**Introduction/ Overview:**

#  Contract Performance and Quality Service Improvement

# & Dementia Care Mapping Report

The Dementia Care Mapping Service which forms part of the Contract Performance and Quality Team; attended to complete a Performance and Quality Service Improvement and Dementia Care Map of (***Name of property***).

This visit forms part of your contract & information sharing with Hull City Council.

Dementia Care Mapping is an observational tool which is used for a variety of purposes in a range of settings

* Assessment and care planning
* Training needs analysis
* Staff development
* Continuous quality improvement
* Benchmarking and quality assurance

For the purpose of this report the home’s people who use/ reside at the service have been identified as ‘service users’.

The Dementia Care Mapping reportin whole is presented in four parts which includes:

* The Dementia Care Mapper’s (DCM) observation of the service, inclusive of recommendations and suggestions.
* An executive summary of the service users that were identified to participate in the Dementia Care Map, where consent was gained by the provider prior to the session.
* A report for each participating service user including data, which the DCM has further broken down by adopting the person centred tool ‘working/ not working’ and further; recommendations and suggestions, to support the provider with person centred care planning and the delivery of care.
* Dementia Care Mapping Tool**™** (information).

The DCM has formatted the report under headings to enable the reader to cross reference from the DCM’s observations to the related recommendations/ suggestions.

**Performance and Quality**

The DCM observed the home’s communal environments to evaluate if they met that of the expected best practice guidelines for care homes that are providing care to service users living with dementia related conditions.

The DCM observations included signage, orientation, points of interest, displaying of information, way finding, memory aids etc.

The DCM is trained to observe unobtrusively and endeavoured not to impact on any part of your service or any individual’s day.

The DCM reported on the service viewed in the section headed ‘Dementia Care Mapper Observations’ of this report.

**What is Dementia Care Mapping?**

Dementia Care Mapping is an observational tool and a process, which is designed to help the provider/ staff to consider and improve in the delivery/ quality of care for people with dementia.

When carrying out observations or a ‘map’ the DCM will observe the identified service users living with dementia; to whom the provider has gained consent. What they write down attempts to capture the experience of care from the perspective of the service user. The DCM will observe the identified service users continuously for a number of hours. The length of the map will depend upon the purpose and resources.

Every five minutes the DCM writes down a **Behaviour Category Code (BCC),** which represents what each person was mainly doing for that five minute period. This is chosen from a list of 23 codes which are denoted by a letter e.g. (F = Eating and drinking, L = Leisure, fun and recreational activities etc.)

In each five minutes the DCM also records a **Mood and Engagement (ME) Value**, which represents how engaged the person is and whether their mood is positive or negative. This is represented on a six point scale **(+5, +3, +1, -1, -3, -5**).

The DCM also has a way of capturing the quality of interactions with staff for each person they are observing; which are represented as **Personal Enhancers,** (PE)’sand **Personal Detractions,** (PD)’s.

(PE)’s are times when a member of staff interacts with a person in a way which has the potential to uphold one or more of his/ her psychosocial/ psychological needs. For example, providing a person with dementia with verbal support in order to complete an action independently would be coded as (PE-12-Enabling), and would support a person’s need for occupation.

(PD)’s are times when an interaction ‘puts down’ a person with dementia and undermines one or more of their psychosocial/ psychological needs of comfort, attachment, identity, occupation and inclusion. For example, talking about him/ her in his/ her presence as if they were not there, would be recorded as

(PD-15-Ignoring), and would undermine a person’s psychosocial/ psychological need for inclusion.

(PE)’sand (PD)’s are recorded as and when they occur.

The purpose of this Dementia Care Mapping report is to evaluate the quality of the life/ care from the perspective of the service users living with dementia at (***Name of property***).

The observational tool was used to gather factual data which was later analysed and can be found in the pages of this report. This data aims to capture the service user’s behaviours (BCC), mood and engagement (ME) values.

