Dementia Care Mapping. National Strategy

Davies Abbott, Ian

Published: 01/03/2022

GWELLIANT CYMRU IMPROVEMENT CYMRU

PRIFYSGOL BANGOR UNIVERSITY

Dementia Care Mapping

National Strategy

2022

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

improvement.cymru

Contents

Foreword

We are a group of voices, of people living with and affected by dementia. We are an independent group free of any agency influence or oversight.

We formed because we believed that Wales would benefit from an independent voice free from any agency influence be it Health, Social Services or Third Sector for people affected by dementia.

It was thought Agencies, Researchers, and Statutory bodies would have a non-aligned sounding board or feedback on their proposals.

As a group we work closely with Improvement Cymru as we are part of a review group as a critical friend, we are also embedded in the dementia care workstreams that support the national and regional delivery of the Wales Dementia Pathway of Standards.

Dementia Care Mapping can support the implementation of the hospital charter by observing dementia care within hospital and care home settings. Dementia care mapping provides opportunities for change and promotes the good care delivered by the workforce.

Lleisiau Dementia – Voices from Wales

1. Introduction

This strategy represents a commitment that all people living with dementia should experience care, which is person-centred, safe and supports their well-being when using care services in Wales. Dementia Care Mapping (DCM) in Wales must be used to understand the experience of care from the perspective of people living with dementia and to inform positive actions to promote person-centred approaches.

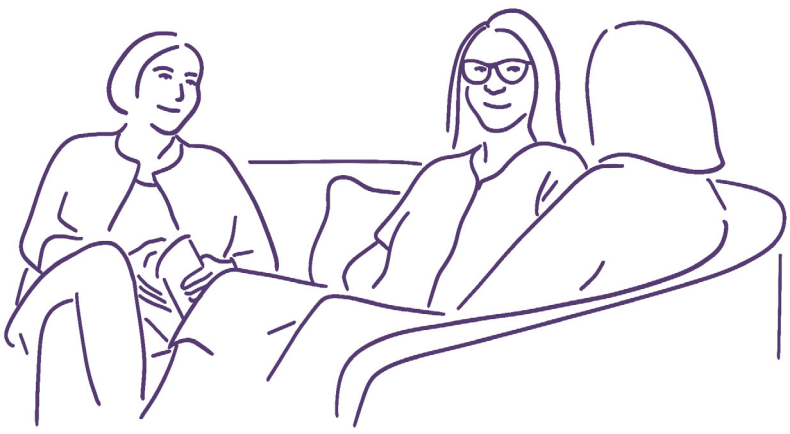
1.1 Background

This is one of several strategies to support care services to meet the *All Wales Dementia Care Pathway of Standards 2021* and supports the vision and principles of the Wales Dementia Friendly Hospital Charter 2022 (Improvement Cymru 2021).

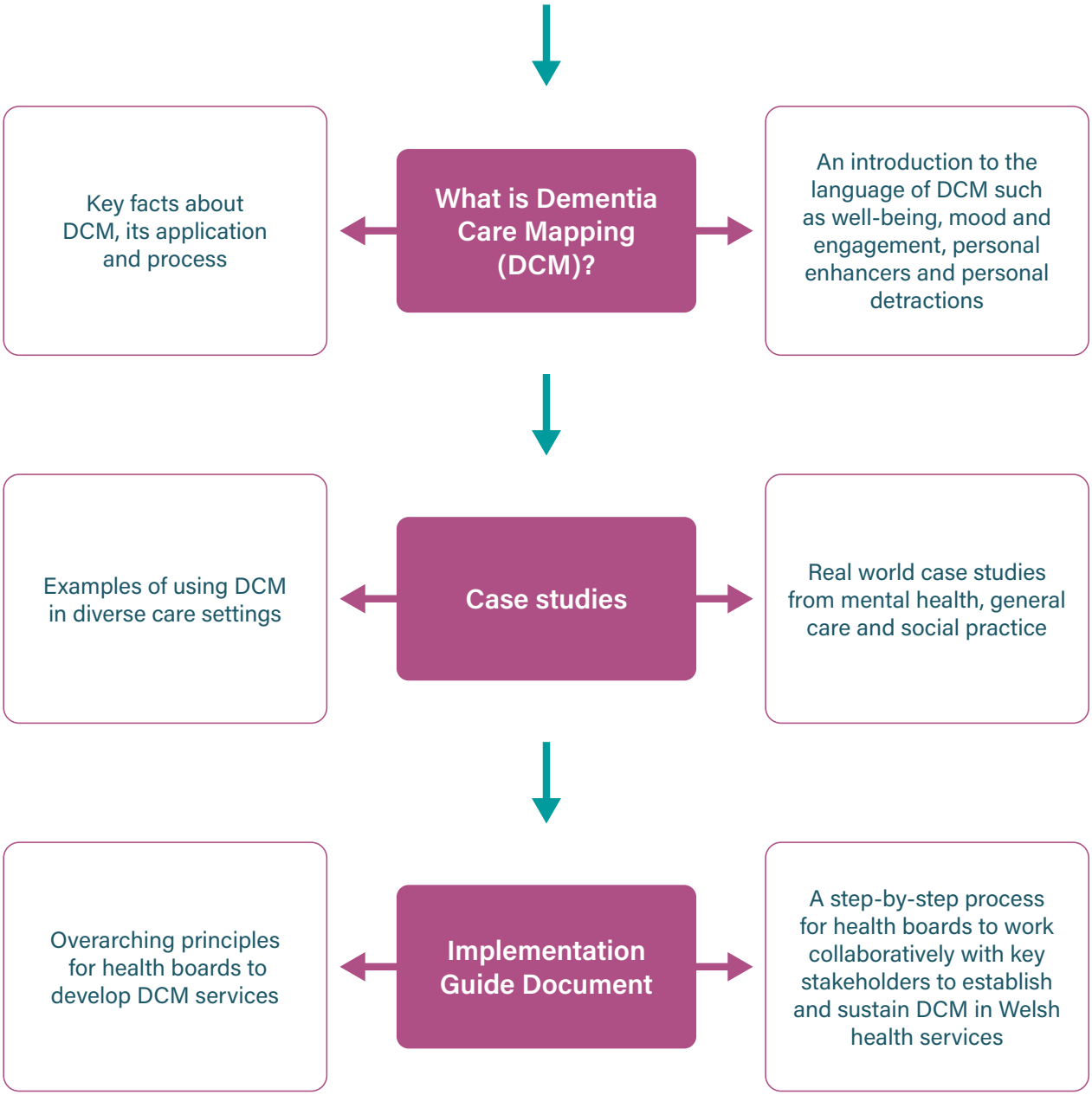
Dementia Care Mapping (DCM) has been recognised in the National Institute for Health and Clinical Excellence (2013) quality standard, *Mental well-being of older people in care homes* and subject to an evidence review by NHS England (2018), which looked at why DCM is important in accomplishing person-centred care. The *Dementia Action Plan for Wales 2018-2022* (Welsh Government, 2018) included the expanded use of DCM as an established approach to achieve and embed person-centred care for people living with dementia. The *All Wales Dementia Care Pathway of Standards* (Improvement Cymru and Welsh Government, 2021) includes DCM as one of twenty priority standards for the country:

