Person-Directed Dementia Care Assessment Tool

A Guide for Creating Quality of Life and Successfully Refocusing Behavior For People with Alzheimer's Disease and Related Dementia In Long Term Care Settings

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
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Developed By
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Bureau of Aging and Disability Resources
In Collaboration with the Bureau of Quality Assurance
Person-Directed Dementia Care Behavior Solutions Study Advisory Committee

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Introduction

This tool was designed to be used as a guide for identifying the elements involved in implementing Person-Directed Dementia Care, also referred to as the "new culture of dementia care," "Person Centered Care," and "culture change." Research has shown that certain core social and emotional needs tend to be neglected for people with dementia when they are in long-term care settings. The "new" approach is to plan for each person with dementia individually; to have the best possible outcome by meeting their needs.

There are nine major sections of this tool that examine specific areas of focus vital in providing person-directed care to individuals with dementia. The tool has been designed to identify existing strengths of, and areas for improvement in, dementia care settings. This tool emphasizes "culture change" elements, because so many current systems of practice focus heavily on the details of physical care. The goal is to provide as much detailed planning to meet an individual's social and emotional needs as is done for physical care under the medical model.

This tool is not meant to be a licensing document or a prescriptive standard. It is also not meant to be scored. The Person-Directed Dementia Care Assessment Tool has been developed as a guide to establish an **initial baseline** to be used to identify key strengths and potential areas for improvement in a dementia care environment. This information is then put into a **Working Document** which provides feedback to the dementia care team. The team then uses the feedback to develop an **Action Plan**. The tool can then be used to re-assess and measure progress, and identify new areas of focus over time.

There are case examples and templates of each document in the Appendix.

The Person-Directed Dementia Care Assessment Tool was developed by an advisory committee of experts, including care providers, regulators, and advocacy groups. It was initially developed for a study to determine what technical assistance and training nursing home special care environments would need to manage difficult behavior. The results of the study were to be used to decrease the incidents of difficult behaviors in dementia residents; decrease the need for, and use of, medications to address behavior symptoms; and improve quality of life. The purpose of the study was to determine whether person-directed approaches could be successfully used with people who have dementia.

Results of the study are very encouraging. The Person-Directed Dementia Care Assessment Tool, resources used to develop and refine the tool, templates and examples for the Working Document and Action Plans, and materials developed for training and technical assistance (including two web-casts, please see page IV for links) that were used in the study are available on the Wisconsin Department of Health and Family Services web site as promising practice resources for dementia care providers.

This study was funded by Civil Money Penalty funds from the Centers for Medicare and Medicaid Services (CMS). Additional training materials used in the study were developed through an Alzheimer's Disease Demonstration Grant to States (ADDGS) that was awarded to Wisconsin.

Definitions

Person-Directed Care (PDC):

- Returns decision making and choices to the person;
- Enhances the primary caregiver's capacity to engage with the person and respond to needs; and
- Establishes a home environment (non-institutional).

Person Centered Dementia Care (PCC):

- Is care centered on the whole person rather than the disease of the brain;
- Is care that is centered on the abilities, emotions and cognitive capacities of the person…not on the losses; and
- Is care that gives equal credence to the psychosocial context of the individual (vs. physical/medical care).

Ability Centered Care/Programming (ACC) – ACC is also called activity focused care. It recognizes the person's abilities and competencies in care planning. Tasks are adapted and modified to provide for the person's involvement at the maximum level of the person's ability. Ability Centered Care recognizes that activities include every event, encounter, and exchange a person has with a staff member, volunteer, relative, or other individual. Activities are redefined as traditional (work related, recreational) and non-traditional bathing, eating, walking). Both independent and structured events are used.

Special Care Environment (SCE) – The residential or non-residential setting is the environment (cultural, social, and physical) where the person with dementia participates and/or resides. It supports the individual's maximum cognitive function and abilities, behavior, and independence while ensuring resident safety.

Special Care Environment Team (SCT) – The SCT consists of staff from all disciplines that work in or support the special care environment. The team has regular meetings to problem-solve, plan, brainstorm new ideas, and evaluate the dementia patient's quality of life, strategies, and approaches being used and team effectiveness.

Interdisciplinary Team (I-Team) – The I-Team consists of Individuals from each major discipline (nursing, therapies, activities, social work, dietary, etc.) who are responsible for conducting ongoing assessments of people who have dementia. They provide input into care planning. The team has regular meetings to review how each aspect of the person's care and function impacts/interacts on the person's quality of life.

Special Care Environment Coordinator (SCEC) – This is the person who functions as the team lead for resources, communication, and follow-through on the SCE plan for people with dementia. The SCE requires a lead person with the responsibility to oversee or coordinate the PDC activities and work with implementing and evaluating new processes and changes for the successful implementing of Person-Directed Care. This person can be from any discipline. Although there is meant to be shared leadership on the SCE Team, the SCE Coordinator is responsible for facilitating the overall plan and making sure that the team works together successfully.

Definitions (Cont'd)

Minimum Data Set (MDS) – This is federal data that is required to be collected and submitted about an individual and his or her function and health status upon admission, quarterly, and with change in function.

Targeted Behavior – The behavioral expressions of need (usually of ill-being) that people with dementia display, that need to be monitored and addressed until they are minimized or stopped. Usually the behavior has a negative effect on self or others, is being addressed through medications, and is being monitored to find strategies that can result in the reduction or stopping of medications.

Quality Improvement Plan (QIP) – This is the plan that is developed by the teams to monitor and measure the outcomes or effects of implementing changes. The plan has stated desired outcomes and timeframes, and data is collected on results so that the team can see if the plan is effective in improving the things they are targeting. The QI Plan is reviewed regularly with the team and staff, and results are shared and ideas solicited for additional plan input.

Activities of Daily Living (ADLs) – The routine tasks that a person must perform, or have help with, to stay functional. Tasks include eating, bathing, dressing, maintaining their belongings, etc.

AIMS, DISCUS and MOSES Assessment Tools – (Please see Appendix for examples or information.) These are standard assessments used to monitor side effects people may develop from taking various medications, particularly anti-psychotics. If certain side effects occur, it is usually an indicator that the medication should be changed or discontinued.

Quality of Life Committee – This committee can serve different functions in different environments. Basically, it is an interdisciplinary team that reviews issues relevant to the quality of life of residents and staff. This could involve monitoring behavior, the physical plant, activities, schedules, food, etc., depending on the special care environment.

Links to Department of Health and Family Services Web-Casts:
http://**dhfs.wisconsin.gov/aging/Genage/ALZFCGSP.HTM**

Introduction to Person-Directed Dementia Care Part 1
http://**dhfs.wisconsin.gov/aging/Genage/ALZFCGSP.HTM**

Person –Directed Dementia Care, Care Planning Part 2
http://**dhfs.wisconsin.gov/aging/Genage/ALZFCGSP.HTM**

Person-Directed Dementia Care Assessment Tool

How to Use This Tool

Each of the nine major sections of this tool contains sub-categories with specific items to assess. Each item is stated in the form of a promising/recommended practice for Person-Directed Dementia Care. (Example – page 2 of the Tool)

ENVIRONMENT
Ambiance:
Goal: Atmosphere is engaging and pleasant to people with dementia, staff, family and visitors.

- Energy and engagement levels are paced throughout the day.
- Television use limited to people with dementia's preferences/desires.
- Warm interactions taking place.
- Pleasant odors.
- "Homey" atmosphere (not institutional).
- Comfortable lounge/wingback/glider rocker chairs, afghans, lamps, artwork, etc., present.
- Ability to get natural light from outdoors.

Beside each item there is a numbered scale that is meant to be circled only. (It is NOT meant to be added to other items and scored.)

1 2 3 4

The scale is meant to indicate the presence or absence of each item, and whether it is a strength or a weakness that needs to be worked on. The number is an indicator of that one item, not a numerical value to be added to others.

1 = Item is not present or is a problem area.
2 = Item is present but could be improved upon at some point.
3 = Item is present in a satisfactory way and could be used as a strength.
4 = Item is a significant strength that can be used to help implement other promising practices.

There are two columns to the right of the numbers; one titled **"Strengths,"** the other titled **"Improvement Areas."** Here the evaluator can indicate the exact situation witnessed, comment made, or example for the working document. It is not necessary to write something about all items. Because special care environments are unique and changing, not all specific items will pertain to each environment, so some items could be "not applicable" (N/A). The feedback collected during the assessment reflects a snapshot in time.

Above the information sections is space for the observer's name, the date and time period of observation, and the name of the environment observed. The tool can be divided into individual sections and assigned to one or more people. Obtaining multiple perspectives during different shifts is ideal. The most important information will come from people who do not work in the environment. This could be an observer from a partnering facility, different department, or location. Be sure that followup observations are done by all or some of the same people that did the first observation so that individuals who have different perceptions do not skew the recognition of progress.

Please see the **Sample Working Document and Directions** for an example of the tool in use.

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
ENVIRONMENT	**Weak - Strong**		
Sound Level **Goal: The environment has a comfortable sound level that is enjoyed by the people with dementia who live there.**			
- Systems are **not** creating noise such as overhead pages, loudspeakers, staff, room and chair alarms (e.g., no over head paging, staff carry phones/ pagers that alarms go to).	**1 2 3 4**		
- Note: minimal use of personal alarms; alarms are not safety devices, they are alerting devices. There has to be supervision on hand to respond to the alert and address the **need** or desire of the individual to stand up (see guidelines for alarm use in the Appendix).	**1 2 3 4**		
- Music is appropriate for people with dementia who desire it (vs. staff choice, which is not appropriate).	**1 2 3 4**		
- Sounds, music and interactions are soothing and/or pleasant.	**1 2 3 4**		
- Pacing of sound from quiet to energetic throughout the day.	**1 2 3 4**		
- Alternatives are available for individuals who want/need quiet or energized areas.	**1 2 3 4**		

Key: **1 = not present or is a problem area**
2 = is present but could be improved upon
3 = is present in a satisfactory way and could be used as a strength
4 = a large strength that can be used to implement promising practices

PLEASE NOTE: Numbers are **NOT** totaled or used to derive a score, they are meant to **reflect the degree of a strength or opportunity** for improvement for a single item.