(PE)’s and (PD)’s are also observed and can be found under the headings of ‘What’s working’ and What’s not working’ for each of the service users included in the report.

For further understanding/ supporting information with regards to the Dementia Care Mapping™ Tool **(see pages *(## - ##)*** of this report. ***(The above page numbers will change when the document is in use.)***

We really appreciate that having mapping/ observations carried out can be an anxiety provoking experience for staff members and service users. If you have any questions about the Performance and Quality Dementia Care Map or the data in this report, please do not hesitate to contact us.

Contract Performance and Quality Team

Dementia Mapping Service

Dementia Care Mapper (DCM):

***(Include the relevant DCM names from list below)***

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Buckingham Street Day Centre

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Adult Social Care

Hull City Council

Website: [www.hullcc.gov.uk](http://www.hullcc.gov.uk)

**Dementia Care Mapper Observations**

**#######:**(***Name of property***)

***The headings listed below are examples/ not exhaustive, however some are typical traits utilised in other reports (delete/ input to meet the reporting needs)***

Dementia friendly residential environment

The DCM spent over a **#######** period within **#######**, the environment ***met/did not*** meet the expected best practice guidelines for that of a dementia friendly residential environment.

Notices/ certificates/ information displayed

Environment/ communal areas

Points of interest

Signage - environment

Orientation

Health and Safety

Infection control

Environment / displaying of meals/ breakfast/ lunchtime

Medication

Diet and Hydration

Moving and Handling

Consent

Dignity

Community spirit/ interactions/ team approach/ practice/ Interventions

Communication

Safeguarding

Activity and the displaying of

Data Protection

Collaborative working/ visiting professionals

Service users’/ team members’ comments

**Recommendations and suggestions –** (***Property name***)

***(The paragraph below above should to be reviewed for each individual report)***

To build on the ***(good)*** practice we have already noted in this report we have further included recommendations/ suggestions to enhance both your environment, develop staff practice, increase service user engagement and well-being.

Agreed action plans for the service provider will be devised at feedback.

(***Enter recommendations/ suggestions under relevant headings***)

**(*The paragraph below is standard – include if appropriate*)**

Dementia friendly residential environment:

The DCM has included a web site link and points to consider for the home’s provider/ registered manager to further research regarding good practice guidelines for care homes that are providing care for people living with dementia type illnesses. The site contains valuable information regarding guidelines for the home’s environment which if adopted, would further support service users with the challenges that they inevitably will face when living with a dementia type illness.

* <http://www.enablingenvironments.com.au>

**Executive Summary - Dementia Care Map:**

Prior to the mapping visit the registered manager identified a service user that would be included in the dementia care map and gained appropriate consent for the individual to be involved in the process.

The DCM positioned herself in the communal areas from (***Enter* *times***); (***number***) service user(s) (***Enter names in full***) was/were included in the dementia care mapping process, where data was collated from (***Enter* *times*** ##:## until ##:##).

**(Name of service user)**

(***Executive Summary; record a summary of what you observed on the day using the Griffith University example***)**.**

On the day of the mapping session (***Enter name)*** #####)

**Data collated during the observation for #####** (***Enter service user name***)

**Scale of Mood and Engagement:**

It is not possible to define someone’s overall level of well-being just by observing them for five minutes. Rather, within the five minute time frame, we observe the service user’s mood state alongside their level of engagement. This is the mood-engagement (ME) value.

Over the period of a whole map a general picture can be built up about a service user’s relative level and range of well-being or ill-being by drawing together and analysing information from all the ME values coded. See below for the range of ME values, those in bold were observed for ###### during the mapping period and are identified in the data on **Graph A**

(***Edit as required - paying particular attention to appropriateness of wording***)

**+5** Exceptionally positive mood or engagement – it is hard to envisage

anything better, very absorbed or deeply engrossed and/or very happy

and buoyant.

**+3** ##% of the map ##### experienced considerable signs of positive mood

or engagement; concentrating but distractible and/or content, happy and

relaxed.

