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Title: Dementia care in hospitals: the potential of inter-professional education to support person-centred practice

The numbers of people living with dementia is increasing globally (Alzheimer's Disease International, 2015) and it is estimated that in England, one in four hospital beds is occupied by a person with dementia (Alzheimer's Society, 2016), although this may not be the reason for admission. Clearly health and social care professionals require knowledge and skills to care for people with dementia, as well as the attitude to see them as people first, and their condition, second. However working in a health and social care system where overnight bed occupancy was recently over 82% and appropriate community-based care provision is similarly at a premium (NHS England 2016) can generate pressures that inadvertently lead to dehumanised care practices. This was evident in a recent report (Alzheimer's Society 2016), which showed poor and variable care for people with dementia in hospital. No single profession is responsible for these inadequacies but the ability to challenge and prevent them, at times appears lacking. Can interprofessional education (IPE) address this issue?

IPE is 'when two or more professions learn with, from and about each other to improve collaboration and the quality of care' (CAIPE 2015). Enhancing collaborative working through shared learning is not new (Illingworth and Chelvanayagam 2007). It has been an established part of health and social care professional education for some time, although the health care policy landscape has evolved, not least the imperative to develop values-based curricula in response to concerns around care quality (Francis, 2013). Interestingly Barr et al. (2000) outlining several benefits of interprofessional education, highlight its potential to establish common value and knowledge bases.

Approval to run profession-specific programmes will depend on the incorporation of a values-based approach. What is perhaps missing is the obligation to demonstrate the promotion of values for person-centred care when working interprofessionally. The ability to ensure person-centred humanised care rests initially with the individual practitioner, hopefully supported by colleagues from their discipline. If this is not evident then it is the duty of colleagues from other professions to challenge and prevent dehumanised care decisions and practices. The Alzheimer's Society report (2016) indicates this did not happen echoing similar findings from the Francis Inquiry (Francis 2013). For example the report found that 'thousands of people with dementia are being discharged (from hospital) between the hours of 11pm and 6am each year' (Alzheimer's Society 2016: 6). Several professions will have been involved in such decisions, at a minimum doctors and nurses. Perhaps these professionals lacked knowledge about the impact of environment and change for those with cognitive impairment (indeed this is also highlighted in the report); nonetheless, at a basic human level, does discharging vulnerable people in the middle of the night seem appropriate?

Some doctors and nurses may feel that they lack agency to challenge hospital policies around 'bed management'. They are however registered practitioners accountable to the public and their regulatory body. That said it is not easy to challenge such decisions in the face of targets and other pressures from employers. In addition a nurse may feel it's not his role to challenge medical decisions or a doctor may not feel that support for a safe discharge put in places by nurses is her

concern. Such professional boundaries must be challenged in order to meet the shared goal of both professions – effective, patient-centred, safe care.

Crossing boundaries to see 'the bigger picture' is one benefit of inter-professional education. Some very innovative models exist, for example Barwell et al. (2013) describe compulsory and optional inter-professional workshops, discussions, presentations and case studies throughout health care professional programmes. These activities break down boundaries by helping participants see one another as people as well as professionals thus challenging stereotypes; provide opportunities to build collaborative relationships; facilitate understanding of one another's roles, as well as share knowledge. However it is important that the teaching resources include not only clinical issues such as managing Stroke clients, but also explores more 'messy' problems such as those described in the Alzheimer's Society report where care decisions juxtapose fulfilling human rights or meeting NHS targets in order to avoid financial penalties.

Health care students may have differing views about the value of IPE (Quinney et al. 2008); some see it as an interruption to their profession specific education, whilst others view it as an opportunity to find out about what other colleagues do. It should fulfill the latter but a more important outcome perhaps is to appreciate their common commitment to person-centred care, as outlined in the NHS constitution (DH 2015). The Alzheimer's Society report highlights the need to 'Fix Dementia Care in Hospitals'. We can contribute to this with effective IPE, through sharing common goals and facilitating collaborative working to challenge and support each other when faced with difficult decisions.

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Dr Janet Scammell, Associate Professor (Nursing), Bournemouth University