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
ENVIRONMENT	**Weak - Strong**		
Ambiance **Goal: Atmosphere is engaging and pleasant to people with dementia, staff, family, and visitors.**			
- Energy and engagement levels are paced throughout the day.	**1 2 3 4**		
- Television use limited to people with dementia's preferences/desires.	**1 2 3 4**		
- Warm interactions taking place.	**1 2 3 4**		
- Pleasant odors.	**1 2 3 4**		
- "Home" atmosphere (not institutional).	**1 2 3 4**		
- Comfortable lounge/wingback/glider rocker chairs, afghans, lamps, artwork, etc., present.	**1 2 3 4**		
- Ability to get natural light from outdoors.	**1 2 3 4**		
Space Configuration **Goal: Space promotes people with dementia's choices and abilities.**			
- Individuals have opportunities for privacy, to be alone or quiet.	**1 2 3 4**		
- Respect for personal space with others; not being too close or crowding. (Ideal is to have private rooms for some or all people.)	**1 2 3 4**		
- Room to move safely and easily, including outdoor spaces.	**1 2 3 4**		
- Places for people to pace and burn energy.	**1 2 3 4**		
- Furniture arrangement promotes engagement, e.g., small areas to interact, angled chair placement.	**1 2 3 4**		
- People with dementia are helped and encouraged to move back and forth between comfortable chairs and wheelchairs throughout the day, and to move from room to room for variety in activities.	**1 2 3 4**		
- Clear safe navigation for promoting independence.	**1 2 3 4**		
- Purposeful activity areas/discovery stations for people with dementia to spontaneously find and do things.	**1 2 3 4**		
- Where architecturally possible, people live in small neighborhoods with a maximum 10 -15 people. Common rooms reflect a home environment.	**1 2 3 4**		

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Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
ENVIRONMENT	**Weak - Strong**		
Lighting, Colors/Patterns **Goal: Lighting and color uses enhance people with dementia's abilities, while providing a pleasant atmosphere.**			
- Adequate lighting for ease of vision, with minimum glare (Note: elders with dementia need about eight times more lighting to see well than the general population).	**1 2 3 4**		
- Plenty of indirect lighting (<u>not</u> having florescent or other bulbs visibly exposed) e.g., wall sconces aimed at ceiling in addition to florescent ceiling lights covered with deflectors, table/floor lamps, recessed light above bedroom doorways and windows to add to natural light.	**1 2 3 4**		
- Lighting is varied according to times of day, and used as a <u>cue,</u> e.g., dimmed and/or less overhead lights for relaxation, evening, and bed times; bright/all lights on for activities.	**1 2 3 4**		
- Contrast in light/dark color between walls, floors, chairs, commodes, etc., for maximum depth perception.	**1 2 3 4**		
- Avoidance of tedious/small print patterns that can cause preoccupation; no patterns, borders or dark blocks on flooring that could induce visual cliffs (look like holes in the floor to people with dementia).	**1 2 3 4**		
- Natural light and views of the outdoors.	**1 2 3 4**		
- Lighting, colors and patterns evoke a calm, uplifting, or comforting feeling, according to area's use.	**1 2 3 4**		
- Colors used in environment are drawn from research about their effects on people with dementia (see Appendix for resources).	**1 2 3 4**		
- Floors are not shiny or glare producing (can be perceived as water by people with dementia).	**1 2 3 4**		

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Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
ENVIRONMENT	**Weak - Strong**		
Visual Cues **Goal: Individualized cues are available to enable people with dementia to engage in and navigate the environment.**			
- Items of curiosity are visually displayed to prompt reminiscence and/or self-initiated activity.	**1 2 3 4**		
- Pictures, words, colors, etc., are used to identify restrooms, individual's own rooms, activity areas, etc.	**1 2 3 4**		
- Clothing and other personal items are laid out during personal care for staff to promote and prompt individuals to use and retain independent skills.	**1 2 3 4**		
- Pictures/words are used on drawers and cupboards to cue where items are kept.	**1 2 3 4**		
- Cues that prompt undesirable behavior are removed (e.g., coats near doors).	**1 2 3 4**		
- Cues are used as prompts or camouflage—"stop/do not enter," or personalized signs, door murals, etc.—to limit safety issues (e.g., wandering, and to promote independence).	**1 2 3 4**		
- Cues displayed to celebrate individual's independent function, promote self esteem (e.g., individual's artwork, awards).	**1 2 3 4**		
- Non-skid strips applied to floor path as cues and to minimize falls in specific areas for people at risk (e.g., between bed and bathroom).	**1 2 3 4**		
- Non-skid surfaces used on bathroom floors and in tubs and showers should provide light/dark contrast to enhance depth perception.	**1 2 3 4**		

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Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
ENVIRONMENT	**Weak - Strong**		
Personalization of Individual Space **Goal: People with dementia's rooms and the common environment are personalized.**			
- Individual's room is personalized with her/his own familiar items. It duplicates the home they lived in, personal preferences, favorite items, furniture, and layout as much as possible. This space is duplicated whenever a person is moved.	**1 2 3 4**		
- People have authorized, personal information displayed so staff can use it as cues to interact well and get to know individuals (e.g. shadow boxes, written information).	**1 2 3 4**		
- Calendars, journals, and correspondence with loved ones are used to record family members past and future visits, and allow for reminiscence with staff and others.	**1 2 3 4**		
- Individuals' rooms are safe for rummaging. Important items are secured in a safe place to prevent rummaging by others, in accordance with family or resident preferences. Individuals can have personal possessions to use in common areas (e.g., favorite chair labeled with person's name to identify it for the person and others).	**1 2 3 4**		
- Signs to identify individuals' rooms are simple with only the person's name (no decorations) printed in size 18 or larger font, upper and lower case letters, and black lettering on white background for clear easy reading by person with dementia (see Appendix for reference).	**1 2 3 4**		
- Roommates shall be assigned/changed according to the health, behavior, and compatibility of each, so that no individual's physical or mental health is negatively affected by the roommate.	**1 2 3 4**		

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Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
LANGUAGE AND COMMUNICATION	**Weak - Strong**		
Language Used and Perceptions Created **Goal: Language used to label and describe things promotes positive and strength-based images (aims the brain for success.)** (Ask yourself "What is being conveyed by the language? **This is a KEY aspect of Person-Directed Care**)			
- Staff behavior and language reflects respect and dignity for the personhood of all individuals. People with dementia are talked to and involved in conversations about them. Individuals are never talked about in front of them.	**1 2 3 4**		
- The language used "aims the brain for success" subconsciously by creating a positive vision of what is wanted (e.g., "Please close the door softly" vs. "Don't slam the door"). Staff communicates using positive language with each others and with people who have dementia.	**1 2 3 4**		
- Negative, generalized labels for people with dementia have been totally eliminated from the vocabulary of staff, signage, and all documentation, including care plans. Examples include "feeder," "wanderer," "toileter," "screamer," "total assist person," "agitated," "difficult," "behavioral," "unmanageable," "redirect."	**1 2 3 4**		
- Positive, and more specifically, descriptive language is used to refer to people with dementia, e.g., "Person who needs help eating," "energetic and exploratory," "needs help in the bathroom." Instead of labeling person with dementia as "agitated," describe the situation and what was done, e.g., "Person is talking loudly about his wife and pacing in his room - so I asked him to tell me about his wife."	**1 2 3 4**		
Key: 1 = not present or is a problem area **2 = is present but could be improved upon**	**3 = is present in a satisfactory way and could be used as a strength** **4 = a large strength that can be used to implement promising practices**		

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Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
LANGUAGE AND COMMUNICATION	**Weak - Strong**		
Language Used and Perceptions Created (Cont'd) - Staff are trained and able to see the positive side of an individual's behavioral communication,(e.g., "person is full of energy in the afternoon" - not "sundowner" label. How can we develop activities for people to express and expend their energy and have fun at this time? - Titles for staff, teams, initiatives, etc., are positive and embody the ideas of expected, positive outcomes (e.g., "trauma team" vs. "transition team," "behavioral management team" vs. "quality of life" team).	**1 2 3 4** **1 2 3 4**		
CARE PLANS			
Establishment of Care Plans **Goal: Care plans are developed by the interdisciplinary team, which includes the person with dementia, family/legal representative and the staff who work directly with the person.** - All people with dementia new to the SCE (or being moved or assigned new staff) receive a comprehensive pre-admission assessment in the environment where they are currently living from at least one of the SCE team members (e.g., director of nursing, social worker). The CNA assigned to work with the individual shadows and interviews the person's current care worker to learn individual preferences/needs for routines, care, etc. - Care plans are updated routinely, daily if needed, based on input from the SCE team; particularly by members who work closest with the person. All updates are shared across shifts daily.	**1 2 3 4** **1 2 3 4**		
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Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
Assessment Information for Care Plans **Goal: Ongoing comprehensive assessments are completed, which address all issues related to the well-being of the person with dementia, and findings are included in the care plan.**			
- There is a comprehensive life story, documented for each individual, which provides an ongoing source of information about the person's life, experiences, values, preferences, emotional triggers, strategies for successful interaction, etc. Staff who work with the person should be familiar with this history and add to it, as more is learned. This is used and incorporated into the care plan in as many ways as possible (**this is the foundation of person-directed care**).	**1 2 3 4**		
- **Pain should be considered the fourth vital sign in all people with dementia.** On a routine basis, individuals are thoroughly assessed for chronic or acute pain using a dementia specific pain screening tool and protocol; especially when there is a change in the person's demeanor. Example below is from "Assessment of Discomfort in Dementia (ADD) Protocol," C. Kovach, PhD, RN.	**1 2 3 4**		
• First, information is obtained from physician, family, and person with dementia about the person's history of past injuries and conditions that could potentially cause current pain, and how they have been remedied/given relief in the past.	**1 2 3 4**		
• Next a comprehensive physical evaluation is done, noting how the person moves and navigates, ranges of motion, skin conditions, complaints, and any body language clues (grimacing, rubbing, holding, talking about a body part, limping, etc.)	**1 2 3 4**		

