Jersey Care Commission

Jersey Care Commission
Care Standards
Service Specific Requirements
Memory Services

Safe
Effective
Caring
Responsive
Well-led

SAFE

Standard 3. Safe systems, pathways and transitions

We work with people and our partners to establish and maintain secure care systems. We manage, monitor, and ensure safety. We make sure that care is continuous, even when people move between different services.

What this means to people:
I know what to do and who I can contact when I realise that things might be at risk of going wrong, or my health condition may be worsening. When I move between services, settings or areas, there is a plan for what happens next, who will do what, and all the practical arrangements are in place.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 15 Shared responsibilities

3.2 Service Specific Requirements

3.2.1 The service has access to a variety of assessment tools to meet the needs of the people using the service. Consider needs associated with language, learning disability, sensory impairment, etc.

3.2.2 There are systems in place to monitor referrals made to other services/ centres.

3.2.3 The service provides information about how to make a referral and waiting times for assessment and treatment.

3.2.4 A clinical member of staff is available to discuss emergency referrals during working hours.

3.2.5 Where referrals are made through a single point of access, these are passed on to the memory service within one working day unless it is an emergency referral.

3.2.6 Initial contact is made with all people who are newly referred within two weeks of referral.

3.2.7 For planned assessments the team sends letters in advance to patients that include:

- The job title and role of the professional they will see.
- An explanation of the assessment process.
- Information on who can accompany them.
- How to contact the team if they have any queries, require support (e.g. an interpreter), need to change the appointment or have difficulty in getting there.

3.2.8 The diagnosis is given within the locally specified target timeframe of 6 weeks, unless any further specialist assessments or investigations are required, or other circumstances cause delay. Reasons for delay are recorded and monitored.

3.2.9 The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient. Where patients consent, the carer is contacted.

3.2.10 If a patient does not attend for an assessment/appointment, the assessor contacts the referrer. If the patient is likely to be considered a risk to themself or others, the team contacts the referrer immediately to discuss a risk action plan.

3.2.11 Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may exist. This should include monitoring a patient's failure to attend the initial appointment after referral and early disengagement from the service.

3.2.12 People who are assessed for the possibility of dementia are asked if they wish to know the diagnosis.

3.2.13 People who are assessed for the possibility of dementia are asked with whom the outcome should be shared.

3.2.14 The assessment includes a basic dementia screen and blood tests in accordance with clinical need. This might include:

- Erythrocyte sedimentation rate (ESR) or C-reactive protein
- Routine haematology, full blood count
- Biochemistry tests (including urea and electrolytes, calcium, glucose, and renal and liver function)
- Thyroid function tests
- Serum vitamin B12 and folate levels
- Simple urinalysis (available on referral)
- Lipid profile/ cholesterol
- Syphilis serology and HIV.

3.2.15 Patients receive a comprehensive, evidence-based assessment which includes their:

- Mental health and medication
- Psychosocial and psychological needs
- Strengths and areas for development
- Suicide risk.

3.2.16 Patients receive a cognitive assessment and mental state examination. This should include:

- Examination of attention and concentration, orientation, short- and long-term memory, praxis, language and executive function.
- Formal cognitive testing using a standardised instrument.

3.2.17 The assessment includes an interview with someone who knows the patient well, where available. The patient should not be present during this interview unless requested.

3.2.18 Patients have a documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers:

- Risk to self
- Risk to others
- Risk from others.

3.2.19 The service has access to in-depth assessment of occupational functioning and neuropsychological assessment as required (e.g. for young onset dementia, complex or abnormal presentations).

3.2.20 Where diagnosis is not disclosed, a clear record of the reasons why is made.

3.2.21 There is timely access to brain imaging (if clinically required) in the assessment of people with suspected dementia to exclude cerebral pathologies and to help establish the subtype diagnosis.

3.2.22 Additional tests and investigations are carried out in accordance with NICE guidance, individual and clinical need, including an electrocardiogram.

3.2.23 During the assessment process, services should review the potential anticholinergic cognitive burden (ACB) e.g. with the aid of a suitable online tool.