**+1** ##% of the mapping period ##### was observed alert and focused on ###

surroundings with no signs of positive or negative mood.

**-1** The remaining ##% of the mapping period ##### was observed showing

small signs of negative mood and/or disengaged/ withdrawn.

**-3** Considerable signs of negative mood: anxiety, distress or anger.

**-5** Extremes of negative mood: apathy, withdrawal, rage, grief or despair.

##### did not experience any mood or engagement levels listed below. We have included a description of the mood and engagement levels for your information.

***Insert Graph*** (*Label with first name only*)

**Graph A** - Mood and engagement values

One aspect of person centred care is the provision of individualised care that meets the needs of a person with dementia for meaningful occupation. Therefore occupational provision needs to take into account individual taste and preferences.

In environments where there is little or no structured activity provided during the day, or environments where this is limited to one or two activities, it can fail to meet individual preferences and capacity for engagement. Therefore, examining the number of different high priority activities can be an indicator of the quality of care.

High category codes we would expect to see are listed below. A list of all codes can be found at the back of this report:

**A,D,E,F,G,I,J,K,L,O,P,R,S,T,V,X,**

See **Graph B** which identifies the behaviour category codes (***Edit as* *required***) **A, B, C, D, E, F, G, I, J, K, L, N, O, P, R, S, T, U, V, W, X, Y** and **Z**

which were observed on the day of the map

***Insert Graph*** (*Label with first name only*)

**Graph B** behaviour categories observed

(***Edit as required***)

1. Interacting with others verbally or otherwise.

**(B)** Being engaged but passively

**(C)** Being disengaged, withdrawn

**(D)** Engaging in self-care

**(E)** Engaging in an expressive or creative activity

**(F)** Eating and drinking

**(G)** Reminiscence and life review

**(I )** Prioritising the use of intellectual abilities

**(J)** Engaging in exercise or physical sports

**(K)** Walking, standing or moving independently

**(L)** Leisure, fun and recreation

**(N)** Sleeping or dozing

**(O)** Displaying attachment to or relating to inanimate objects

**(P)** Receiving practical, physical or personal care

**(R)** Engaging in a religious activity

**(S)** Engaging in sexual expression

**(T)** Direct engagement of the senses

**(U)** Attempting to communicate but not receiving a response

**(V)** Engaging in work or work-like activity

**(W)** Repetitive self-stimulation of a sustained nature

**(X)** Episodes related to excretion

**(Y)** Interaction with oneself in the absence of any observable other

**(Z)** Fits none of existing categories

**What’s working for #####** (***Enter service user name***)

**What’s not working for #####**

**Recommendations and suggestions for #####**

**Data collated during the observation for #####** (***Enter service user name***)

**Scale of Mood and Engagement:**

It is not possible to define someone’s overall level of well-being just by observing them for five minutes. Rather, within the five minute time frame, we observe the service user’s mood state alongside their level of engagement. This is the mood-engagement (ME) value.

Over the period of a whole map a general picture can be built up about a service user’s relative level and range of well-being or ill-being by drawing together and analysing information from all the ME values coded. See below for the range of ME values, those in bold were observed for ###### during the mapping period and are identified in the data on **Graph C**

(***Edit as required - paying particular attention to appropriateness of wording***)

**+5** Exceptionally positive mood or engagement – it is hard to envisage

anything better, very absorbed or deeply engrossed and/or very happy

and buoyant.

**+3** ##% of the map ##### experienced considerable signs of positive mood

or engagement; concentrating but distractible and/orcontent, happy and

relaxed.

**+1** ##% of the mapping period ##### was observed alert and focused on ###

surroundings with no signs of positive or negative mood.

**-1** The remaining ##% of the mapping period ##### was observed showing

small signs of negative mood and/or disengaged/ withdrawn.