> *Organisations and care settings providing intensive dementia care (this includes mental health and learning disabilities inpatient settings) will provide the framework and structure for Dementia Care Mapping (DCM) to become routine practice, supporting clinical reasoning and decision making. Mental health DCM services will offer DCM support to acute care, prisons and care homes settings.*

DCM was initially developed at Bradford University through the work of Tom Kitwood and Kathleen Bredin in the early 1990's. The following years have seen DCM established as the gold standard for evaluating care from the perspective of the person living with dementia, whilst the tool has continued to undergo research informed revisions. The tool is used across the world to support the delivery of person-centred dementia care.



Navigating the Guidance



1.2 Purpose and scope

This strategy, alongside the implementation guide, outlines the actions, which health boards across Wales will need to complete to support the achievement of the DCM standard in the *All Wales Dementia Care Pathway of Standards* (Improvement Cymru and Welsh Government, 2021).

Whilst some health boards will be further along in meeting the DCM standard than others, the implementation guide should be used to support local assessment, planning and delivery, and align with other interventions and approaches used to enhance dementia care.

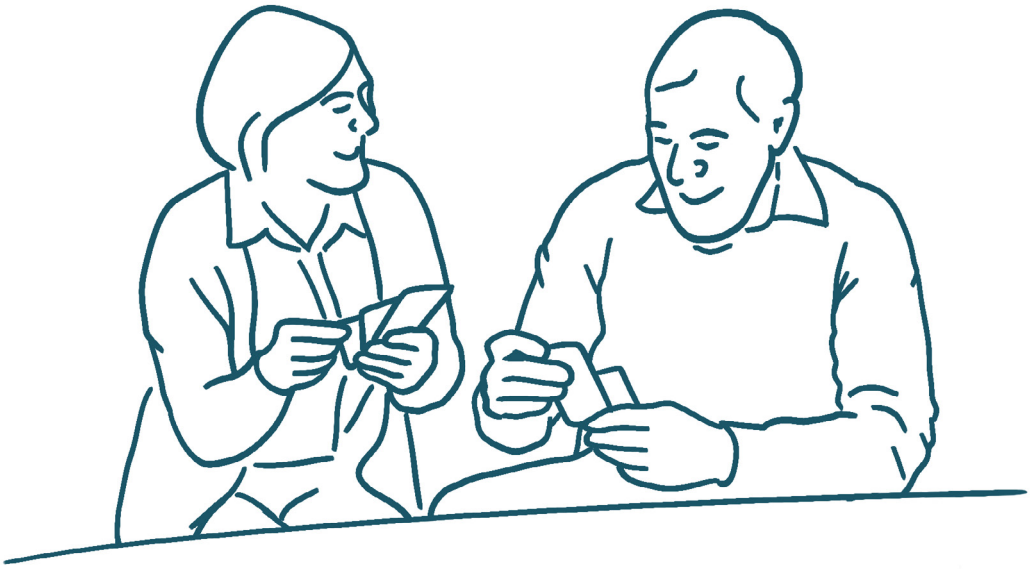
This strategy and implementation guide are primarily aimed at health board commissioners, who should identify key stakeholders and resources to achieve the DCM standard. The documents also support key stakeholders, including DCM mappers within health boards, to develop their own roles within this process and approach to practice.

1.3 How was the strategy and guide developed?

The strategy and implementation guide were developed through a series of workshops and consultation exercises.

Current DCM mappers engaged in two Appreciative Inquiry workshops to consider the future vision for DCM practice in Wales and the actions required to support this. The outcomes from these workshops were reported to Welsh Government through Improvement Cymru as part of the evaluation of actions documented in the *Dementia Action Plan for Wales 2018-2022* (Welsh Government, 2018). Care staff from health boards, the private care sector and family members and carers of people living with dementia attended workshops delivered across health board localities in Wales to consider the local strategy for DCM in that area.

Drafts of the strategy and implementation guide were shared through a consultation exercise with members of the Lleisiau Dementia Voices and CABAN groups. The strategy and guide were also shaped by the feedback and suggestions of Dementia Care Mappers in Wales and the DCM leads from Welsh health boards.