3.2.24 The assessment includes a physical health review, which takes place as part of the initial assessment or as soon as is practically possible. The review includes but is not limited to:

- Details of past medical history including long COVID
- Current physical health medication, including side effects and compliance with medication regime
- A check of vision, hearing, mobility and falls.
- Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use.

3.2.25 The assessment includes arrangement for patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan or care and treatment plan.

SAFE

Standard 6. Safe Environments

We detect and control possible risks in the care environment. We make sure that the equipment, facilities, and technology support the delivery of safe care.

What this means to people:

- I feel safe in the care environment
- I am protected from harm caused by the use of faulty equipment
- I am protected from harm caused by any defect in the building where my care is provided
- Staff who care for me, or support me, are trained to operate equipment and know what to do when things go wrong.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 9A Need for consent
Regulation 8 Person-centred care
Regulation 11 Safeguarding
Regulation18 Premises and equipment

6.2 Service Specific Requirements

6.2.1 The environment is clean, comfortable and welcoming. This includes dementia-friendly facilities, clear and large signs, firm seating at the right height, handrails, good lighting, high colour contrasts etc.

6.2.2 Clinical rooms are private and conversations cannot be over-heard.

6.2.3 The environment complies with current legislation on accessible environments. Relevant assistive technology and equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.

6.2.4 There is an alarm system in place (e.g. panic buttons) and this is easily accessible for patients, carers and staff members.

6.2.5 All patient information is kept in accordance with current legislation. This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.

6.2.6 Everyone can access the service using public transport or transport provided by the service.

SAFE

Standard 7. Safe and effective staffing

We make sure there are enough qualified, skilled, and experienced staff who are well supported and receive effective supervision and development. They work together effectively to provide safe care that meets people's individual needs.

What this means to people:

- I always receive safe care and treatment delivered by competent staff
- Staffing levels and skills are planned and reviewed to provide safe care
- I know who my named nurse or key worker is and know how to contact them

Relevant regulatory requirements

Regulation 2 Fitness criteria
Regulation 8 Person-centred care
Regulation 17 Workers

7.2 Service Specific Requirements

7.2.1 The team is able to identify and manage an acute physical health emergency.

7.2.2 Patient or carers with experience of memory services are involved in the interview process for recruiting staff members. This could include co-producing interview questions or sitting on the interview panel.

7.2.3 When there are concerns about low staffing levels, for example in relation to annual leave, vacancies or other absence, the team puts a plan in place to provide adequate cover for the patients under the care coordination of that staff member.

7.2.4 The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.

7.2.5 There are robust systems of communication in place that support staff to work efficiently and effectively as a multidisciplinary team. This might include IT systems, communication books, bulletin boards, email, up-to-date contact numbers, formal systems for relaying messages.

7.2.6 The team has protected time for team building and discussing service development at least once a year.

7.2.7 Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet to think about team dynamics and develop their clinical practice.

7.2.8 The service actively supports staff health and well-being. For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.

7.2.9 Staff members are able to take breaks during their shift that comply with the European Working Time Directive. They have the right to one uninterrupted 20-minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks.

7.2.10 All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. Supervision should be profession specific as per professional guidelines and be provided by someone with appropriate clinical experience and qualifications and includes discussing caseloads.

7.2.11 All staff members receive line management supervision at least monthly.

7.2.12 Staff members have access to study facilities (including books and journals on site or online) and time to support relevant research and academic activity.

7.2.13 New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.

7.2.14 Patients, carers and staff members are involved in devising and delivering training.

7.2.15 Shared in-house multi-disciplinary team training, education and practice development activities occur in the service at least every 3 months.

7.2.16 Clinical staff fulfil the competencies of Tier 2 or above in the Health Education England (HEE) Dementia Core Skills or Wales Good Work Framework, Education and Training Framework or equivalent that includes the following topics:

- Dementia awareness
- Dementia identification, assessment and diagnosis
- Dementia risk reduction and prevention
- Person-centred care
- Communication, interaction and behaviour in dementia care
- Health and well-being in dementia care
- Pharmacological interventions in dementia care
- Living well with dementia and promoting independence
- Families and carers as partners in dementia care
- Equality, diversity and inclusion in dementia care
- Law, ethics and safeguarding in dementia care
- End of life dementia care
- Research and evidence-based practice in dementia care

7.2.17 Administrative and reception staff have received training in dementia and fulfil competencies in Dementia Core Skills, or dementia awareness training.

