

# Dementia Mapping Services Framework/ Narrative

Team Information



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# 1. Overview

## Aim

- 1.1 We aim to work jointly with providers in an inclusive manner that provides good person centred outcomes for service user's. The expectation is for all stakeholders to support continuous improvement, striving towards excellence in dementia care.

## Key elements

- 1.2 Dementia Care Mapping is an observational framework developed at the University of Bradford which records quality of life and quality of care from the perspective of the person living with Dementia.
- 1.3 Dementia Care Mapping is both an 'Observational Tool' and a 'Process', which are designed to help the provider to consider and improve in the delivery and quality of care for service user's with dementia. The observational tool is used for a variety of purposes in a range of settings
- Performance and Quality
  - Assessment and care planning
  - Training needs analysis
  - Staff development
  - Continuous quality improvement
  - Benchmarking and quality assurance
- 1.4 The Dementia Mapping Service is part of the Contracts Performance & Quality Team (CP&QT), within Adults Social Care. Together they ensure that services not only meet the contractual requirements, but more importantly meet the quality and outcomes of service user's using them. The data collated when analysed evidences the service user's mood, engagement and well-being.
- 1.5 Dementia Care Mapping is central to improving the quality of care for service user's with Dementia and is closely aligned with the National Dementia Strategy on Living Well with Dementia<sup>1</sup>.
- 1.6 Dementia Care Mapping is recognised in key policy and guidance nationally and relates to and cross references the following:
- 1.7 The UK's Audit Commission (2000) *Forget me not report on mental health services for older people*<sup>2</sup>.  
The Social Care Institute for Excellence and National Institute for Health and Clinical Excellence (2006) *Guideline on supporting people living with dementia*
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*and their carers in health and social care*<sup>3</sup>. The National Audit Office (2010) *Improving Dementia Services in England – an Interim Report*<sup>4</sup>. The British Standards Institute has published the first Publicly Available Specification (PAS) in the use of *Dementia Care Mapping for improved person-centred care in a care provider organisation*<sup>5</sup>.

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<sup>1</sup> <https://www.gov.uk/government/news/living-well-with-dementia-a-national-dementia-strategy#>

<sup>2</sup> <https://www.legislation.gov.uk/ukxi/2000/2253/contents/made>

<sup>3</sup> <https://www.scie.org.uk/publications/misc/dementia/>

<sup>4</sup> <https://www.nao.org.uk/report/improving-dementia-services-in-england-an-interim-report/>

<sup>5</sup> <https://www.bsigroup.com/en-GB/about-bsi/media-centre/press-releases/2010/12/BSI-Guidance-is-key-to-improve-dementia-Care/>

## 2. Dementia Care Mapping

2.1 The process utilised by the Dementia Mapping Service consists of two separate but integral parts:

- Mapping - The Dementia Care Mapper, DCM will endeavour to observe the participant's mood state alongside their level of engagement. This is achieved by continuous observation based on coding within five minute time frames. Over the period of a whole map a general picture can be built up about a participant's relative level and range of well-being or ill-being by drawing together and analysing information.
- Observations - The purpose of 'Observations' is to support the provider/ referring professional in an effort to eliminate or consider triggers to challenges, which are being experienced by the provider of the service. The 'Observations' are undertaken from the service user's perspective ensuring quality person-centred care is foremost. This will support all relevant service areas and professionals to have an insight into the service user's communication, in turn enabling better informed person centred care planning.

## 3. Mapping Purpose

3.1 The purpose of Dementia Care Mapping is to evaluate the quality of life/ care from the perspective of the service user's living with dementia. The DCM currently observes in residential establishments, Hospital Trusts, Extra Care facilities and when appropriate, Day Services. The observational tool will be used to gather factual data which will later be analysed and can be found in the pages of the report. This data aims to capture the service user's behaviours (*appendix 1. Behaviour Category Codes (BCC)*) and mood/ engagement (*appendix 2. Mood and Engagement (ME) values*). Personal Enhancers (PE's) and Personal Detractors (PD's) also observed (*appendix 3. Personal enhancers and Personal detractors*) and can be found under the headings of 'What's working' and 'What's not working' for each of the service user's included in the report.

3.2 The DCM will undertake observations to indicate/ highlight areas of performance and quality for monitoring or evaluating purposes.