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Topic and Details	Scale	Strengths	Improvement Areas
CARE PLANS	**Weak - Strong**		
Assessment Information for Care Plans (continued): • Comfort care measures should be taken (i.e., repositioning, warm compresses or baths, massage, activities that loosen or stretch stiff areas).	**1 2 3 4**		
• Trial of a physician-approved pain reliever (e.g., acetaminophen) should be used as part of the assessment to see if it influences person's condition/behavior. If so, a pain maintenance schedule needs to be put in place.	**1 2 3 4**		
- Upon admission, individuals are screened to verify the type of dementia present and to discover any potentially treatable causes of cognitive decline.	**1 2 3 4**		
- Upon admission, or whenever there is any cognitive change in a person, potentially treatable causes of cognitive decline are reviewed and assessed, including the following: • Hearing/vision loss or not using aids/glasses • Thyroid function • Depression • Medication side effects/interactions or toxicity • Vitamin/nutrient deficiency • Fluctuating blood sugar • Diabetes • Dehydration • Constipation • Bladder infection or other illness	**1 2 3 4**		
- Any physician orders for screening are requested when contacting the physician to prevent unnecessary medication changes/additions, or results of screening are shared.	**1 2 3 4**		

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Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
CARE PLANS	**Weak - Strong**		
Assessment Information for Care Plans (continued): - The person's social and emotional needs are assessed and planned for as carefully as their physical care: • The need to be useful (See Appendix for reference) • To still care (for others/self) • To give and receive love • To have self-esteem boosted • To experience joy and laughter	**1 2 3 4**		
- Staff are aware of individuals' trauma histories so that they can be sensitive to care issues that could trigger behavior, and so they can initiate effective calming approaches.	**1 2 3 4**		
- People with dementia receive a functional assessment of strengths and abilities; including fine and gross motor skills as they relate to feeding, dressing, self-care, ambulation, positioning related to using or eliminating a chair alarm, etc., and leisure activities. This allows opportunities for improvement and self-sufficiency to be incorporated into the care plan to avoid excess disability and increase well-being.	**1 2 3 4**		
- Individuals with dementia (with help from family as needed), identify a list of favorite things that can be used by staff in personalizing activities, etc.	**1 2 3 4**		
- There is a process in place for developing care plans utilizing the specific knowledge of the direct service staff who works with each of the individuals in the SCE.	**1 2 3 4**		

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Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
CARE PLANS	**Weak - Strong**		
Content of Care Plans **Goal: The interdisciplinary plan of care is based on findings from assessments; and contains approaches that meet the person with dementia's needs, maintain strengths, and have realistic goals that promote quality of life**			
- Goals/outcomes are ability-centered, simple, and success-oriented.	**1 2 3 4**		
- The language of outcomes and goals is very specific and stated **positively** to inform those using the care plan of ways to assist people to achieve maximum function, based on their current and potential strengths and abilities (not disabilities). **This is ability-centered care**.	**1 2 3 4**		
- Care plans are written in personalized, easy-to-understand "I" statements, written from the person with dementia's perspective, e.g., "I have…" (See Outcomes Care Planning Tool.)	**1 2 3 4**		
- Ways to meet the individual's quality of life needs (e.g., social/emotional) and care needs are incorporated into the care plan (see page10).	**1 2 3 4**		
- Goals reflect the person with dementia's personal choice, and the support and flexibility needed to meet those choices, e.g., individuals have the ability to personalize schedules according to own routines—bathing/meals/waking and sleeping, visitors, etc.	**1 2 3 4**		
- MDS scores should correlate directly with the assessments done, and the related care or activity included in the care plan.	**1 2 3 4**		

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Topic and Details	Scale	Strengths	Improvement Areas
CARE PLANS	**Weak - Strong**		
Use of Care Plans **Goal: Care plans are working documents that help everyone know a person and are used to meet the person's needs or desires. They are adapted as often as person's needs/desires change.**			
- Care plans are work tools and available at all times to all staff directly assisting the person with dementia.	**1 2 3 4**		
- Staff look at and use their individual's care plans daily (Staff should be able to identify the name of the person based on their care plan).	**1 2 3 4**		
- The same staff, even "substitute" staff, should work with the same people every day to preserve familiarity and build relationships that can enhance the care plan.	**1 2 3 4**		
- Information about an individual's life history is constantly added to the care plan. It is an evolving document that is used in a person's daily life activities.	**1 2 3 4**		
- **Suggestion**: Create a binder that includes all participants with dementia's care plans, photos, lists of favorite things, social history, etc., for staff to reference and add to.	**1 2 3 4**		
- If staff members use notes, care sheets or "cheat sheets," they must **match the current care plan every day**. Try using symbols to represent common items and allow for more details on the care sheets. Have all three shifts document in them, and turn them in each day to make changes to care plans or other cares, as needed.	**1 2 3 4**		
- Information that is gathered in ongoing assessments is analyzed, shared with the team, and reflected in the care plan daily.	**1 2 3 4**		

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Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
ACTIVITIES	**Weak - Strong**		
Activities Practice **Goal: Everything about the person with dementia's day should be approached by all staff as an opportunity to engage the person in life, and to learn from, and about, the person, in order to use the information to meet the individual's preferences and needs.** **Special Care Environment (SCE) Team**:			
- <u>All staff</u> on the SCE team are committed to, and able to, enjoy conducting/participating in activities with people who have dementia.	**1 2 3 4**		
- All staff receives continuous training and empowerment in conducting/participating in activities.	**1 2 3 4**		
- SCE staff serve as role models for activity participation, and support the "activities practice" as a priority in the daily life of the individual's environment.	**1 2 3 4**		
- The SCE team values, conducts, and plans personal engagement in activities and activity participation, as much as they value planning and providing quality care/tasks.	**1 2 3 4**		
- The SCE has an activity professional, who is a team leader, to teach and mentor all other staff in engaging individuals in activity processes, and who also facilitates the planning and preparation of daily activities.	**1 2 3 4**		
- The activity professional works with other team members to facilitate or conduct large–scale, more complex activities such as outings, family parties, etc.	**1 2 3 4**		