7.2.18 All staff complete statutory and mandatory training consistent with their roles. This includes equality and diversity, information governance, basic life support, safeguarding, risk assessment and risk management.

7.2.19 The team receives training, consistent with their roles, on the roles of the different health and social care professionals, staff and agencies involved in the delivery of care to people with dementia.

7.2.20 The team receives training, consistent with their roles, on the use of legal frameworks, such as the Mental Health (Jersey) Law 2016 and the Capacity and Self-Determination (Jersey) Law 2016.

7.2.21 The team receives training, consistent with their roles, on undertaking nutritional screening using a validated nutritional risk assessment tool.

7.2.22 The team receives training, consistent with their roles, on physical health assessment. This could include training in understanding physical health problems, physical observations and when to refer the patient for specialist input.

7.2.23 The team receives training, consistent with their roles, on the use of cognitive assessments, with a focus on consistency and the appropriate application of national guidance. This training is refreshed annually.

7.2.24 The team receives a range of training from other professionals involved in the work of the memory service, e.g. neuroradiologists, social workers.

7.2.25 Staff members follow inter-agency safeguarding protocols. This includes escalating concerns if an inadequate response is received to a safeguarding referral.

7.2.26 There are measures in place to ensure staff are as safe as possible when conducting home visits. These include:

- Having a lone working policy in place
- Conducting a risk assessment
- Identifying control measures that prevent or reduce any risks identified.

7.2.27 The team works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. Services support interpreters with advice on dementia awareness and training where practical.

7.2.28 The service is appropriately and adequately staffed, including the following:

- A medical practitioner and a multidisciplinary team consisting of at least two other professions
- A mental health nurse
- A clinical psychologist or neuropsychologist
- An occupational therapist
- A peer support worker
- A speech and language therapist
- A dietician
- A physiotherapist
- A social worker
- A geriatrician
- A neurologist
- An old age psychiatrist.

7.2.29 There is a named lead within the service for people with young onset dementia. The service has access to a sufficient level of administrative support to meet current demand.

SAFE

Standard 9. Medicines optimisation

We make sure that medicines and treatments are safe and meet people's needs, capacities, and choices. We involve people in planning their care, even when things change.

What this means to people:

- I feel safe and am supported to understand and manage any risks.
- I know what to do and who I can contact when I realise that things might be at risk of going wrong, or my health condition may be worsening.
- If my treatment, including medication, has to change, I know why and am involved in the decision.
- I have considerate support delivered by competent people.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 9 Personal plans and care records
Regulation 14 Management of medicines

9.2 Service Specific Requirements

9.2.1 The service provides or can signpost/ refer on to services that will offer information, advice and support to assess and manage pharmacological treatment.

9.2.2 When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded.

9.2.3 Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. Side-effect monitoring tools can be used to support medication reviews.

9.2.4 Patients and carers are able to discuss medications with a specialist pharmacist.

9.2.5 Patients who develop psychotic symptoms or behaviour that challenges are only offered antipsychotic medication when the severity and associated risks are high and when other options have been considered and excluded.

9.2.6 Where antipsychotic medication is given, this prescription is recorded and a single, named individual is responsible for undertaking a review, which should include a physical assessment every 3 months unless a physical health abnormality arises.

9.2.7 Patients prescribed psychotropic medication, e.g. anti-depressants, benzodiazepines, have this reviewed in accordance with NICE guidelines.

9.2.8 For patients who are taking antipsychotic medication, the memory service maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the patient's condition has stabilised. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.

EFFECTIVE

Standard 11. Delivering evidence-based care and treatment

We work with people to plan and provide care and treatment, considering what matters to them. Our approach aligns with the law and follows the latest evidence-based best practices and standards.