## 4. Mapping Process

4.1 Prior to undertaking a dementia care map of the service the DCM will inform the provider of the visit giving seven days' notice. The DCM will contact the provider by telephone and confirm by email (*appendix 4. Email to provider regarding mapping visit*). This will include an overview of the mapping process (*appendix 5. Overview of the mapping procedure*) and an accompanying flyer (*appendix 6. Flyer*) will also be sent for the provider to display in the home's communal areas; to outline/ inform of the purpose of the visit.

- 4.2 The DCM will report on the service user. For the purpose of the report the other people who access/ reside at the service will be identified as 'service users'.
- 4.3 When carrying out the map the DCM will observe the identified service user to whom the provider has gained consent for their inclusion in the mapping process. Information recorded attempts to capture the experience of care from the perspective of the service user. The DCM will observe the service user continuously for a number of hours.
- 4.4 The time length of the map will depend upon the purpose and resources.
- Performance and Quality
  - Assessment and care planning
  - Training needs analysis
  - Staff development
  - Continuous quality improvement
  - Benchmarking and quality assurance
- 4.5 Every five minutes the DCM will record on the data sheet, (*appendix 7. Raw Data Sheet*), a (BCC) which represents the main activity undertaken by the service user. The BCC is selected from a list of 23, each denoted by a code letter, for example; F = Eating and drinking, L = Leisure, fun and recreational activities. Also within each time frame the DCM records an ME value, representing how engaged the service user is and whether their mood is positive or negative. This is represented on a six point scale; +5, +3, +1, -1, -3, -5.
- 4.6 The DCM also captures the quality of interactions with staff members, for each service user they are mapping, which are represented as PE or PD. There are 17 types each of PE and PD that a DCM might record during a map. For example personal enhancers can be recorded as 'Enhancing' (e) or 'Highly Enhancing' (he) and similarly detractors recorded as 'Detracting' (d) or 'Highly Detracting' (hd).
- 4.7 The PE represents an interaction with a service user in a way which has the potential to uphold one or more of their psychosocial/ psychological needs (these needs are: comfort, attachment, identity, occupation and inclusion); (*appendix 8. Psychological needs*). For example; providing a service user with dementia, verbal support in order to complete an action independently, would be coded as 'Enabling' and would support a service user's need for occupation. This would be illustrated in the Dementia Care Mapping report (*appendix 9. Dementia Care Mapping Report*) as: PE-12-Enabling.
- 4.8 The PD represents an interaction that 'puts down' a service user with dementia and undermines one or more of their psychosocial/ psychological needs For example; talking about them in their presence as if they were not there, would be recorded as 'Ignoring' and would undermine a person's psychosocial/ psychological need for inclusion. This would be illustrated in the report as: PD-15-Ignoring.

- 4.9 (PE) and (PD) are recorded as and when they occur.
- 4.10 On completion of the mapping session the DCM will meet with the provider/ appropriate appointed person to verbally feedback and indicate areas of 'best practice' for that of a 'dementia friendly' residential home. The DCM will complete a verbal feedback confirmation form, (*appendix 10. Verbal feedback form – mapping visit*), confirming the interim findings and concerns that have been discussed during the meeting. The provider will be asked to sign to confirm that the interim findings and concerns have been discussed at the meeting with the DCM.
- 4.11 The DCM will complete safeguarding alerts, inclusive of actions and outcomes, as required and inform in feedback of the need to refer or share the observational findings; with the referring professional and other partnering agencies or regulatory bodies.
- 4.12 The DCM will produce a detailed report.
- 4.13 The Dementia Care Mapping report is presented in four parts which includes:
- The mapping of the service inclusive of recommendations and suggestions.
  - The 'Map' of the service users who were identified to participate in the map.
  - A report for each participating service user including data, utilising the person centred tool 'What's working/ What's not working' together with recommendations and suggestions, to support the provider with person centred care planning and the delivery of care.
  - Dementia Care Mapping Tool™ (information).
- 4.14 The report will be Risk Rated (RAG) and formatted to aid the reader to cross reference from the DCM map/ observations of the service to the related recommendations/ suggestions.
- 4.15 The report once completed, will be sent to the provider via email (*appendix 11. Email re completed report to provider & confirm feedback meeting*) together with supporting information/ websites (*appendix 12. Standard Appendix*) and an application form for training sessions from Hull City Council, (*appendix 13. Generic Application form*). The email will also propose a date and time to review the report with the provider/ appropriate person(s). This meeting will be to discuss with the provider/ appropriate person(s) the report findings and to devise an agreed action plan(s) for the service.
- 4.16 Following the meeting the DCM will produce the action plan(s) (*appendix 14. Action Plan*) as discussed/ agreed and email (*appendix 15. Email to send action plans for confirmation & provider's feedback*) to the provider and request formal confirmation/ agreement to the action plan(s).
- 4.17 The Dementia Care Mapping report and action plans will be shared with the (CP&QT) and will be available to other regulatory bodies' e.g.: CQC, Safeguarding etc if required. The DCM will email the (CP&QT), (*appendix 16.*