**-3** Considerable signs of negative mood: anxiety, distress or anger.

**-5** Extremes of negative mood: apathy, withdrawal, rage, grief or despair.

##### did not experience any mood or engagement levels listed below. We have included a description of the mood and engagement levels for your information.

***Insert Graph*** (*Label with first name only*)

**Graph C** - Mood and engagement values

One aspect of person centred care is the provision of individualised care that meets the needs of a person with dementia for meaningful occupation. Therefore occupational provision needs to take into account individual taste and preferences.

In environments where there is little or no structured activity provided during the day, or environments where this is limited to one or two activities, it can fail to meet individual preferences and capacities for engagement. Therefore, examining the number of different high priority activities can be an indicator of the quality of care.

High category codes we would expect to see are listed below. A list of all codes can be found at the back of this report:

**A,D,E,F,G,I,J,K,L,O,P,R,S,T,V,X,**

See **Graph D** which identifies the behaviour category codes (***Edit as* *required***) **A, B, C, D, E, F, G, I, J, K, L, N, O, P, R, S, T, U, V, W, X, Y** and **Z**

which were observed on the day of the map

***Insert Graph*** (*Label with first name only*)

**Graph D** behaviour categories observed

(***Edit as required***)

1. Interacting with others verbally or otherwise.

**(B)** Being engaged but passively

**(C)** Being disengaged, withdrawn

**(D)** Engaging in self-care

**(E)** Engaging in an expressive or creative activity

**(F)** Eating and drinking

**(G)** Reminiscence and life review

**(I )** Prioritising the use of intellectual abilities

**(J)** Engaging in exercise or physical sports

**(K)** Walking, standing or moving independently

**(L)** Leisure, fun and recreation

**(N)** Sleeping or dozing

**(O)** Displaying attachment to or relating to inanimate objects

**(P)** Receiving practical, physical or personal care

**(R)** Engaging in a religious activity

**(S)** Engaging in sexual expression

**(T)** Direct engagement of the senses

**(U)** Attempting to communicate but not receiving a response

**(V)** Engaging in work or work-like activity

**(W)** Repetitive self-stimulation of a sustained nature

**(X)** Episodes related to excretion

**(Y)** Interaction with oneself in the absence of any observable other

**(Z)** Fits none of existing categories

**What’s working for #####** (***Enter service user name***)

**What’s not working for #####**

**Recommendations and suggestions for #####**

**The following training courses are delivered free of charge from the**

**Hull City Council**

Understanding Dementia & Responding Positively

Life Story Work (expression of interest)

Meaningful Activities (expression of interest)

*(Include if applicable)*

* The DCM has attached an application form for the training sessions

To apply contact Endeavour Learning & Skills Centre

 Beverley Road

 Hull

 HU3 1UR

 Tel: (01482) 612442

 Email: learninganddevelopment@hullcc.gov.uk

You can also find many helpful items of information and related websites on the Dementia Care Mapping services’ Face book page under ‘Dementia Academy Hull.’

**Meeting the Psychological Needs of People with Dementia at #####**(***Name of property***).

Five major psychological needs have been identified that people with dementia have.

These needs are often in danger of not being met in formal settings; the psychological needs include comfort, identity, attachment, occupation and inclusion

**Comfort**

Comfort is about the provision of tenderness, closeness and soothing. It promotes security and decreases anxiety, it helps people relax. Comfort can be provided through physical touch, or through comforting words or gestures. Comfort also includes physical comfort with one’s body.

Expressions of warmth, holding and a relaxed pace will help people achieve their need for comfort.

A lack of comfort will be experienced by those who are in pain, or who feel physically ill or unwell, or who are sitting or lying in an unpleasant place.

Intimidation, withholding and outpacing will undermine the need for comfort being met.

**Identity**

Identity relates to knowing who one is and to having a sense of continuity with the past. It is also about having a life-story that is held and maintained, either by the person with dementia, or for them by others. Others know about you, they know who you are and they hold you in esteem.