What this means to people:

- I am involved in the planning of my treatment and care.
- I am able to influence important decisions about my treatment and care.
- I can give or withhold my consent freely.
- The care I receive is personalised to my preferences and supported by best practice.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 9 Personal plans and care records
Regulation 12 Cleanliness and infection control
Regulation 13 Nutrition and hydration
Regulation 14 Management of medicines
Regulation 16 Control and restraint

11.2 Service Specific Requirements

11.2.1 Psychosocial interventions and post-diagnostic support are available regardless of dementia subtype and age. An audit should be carried out of the diagnoses of people offered/ participating in psychosocial interventions and support groups.

11.2.2 An audit of the capacity to provide psychosocial interventions, and the uptake of psychosocial interventions offered is carried out every 2 years.

11.2.3 People with dementia have access to a local programme of appropriate group Cognitive Stimulation Therapy (CST).

11.2.4 People who have participated in group Cognitive Stimulation Therapy (CST) have access to an age-appropriate maintenance CST programme.

11.2.5 Patients have access to cognitive rehabilitation according to their clinical needs. Cognitive rehabilitation constitutes an individualised approach where personally relevant goals are identified, and the therapist works with the patient and his/ her family to devise strategies to address these. The emphasis is on improving performance in everyday life rather than on cognitive tests, building on the patient's strengths and developing ways of compensating for impairments.

11.2.6 People with dementia and their carers have access to a group reminiscence or life story programme.

11.2.7 All staff members who deliver therapies and activities are appropriately trained and supervised.

11.2.8 The memory service has access to advice and support on assistive technology and telecare solutions designed to assist people with activities of daily living.

11.2.9 Patients and their carers have access to tailored psychosocial interventions for behaviour that challenges (e.g. Functional Analysis-based intervention as part of a multi-component psychosocial intervention, delivered by appropriately trained staff).

11.2.10 Carers are offered an assessment, and intervention/s if appropriate, for their emotional, psychological and social needs, provided by appropriately qualified professionals. Please see interventions included in the British Psychological Society: A guide to psychosocial interventions in the early stages of dementia.

11.2.11 People with dementia have access to art/ creative therapies.

11.2.12 The team signposts younger people with dementia to structured activities such as vocational rehab, employment support and workplace adjustments.

11.2.13 Clinical outcome measurement is collected at two time points (at assessment and discharge). This includes patient-reported outcome measurements where possible.

11.2.14 Progress against patient-defined goals is reviewed collaboratively between the patient and staff members during clinical review meetings and at discharge.

EFFECTIVE

Standard 12. How staff, teams and services work together

We collaborate well between teams and services to help people. We ensure that people who use services only have to tell their story once, by sharing their needs assessment when they move between different services.

What this means to people:

- I only have to tell my story once, and the care I receive is based on teams working together, even when I move between services
- I can expect that all information provided will be treated confidentially and held securely
- My care records will be shared appropriately with my knowledge and consent and on a need to know basis.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 15 Shared Responsibilities

12.2 Service Specific Requirements

12.2.1 The memory service prioritises continuity of care. By ensuring that a core and consistent teamwork in the service every week and by providing access to a named worker (e.g. lead professional, key worker, dementia advisor, care navigator, case manager).

12.2.2 The service provides training and outreach to other professionals and staff whose responsibilities include providing care and treatment of older people with dementia/ suspected dementia (e.g. GPs; residential care, nursing homes and sheltered housing; domiciliary care; day care; hospital care, including inpatient services).

12.2.3 The memory service has links with local home care and social care services.

12.2.4 The memory service provides education on the prevention of dementia within the local community. This could be disseminated through events, local newspapers/ radio stations or posters etc., and could be done jointly with partner organisations

12.2.5 The service works with other organisations involved in preventative work for those vulnerable to dementia e.g. people who have had a stroke or have Parkinson's Disease.

12.2.6 The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment. The letter includes a summary of advice given to the person, driving status and the need to inform the DVLA or other relevant agencies if necessary and any need for GP review of the person's physical risk factors (e.g. risk of stroke, high blood pressure, diabetes, smoking, medication).

12.2.7 Specialist advice is taken when interpreting investigations/ assessments/ scans in people with complex needs, such as learning disabilities and those with young onset or rare dementias.

12.2.8 The service works with other agencies concerned with the early identification of Mild Cognitive Impairment (MCI) to provide psychoeducation and advice and interventions as required.

