The Reconnect Service is funded by Somerset County Council, it is free to residents of Somerset and is delivered by a floating support model - Support workers visit once a week, generally, and work with the client to achieve the goals agreed with them in their support plans..

Five top tips

1. Recruit staff on a basis of values and competencies.
2. Good staff training and support.
3. Allow staff time to build rapport with the person being supported.
4. Treat staff as professional experts, value them and listen to their feedback.
5. Set clear support goals that are measurable and time limited.

In practice

This case study is about MB. He was referred to Reconnect following a hospital admission for a fall. His wife had died sixixix1dpertA9.3(em4evisp.mr aime cn/GST[25 scn/GS0 gs/T10 1 Tf-1.58

- accessing services such as a handyman
- talking on the phone
- conversing with men
- remembering appointments
- remembering medication
- remembering to have a daily hot meal
- attending activities on his own
- joining in with other people.

Research was undertaken to give informed choices to MB. Time was taken for discussions, ensuring that MB felt valued. A person-centred approach with respect was given at all times. Responsibilities were given back to MB, through his involvement with the Reconnect service and his feedback was valued.

Staff spent time getting to know MB; building trust and rapport with him. It had been identified at the initial assessment that he needed support with safety in the home, managing his paperwork and support with monitoring and maintaining his health.

MB was paranoid about his doctor. This was discussed and his reasons were listened to. He was given information on how to change his doctor. A list of local GP surgeries in the area that were accessible to MB was compiled and MB chose his preferred doctor and the worker supported him with registering. The support worker discussed with him how he could remember the reason why he was attending the doctor and what was said by the doctor. MB started writing down what he was going to see the doctor about and the GP agreed to give MB a printout of the outcomes of the visits. The GP referred MB to a physiotherapist to help with the pains in his neck.

Support was given to complete a home safety check and adaptations were discussed, agreed, completed and implemented.

His mail was sorted and his late wife's savings were transferred into his account after he was given support to get a copy death certificate as the original was lost. Bills were put onto direct debit and cheques were written out and posted. This was achieved by the worker reading out the mail to MB and discussing what to do with it. This support was on-going throughout his time with the service.

MB started showing more paranoid thoughts. The doctor did not want to prescribe medication as the medication could worsen the dementia. Other methods of how to combat his paranoia were discussed and they decided together that social inclusion and activities may help to distract MB from the things that were playing on his mind. The support worker researched local activities and introduced these activities to MB. It was agreed with MB that the worker would attend with him for the first three times and then the worker would withdraw and MB would attend on his own. When this was put into practice, MB stopped going after a couple of times on his own. This was discussed with MB and he agreed to pay for a person to attend activities with him on a one-to-one basis. A befriender was introduced and it was arranged for the befriender to take MB out once a week and join in with social groups. MB enjoyed this so it was agreed for the befriender to take him out twice a week. Sometimes they went shopping, to the hairdressers, to singing for the brain sessions, on walks or visits to garden centres.

Other support given as the dementia worsened included:

- information and introduction to community transport
- medication put into blister packs and delivered

Being flexible with time enabled MB to deal with issues that were important to him and his safety thus enabling MB to stay in his own home for as long as was possible.

MB had two Reconnect workers; one worker to deliver the support and one to review his support needs and this provided continuity of support.

As the dementia advanced, the paranoia worsened and MB felt that people were out to get him. He believed that people from TV were real and they wanted to steal his home. He then started thinking that home care service staff were planning to poison him and refused to eat or drink at times. He started raising his voice at his neighbours. The only people he trusted were the Reconnect worker and the befriender. The Reconnect worker communicated her concerns

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Specialist dementia and learning disabilities learning

The Fremantle Trust is a registered charity and not-for-profit business providing care and support services for older people and adults with a learning disability. In operation since 1992, The Fremantle Trust has homes and supported living services in Buckinghamshire, Barnet and Harrow, Maidenhead, Milton Keynes and Bedfordshire. In total over 1,700 staff provide services to almost 2,000 people.