2 Dementia Care Mapping (DCM)

DCM is rooted in the concept of person-centred care. Whilst the term 'person-centred care' may appear generally overused and under defined, Tom Kitwood, in the development of DCM provided guidance about what constituted person-centred care for the person living with dementia. Brooker (2003) developed Kitwood's ideas to propose four major elements, which make up person-centred dementia care.

These four elements, known as VIPS, are:

1. Valuing people living with dementia and their carers (V)
2. Treating people as individuals (I)
3. Looking at the world from the perspective of the person living with dementia (P)
4. Providing a positive social environment for the person living with dementia to experience relative well-being (S)

The principal aim of person-centred care is to maintain the personhood of people living with dementia. Kitwood defined personhood as:

> *'A standing or status that is bestowed upon one human being, by others, in the context of relationships and social being. It implies, recognition, respect and trust'*
>
> (Kitwood, 1997 p.8)

The aim of DCM is to understand whether the maintenance of personhood and therefore the provision of person-centred care, is observed in the experiences of people living with dementia.

2.1 What is Dementia Care Mapping (DCM)?

DCM is an observational tool, which supports practitioners to record quality of life and care from the perspective of the person living with dementia. The aim of DCM is to appreciate the experience of living with dementia as a means to understand how the current provision of care effects the person's quality of life and to support the development of future care, which promotes person-centred approaches.

To become a trained DCM mapper, an individual must attend and pass a training programme held by the University of Bradford. These are offered across locations around the country. In Wales, large groups of mappers have been trained through bespoke programmes delivered in Cardiff. To enquire about DCM training, visit the University of Bradford's website at: https://www.bradford.ac.uk/dementia/dcm/

DCM is a tool with great potential and has been used for:

Individual assessments and care planning

Through observations of one person's experience, it is possible to gain an understanding about which activities or events result in feelings of positive or negative well-being. By understanding the aspects of life that bring the person happiness, care plans are developed to support the continued provision of these experiences.

Understanding the culture of care

By observing a group of people living with dementia in one care setting, it is possible to understand the provision of care within that setting. These observations can support care staff to recognise when their interactions with people living with dementia lead to increased well-being, promoting these actions further. Interactions, which lead to less positive consequences from the perspective of the person living with dementia can be reflected upon and eliminated from practice.

Particular periods of the day may be chosen for observation if they are areas which require improvement or the impact of a development is being observed (e.g. activities, mealtimes).

Staff training and development

Observations of practice can inform the training needs of health care staff. These maps also provide an opportunity to assess the impact of staff training and development strategies.

Research and audit

DCM has historically been described as a highly appropriate audit tool in formal NHS settings (Brooker, Foster, Banner, Payne, & Jackson, 1998). It has been subject to ongoing research since its inception, with recent studies considering how the tool may reduce agitation (Surr et al., 2020), improve quality of care (Griffiths, Robinson, Shoesmith, Kelley, & Surr, 2021) and effect job satisfaction for care staff (Schaap, Finnema, Stewart, Dijkstra, & Reijneveld, 2019). DCM has also been regularly used as a research tool, with studies using DCM to consider diverse subjects, including person-centred care (Quasdorf et al., 2017) elder clowning (Kontos et al., 2016) and dementia learning communities (Sheaff, Sherriff, & Hennessy, 2018).

DCM should be regarded as a tool (the observations) and a process. DCM is a process to support the development of person-centred care for people living with dementia. It requires mappers to have an in-depth understanding of person-centred care and the DCM tool but also involves collaboration with care staff and managers, who must be prepared for any mapping activities. Feedback from mapping exercises must be delivered accurately and sensitively to the team. The feedback is then used by care staff to develop action plans to support the development of person-centred approaches to care.

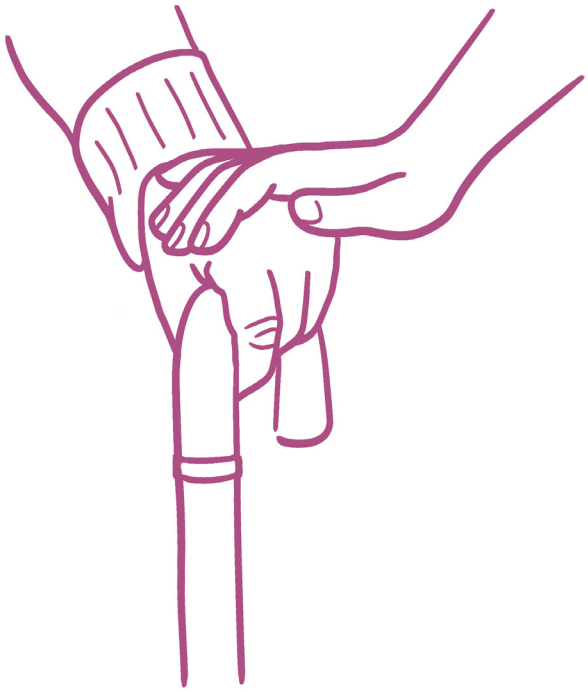
2.2 Well-being

A person's well-being is an indicator of their quality of life. Observations during DCM are particularly concerned with the emotional and psychological well-being of people living with dementia. Well-being is usually reported by the person themselves but for people living with dementia, this may be more difficult depending on the severity of their cognitive impairments. However, what people living with dementia have to say about their well-being should still be recognised and acted upon, with DCM used to support this understanding.

Indicators of well-being and ill-being in people living with dementia were developed by Kitwood & Bredin (1992) to described observable verbal and non-verbal behaviours. Indicators of well-being include the showing of pleasure, helping others and the initiation of social contact. Indicators of ill-being include physical discomfort, boredom and being left unattended when distressed. During a DCM exercise, a trained mapper observes a person or people living with dementia to understand their quality of life, or well-being.