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Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
ACTIVITIES	**Weak - Strong**		
Activities Implementation **Goal: The activity engagements that people with dementia experience are nurtured by a paced flow of energy throughout the day meant to foster physical, social, cognitive, emotional, self-care and creative abilities**.			
- All individuals with dementia have regular, solicited input into choosing or suggesting all activities.	**1 2 3 4**		
- Individuals are given opportunities to wake up and start the day when and how they prefer.	**1 2 3 4**		
- Activities are varied by energy level and types of participation that allow for:	**1 2 3 4**		
• Burning energy being physically active, exercising.	**1 2 3 4**		
• Maintaining cognitive and creative abilities, and boosting self esteem.	**1 2 3 4**		
• Being alert and having appetite during meals.	**1 2 3 4**		
• Relaxation and rejuvenation.	**1 2 3 4**		
• Experiencing a sense of community participation and belonging to a group, and caring for others.	**1 2 3 4**		
• Feeling useful and able to contribute with productive work.	**1 2 3 4**		
• Experiencing and giving love and affection.	**1 2 3 4**		
• Fun and spontaneity!	**1 2 3 4**		
(See Appendix for activity pacing throughout the day and structuring group/individual activities).			
- The SCE has an activity plan that is followed, with reasonable equivalents of activities substituted if problems arise with the planned activity.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
ACTIVITIES	**Weak - Strong**		
Activities Implementation (continued): - All SCE team members are involved in the planning of activities and contributing to conducting activities according to their strengths. - The environment has purposeful activity areas/discovery stations where staff and people with dementia can access resources to help them interact spontaneously. - All staff have access to activity supplies. - Individuals are **invited** to join in activities. People can accept or decline as desired or tolerated, with their choice, respect, and dignity honored. - Individuals have the option of doing other things, if preferred. - Family members have access to activity supplies and are encouraged and educated by SCE staff to participate in special activities enjoyed by their loved one. - Family members are welcome to participate in the activities and life of the environment, if appropriate, and if so desired. (See Appendix for resource)	**1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
ACTIVITIES	**Weak - Strong**		
Types of Activities **Goal: Activities vary from formal to informal, group to individual, structured to spontaneous.**			
- Structured "Clubs" that meet regularly, e.g., "Spark of Life Clubs" from Dementia Care Australia, are excellent for specific focus on social and emotional needs. (See appendix)	**1 2 3 4**		
- Large group and small group.	**1 2 3 4**		
- Activities of Daily Living (ADLS) allows opportunities to reminisce, foster skills, make the routines fun, allow person to practice self-care skills, make the bed, etc.	**1 2 3 4**		
- One staff to one person with dementia (1:1) planned skill building/contributing to the SCE community via productive work, sharing, reminiscing, etc.	**1 2 3 4**		
- Outings in the community, and people from the community coming **into** the SCE. (See Appendix for information on facilitating Artist in Residence programs).	**1 2 3 4**		
- Creative activities that encourage expression, creativity and involve the senses, emotions and imagination, e.g., aromatherapy, TimeSlips Creative Story Telling* process. (See Appendix)	**1 2 3 4**		
- Physical exercise to encourage improvement in balance/mobility/range of motion and to burn up energy.	**1 2 3 4**		
- Specialized activities that mirror an individual's past interest/routines, etc. For example, a woman who was an evening stage entertainer is given her makeup at the time of day she would normally get ready—this prevents her late afternoon restlessness.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
ACTIVITIES	**Weak - Strong**		
Activity Engagement Process **Goal: All Activities have a similar process of engagement between staff and people with dementia**.			
- Always approach a person from the front. Greet using the person's name and introduce yourself and make eye contact. Touch only if the person welcomes it.	**1 2 3 4**		
- **Invite** the person to engage with you/group.	**1 2 3 4**		
- Offer choices and allow person to make choices.	**1 2 3 4**		
- Allow person to go at his/her own pace and to do as much as possible for him/herself. Be lighthearted and use humor to fill the time.	**1 2 3 4**		
- Do **with, not for, or to**, the person. Join them and engage together (e.g., "we" are doing this).	**1 2 3 4**		
- Ask the person what **he or she is thinking or feeling**, instead of "quizzing" or putting them on the spot. Quizzing emphasizes the person's disability, lowers self esteem.	**1 2 3 4**		
- Paraphrase to the person what you think he/she said or conveyed through words, body language, gestures or sounds to check communication and validate the person's contribution.	**1 2 3 4**		
- Repeat to the group what the person has said so they can respond. Ask others for input as well.	**1 2 3 4**		
- Offer generous encouragement and compliments.	**1 2 3 4**		
- Be flexible according to person's mood. Validate the person's feelings with acknowledgement and empathy.	**1 2 3 4**		
- Thank the person and praise/celebrate the success.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
PROBLEM SOLVING PROCESSES FOR WORKING WITH PEOPLE WITH DEMENTIA'S BEHAVIORAL COMMUNICATION	**Weak - Strong**		
Process for Understanding Individual's Behavior Communication Goal: There is an established, team guided process in place to learn about what needs the person with dementia is expressing with his or her behavior, and ways to support the person.			
- There is a way to evaluate staff interactions with the individual to determine if the problem is actually the staff member's technique/beliefs, etc. (i.e., whose problem is this really?).	**1 2 3 4**		
- Information about the person, behavior, and situation is collected and documented through several means including:	**1 2 3 4**		
• Subjective observation.	**1 2 3 4**		
• Medical evaluation.	**1 2 3 4**		
• Social history, e.g., routines, skills, interests, wishes.	**1 2 3 4**		
• Asking family and the person with dementia about what they think is happening.	**1 2 3 4**		
- All team members are trained in the process, it is conducted on all shifts, **and** there is time set aside for the team to analyze and share information daily/routinely with all three shifts.	**1 2 3 4**		
- Changes for supporting the person with dementia (sometimes also called interventions) are monitored for effectiveness with one approach trial at a time to measure effectiveness.	**1 2 3 4**		
- Success is documented and shared with **all** team members on **all** shifts, and multiple successful options are sought and shared so that there are several ways to support individuals.	**1 2 3 4**		
- All new people with dementia have a pre-admission assessment of known behavior concerns done in their current environment by the Director of Nursing and/or other SCE staff before moving in.	**1 2 3 4**		

Key: **1 = not present or is a problem area**
2 = is present but could be improved upon
3 = is present in a satisfactory way and could be used as a strength
4 = a large strength that can be used to implement promising practices

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
PROBLEM SOLVING PROCESSES FOR WORKING WITH THE PERSON WITH DEMENTIA'S BEHAVIORAL COMMUNICATION	**Weak - Strong**		
Procedure for Documenting Behavior when Concerns Arise **Goal: There is a procedure followed to ensure appropriate documentation is done to provide the team with critical information to make decisions.** **Behavioral documentation** (See appendix for suggested video, resources.)			
1. Target the behavior to monitor.	**1 2 3 4**		
2. Have different people use the same format to record observations of the person at different times of day and different shifts over a period of at least 2-3 days. Things that should be documented are conditions in the environment, people present, sequences of activities/events taking place, time of day, etc.; and what is present before, during, and after behavior occurs—noting what makes it better or worse (external factors to the person).	**1 2 3 4**		
3. Combine the observations with assessment data. Include examination of the five basic social/emotional needs (page 10), current medications, health issues, person's own feedback, and other internal factors of the person that could be influencing behavior.	**1 2 3 4**		
4. Have staff write down (or question) their perception of "problem behavior." Who is it a problem for, when, etc. (Evaluate input to determine need for improvement, education, etc.)	**1 2 3 4**		
5. Analyze information as a team. Formulate and write a list of multiple solutions/ideas to try.	**1 2 3 4**		
6. Continue to have staff observe and gather the same information, on the same form, in the same manner as #2 above. Then meet and re-analyze the data collected to compare results.	**1 2 3 4**		
7. Always work towards having multiple, written approaches that have worked and are shared with and available to all staff.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
PROBLEM SOLVING PROCESSES FOR WORKING WITH THE PERSON WITH DEMENTIA'S BEHAVIORAL COMMUNICATION	**Weak - Strong**		
Guidelines for using medication for behavior symptoms: 1. People with dementia receive the appropriate medication for their diagnosis and symptoms.	**1 2 3 4**		
2. Antipsychotic/anti-anxiety or hypnotic medications are not used to address behavior symptoms until all other non-medicating options have been used for a trial period. Use of these medications is done in consultation with a gero-psychiatrist or similar dementia expert. (See Appendix for list of dementia diagnostic clinics.)	**1 2 3 4**		
3. People with dementia receive the lowest possible dose of the most conservative drugs for the shortest duration possible to maintain well being; only after all non-pharmacological approaches have been exhausted. Facilities determine this in consultation with both a pharmacy and dementia expert physician, **through staff who is trained in how to effectively use the physician/pharmacy as a resource. A**ntidepressants are more conservative and can be far more effective for certain conditions than drugs such as Haldol.	**1 2 3 4**		
4. People with dementia have been assessed for a trial of appropriate Alzheimer's/dementia medication (e.g., Cholinesterase inhibitors such as Aricept and others, or Mematine). These medications are continued as long as appropriate, based on current research.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer		Time Period of Observation
Topic and Details	**Scale**	**Strengths**	**Improvement Areas**
PROBLEM SOLVING PROCESSES FOR WORKING WITH THE PERSON WITH DEMENTIA'S BEHAVIORAL COMMUNICATION	**Weak - Strong**		
Guidelines for medication use for behavior symptoms (continued): 5. When people with dementia are receiving antipsychotic/antianxiety or hypnotic medications, regulations are followed for use. - An Abnormal Involuntary Movement Scale (AIMS), Dyskinesia Identification System: Condensed User Scale (DISCUS), or Multi-dimensional Observation Scale for Elderly Subjects (MOSES) assessment has been done as prescribed. (See Appendix.) - Reduction of antipsychotic medications in the past six months. - Reduction of anti-anxiety medications in the past four months. 6. Targeted behavior symptoms being managed are addressed on a daily basis, or more frequently, as needed. Basic social and emotional needs are considered for all approaches (page 10). **Successful strategies are documented and shared with all staff. (See recommended sample form that allows for specific description of behavior—not labels—and specific descriptive documentation of success, in Appendix.)**	**1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
COMMUNICATION AND LEADERSHIP	**Weak - Strong**		
Communication:			
- There are **specific** processes in place to encourage and ensure effective communication, which **are reviewed regularly for effectiveness.**	**1 2 3 4**		
- Information is shared with, and solicited from, staff on all shifts routinely every day.	**1 2 3 4**		
- Staff perception of those on other shifts is positive.	**1 2 3 4**		
- Problems arising between shifts/staff are worked through in a timely way with team/Special Care Environment (SCE) Coordinator and solutions supported by the team.	**1 2 3 4**		
- Any staff member working with a person who has dementia **must build rapport** with the individual over a **period of time until the person with dementia is comfortable,** before performing personal care, toileting, and bathing. A staff member should be teamed with the primary caregiver to aid development of rapport with individual.	**1 2 3 4**		
Leadership:			
- Leaders at all levels of the organization are knowledgeable, involved in, and supportive of, the changes needed to implement person-directed care.	**1 2 3 4**		
- The special care environment staff has confidence and trust in their leaders.	**1 2 3 4**		
- Leadership is shared, not subject to position/title; anyone can have leadership in areas at which they excel, and mentor others, as needed.	**1 2 3 4**		
- Leaders model and mentor PDC principles, spend time regularly engaging with people who have dementia and encourage staff with compliments and recognition for **things done right.** (Also see roles of team members.)	**1 2 3 4**		

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4 = a large strength that can be used to implement promising practices

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Goal: The Special Care Environment (SCE) staff operates as an interdependent interdisciplinary team with flexible roles that allow for person-directed care (PDC) practices.			
Team Structure:			
- The SCE has a clear reporting structure that allows staff to access information and support, as/when needed.	**1 2 3 4**		
- The SCE team consists of **all disciplines** and each member provides input to the SCE team (e.g., nursing, activities, social work, SCE coordinator, dietary, housekeeping, laundry, maintenance, therapy, DON and administrator, owner/CEO).	**1 2 3 4**		
- All team members have knowledge about dementia and how to communicate and work with all individuals who have dementia in the SCE, regardless of primary caregiving duties.	**1 2 3 4**		
- The SCE team and others working on the SCE (e.g., volunteers) have knowledge of person-directed care principles (PDC), and the ability to interpret them and carry them out in daily interaction with people who have dementia.	**1 2 3 4**		
- The SCE staff all work as a team.	**1 2 3 4**		
- The SCE staff members have a team identity.	**1 2 3 4**		
- The SCE has a unique name that gives it its own identity.	**1 2 3 4**		
- Team members treat family members as a resource, drawing information and expertise from family members regarding their loved ones on the SCE.	**1 2 3 4**		
- Team members encourage and include family member participation in the life of the SCE.	**1 2 3 4**		

