**Dementia Friendly Practice Award**

**Implementation**

* Attendance at the ‘Dental care for people with dementia’ training delivered by HEE and bookable via Maxcourse.
* Practice Facilitator to telephone support the dental practice and go through the framework below if required
* Dementia Friendly Dentistry Award for the practice

Accreditation sheet for Dementia Friendly Dentistry award and Healthy Living Dentistry.

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| **Outcome measure- to be completed before facilitator visits** | **Evidence** | **Date achieved** |
| 1. Clinical team members have read guide/toolkit and know where to find it in the practice, please fill out a word document with staff signatures  | Evidence of dissemination  |  |
| 2. At least one dentist and one team member (all team members are welcome) to attend the HEE ‘dental care for people with dementia’ course delivered via Teams.  | Certificate  |   |
| 3. The lead or named dementia friends champion to complete the Kings fund audit before the delivery of the in-house dementia friends training, delivered by the PCF via Teams. | DiscussionAudit |  |
| 4. Please sign up to the LDAAThe practice has an action plan to improve the patient experience (may be completed after actions found from Kings fund audit, the same actions to be submitted on local dementia action alliancewebsite- <https://www.dementiaaction.org.uk/north_west> | DiscussionCompleted action planEvidence of NDAA |  |
| 5. The practice will have evidence of improvement of the practice environment  | Photographs to send to PCF Natasha or Pauline | PLANT WORLD |
| 6. The practice becomes a member of the National Dementia Action Alliance. Signed up on line and add actions once completed kings fund audit <https://nationaldementiaaction.org.uk> | Named person responsible  |  |
| 6. Practice staff will participate in a facilitated team meeting delivered by HLD lead or practice manager:* Ensure all practice staff are aware of and read the dementia toolkit
* Disseminate learning from training to all new staff members as part of induction
* Implement this team action plan to enable tools from within the good practice guides to become embedded within the daily routine of the practice protocols
 | Notes of meetingAction plan and date whole team informed of introduction of the guide materials. |  |
| **PRACTICE NAME** |  |
| **CONTRACT NUMBER** |  |
| **NAME OF PROVIDER OR PRACTICE MANAGER** |  |
| **SIGNED** |  |
| **DATE COMPLETED** |  |
| **Comments from primary care facilitator** |  |
| **Name of Primary care facilitator** |  |
| **Date & Signature of facilitator** |  |