*Email*), to inform that the report has been uploaded to the (CP&QT) shared drive.

- 4.18 The Contracts Performance & Quality Team Concern Form (*appendix 17. CP&QT concern form*) will be completed by the DCM and emailed (*appendix 18. Email to send concern form*) to the (ASCCP&QT) inbox, if concerns identified within the report have not be actioned or met by the provider.
- 4.19 A copy of the Dementia Care Mapping report will be emailed for information purposes to Head of Personalisation, Social Work & Occupational Therapy (ASC), (*appendix 19. Dementia Care Mapping report +action plans*).

## 5. Observation Purpose

- 5.1 The purpose of 'Observations' are an attempt to identify any concerns, patterns or potential triggers that impact on the service user's wellbeing, which may result in challenges being experienced by the provider/ service. The aim is to support care providers and relevant professionals to have a better understanding of the identified service user's needs in order to support in:

- Informed assessment and care planning
- Funding (placement/ 1:2:1 staff)
- Training needs analysis
- Staff development
- Continuous quality improvement
- Benchmarking and quality assurance
- Sustaining service user's placement if at risk

- 5.2 'Observations' are on a referral basis only and are currently referred to the Dementia Care Mapping Team (DCMT) by other professionals i.e.:

- Continuing Health Care Practitioners
- Social Work Teams
- General Practitioners
- District/ Community Nurses
- Community Psychiatric Teams (including Community Psychiatric Nurse (CPN))
- Psychologists
- Best interest Assessors
- Court of Protection

(This list is not exhaustive.)

## 6. Observation process

- 6.1 Referrals must be completed on the official observation referral paperwork, (*appendix 20 (A). Observation referral form*), which must be requested directly from the DCMT or located on 'Connect To Support' web site. The form must be



completed in full, and the referrer must ensure that consent has been sought/ confirmed in order that the participant can be included in the process prior to the referral being submitted.

- 6.2 Once completed, the observation referral form should be sent electronically to the Dementia Academy 'inbox'.
- 6.3 The DCMT will assess the referral against the team's current observation criteria (*appendix 21. Observation criteria doughnut*) and Risk Rate (RAG) accordingly. Referrals are not currently accepted directly from a service user, family member or service providers or for service users living outside of the Hull City boundary. This is with regards to the team's current capacity, resources and funding.
- 6.4 A member of the DCMT will respond/ contact the referrer and inform if the referral meets that of the current observation criteria.
- 6.5 The DCM will liaise with the referrer/ service provider and any other relevant professionals currently involved with the identified service user. This is in order to collate supporting information prior to the observation taking place.
- 6.6 The DCM will inform the service provider of their impending visit and request that the home's staff team are informed. The specific date/ time are not required to be identified, although this is generally determined by the service user's daily routine or patterns.
- 6.7 There is an expectation that the DCM would be allowed access to the building to complete the observations regardless of the time of day. In the event of an early morning or late evening visit, the DCM will inform the provider/ appropriate appointed person of the expected arrival time.
- 6.8 The DCM will complete an initial observation and if required, attend to carry out further observational visit(s). As part of the process the DCM will require access to the service user's documented information such as care plans, medication records, monitored recordings etc.
- 6.9 On completion of the observation the DCM will meet with the provider/ appropriate appointed person to verbally feedback their initial findings. The DCM will complete a verbal feedback confirmation form (*appendix 22. Verbal feedback form – Observation*), identifying the interim findings and any concerns that have been discussed during the meeting. The provider will be asked to sign the verbal feedback form to confirm the points discussed.
- 6.10 The DCM will complete safeguarding alerts, inclusive of actions and outcomes, as required and inform in feedback of the need to refer or share the observational findings; with the referring professional and other partnering agencies or regulatory bodies.
- 6.11 The DCM will document their findings in a report format.