Key: 1 = not present or is a problem area
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4 = a large strength that can be used to implement promising practices

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Goal: The Special Care Environment (SCE) staff operate as an interdependent interdisciplinary team with flexible roles that allow for person-directed care (PDC) practices.			
Certified Nursing Assistant's Role (CNA):			
- Engages in and leads activities with people who have dementia.	**1 2 3 4**		
- Delegates to and/or educates others.	**1 2 3 4**		
- Provides ongoing input into care planning and activities.	**1 2 3 4**		
- Provides input in administrative/team issues/decisions.	**1 2 3 4**		
- Accesses and uses care plans daily, and submits changes promptly to SCE coordinator, nurse, medical technician, activities professional, etc.	**1 2 3 4**		
- Identifies individuals based on their care plan.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Able to prioritize PDC interactions over tasks that are not vital to care (has minimal housekeeping duties so can spend time with PDC).	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Nursing Role (and Medical Technicians):			
- Provides team leadership and role modeling.	**1 2 3 4**		
- Possesses skill in, and conducts, assessments.	**1 2 3 4**		
- Uses training and mentoring in supervisory skills.	**1 2 3 4**		
- Knowledgeable in, and practices, ways to empower Certified Nursing Assistants (CNAs), and in ways to promote teambuilding.	**1 2 3 4**		
- Knowledgeable about medications and processes for deciding if non-medication interventions are needed, or have been exhausted, before administering PRN medication for behavior symptoms.	**1 2 3 4**		
- Proficient at documentation that is specific, and avoids negative labels.	**1 2 3 4**		
- Engages in activities with people who have dementia.	**1 2 3 4**		
- Delegates to and/or educates others.	**1 2 3 4**		
- Provides ongoing input into care planning and activities.	**1 2 3 4**		
- Provides input in administrative/team issues/decisions.	**1 2 3 4**		
- Accesses, uses and updates care plans daily (as needed).	**1 2 3 4**		
- Identifies individuals based on their care plan.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Able to prioritize PDC interactions over tasks that are not vital to care.	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Social Work Role:			
- Provides support to the family in coping with loved one's changes. Encourages families to have positive involvement and to receive education on dementia.	**1 2 3 4**		
- Works as a liaison between families and the SCE.	**1 2 3 4**		
- Effectively uses families as a team resource.	**1 2 3 4**		
- Serves as leader for quality of life and rights issues.	**1 2 3 4**		
- Serves as the person with dementia's advocate.	**1 2 3 4**		
- Engages in activities with people who have dementia.	**1 2 3 4**		
- Delegates to, and/or educates others.	**1 2 3 4**		
- Provides ongoing input into care planning and activities planning.	**1 2 3 4**		
- Works with SCE team to develop people's social histories.	**1 2 3 4**		
- Provides input in administrative/team issues/decisions.	**1 2 3 4**		
- Accesses and uses care plans daily.	**1 2 3 4**		
- Identifies individuals based on their care plan.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Able to prioritize PDC interactions over tasks that are not vital to care.	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Activities Professional Role:			
- Conducts activities while modeling and encouraging activity participation to develop staff skills and comfort in engaging in activities with people who have dementia.	**1 2 3 4**		
- Plans, models and teaches Ability Centered Care (ACC) programming to all staff.	**1 2 3 4**		
- Delegates to, role-models, and educates others on leading activities for individuals with dementia.	**1 2 3 4**		
- Facilitates/organizes specialized activities.	**1 2 3 4**		
- Monitors/reorders activity supplies that remain in the SCE.	**1 2 3 4**		
- Provides support, encouragement, resources, and education to families on techniques for positive interactions and successful activity-based visits with loved ones in the SCE.	**1 2 3 4**		
- Receives ongoing education and stays up-to-date in the latest and innovative Alzheimer's/dementia activity therapies.	**1 2 3 4**		
- Conducts functional assessments of individual's **abilities**.	**1 2 3 4**		
- Provides ongoing input into care planning and activities and **seeks routine input from people with dementia** on activities planning.	**1 2 3 4**		
- Provides input in administrative/team issues/decisions.	**1 2 3 4**		
- Accesses, reviews, and updates care plans.	**1 2 3 4**		
- Identifies individuals based on care plan.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Able to prioritize PDC interactions over tasks that are not vital to care.	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Director of Nursing Role (DON)*			
- The Director of Nursing and Special Care Environment Coordinator are partners of **equal standing** in leadership.	**1 2 3 4**		
- Supports, encourages and empowers staff to do jobs.	**1 2 3 4**		
- Knowledgeable about all types of dementia, causes of delirium, reversible dementia symptoms, and working effectively with individual's behavior symptoms*****.	**1 2 3 4**		
- Leads, mentors, models, and encourages the team to implement person-directed care (PDC) concepts.	**1 2 3 4**		
- Engages in activities, and will model activity participation with individuals to encourage other staff to do so.	**1 2 3 4**		
- Delegates and/or educates others.	**1 2 3 4**		
- Provides ongoing input into care planning, activities planning, environment, and staff/team development*****.	**1 2 3 4**		
- Provides and **asks** staff, families, individuals, etc., for input on administrative/team issues/decisions.	**1 2 3 4**		
- Accesses and uses care plans regularly. May not be appropriate to do so daily, based on responsibilities. Does have role in reviewing care plans for PDC practices, appropriate medication use, etc., every week.	**1 2 3 4**		
- Identifies individuals based on care plan.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Encourages and models the flexibility to prioritize PDC interactions over tasks that are not vital to care.	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		
*** = Duties/skills/knowledge SCE Coordinator can have.**			

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Special Care Environment (SCE) Coordinator Role*			
- Provides leadership to SCE and team, working closely in partnership with the DON on an **equal footing** in leadership.	**1 2 3 4**		
- Manages the "big picture," coordinating program planning and management roles (training, policies, environment, etc.).	**1 2 3 4**		
- **Is a specialist** in dementia care issues and programming*****.	**1 2 3 4**		
- Advocates for the SCE, the team, and people with dementia's needs, ensuring adequate staffing, budget and activities.	**1 2 3 4**		
- Supports, encourages, mentors, and empower the staff and team to work collaboratively, and take on special projects and roles in which they are interested.	**1 2 3 4**		
- Leads, mentors, models, and encourages the team to implement person-directed care (PDC) and ability-centered care (ACC).	**1 2 3 4**		
- Engages in activities, and models activity participation to help staff engage comfortably in activities with individuals.	**1 2 3 4**		
- Role–models, teaches delegation, and educates others.	**1 2 3 4**		
- Provides leadership and guidance in care planning and activities planning; involving the SCE team, people with dementia, and their families in the processes*****.	**1 2 3 4**		
- Leads and solicits staff, team, family, and people with dementia's input on administrative/team issues/decisions.	**1 2 3 4**		
- Knows the people with dementia's families and encourages their help, feedback, and positive participation in the SCE.	**1 2 3 4**		
- Accesses, reviews, updates, and uses care plans daily.	**1 2 3 4**		
- Identifies individuals based on care plan.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Encourages and models the flexibility to prioritize PDC interactions over tasks that are not vital to care.	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		
*** = Also see Director of Nursing Role for possible duties.**			