Identity is supported by respect, acceptance and celebration.

Identity can be undermined particularly by infantilisation, labeling, and disparagement.

**Attachment**

Attachment relates to bonding, connection, nurture, trust and relationship. It also relates to security in relationships, and feeling that one has trusted others to whom you can turn in times of trouble or need. When people are anxious the need to feel attached to someone or something familiar often increases to a significant degree.

Attachment needs can be supported by acknowledgement, genuineness and validation.

Attachment can be undermined by accusation, treachery and invalidation.

**Occupation**

Occupation relates to being involved in activity in a way that is personally meaningful. It also relates to having a sense of agency, which is about feeling one has control over the world and can make things happen. It is about feeling that you can have an effect and impact on what is done and how.

Occupation is supported by empowering, enabling, facilitating and collaborative approach.

Occupation is undermined by disempowerment, disruption, imposition and objectification.

**Inclusion**

Inclusion is about bringing or being brought into the social world, either physically or verbally. It relates to facilitating engagement where there would otherwise be none, and making a person feel they are part of the group, and are welcomed and accepted.

Recognising people’s worth, including them in discussions and activities emphasising a sense of belonging and having fun together all support the need for people to feel included.

Stigmatising, ignoring, banishment and mockery undermine the need for inclusion being met.

**Personal Enhancers and Personal Detractors**

The way in which care practices and environments in formal care settings can serve to undermine the personhood and well-being of a person with dementia is called malignant social psychology.

**Personal Enhancers,** (PE)’s

Being fully present and psychologically available to people with dementia is a principal requirement of caregivers. A number of ways have been identified in which caregivers could demonstrate this in their practice, which was called positive person work. Concrete examples have been identified in the same way as for malignant social psychology.

(PE)’s provide a record of positive person work observed in a care setting and in particular the skills, talents and creativity of care workers.

There are 17 types of (PE)’s and (PD)’s that a DCM might record during a map. These 17 types can be further subdivided into categories that support the core psychological needs being met.

**Rating Personal Enhancers**

Personal Enhancers are rated on a two-point scale:

Enhancing (e) An episode is supportive of the personhood of a participant and shows use of interpersonal skills on behalf of the care worker.

Highly enhancing (he) An episode is highly supportive of the personhood of the participant and shows use of a high level of interpersonal skills on behalf of the care worker.

**Supporting Comfort Needs**

**PE1 Warmth**

Demonstrating genuine affection, care and concern for the participant.

**PE2 Holding**

 Providing safety, security and comfort to a participant.

**PE3 Relaxed Pace**

Recognising the importance of helping create a relaxed atmosphere.

**Supporting Identity Needs**

**PE4 Respect**

Treating participants as valued members of society and recognising their age and experience.

**PE5 Acceptance**

Entering into a relationship based on an attitude of acceptance or positive regard for the participant.

**PE6 Celebration**

Recognising, supporting and taking delight in the skills and achievements of the participant.

**Supporting Attachment Needs**

**PE7 Acknowledgement**

Recognising, accepting and supporting participants as unique and valuing them as individuals.

**PE8 Genuineness**

Being honest and open with participants in a way that is sensitive to their needs and feelings.

**PE9 Validation**

Recognising and supporting the reality of the participant. Sensitivity to feeling and emotion to take priority.

**Supporting Occupation Needs**

**PE10 Empowerment**

Letting go of control and assisting the participant to discover or employ abilities and skills.

**PE11 Facilitation**

 Assessing levels of support required and providing them.

**PE12 Enabling**

 Recognising and encouraging a participant’s level of engagement within a frame of reference.

**PE13 Collaboration**

Treating the participant as a full and equal partner in what is happening, consulting and working with them.

**Supporting Inclusion Needs**

**PE14 Recognition**

Meeting the participant in his or her own uniqueness, bringing an open and unprejudiced attitude.

**PE15 Including**

Enabling and encouraging the participant to be and feel included, physically and psychologically.