All mapping occurs in communal areas of the care setting. For each five minutes of observation, codes are allocated to indicate what has happened during that Time Frame (TF). The Behaviour Category Code (BCC) describes the dominant behaviour of the person during those five minutes. Identifying the dominant behaviour relies on different criteria, including how long the person engaged in the behaviour or whether the behaviour had a low or high potential for well-being. The Mood-Engagement Value is recorded every five minutes to indicate the experience of affect and engagement during that period. The average Mood-Engagement Value over the entire period of mapping, creates a Well/Ill-being (WIB) score which indicates the relative well-being experienced by the person or people over that period of time.

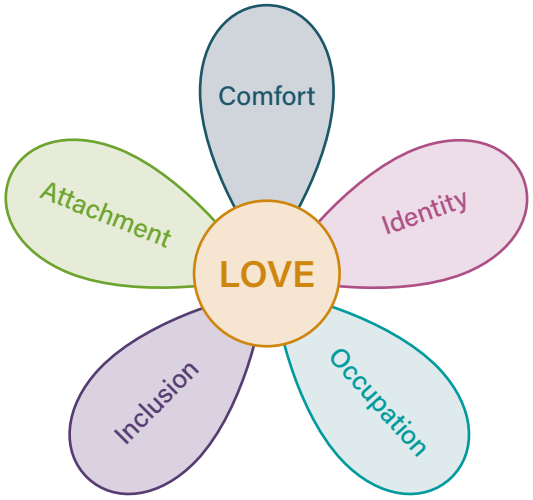
Both the Mood-Engagement Value and WIB are scored within a range of -5 to +5. A score of -5 indicates a person who is very distressed or is displaying very great signs of negative mood. A score of +5 indicates a person who is very happy, in a very positive mood or deeply engaged with an activity. A neutral experience, when there are no signs of positive or negative mood or engagement would be indicated by a score of +1.



2.3 Enhancers and Detractions

Tom Kitwood (1997) described the psychosocial needs of people living with dementia. These psychosocial needs describe the support that people living with dementia need to uphold their personhood. Kitwood illustrated these psychological needs as a flower with five overlapping petals to represent five needs. The central need of Love illustrates unconditional positive regard and acceptance, which is crucial to maintaining the personhood of people living with dementia.

- **Attachment** indicates the people and things, which we are close to or wish to be closer too. It is also aligned to feelings of trust and security, with people feeling the need to turn to their attachments during periods of crisis or anxiety. People with dementia can have their attachment needs threatened when entering care settings as they are away from home and may not have regular contact with familiar people. Kitwood believed that *"Without the reassurance that attachments provide it is difficult for any person, of whatever age, to function well. There is every reason to suppose that the need for attachment remains when a person has dementia; indeed it may be as strong as in early childhood".*
- **Comfort** is about the need for psychological warmth. When people feel psychologically comforted, they will feel less anxious and safe in their environment. The need for comfort can be provided through physical means, which could be as simple as giving the person a hug or holding their hand. For others, soothing words and actions, which display kindness towards the person, will be a source of comfort.
- **Identity** is about how the person thinks and feels about themselves. *'As humans, we have a sense of self, and at best, we are proud of our abilities and feel respected by other persons'* (Norberg, 2019). People living with dementia may rely on those around them to support their sense of self. For identity to be upheld, the life story of the person must be maintained, either by themselves or by people supporting the person living with dementia.
- **Occupation** relates to more than a job role but indicates a sense that one's actions are purposeful and have meaning to others. Occupation and activity are essential for all human beings and this need does not diminish due to age or cognitive decline. People living with dementia can be at risk in care settings if caregivers have a 'can't do' attitude, which will often lead to the person becoming disengaged, as they are denied activities or offered activities without purpose.
- **Inclusion** is about being part of something bigger than oneself. The risk of social isolation for people living with dementia is considerable. If the person is made to feel excluded, they are less likely to attempt this inclusion themselves and risk isolation, which may lead to depression and further cognitive decline. Recognising the need for people living with dementia to be part of the social world is crucial in meeting the need for inclusion.



Kitwood described behaviours of caregivers, which upheld and supported these psychological needs and called these Positive Person Work. In DCM, these are referred to as Personal Enhancers (PEs). Behaviours of caregivers, which undermine the psychological needs are called Malignant Social Psychology, referred to as Personal Detractions (PDs) in DCM. Whilst observing for well-being in people living with dementia, mappers will also record incidents of PEs and PDs. These provide valuable insights into how the interactions between caregivers and the person living with dementia may affect well-being.

Comparing Well/ill-being (WIB) scores between different mapping exercises should not be used as an indicator of improved care (unless these are completed in quick succession, involving the same person) in a care setting. However, the occurrence of PEs and PDs can provide a sound insight into the culture of care over different mapping periods. Page, Davies-Abbott and Phillips (2020) described how the occurrence of PEs and PDs could be compared over mapping exercises, even when there is variance between the number of people mapped and the length of mapping. In their paper, they argued that both PEs and PDs could be illustrated as occurrences within numbers of TFs. For PEs, a lower number indicated a positive outcome as PEs were observed frequently, although a score of 0 would indicate that no PEs were observed. In comparison, a higher number was more desirable for PDs as this would indicate that these are less frequently observed although the most desirable occurrence would be 0, meaning that no PDs were observed during the mapping period.

2.4 Preparation

The DCM process begins with preparing staff, families, carers and the people being observed for the mapping exercise. DCM is described as a cycle, which is illustrated in this framework created by the University of Bradford:

The period of preparation involves the sharing of information about the process and provides the opportunity for stakeholders to ask any questions.

The DCM exercise includes the observation of the person and or people and the analysis of the captured data, which is developed into feedback for the care staff in the setting.

2.5 Feedback

Feedback should be given to the care setting as soon as possible after the mapping exercise has been completed.