12.2.9 Health and Social Care funders, in consultation with local partners, people with memory problems/ dementia/ suspected dementia and carers, have a local integrated care pathway based on best practice, which includes referral to national or regional specialist centres and exit from the service, where appropriate. This includes specifically a pathway for young onset dementia, people with learning disabilities and people with rarer types of dementia where diagnosis is more complex and likely to be delayed.

12.2.10 The service provides or can signpost/ refer on to services that will offer assessment and intervention for patients who develop non-cognitive symptoms. For example, mood disorders, psychotic symptoms and behaviour that challenges.

12.2.11 The service provides or can signpost/ refer on to services that will offer information, advice and support with communication problems. For example, speech and language therapy and audiology.

12.2.12 The service provides or can signpost/refer on to services that will offer information, advice and support on dietary interventions to help the person adapt dietary intake to help achieve full nutritional requirements.

12.2.13 The team supports patients to access organisations, with whom they have joint working protocols, which offer:

- Housing support
- Support with finances, benefits and debt management
- Social services.

12.2.14 The service provides or can signpost/ refer on to support services for patients and carers.

12.2.15 The service provides or can signpost/ refer on to a range of respite/short break services.

12.2.16 The service is able to refer to genetic counselling for patients and their unaffected relatives (where there is likely to be a genetic cause for their dementia).

12.2.17 The service can refer on to specialist services for rare or young onset dementia and/ or complex care needs (e.g. regional/ tertiary neurology/ neuropsychiatry services, learning disability services).

12.2.18 When patients are transferred between community services, there is a handover which ensures that the new team have an up-to-date care plan and risk assessment.

RESPONSIVE

Standard 21. Person-centred care

We make sure people are at the centre of their care and treatment choices, and we decide, in partnership with them, how to respond to any relevant changes in their needs.

What this means to people:
I have care and support that is coordinated, and everyone works well together with me.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 8 Person-centred care
Regulation 9A Need for consent

21.2 Service Specific Requirements

21.2.1 Appointment times and locations are flexible, with the patient's needs being taken into consideration. This might include offering home visits if appropriate.

21.2.2 Staff members treat patients and carers with compassion, dignity and respect.

21.2.3 Patients feel listened to and understood by staff members.

21.2.4 Patients feel welcomed by staff members when attending their appointments. Staff members introduce themselves to patients and address them using their preferred name and correct pronouns.

21.2.5 Assessments of patients' capacity to consent to care and treatment are performed in accordance with current legislation.

21.2.6 There are systems in place to ensure that the service takes account of any advance care plans (e.g. advance directives, advance statements, Lasting Powers of Attorney) that the patient has made. These are accessible and staff know where to find them.

21.2.7 Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.

21.2.8 The team follows a protocol for responding to carers when the patient does not consent to their involvement.

21.2.9 Carers are offered individual time with staff members to discuss concerns and their own needs. The patient should not attend this meeting.

21.2.10 People with dementia/ suspected dementia and their carers are given pre-diagnostic counselling. This includes a discussion about the possibility of a diagnosis of dementia.

21.2.11 People with dementia and their carers are offered a post-diagnostic meeting. This might include education, treatment, support groups or one-to-one support.

21.2.12 The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers.

21.2.13 The service has access to specialist post-diagnostic counselling provided by a psychologist or other appropriately qualified professional for people with specific needs. This includes genetic and rarer disorders, and severe adjustment reactions to the diagnosis.

21.2.14 People who are diagnosed with dementia are allocated a named worker within the CMHT to co-ordinate their care.

21.2.15 Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan, and they are offered a copy. Where possible, the patient writes the care plan themselves or with the support of staff.

21.2.16 Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.

21.2.17 Discharge or onward care planning is discussed with patients and their carers at the first and every subsequent care plan review.

21.2.18 Patients are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan. This includes promoting brain health awareness, improving general health, living positively and maximising quality of life after diagnosis.

RESPONSIVE

Standard 24. Listening to and involving people

We make sure it's easy for people to share their thoughts, feedback or complaints about their care. We include them in decisions about their treatment and let them know what changes have been made.