**PE16 Belonging**

Providing a sense of acceptance in a particular setting regardless of abilities and disabilities.

**PE17 Fun**

Accessing a free, creative way of being and using and responding to the use of fun and humour.

**Personal Detractions,** (PD)’s

In Dementia Care Mapping concrete examples of episodes of a malignant social psychology have been identified as (PD)’s.

**Rating Personal Detractions**

Personal Detractions are rated on a two point scale:

Detracting (d) An episode mildly or moderately detracts or ‘puts down’ the participant.

Highly detracting (hd) An episode severely or very severely detracts or ‘puts down’ the participant.

Although it is not always possible to decide exactly what psychological need is being undermined, (PD)’s can be generally grouped around these main psychological needs.

**Undermines Comfort Needs**

**PD1 Intimidation**

 Making a participant frightened or fearful by using spoken threats or physical power.

**PD2 Withholding**

Refusing to give asked for attention, or to meet an evident need for contact.

**PD3 Outpacing**

 Providing information and presenting choices at a rate too fast for a participant to understand.

**Undermines Identity Needs**

**PD4 Infantilisation**

Treating a participant in a patronising way as if she or he were a small child.

**PD5 Labeling**

 Using a label as the main way to describe or relate to a participant.

**PD6 Disparagement**

Telling a participant that he or she is incompetent, useless, worthless or incapable.

**Undermines Attachment Needs**

**PD7 Accusation**

Blaming participants for things they have done, or have not been able to do.

**PD8 Treachery**

Using trickery or deception to distract or manipulate participants in order to make them do or not do something.

**PD9 Invalidation**

Failing to acknowledge the reality of a participant in a particular situation.

**Undermines Occupation Needs**

**PD10 Disempowerment**

 Not allowing participants to use the abilities that they do have.

**PD11 Imposition**

Forcing participants to do something, over-riding their own desires or wishes, or denying them choice.

**PD12 Disruption**

 Intruding in or interfering with something participants are doing, or crudely breaking their ‘frame of reference’.

**PD13 Objectification**

Treating participants as if they were lumps of dead matter or objects.

**Undermines Inclusion Needs**

**PD14 Stigmatisation**

Treating participants as if they were diseased objects, aliens or outcasts.

**PD15 Ignoring**

 Carrying on (in conversation or action) in the presence of a participant as if he or she is not there.

**PD16 Banishment**

 Sending the participant away, or excluding him or her; physically or psychologically.

**PD17 Mockery**

Making fun of participants; teasing, humiliating them and making jokes at their expense.

**List of Behaviour Category Codes**

**A Articulation** Interacting with others verbally or otherwise

**B Borderline** Being engaged, but passively

**C Cool**  Being disengaged, withdrawn

**D Doing for self** Self-care

**E Expression** Expressive or creative activities

**F Food**  Eating, drinking

**G Going Back** Reminiscence and life review

**I Intellectual**  Prioritising the use of intellectual abilities

**J Joints**  Exercise or physical sports

**K Kum and go** Walking, standing or moving independently

**L Leisure** Leisure, fun and recreation

**N Nod, Land of** Sleeping, dozing

**O Objects** Displaying an attachment to or relating to inanimate objects

**P Physical care** Receiving practical, physical or personal care

**R Religion** Religious activity

**S Sex** Sexual expression

**T Timalation** Direct engagement of the senses

**U Unresponded to** Attempting to communicate but not receiving a response

**V Vocational**  Work or work-like activity

**W Withstanding** Repetitive self-stimulation of a sustained nature

**X X-cretion**  Episodes related to excretion

**Y Yourself** Interaction with oneself in the absence of any

observable other

**Z Zero option**  Fits none of existing categories

Contract Performance and Quality Team

Dementia Mapping Service

(Formerly Dementia Academy)

Buckingham Street Day Centre

Buckingham Street

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HU8 8UG

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 You can also find us on: Under Dementia Academy Hull