Feedback should be delivered carefully as care staff may be anxious about what has been observed. Equally, mappers also need to be supported when they are feeling nervous about delivering feedback. Feedback sessions should be delivered with the same attitudes towards person-centredness and empathy as the DCM exercise.

No care staff should be identified during feedback. The focus of the feedback is the experience of the person living with dementia. Therefore, if there are incidents of PDs to feedback, the individual caregiver involved should not be identified. Identifying the caregiver risks an allocation of blame, which will not support the care team to develop an overall action plan. Equally, caregivers who instigated PEs should not be identified, for the same reasons.

Written feedback must also be shared by the mapping team with the care setting. The amount of information shared in these written reports should depend on the purpose of the mapping exercise. Feedback may also be shared with other stakeholders if appropriate and confidentiality is maintained for all parties. Both written and verbal feedback should avoid DCM jargon, unless those receiving the feedback are also trained DCM mappers.

2.6 Action Planning

This is a crucial part of the DCM process. Whilst the DCM exercise provides the insight into the experiences of people living with dementia in the care setting, these experiences must then influence the care delivered.

Whilst the mapper may support care staff to develop an action plan once they have been provided with feedback, the development of the action plan should be led and owned by staff from the care setting. It is the care staff who must realise the action plan in practice and therefore responsibility for its creation and delivery lies with them, not the mapper. It may be helpful to identify the group responsible for action planning during the DCM preparation phase.

Whilst the results of a DCM cycle may lead to action plans, which suggest resource issues within the mapped environment, this should not be the focus of any action plan. The action plan must be developed and owned by care staff who have direct contact with people living with dementia in the care environment. The plans developed through DCM should identify actions, which can be achieved by those staff. Action plans should not be used to identify actions for people who are disconnected from the care processes of the environment unless they are directly tied to practical actions undertaken by the care staff.

Action plans should include time-focused propositions to ensure that actions are undertaken and can be reviewed appropriately, whether through further mapping or the care environment's existing interventions and governance procedures. The actions proposed during this stage may require very little time to implement or be part of a larger project, but staff should indicate during action planning when these actions will be achieved and measured.

Not all staff from the care environment may be present during formal action planning but there must be a process for sharing action plans and feedback with all staff. Handovers and staff meetings can be suitable times for sharing this information verbally. There should also be brief written accounts of the DCM findings and action plan available to all staff. Staff should be asked to sign the document once they have read this synopsis as a record of their awareness. Propositions developed in action planning should also be displayed in staff areas to continually alert staff to these new procedures.

Action planning should not be the end of the DCM process but part of a cycle of development. The DCM cycle should continue to be used to evaluate progress and create new action plans to support the delivery of person-centred care.

3 Dementia Care Mapping (DCM) case studies

DCM is a versatile tool in assessing and supporting the provision of person-centred dementia care across care environments. Real life case study examples presented in this section illustrate how DCM has been used in Wales in mental health and general inpatient care settings and as an evaluation tool for an intervention, delivered in a health board setting, by a third sector organisation. A case study is also presented to illustrate how one health board has progressed its DCM provision since the publication of the Dementia Action Plan for Wales (2018-2022), to embed the tool in practice and create full-time roles to lead DCM in the health board.

3.1 Case Study One: Developing Dementia Care Mappers

Jo Daunt, DCM Team Lead at Cardiff and Vale University Health Board (UHB) shares her experiences of being a mapper.

In 2018, Cardiff and Vale UHB offered an exciting opportunity for two part-time Dementia Care Mapping lead roles. The leads would have a dedicated two days a week to support mapping across the health board. Having undertaken the Advanced DCM training and already mapping in some ward areas, I was lucky enough to be given the role of mapping lead alongside Emma Roberts, who is the deputy team lead.

We initially undertook a scoping exercise to explore the existing pool of mappers within the UHB and establish those who were willing and able to restart mapping.

Contracts were drawn up between mappers and their managers to ensure a formal agreement was in place. As leads, we then supported all mappers to complete their Inter-Rater Reliability (IRR) score to 70% or above, repeated annually. This ensures that all mapping observations are reliable and valid.

Our next step was to support and coordinate the mapping cycles within the mental health older person's inpatient wards. Mapping had already begun in these areas but now all data could be centrally collated by the team leads. Supervision and support for all mappers was established and regular meetings were held to reflect on each part of the cycle.

We then explored how DCM could be expanded within relevant areas in the District General Hospital (DGH). We realised that our approach to mapping needed to be adapted to take into account differing levels of staff dementia training, ward layouts and routines. More time to initially brief staff was required prior to starting the mapping cycles. DCM link workers were identified on each ward to enable effective communication and mapping cycles were established on several general medical wards. Following this, referrals were also received requesting individual maps, to assist with care planning.

Evidence of improvements in person-centred care can be seen in changes to every day practice and captured through the rolling programme of mapping cycles.

We have seen some very practical changes: for example, changing the layout of a day room to

encourage greater social interaction; to staff initiating discussions around the use of language and how it can be more person-centred.

Staff have fed back that the process not only allows for greater reflection on how their interactions impact others, but also allows for celebration of the many areas of excellent practice seen on a day to day basis.

"No-one has ever asked us that question before".

"It makes you think about the things you do every day and the way it can affect patients".