Five top tips for other managers

1. Consider a specialist development pathway using the Qualifications and Credit Framework (QCF) units.
2. Engage managers in the development and delivery of all programmes.
3. Have a champion or lead for particular areas of specialisms.
4. Devise interactive workshops to deliver learning in 'bite-sized chunks' – keep it simple.
5. Encourage staff to identify their own preferred learning styles.

In practice

This case study sets out a novel approach to specialist dementia and learning disabilities learning developed by The Fremantle Trust's Development and Education Centre.

Initially designed for staff working with older people, the approach recognises several truisms:

Working in care homes for older people in the UK means working with older people who have dementia – it's a specialist area of work that needs to be embraced.

Following initial induction and mandatory training, staff at Fremantle Trust have been offered a mix of dementia learning opportunities. These include:

- dementia induction using an in-house manual and one-to-one sessions with a dementia advisor
- a qualification pathway using the Level 2 Award in Awareness of Dementia (QCF)
- expert speakers at The Buckinghamshire Dementia Forum, created and hosted by The Fremantle Trust
- a suite of 12 in-house specially designed training sessions/workshops (since 2012)
- online opportunities provided by the Aged Care Channel (since 2014).

Out of all of these, the in-house sessions were regularly used while the BTEC qualification was the least used. In fact the drop-off rate for the qualification was high, with staff quoting various reasons for being unable or unwilling to continue. For example, the fact that they felt that they had no 'quick wins' and were isolated from other learners.

To redress this imbalance and to regenerate enthusiasm for the qualification, the Fremantle Trust's practice lead in dementia revised the existing Level 2 Award portfolio and devised a new, time-limited programme.

The revised BTEC in dementia course is structured to be completed within a four-month timescale. Groups of 10 staff are formed working in the same geographical areas with four groups in each cohort. Each of the units of the qualification is supported by a specific workshop that addresses the following topics:

- dementia awareness (QCF DEM 201)
- the person-centred approach to the care and support of individuals with dementia (QCF DEM 202)
- understand the factors that can influence communication and interaction with individuals who have dementia (QCF DEM 205)
- understand equality, diversity and inclusion in dementia care (QCF DEM 207).

Within the workshops, the objectives of the course assignments for each unit are explored; staff get the chance to discuss the challenges of dementia care in the workplace.

While developing this programme, including the portfolio and workshops, it became apparent that the model could be replicated for other qualifications, especially the Level 2 Award in Supporting Individuals with Learning Disabilities. With that in mind, staff from the Development and Education Centre and specialist learning disability staff used the portfolio template to create a new learning disability portfolio and to accompany this, specific workshops were created for another cohort of staff eager to follow the programme.

The Fremantle Trust finds that the model for this programme works because timescales and deadlines for the workshops and completion of assignments are set. This maintains momentum and gives group support. Because the programme is divided into four sections, staff can easily see their progress – creating a ‘quick win’. Staff are motivated to do a qualification that is ‘manageable’ but also recognise the value in these certificates, awards and units in contributing to a full diploma at a later stage.

Some of the evaluation comments gathered about the programme include that:


- it has rated what staff thought about dementia knowledge and practice
- it has given staff confidence to challenge others whose practice falls short
- staff feel that they can justify sitting down with residents and engaging with them
- managers report an increase in staff knowledge and competence.

Useful resources

Joseph Rowntree Foundation – *S* *D*
www.jrf.org.uk/publications/supporting-derek

Skills for Care
West Gate
6 Grace Street
Leeds
LS1 2RP
telephone 0113 245 1716
email info@skillsforcare.org.uk
web www.skillsforcare.org.uk/dementia

[@skillsforcare](https://twitter.com/skillsforcare) 

www.facebook.com/skillsforcare 

www.youtube.com/skillsforcare

www.linkedin.com/company/skills-for-care 