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Administrator Role:			
- Communicates with CEO and/or owners regularly about the SCE; and advocates and gains support for implementation of PDC culture change, plans, and changes that need to be made.	**1 2 3 4**		
- Periodically, is physically present on SCE, visible to, and **knows** staff, people with dementia, and their families.	**1 2 3 4**		
- Feeds the enthusiasm of SCE team, especially during times of change. Recognizes and rewards creativity.	**1 2 3 4**		
- Delegates to, and/or educates others; especially by harnessing the energy of staff who are interested in certain ideas/roles by putting them into that specialty/position.	**1 2 3 4**		
- Allows the SCE team to make decisions and manage the SCE in the best interest of the people with dementia.	**1 2 3 4**		
- Hires good people and supports them.	**1 2 3 4**		
- Knows the individuals who live in the SCE.	**1 2 3 4**		
- Periodically, makes it a point to engage in activities and model activity participation in order to be a role model to staff and to get to know the people with dementia in the SCE better.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Supports, empowers, encourages, and rewards staff for implementing person-directed care practices (PDC).	**1 2 3 4**		
- Supports the prioritizing of PDC interactions over tasks that are not vital to care, and ensures that it is reflected in policies and job descriptions as well as practices.	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Dietary Role:			
- Knows and advocates for individual's dietary preferences/needs.	**1 2 3 4**		
- Knows the life stories of the people in the SCE.	**1 2 3 4**		
- Engages in activities, especially during times when meals are served.	**1 2 3 4**		
- Delegates to, and/or educates others.	**1 2 3 4**		
- Provides ongoing input into care planning and activities planning, and shares observations of people with dementia with rest of the team.	**1 2 3 4**		
- Provides input into administrative/team issues/decisions.	**1 2 3 4**		
- Accesses and uses care plans.	**1 2 3 4**		
- Identifies individuals based on care plan.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Able to prioritize PDC interactions over tasks that are not vital to care.	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		
Housekeeping/Laundry Role:			
- Communicates with families and individuals about personal belongings.	**1 2 3 4**		
- **Included in SCE team shift reporting.**	**1 2 3 4**		
- Engages people who have dementia in activities, especially when in their rooms; and encourages activities of daily living, reminiscence, etc.	**1 2 3 4**		
- Delegates to, and/or educates others.	**1 2 3 4**		
- Provides ongoing input into care planning and activities planning, and shares observations of people with dementia with rest of the team.	**1 2 3 4**		
- Provides input for administrative/team issues/decisions.	**1 2 3 4**		
- Knows the life stories of the people in the SCE.	**1 2 3 4**		
- Identifies vital care plan issues for individuals.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Able to prioritize PDC interactions over tasks that are not vital to care.	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
TEAM STRUCTURE AND ROLES	**Weak - Strong**		
Maintenance Role:			
- Offer resources for activities when appropriate, e.g., help put together toolbox activities, help plan 1:1 tasks that people with dementia can do safely, give input to SCE team about interests that they perceive individuals to have, and help brainstorm special activities for people with mechanical interests.	**1 2 3 4**		
- Works with SCE team to make special accommodations to the environment that enhance people with dementia's quality of life and supports retention of their abilities.	**1 2 3 4**		
- Shares observations of people with dementia with rest of the team.	**1 2 3 4**		
- Engages in activities with people who have dementia.	**1 2 3 4**		
- Delegates to, and/or educates others.	**1 2 3 4**		
- Provides ongoing input into care planning and activities planning.	**1 2 3 4**		
- Provides input in administrative/team issues/decisions.	**1 2 3 4**		
- Knows the life stories of the people who are in the SCE.	**1 2 3 4**		
- Identifies individuals' vital care plan issues.	**1 2 3 4**		
- Perceives their role as a vital part of the SCE team.	**1 2 3 4**		
- Able to prioritize PDC interactions over tasks that are not vital to care.	**1 2 3 4**		
- Feel empowered to do their jobs.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
STAFF KNOWLEDGE AND TRAINING	**Weak - Strong**		
Attitudes:			
- Staff value the **person first,** knows him or her as an individual, and sees the dementia as a disability of certain parts of the brain rather than thinking of the person in terms of their disease and symptoms first.	**1 2 3 4**		
- The staff member's focus is on the **quality of their interaction** with people who have dementia, and know that this is more important than performing "tasks" (e.g., making beds, passing towels, etc.).	**1 2 3 4**		
- **Labels** such as "feeder," "wanderer," "screamer," etc., are **never used to describe individuals** out of respect for who they are as a person. Staff believes this is so important that **they remind each other** when someone slips and uses negative labeling.	**1 2 3 4**		
- Staff members are aware of, and believe in, the strengths and potential of the person with dementia; and are always seeking ways to use strengths to enhance the individual's quality of life.	**1 2 3 4**		
- The attitudes that staff have towards behavior symptoms that the people in their care are displaying reflect respect, the knowledge that **all behavior is communication,** and they seek to learn what the person is saying through the behavior.	**1 2 3 4**		
- Staff members seek to understand the unmet social and emotional needs, as well as physical needs, of people with dementia when working with behavior symptoms.	**1 2 3 4**		
- When staff members recognize a situation that is not in keeping with PDC, they take action and **do** something about it.	**1 2 3 4**		
- Personal conversations among staff are allowed **only** on off-floor time, never in front of people with dementia.	**1 2 3 4**		

Key: 1 = not present or is a problem area
2 = is present but could be improved upon
3 = is present in a satisfactory way and could be used as a strength
4 = a large strength that can be used to implement promising practices

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
STAFF KNOWLEDGE AND TRAINING	**Weak - Strong**		
Attitudes (continued):			
- Staff beliefs about dementia reflect current and accurate knowledge in the field, the multiple causes for dementia symptoms, and the multiple types of dementia. (See Appendix on types of dementia.)	**1 2 3 4**		
- All staff members, regardless of their position, feel they are an important part of the SCE team, are important to the people in their care, and feel good about their work.	**1 2 3 4**		
- People who work in the SCE feel that they would like to live there if they had dementia. **(True test of PDC.)**	**1 2 3 4**		
Training Resources and Frequency:			
- All staff members have regular, paid opportunities to acquire training, especially on dementia issues, which is sufficient to provide them with the confidence to do their jobs well.	**1 2 3 4**		
- Mentoring is valued in the culture. There are leadership/senior staff members who mentor others as a routine practice.	**1 2 3 4**		
- Staff can identify who their mentors are, and benefit from the mentoring process.	**1 2 3 4**		
- All staff have input into training topics and opportunities in which they are interested.	**1 2 3 4**		
- The CEO supports supervisors making training decisions, and there is an adequate training budget for needs of SCE.	**1 2 3 4**		
- Potential constraints that would prevent staff from being trained are planned and budgeted for, so that staff can truly benefit from thorough training, i.e., **not** just a few minutes between shift changes.	**1 2 3 4**		
- **Internal**—Books, guides, videos, mentors, and staff/team meetings are all available and used to develop staff, and to get CEU credits.	**1 2 3 4**		
- **External**—Staff are paid to attend workshops, conferences (e.g., Alzheimer's Association Dementia Specialist Training).			

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
STAFF KNOWLEDGE AND TRAINING	**Weak - Strong**		
Best/Promising Practice Knowledge and Topics for Education Goal: Staff are supported in order to develop confidence and expertise in dementia care and other skills/knowledge needed to perform their jobs with confidence and enjoyment.			
- Knowledge and understanding of person-directed care and of ability-centered care programming and implementation.	**1 2 3 4**		
- Special dementia focused training, e.g., "Best Friends Approach," "TimeSlips Creative Story Telling Process," "Alzheimer's Association," "Dementia Specialist."	**1 2 3 4**		
- Have a strong understanding of Alzheimer's disease.	**1 2 3 4**		
- Related types of dementia—strong understanding of different types of dementia people in the SCE may have.	**1 2 3 4**		
- Knowledge of each person's dementia and how their symptoms, changes in perception, etc., are experienced.	**1 2 3 4**		
- Shared observation and problem solving process used for understanding behavior symptoms (pages 18 – 21).	**1 2 3 4**		
- Potentially problematic ways of interacting with persons who have dementia vs. positive, successful approaches.	**1 2 3 4**		
- Skills for communicating with people who have dementia, especially familiar with non-verbal signals.	**1 2 3 4**		
- Clinical Standards of Practice (ADLs, bathing, etc.)	**1 2 3 4**		
- Pain management, specifically for people who have dementia.	**1 2 3 4**		
- Nutritional issues for people with dementia.	**1 2 3 4**		
- Activities planning, engagement, groups and pacing of energy levels, and involvement throughout the day.	**1 2 3 4**		
- Medications and medication management.	**1 2 3 4**		
- Management of concurrent medical conditions.	**1 2 3 4**		
- Recognizing and preventing reversible causes of dementia symptoms (e.g., dehydration, urinary tract infections).	**1 2 3 4**		
- Team building, communication, and delegation skills.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
POLICIES AND PROCEDURES	**Weak – Strong**		
Goal: Policies and procedures support person-directed care (PDC) practices for people with dementia and staff, and use quality improvement processes to guide change in the SCE.			
Quality Improvement (QI) Process for the SCE:			
- Information being measured is meaningful to PDC practices, and the team values the collection of the data; because they are tracking the results together and making decisions/changes based on the results.	**1 2 3 4**		
- **Outcomes** are measured, meaning the results of what **happens** to people in the SCE because of certain practices. (Customer satisfaction, tracking numbers of hours, monetary expenditures, etc., are not considered outcomes.)	**1 2 3 4**		
- Poor measures are seen as **baselines from which** to improve, and opportunities to learn and try new things (not a punitive measure that negatively impacts the team).	**1 2 3 4**		
- All staff working in the SCE know about the QI process—how the results are measured, the role they have in results, goals for future, and ways the goals are being pursued.	**1 2 3 4**		
- Information about the SCE's QI process is routinely shared with staff, and the results are used to make decisions and implement new goals by the SCE team.	**1 2 3 4**		
- The SCE has a "Quality of Life Committee" that monitors the environment for QOL issues.	**1 2 3 4**		

Key: 1 = not present or is a problem area
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3 = is present in a satisfactory way and could be used as a strength
4 = a large strength that can be used to implement promising practices

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
POLICIES AND PROCEDURES	**Weak – Strong**		
Person-Directed Care Practices:			
- Job descriptions and policies reflect person-directed care (PDC) values; such as ability to participate in activities, and reinforcement for PDC instead of focusing on getting all busy work done like "making beds."	**1 2 3 4**		
- Staff members at all levels have the autonomy to make decisions within a framework of clearly communicated guidelines.	**1 2 3 4**		
- Staff are valued, and treated with respect.	**1 2 3 4**		
- Leaders value and reinforce person-directed care practices in staff behavior and nurture PDC practices through rewards and disciplinary actions.	**1 2 3 4**		
- The same staff works with the same people every day to preserve familiarity and build relationships that can enhance the care plan. Even "substitute" staff have people they regularly care for, and people with dementia know the staff.	**1 2 3 4**		
- Because of the team approach and work sharing, all staff know all of the people with dementia and **can respond to anyone's needs promptly, when asked, or if the primary caregiver is busy.**	**1 2 3 4**		
- Whenever there is a change in staff assignments, the new staff member shadows and interviews the primary caregiver to learn about the person with dementia's preferences and to build rapport with that person.	**1 2 3 4**		
- Any staff working with a person who has dementia **must build rapport** with the individual for a period of time until the person with dementia is comfortable, before performing personal care, toileting, and bathing.	**1 2 3 4**		
- PDC solutions and ideas are regularly discussed by the team through the use of **Learning Circles** (see Appendix). Solutions are advocated for by the team leaders when changes need to be made.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
POLICIES AND PROCEDURES	**Weak - Strong**		
Person-Directed Care Practices (continued):			
- Feedback shared with staff about person-directed care practices is highly positive. Negative staff comments about changes should be analyzed, and alternatives discussed.	**1 2 3 4**		
- Everyone is regularly asked for feedback on how PDC practices are working, including people with dementia, family, and SCE team members.	**1 2 3 4**		
Special Care Environment:			
- The special care environment (SCE) has its own budget, which is adequate for providing for needs of people with dementia, activities, staff, and training.	**1 2 3 4**		
- Staffing is realistic and adequate to address social, emotional, and physical needs of people with dementia, as well as their quality of life.	**1 2 3 4**		
- There is a designated SCE coordinator providing leadership.	**1 2 3 4**		
- There is a designated lead person (each shift/weekends) who interfaces with supervisor (on call) and physicians, who has the skills and knowledge to use the physician as a resource when issues arise (avoids use of inappropriate medication orders – see medication section).	**1 2 3 4**		
- Staff training is available to promote confidence and expertise.	**1 2 3 4**		
- Practice tips are posted as reminders.	**1 2 3 4**		
- There are clear, written criteria for SCE admission, discharge, and exclusion. The criteria assure that the people who are in the environment are appropriate for the programming and their peers. People with high medical needs or hospice services are able to be transferred. People with early stage dementia are excluded and stay with the general population in order to avoid duress.	**1 2 3 4**		
- The special care environment (SCE) has its own Quality Improvement (QI) plan. The staff know it and participate.	**1 2 3 4**		