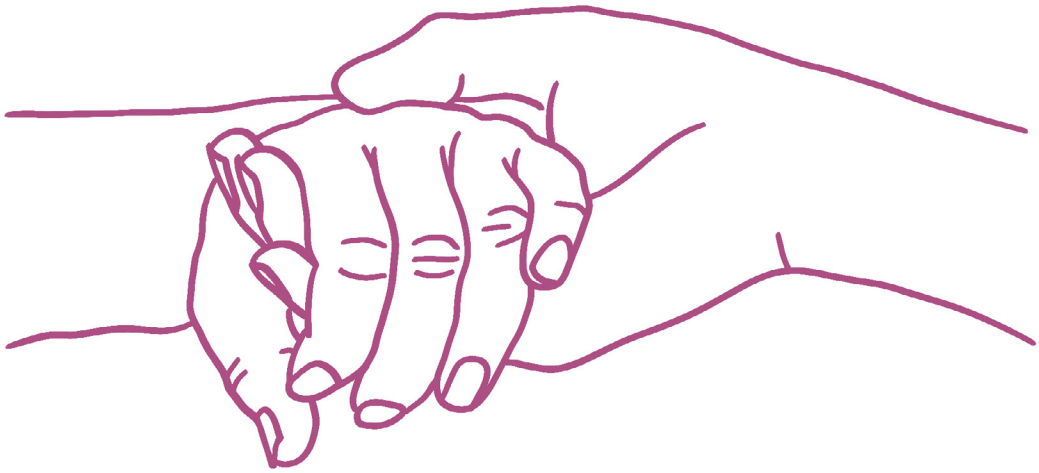
"Hearing about some of the good practice seen on the ward is really good, it's stuff that never usually gets fed back".

We quickly recognised that to grow and develop the service to its full potential, full time coordination of DCM would be essential and an increase in the number of basic mappers would also allow for a more timely and responsive team.

The DCM team lead has now been made a full-time position, with the hope of also expanding the deputy team lead to a full-time position in the near future.

Fourteen more basic DCM places were offered across health, social care, care homes, third sector and informal carers, with a view to the team leads supporting the role out of mapping in their respective areas. This now means we have a team of 19 mappers that work across many settings.

Now entering our third year, the mapping team has successfully achieved their short and medium-term goals as outlined in the University Health Board's DCM Strategy. With the establishment of one full-time post, long-term goals and the overall vision for the future of DCM appears more achievable. DCM is a powerful tool for cultural change and has a wide range of possible applications. Exploring its potential in a full-time role, is both a stimulating challenge and an exciting opportunity.



3.2 Case Study Two: Mental health services

This case study is taken from the results of two DCM exercises completed on the same older person's mental health ward.

As part of a routine quarterly mapping exercise, two qualified DCM mappers engaged in a four-hour observation of eight people living with dementia on the ward. The mapping results included a good occurrence of PEs, with these positive actions observed once every 10 TFs. Two occurrences of PDs occurred, which were included in the feedback to the ward and used to develop the staff's action plan.

The first PD was observed when a staff member was supporting five people living with dementia to engage in a creative activity. Another staff member asked the activity focused member of staff to complete another task, leaving the five patients disengaged. At the time there were three other staff members who were not engaged with direct care who could have been given the task, allowing the activity to continue. This PD negatively impacted on the people living with dementia's psychological need of occupation.

The second PD was observed during a musical activity when a person living with dementia was asked 'are you singing?' by a staff member. The person replied 'yes' and the staff member stated 'Well, I can't hear you.' The person looked hurt and stopped singing. She looked around the group, stood up and left.

The feedback included the occurrences of PEs and PDs, with the former experiences used to influence an action plan to reduce the occurrence of PDs in the future. The action plan recognised that positive person approaches were regularly observed, particularly when patients were engaged in expressive activities offered on the ward. A key action from this was that staff must be alerted and praised regarding this positive practice and how their actions supported engagement in ward activities.

The following quarter, the care environment was mapped again. The provision of person-centred activities remained an ongoing feature of care delivery on the ward. However, when results were compared to the previous quarter, the occurrence of PEs had increased to one every 5 TFs and unlike the previous map, there were no incidents of PDs when actions by staff disrupted the involvement of people in creative or person-centred activities.

3.3 Case Study Three: General health services

This case study looks at how DCM was introduced to general wards in one Welsh health board and an action plan developed by one ward team.

A brief scoping exercise of the general wards within the DGH revealed that the majority of staff were unfamiliar with the DCM tool. It was also apparent that there was a range of experience and confidence levels when supporting or caring for people living with dementia. Whilst person-centred care was a familiar concept, the opportunity for reflection and evaluation was varied.

The scoping exercise also highlighted some practical issues that needed to be considered – the layout of the wards often differed from mental health wards, as did the daily routine. Individuals tended to remain at their bedsides for longer periods and on the whole, there was less focus on utilising day rooms for social activities.

Prior to mapping, educational workshops were held to explain the process. These were short 15 minute PowerPoint presentations that ran concurrently over a period of a few hours. This format allowed us to reach as many staff members as possible during busy shift patterns. The workshops gave an overview of the mapping process and how it could promote person-centred care. They also highlighted the importance of a collaborative approach to action planning in achieving change. It also provided staff members the opportunity to ask questions.

Mapping was commenced over a busy lunchtime period. One mapper was situated in the dining room, the other was situated in a ward bay. A total of five individuals were mapped.

The mapping data was collated and a report was formulated. The staff decided to address two areas highlighted from the map, which led to the development of an Action Plan:

- It was noted that some individuals were offered the opportunity to eat socially in the dining room whilst others remained at their bedsides.
- The dining room television was left on during the lunchtime period as well as the radio, making conversations difficult.

Action Plan

GOAL	ACTION	WHO IS RESPONSIBLE?	REVIEW DATE
For all patients to be offered the opportunity to eat socially during meal times	Smaller, portable tables to be set up in bay areas, allowing all patients the opportunity to eat socially	Ward Manager Deputy Ward Manager	4 weeks' time
Promote a calm and relaxed atmosphere during meal times	Staff to ask patients whether they would like the radio or television playing during mealtimes. For patients to decide the type of music/programme playing	Activity Coordinator Ward Manager	4 weeks' time

The DCM team reviewed the Action Plan on the date specified. The ward had trialled the use of smaller tables in patient bays and found that patients were pleased to be given the choice. The tables had now become part of the ward routine and often remained up for longer than just mealtimes, as they allowed for greater social engagement.