- 6.12 The 'Observation' report, (*appendix 23. Observation Report*) includes detailed observations of the service user, staff members interactions and recommendations and suggestions, which will be Risk Rated (RAG) to support the provider in:
- 'Best practice'
  - Service delivery
  - Care planning etc.
- 6.13 The report once completed, will be emailed to the referrer (*appendix 24. Email to referrer - completed Observation report*) and service provider. The service provider's email (*appendix 25. Email to provider - completed Observation report - confirm feedback meeting*) will offer the opportunity to meet with the DCM for further feedback (or confirm a pre-arranged meeting). This meeting is in order to discuss the report findings and where necessary devise an action plan for the service user.
- 6.14 Following the meeting the DCM will email (*appendix 26. Email to provider - agreed Action Plans for confirmation*) the devised action plan to the provider and request their confirmation/ agreement.
- 6.15 The report/ action plan will be shared with the (CP&QT) and will be available to other regulatory bodies' e.g.: CQC, Safeguarding etc. if required. The DCM will email the (CP&QT) (*appendix 16. Email*) to inform that the report has been uploaded to the (CP&QT) shared drive.
- 6.16 The Contracts Performance & Quality Team Concern Form (*appendix 17. CP&QT concern form*) will be completed by the DCM and sent (*appendix 18. Email to send concern form*) to the (ASCCP&QT) inbox, if concerns identified within the report have not be actioned or met by the provider.
- 6.17 A copy of the 'Observation' report will be emailed for information purposes to Head of Personalisation, Social Work & Occupational Therapy (ASC), (*appendix 19. Observation report +action plans*).

## **7. Further support**

- 7.1 Additional support may be offered in areas of handholding (dependent on team capacity, resources, time specific etc.) with regards to:
- Advice on activity plans
  - Recording templates
  - Daily living care profiles
  - Person centred planning
  - In house training etc.

7.2 At times the DCM may support by attending reviews and 'Best Interest' meetings in order to support the referring person/ provider in meeting service users' needs.

## 8. Summary

8.1 The DCMT is to support care providers and relevant professionals to have a better understanding/ insight of the identified service users' needs in order to support in:

- Best practice
- Service delivery
- Informed assessment/ person centred care planning

The overall aim is to improve the quality of life for people living with dementia in Hull.

## 9. Contacts

[www.dementiaacademy@hullcc.gov.uk](mailto:www.dementiaacademy@hullcc.gov.uk)

You can also find us on:



Under Dementia Academy Hull

## 10. Appendices

- Appendix 1 (List of Behaviour Category Codes (BCC's))
- Appendix 2 (Mood and Engagement (ME) Values)
- Appendix 3 (Personal Enhancers & Personal Detractions)
- Appendix 4 (Email to provider regarding mapping visit)
- Appendix 5 (Overview of the mapping procedure)
- Appendix 6 (Flyer to accompany email confirming mapping visit)
- Appendix 7 (Raw Data Sheet)
- Appendix 8 (Psychological needs)
- Appendix 9 (Draft Dementia Care Mapping Report)
- Appendix 10 (Verbal feedback form – mapping visit)
- Appendix 11 ((Email re completed report to provider & confirm feedback meeting)
- Appendix 12 (Standard Appendix of supporting information & websites)
- Appendix 13 (Generic Application form)
- Appendix 14 (Action Plan)
- Appendix 15 (Email to send action plans for confirmation & provider's feedback)
- Appendix 16 (Email to CPQT to inform report & action plans are on the shared drive)
- Appendix 17 (CP&QT concern form)
- Appendix 18 (Email to send concern form to ASCCP&QT)
- Appendix 19 (Email to Head of Personalisation, Social Work & Occupational Therapy-  
Dementia Care Mapping report +action plans or Observation report  
+action plans)
- Appendix 20 (Observation referral form)
- Appendix 21 (Observation criteria doughnut)
- Appendix 22 (Verbal feedback form – Observation)
- Appendix 23 (Draft Observation Report)
- Appendix 24 (Email to referrer - completed Observation report)
- Appendix 25 (Email to provider - completed Observation report - confirm feedback  
meeting)
- Appendix 26 (Email to provider - agreed Action Plans for confirmation – Observation)
- Appendix 27 (Risk Rating Guidance & Matrix (RAG))