What this means to people:

- I am included in decisions about my treatment, and my voice is heard.
- The process of sharing thoughts, feedback, and concerns is easy for me to use.
- I am involved in decisions about my care, and I am told what has changed as a result.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 8 Person-centred care
Regulation 14 Management of medicines
Regulation 19 Reviewing the quality of the service
Regulation 22 Complaints and representations

24.1 Service Specific Requirements

24.1.1 There is an accessible website for the memory service. This could contain information about what to expect during appointments, relevant health advice and factsheets, contact numbers and a map etc.

24.1.2 A local written protocol is available to assist memory service staff in informing patients about managing issues around driving. A protocol Is in place for staff responsibilities in informing the patient and authorities of risks associated with driving.

24.1.3 Patients are given accessible written information which staff members talk through with them as soon as is practically possible. This information includes:

- Their rights regarding consent to treatment
- How to access advocacy services
- How to access a second opinion

- Interpreting services
- How to view their records
- How to raise concerns, complaints and give compliments

24.1.4 The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to:

- Voluntary organisations
- Community centres
- Local religious/ cultural groups
- Age-appropriate peer support networks.

24.1.5 Patients (and carers, with patient consent) are offered written and verbal information about the patient's dementia and treatment. Verbal information could be provided in a 1:1 meeting with a staff member or in a psychoeducation group. Written information could include leaflets or websites.

24.1.6 Where appropriate to their needs, patients and carers are given written information about, and signposted to, sources of financial and legal advice.

24.1.7 Where appropriate to their needs, people with dementia and carers are given written information about medico-legal issues, including lasting power of attorney.

24.1.8 The team provides each carer with accessible carers' information. Information is provided verbally and in writing (e.g. a carers' pack). This includes; the names and contact details of key staff members in the team and who to contact in an emergency and local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.

24.1.9 Where appropriate to their needs, patients and carers are given written information on how to create a document about their own preferences and habits.

24.1.10 The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. Feedback is independently sought (i.e. not by the clinical team). Their feedback is reviewed alongside other feedback to make it as accurate as possible. Staff members are informed of feedback from patients and carers.

24.1.11 The service provides patients and their carers with information about adding their details to a research participation register and opportunities to participate in local, national and international research.

24.1.12 Carers are advised on how to access a carers' assessment, provided by an appropriate agency. This advice is offered at the time of the patient's initial assessment, or at the first opportunity and carers are made aware that they can access this at any point in their subsequent caring.

WELL-LED

Standard 28. Shared direction and culture

We develop a shared a vision and align our strategy and culture to meet it. Our approach is based on transparency, equity, equality and human rights, diversity and inclusion, and engagement. We understand and seek to meet the challenges and the needs of people and our island community.

What this means to people:

- My care provider is transparent and promotes values such as equality, diversity, and inclusion
- I am included in important decisions about my treatment and care
- My views are sought and listened to by the people who care for me
- I am respected for who I am and am treated at all times with courtesy and respect.

Relevant regulatory requirements

Regulation 3 Conditions of registration: general
Regulation 5 Conduct a regulated activity
Regulation 6 Openness and transparency
Regulation 7 Respect and involvement
Regulation 8 Person-centred care
Regulation 11 Safeguarding
Regulation 19 Reviewing the quality of the service
Regulation 20 Provision of updated information and review of Statement of Purpose

28.2 Service Specific Requirements

28.2.1 The service reviews data at least annually about the people who use it. Data is compared with local population statistics and action is taken to address any inequalities of access where identified. These data are used to understand who is accessing the service, identify under-represented groups, promote the service to these groups and improve the accessibility of the service.

28.2.2 The diagnosis rate covered by the memory service is at least 66%.

28.2.3 The service is developed in partnership with appropriately experienced patient and carers who have an active role in decision making.

28.2.4 The service's clinical outcome data are reviewed at least every six months. The data is shared with commissioners/funders, the team, patients and carers, and used to make improvements to the service.

28.2.5 The team is actively involved in quality improvement activity.

28.2.6 The team actively encourages patients and carers to be involved in quality improvement initiatives.

28.2.7 Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.

28.2.8 Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.

28.2.9 When mistakes are made in care this is discussed with the patient and their carer.

28.2.10 Staff members, patients and carers who are affected by a serious incident are offered post-incident support.

28.2.11 Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or 'whistleblowing'.