Staff now ensured that patients were involved in deciding whether there should be music or the television playing in the dining room. This helped create a relaxed, sociable atmosphere and ensured that the environment did not become overly noisy or distracting.

3.4 Case Study Four: Social care and third sector services

This case study illustrates how DCM was used to evaluate the impact of a creative activity on the well-being of people living with dementia.

The DCM team were approached to undertake an evaluation exercise. They were asked to explore the impact on patient well-being of a therapeutic group, delivered by a third sector service on a general rehabilitation ward. The third sector service had extensive experience in working with patients in a meaningful, person-centred way, with the aim of encouraging interaction and reducing social isolation.

The mapping process was used to assess the levels of mood and engagement of four patients. The first map was undertaken during the normal ward routine, where no organised activity was taking place. The second map was undertaken with the same four individuals, during an organised activity session, delivered by the third sector service. The session centred around a creativity theme using art materials.

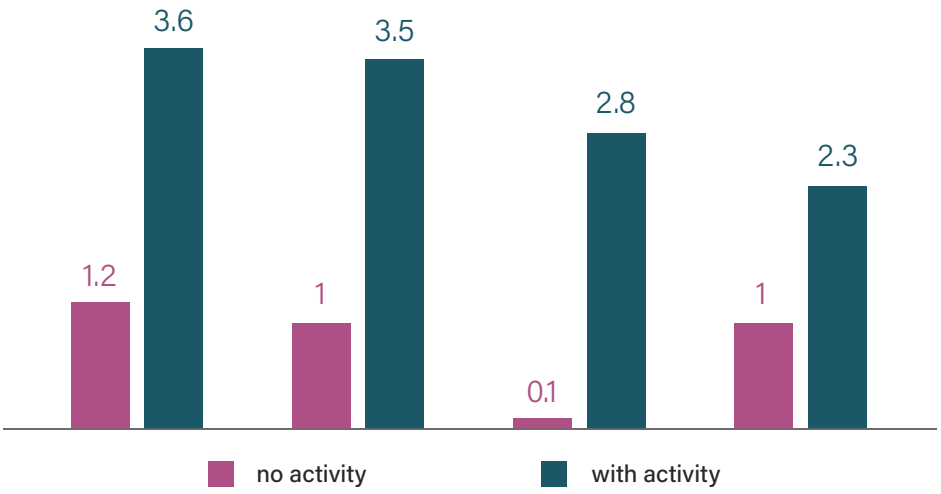
The data from each mapping session was collated and an individual WIB score for each patient was determined.

The graph illustrates that the WIB score for each individual, is significantly higher when participating in the creative activity delivered by the third sector service. Observations noted during the mapping session found that the benefits to well-being extended beyond the creative activity itself. The bringing together of patients in a safe, supportive environment, allowed the opportunity to connect and engage with others even after the formal group had ended.

The group facilitators were highly skilled in ensuring a relaxed, inclusive atmosphere. This allowed all participants to feel engaged and supported. The facilitators obviously knew the patients well and anticipated their needs. They displayed great warmth and set a relaxed pace ensuring both patients and visiting relatives felt welcomed and valued.

The third sector service was able to use the data from the mapping exercise to evidence the positive impact their service was having on individuals. Such evidence can be used to help provide an evidence base for interventions and help ensure patients have continued access to services that promote and enhance well-being.

Individual WIB Scores



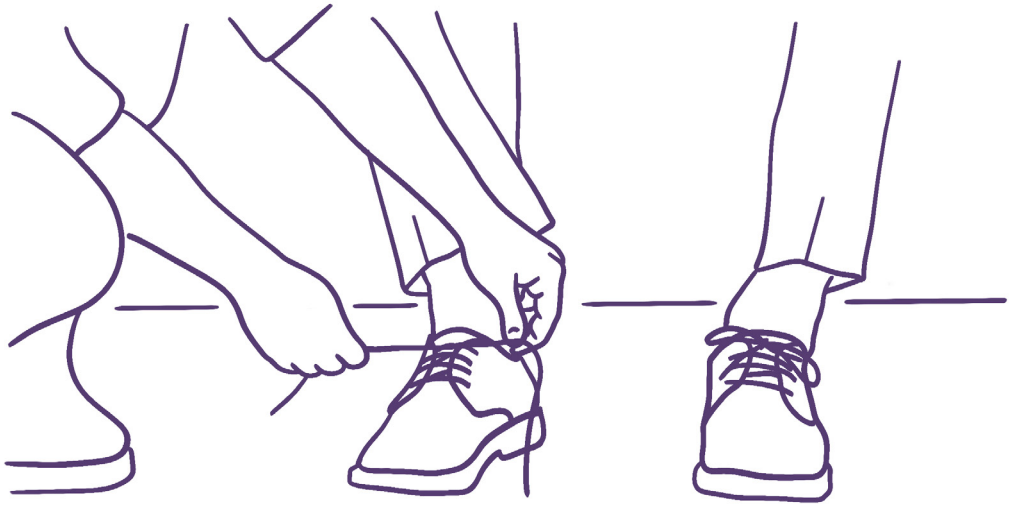
4 Dementia Care Mapping (DCM) Implementation Guide

DCM is included in the *All Wales Dementia Care Pathway of Standards* (Improvement Cymru and Welsh Government, 2021). The delivery of the standards is expected in 2023 with a focus on readiness and self-assessment prior to the delivery period. The period of readiness leading up to delivery provides an opportunity to align existing work and interventions, review systems, review resources and engage with communities and partners to develop a regional integrated approach to implementing the dementia standards.