Person-Directed Dementia Care Assessment Tool

Name – Environment/Facility	Name – Observer	Time Period of Observation

Topic and Details	Scale	Strengths	Improvement Areas
POLICIES AND PROCEDURES	**Weak - Strong**		
Special Care Environment (continued): - The criteria for admission/discharge are realistic for persons with dementia, and there are provisions included that specify how problems are addressed proactively to promote discharge. - SCE policies and procedures are reviewed with families and individuals before admission and as needed thereafter, including admission and discharge policies. Families/individuals are given copies of these policies.	**1 2 3 4** **1 2 3 4**		
Person with dementia's involvement in decision making, and choices: - The SCE (or larger organization) has a resident council with people from the SCE represented. - People with dementia and their representatives regularly provide input into their care plan. - People with dementia are given opportunities and options to make day to day decisions/choices (e.g., food, clothing, rising and bed times). - People's preferences are honored and respected (e.g., likes/dislikes, schedule, participation preferences). - Specifically: Policies and procedures allow for bathing, meals, etc. and take account of personal preferences/choices and flexibility (e.g., sleep in and have a light breakfast in the environment, bathe/shower at time of day desired or beneficial for health issues, and as often as desired not on the set schedule). - People living in the SCE, are allowed to have family present as often as desired and are given support and privacy.	**1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4** **1 2 3 4**		

PERSON-DIRECTED DEMENTIA CARE ASSESSMENT TOOL APPENDIX

Resource	Location
INTRODUCTION	
Webcast on introduction to Person-directed care. **Plan Templates** and Sample of each in use.	Introduction to Person-Directed Care Part 1: Webcast and power point. http://dhfs.wisconsin.gov/aging/genage/alzfcgsp.htm **Assessment Tool Use Sample** **Working Document** Sample and Template **Action Plan** Sample and Template Attachments.
AIMS, DISCUS and MOSES Assessment Tools	**Abnormal Involuntary Movement Scale—**http://www.atlantapsychiatry.com/forms/AIMS.pdf **Dyskinesia Identification System Condensed User Scale** http://www.dmr.state.ct.us/publications/centralofc/hcs_ma2000-2.htm **Multidimensional Observation Scale for Elderly Subjects** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=3598087&dopt=Abstract
ENVIRONMENT	
Guidelines for Alarm Use	Attachment. **"Personal Alarms: Safety Device or Hazard?"** By Julie Button, Ombudsman, **Wisconsin Board on Aging and Long Term Care**
Designing Environments for People with Dementia	
IDEAS: Innovative Designs in Environments for an Aging Society—Articles	http://www.ideasconsultinginc.com/articles.asp Includes uses of color, building design, how to design bathing rooms, effects of environment on people with dementia.
Creating Successful Dementia Care Settings By **IDEAS**	**Health Professions Press—**Three video and four book set http://www.healthpropress.com/store/calkins-2718/index.htm
The Center for Health Design Resources—Articles and other resources	http://www.healthdesign.org/resources/pubs/articles/essays/alzheimers_design.php
Color your World and Theirs Article on effects of color on people with dementia.	The Spark of Life newsletter, May 2004. **Dementia Care Australia** http://www.dementiacareaustralia.com/docs/Newsletter_May_2004.pdf Or: http://www.dementiacareaustralia.com/newsletter.html
The Complete Guide to Alzheimer's Proofing Your Home	By Mark Warner, **Ageless Design** http://www.agelessdesign.com/ or http://alzstore.com/Shop/Category.php?CategoryID=6

PERSON-DIRECTED DEMENTIA CARE ASSESSMENT TOOL APPENDIX

Resource	Location
Research on Signage Guidelines	(Information is referenced in tool) By Jane Verity, **Dementia Care Australia** from **"Rekindling the Spark of Life, Joyful Activities for people with Dementia"**
CARE PLAN ASSESSMENTS	
The Assessment of Discomfort in Dementia (ADD) Protocol	By Christine Kovach, PhD, RN. **University of Wisconsin- Milwaukee,** pain assessment tool now part of new manual—**The Serial Trial Intervention Training Manual** Available at the **Center on Age and Community—** http://www.uwm.edu/Dept/ageandcommunity/Resources/products.html
National Alzheimer's Association Guidelines for Dementia Care Practice	**The Alzheimer's Association Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes—**Was developed from the latest evidence in dementia care research and the experience of professional direct care experts. http://www.alz.org/qualitycare/dementia_care_pract.asp
The basic needs of people with dementia not commonly met in long-term care settings.	(Information is referenced in tool) By Jane Verity, **Dementia Care Australia** from "**Rekindling the Spark of Life, Joyful Activities for People with Dementia**": http://www.dementiacareaustralia.com/tapes.html And Tom Kitwood "**Dementia Reconsidered**" **University of Bradford, England** http://www.dementiacareaustralia.com/shop.html
Twenty Questions Favorite Things	Attachment. Developed by **Luther Manor Adult Day Services**, Beth Meyer Arnold Director http://www.luthermanor.org/adultday.asp
Applying Person-Directed Care to the Care Planning Process	**Webcast (Part 2), Power Point and Handout "Applying Person-Directed Care to Dementia Care Planning" document on process with before and after sample care plans.** Attachment. Developed as part of the study by Cathy Kehoe, Alzheimer's Service Developer Wisconsin Department of Health and Family Services. http://dhfs.wisconsin.gov/aging/genage/alzfcgsp.htm
Indicators of Well-Being and Ill-Being in People with Dementia	From the **Well-Being Profile** developed by Errollyn Bruse and the Bradford Dementia Group, University of Bradford Bradfordshire, England. To purchase contact: Dawn Brooker, D.J.Brooker@Bradford.ac.uk Description: http://www.brad.ac.uk/health/dementia/dcm/courses/coursecontent.php

PERSON-DIRECTED DEMENTIA CARE ASSESSMENT TOOL APPENDIX

Resource	Location
Assessing Strengths in People with Dementia for Activities Programming	**The Functional Assessment Tool for Activity Professionals** **Functional Assessment Tool Kit** **Creative Solutions to Dementia Programming Part 1** VHS or DVD format, 2 hrs of continuing education NCCAP approved **Creative Solutions to Dementia Programming Part 2** VHS or DVD format, 1.5 hrs of continuing education NCCAP approved. Contact: Cindy Musial Olson cmolson@activitiespro-ed.com or 1-920-457-3272
CARE PLAN CONTENT	
Using "I" statements for care plan outcomes	**Dementia Quality of Life Outcomes Planning Tool** (on DHFS web site page) http://dhfs.wisconsin.gov/aging/dementia/outcomes.htm **Narrative Care Plans** (Christine Krugh, Riverview Health Center, ckrugh@riverview-retirement.org) **Presentation:** www.hce.org/Education/PersonDirectedCarePlan.ppt
Ability Centered Care or **Activity Based Care**	**The State of Illinois Administrative Code:** http://www.ilga.gov/commission/jcar/admincode/077/077003000U70300R.html (see attachment for rest of code) **Activity Based Care—Alzheimer's Association** www.alz.org or http://www.alz.org/services/activitybasedcare.asp
ACTIVITIES	
Activity Pacing Throughout the Day	Attachment. Description of activity rhythm across the day, developed during the study as a resource for suggested practice.
Developing plans, programs and activities for families who visit	**Alzheimer's Disease—Activity Focused Care**, **2nd Edition**, by Carly Hellen http://www.alzheimersbooks.com/072a%20ActivityFocused.html
ACTIVITIES: Promising / Best Practice	
Clubs to engage residents in meaningful interactions and meet core needs	"**Rekindling the Spark of Life, Joyful Activities for People with Dementia"** Structured Club Models to meet resident's social and emotional needs for well-being. Presentation can be purchased in a 3 part video training set. By Jane Verity, **Dementia Care Australia** http://www.dementiacareaustralia.com/articles.html#joyful
Creativity and dementia	**Time Slips Creative Story Telling Process Training/Video**, By Anne Basting **"Creativity and Dementia" a Guide** By Anne Basting, Director, University of WI-Milwaukee Center on Age and Community http://www.uwm.edu/Dept/ageandcommunity/Resources/products.html