The DCM implementation guide presents a step-by-step guide for health boards to consider the current provision of DCM within their locality, develop a service model and deliver change. The implementation guide is presented separately from this strategy document.

Abbreviations

BCC	Behaviour Category Code
DCM	Dementia Care Mapping
DGH	District General Hospital
PD	Personal Detraction
PE	Personal Enhancer
TF	Time Frame
UHB	University Health Board
WIB	Well and Ill-being



References

Brooker, D., Foster, N., Banner, A., Payne, M., & Jackson, L. (1998). The efficacy of Dementia Care Mapping as an audit tool: Report of a 3-year British NHS evaluation. *Aging and Mental Health,* 2(1), 60–70. https://doi.org/10.1080/13607869856957

Brooker, Dawn. (2003). Reviews in Clinical Gerontology What is person-centred care in dementia? What is person-centred care in dementia? *Reviews in Clinical Gerontology, 13*(13), 215–222. https://doi.org/10.1017/S095925980400108X

Griffiths, A. W., Robinson, O. C., Shoesmith, E., Kelley, R., & Surr, C. A. (2021). Staff experiences of implementing Dementia Care Mapping to improve the quality of dementia care in care homes: a qualitative process evaluation. *BMC Health Services Research, 21*(1), 138. https://doi.org/10.1186/s12913-021-06152-6

Improvement Cymru and Welsh Government (2021) All Wales Dementia Care Pathway of Standards. Improvement Cymru and Welsh Government

Kitwood, T. (1997). *Dementia Reconsidered: The Person Comes First.* Buckingham [England], Open University Press.

Kitwood, T., & Bredin, K. (1992). Towards a theory of dementia care: Personhood and well-being. *Ageing and Society,* (12), 269–287. https://doi.org/10.1017/S0144686X0000502X

Kontos, P., Miller, K.-L., Colobong, R., Palma Lazgare, L. I., Binns, M., Low, L.-F., … Naglie, G. (2016). Elder-Clowning in Long-Term Dementia Care: Results of a Pilot Study. *Journal of the American Geriatrics Society, 64*(2), 347–353. https://doi.org/10.1111/jgs.13941

National Institute for Health and Clinical Excellence (2013) Mental well-being of older people in care homes. Quality Standard [QS50]. National Institute for Health and Clinical Excellence

NHS England (2018) Dementia Care Mapping - evidence review. NHS England

Norberg, A. (2019). Sense of Self among Persons with Advanced Dementia. In *Alzheimer's Disease* (pp. 205–221). Codon Publications. https://doi.org/10.15586/alzheimersdisease.2019.ch13

Page, S., Davies-Abbott, I., & Phillips, M. (2020). Same map, different direction – Exploring new opportunities that dementia care mapping™ can offer to acute mental health admission wards for older people – Innovative practice. Dementia, 19(2). https://doi.org/10.1177/1471301216675677

Quasdorf, T., Riesner, C., Dichter, M. N., Dortmann, O., Bartholomeyczik, S., & Halek, M. (2017). Implementing Dementia Care Mapping to develop person-centred care: results of a process evaluation within the Leben-QD II trial. *Journal of Clinical Nursing, 26*(5–6), 751–765. https://doi.org/10.1111/jocn.13522

Schaap, F. D., Finnema, E. J., Stewart, R. E., Dijkstra, G. J., & Reijneveld, S. A. (2019). Effects of Dementia Care Mapping on job satisfaction and caring skills of staff caring for older people with intellectual disabilities: A quasi-experimental study. *Journal of Applied*

Research in Intellectual Disabilities, 32(5), 1228–1240. https://doi.org/10.1111/jar.12615

Sheaff, R., Sherriff, I., & Hennessy, C. H. (2018). Evaluating a dementia learning community: Exploratory study and research implications. *BMC Health Services Research, 18*(1). https://doi.org/10.1186/s12913-018-2894-3

Surr, C. A., Holloway, I., Walwyn, R. E. A., Griffiths, A. W., Meads, D., Kelley, R., … Farrin, A. J. (2020). Dementia care mapping™ to reduce agitation in care home residents with dementia: The epic cluster rct. *Health Technology Assessment, 24*(16), 1–174. https://doi.org/10.3310/hta24160

Welsh Government. (2018). Dementia Action Plan for Wales. Welsh Government.

Acknowledgements

Dr Ian Davies Abbott

Lecturer in Healthcare Sciences (Mental Health Nursing), Dementia Studies Course Lead, School of Medical and Health Sciences, Bangor University, who has developed the strategy and guide with key partners, in support of the Improvement Cymru Dementia Care Programme

We would like to express our thanks to members of the Lleisiau Dementia Voices and CABAN groups for their input into the development of the national strategy and implementation guide.

We would also like to thank the following for their valuable feedback, guidance and suggestions during the development of these documents:

Dementia Care Mappers

DCM leads from across Wales

Practitioners and senior leads

Joanne Daunt, Clinical Lead, DCM Team, Cardiff and Vale University Health Board Mental Health Services

Emma Roberts, Dementia Care Advisor, Mental Health Liaison Psychiatry, Cardiff and Vale University Health Board

Michaela Morris, Dementia Care Programme Lead, Improvement Cymru.

You can keep up-to-date with developments by visiting our website and signing up for our monthly e-newsletter:

www.improvement.cymru

You can also follow us on social media:

Follow us on Twitter @ImprovementCym

Like us on Facebook

Subscribe to us on YouTube

Connect with us on our LinkedIn page

Improvement Cymru

2 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Published March 2022

Bangor University Registered Charity No. 1141565

GWELLIANT CYMRU IMPROVEMENT CYMRU

Learn
Improve
and Assure