PERSON-DIRECTED DEMENTIA CARE ASSESSMENT TOOL APPENDIX

Resource	Location
	In The Moment training web site – using the creative and spontaneous activities and non-verbal communication with people who have dementia. By Karen Stobbe. http://www.in-themoment.com/
	ARTCARE – developing an artist in residence program for activities. **Luther Manor Adult Day Services—**http://www.luthermanor.org/ARTCARE.pdf http://www.luthermanor.org/pcc.pdf
Relationship building with people who have dementia	**Accepting the Challenge** training DVD. 1-919-832-3732 www.alznc.org Teepe Snow, Program Director Eastern North Carolina Alzheimer's Chapter
	"**The Best friend's Approach to Dementia Care**" (Series of 5 books and a video) By Virginia Bell and David Troxel—http://www.healthpropress.com/store/alzheimers.htm
	The Validation Training Program—Simple Techniques for Communicating with People with "Alzheimer's- Type Dementia," Second Edition By Naomi Feil, M.S.W. http://www.healthpropress.com/store/alzheimers.htm
PROBLEM-SOLVING BEHAVIOR COMMUNICATION	
Wisconsin Alzheimer's Association Chapters **Dementia Specialist Training**	**Greater Wisconsin Chapter—**http://www.alzgw.org/ **South Central Wisconsin Chapter—**http://www.alzwisc.org/ **Southeastern Wisconsin Chapter—**http://www.alzheimers-sewi.org/
Processes for observing, documenting and problem solving	Video by **IDEAS** showing influence of environment on behavior from the resident's point of view. **Minimizing Disruptive Behaviors** http://www.healthpropress.com/store/calkins-2769/index.htm#minimizing
	Behavior Analysis Worksheet developed for use during project. Attachment.
	"Bathing Without A Battle" Video & Package http://www.bathingwithoutabattle.unc.edu/MainFrame_MainPage.htm
	Alzheimer's Disease – Activity Focused Care, **2nd Edition**, by Carly Hellen Extensive guide for behavior profiling, observation and analysis. http://www.alzheimersbooks.com/072a%20ActivityFocused.html
	Training Manual for Alzheimer's Caregivers (on DHFS web site) by Cathy Kehoe http://dhfs.wisconsin.gov/aging/genage/caregivers.htm Accompanying Article **Becoming an Alzheimer's Caregiver: Replacing Good Intentions with Powerful Skills** - Attachment.
	Behaviors in Dementia Best Practices for Successful Management Edited by Mary Kaplan, M.S.W., & Stephanie Hoffman, Ph.D. http://www.healthpropress.com/store/kaplan-2432/index.htm

PERSON-DIRECTED DEMENTIA CARE ASSESSMENT TOOL APPENDIX

Resource	Location
	Dealing with Physical Aggression in Caregiving **Physical and Non-Physical Interventions (2 Part Video)** Developed by Carly Hellen , OTL/R, and Peter Sternberg, L.C.S.W. http://www.healthpropress.com/store/hellen-TN13/index.htm
	Caring for People with Challenging Behaviors, Essential Skills & Successful Strategies in Long-Term Care. By Stephen Weber Long http://www.healthpropress.com/
MEDICATION USE (OR NOT TO USE)	
Accessing a dementia diagnostic expert	Attachment. **Wisconsin Alzheimer's Institute Affiliated and Other Diagnostic Clinics** http://www.medsch.wisc.edu/wai/
	Attachment. **Suggested form for Tracking Target Behavior** – allows for specific descriptions and solutions. (Courtesy of **Hillview Health Care,** LaCrosse WI
STAFF KNOWLEDGE	
Non-Alzheimer's types of dementia	**Handout on Types of Front-temporal Dementias.** Attachment. **Association for Front-temporal Dementias** http://www.ftd-picks.org/ **Lewy Body Dementia Association** http://www.lewybodydementia.org/ **E-Medicine** http://www.emedicine.com/NEURO/topic436.htm Frontal disorders http://www.emedicine.com/NEURO/topic140.htm Frontal Temporal http://www.emedicine.com/NEURO/topic596.htm Lewy Body Dementia
TEAM COMMUNICATION	
Learning Circles	Attachment **Description of Learning Circle Process** Process developed by **LaVerene Norton** of **Action Pact,** Milwaukee, Wisconsin http://www.culturechangenow.com/tnc.html

PERSON-DIRECTED DEMENTIA CARE ASSESSMENT TOOL APPENDIX

PERSON-DIRECTED CARE RESOURCES

Eden Alternative—www.edenalt.com

Pioneer Network—www.pioneernetwork.net

Wellspring—www.wellspringis.org

Action Pact – Culture Change Now—http://www.culturechangenow.com/

Wisconsin Adult Day Services Association (WADSA)—http://www.wadsa.org/code/home.php?area=1

The Almost Home Film – PBS Documentary and Culture Change Learning Site—http://www.almosthomedoc.org/

PEAK - Promoting Excellent Alternatives in Kansas nursing homes—http://www.k-state.edu/peak/
Book: **Pioneering Change** can be downloaded off the web site.

Shifting from a Medical Model of Dementia Care to a New Culture of Person-Directed/Centered Care
"Why Implement Person-Directed Care?" Christa Monkhouse, Attachment from lecture.
"Journal of Social Work and Long Term Care," article by Christa Monkhouse
"Beyond the Medical Model: The Eden Alternative in Practice a Swiss Experience" p. 339
http://www.haworthpress.com/store/E-Text/View_EText.asp?a=3&fn=J181v02n03_TOCFM&i=3%2F4&s=J181&v=2

OTHER ASSESSMENT TOOLS

Artifacts of Culture Change Tool, Centers for Medicare and Medicaid (CMS), http://siq.air.org/portfolio.asp?RID=179
The Artifacts of Culture Change tool is a self-evaluation questionnaire tool for nursing homes to examine how their practices compare to culture change innovator homes. Items include a large set of changes made to policies, resident autonomy, staffing enhancements, and to buildings/environments. It is a self-evaluation questionnaire, not a regulatory tool.

Culture Change Staging Tool—Web-based questionnaire known as the **Culture Change Staging Tool** can assess nursing homes in 12 domains commonly found in culture change homes. http://www.myinnerview.com/ccstagingtool.php

Person Directed Care Toolkit - TMF Health Quality Institute Many creative ideas for implementing culture change.
http://www.tmf.org/nursinghomes/pdc/index.htm

PERSON-DIRECTED DEMENTIA CARE ASSESSMENT TOOL APPENDIX

Qualis Health is one of a group of 22 QIOs who conducted the Person-Directed Care (PDC) pilot project. **Idaho and Washington** were both part of the project. The pilot ran from October 2004 to July 2005 and encompassed transformational practices and procedures in three domains, workplace practice, care practice, and environment. http://www.qualishealth.org/qi/pdc.cfm

Colorado Person-Directed Care Project—http://www.cfmc.org/nh/nh_pdc-overview.htm

St. Louis Accord—http://www.riqualitypartners.org/st_louis_accord/index.php

Rhode Island—
http://www.stratishealth.org/clientuploads/pdfs/11_05_Continuum.pdf?PHPSESSID=193a34a882196648d72a5f631ca36c50

Indiana State Department of Health Guidelines for Special Care Units—http://www.in.gov/isdh/regsvcs/ltc/alzinfo/index.htm

National Clearing House on the Direct Care Workforce—http://www.directcareclearinghouse.org/index.jsp

Person Directed Care (PDC) Initiative—Six Georgia nursing homes worked to explore new approaches to long-term care as part of a multi-state pilot program conducted by the Centers for Medicare & Medicaid Services (CMS).The goal is to test materials that will help staff tailor services to the people under their care. This person-directed approach focuses on learning more about the residents—their individual histories, hobbies, preferences and routines—as well as building relationships among staff. The pilot also stresses involvement of all staff in a nursing home and increasing their input into decision-making. http://www.gmcf.org/nursing_home/pdc.shtml

Wisconsin Coalition for Person-Directed Care—http://dhfs.wisconsin.gov/rl_DSL/NHs/nh05-014.htm

CARE Wisconsin Coalition Contacts: Krista S. Moore, Ph.D., Program Director for Master of Arts in Gerontology, Mount Mary College moorek@mtmary.edu
Nancy Tischer St. John's on the Lake, Milwaukee -subject of "Almost Home" PBS Documentary. ntischer@saintjohnsmilw.org

Wisconsin Ombudsman Web Site resources for PDC guidelines—http://longtermcare.state.wi.us/home/

OTHER RESOURCES

End Stage and Dementia White Paper University of Wisconsin Center on Age and Community
http://www.uwm.edu/Dept/ageandcommunity/documents/end_stage_dementia_and_culture_change_roundtable_white_paper_11-3-05.pdf

Virtual Dementia Tour Kit—http://www.secondwind.org/ (Click on Virtual Dementia in left hand column)
Since caregivers have never personally experienced the physical limitations of aging, dementia or life in an elder care community, becoming sensitized by means of special training is essential to provide good care. The Virtual Dementia Tour (VDT) Kit will help sensitize staff to

the issues of residents which results in better care. This powerful training tool is the offspring of a study conducted in elder care communities. The findings were so incredible that a kit was designed to assist in replicating a heightened level of sensitivity in your own facility. The VDT simulates Dementia as well as some of the physical problems associated with aging.

Alzheimer's disease and Down syndrome—E-Medicine
http://www.emedicine.com/neuro/topic552.htm

"Rise and Shine at your Leisure" A "how to" for the Five Meal a Day Plan
It is published by Riverview Health Services, Inc.,
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This publication is designed to help anyone implement the five-meal a day process, this works best when implemented by a committee, and does take an investment in equipment.

Odor Control Guidelines for Special Care Units
Attachment. This information was developed as a resource during the project.

Guide for Use of Disguised Doors and Other Preventative Exiting Strategies for People with Dementia in Facilities
Attachment, developed for Wisconsin Assisted Living facilities, but ideas applicable to any environment.