DEFINING QUALITY DEMENTIA CARE

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Defining Quality Care: Dementia Care Practice Recommendations

Quality Care: History
• Guidelines for Dignity
• Key Elements of Dementia Care
• Dementia Care Practice Recommendations
Quality Care: Today

- Evidence-based practices
- 56 recommendations by 27 expert authors
- Applicable to various care settings and throughout the disease continuum
- Published as a supplement to Feb 2018 issue of The Gerontologist
- Foundation for quality person-centered care

Dementia Care Practice Recommendations

Person-Centered Focus

- Know the person
- Person’s reality
- Meaningful engagement
- Authentic, caring relationship
- Supportive community
- Evaluation of care practices
Know the person living with dementia
• Gather knowledge of the person (past and present) in assessment
• Include the individual, family and friends
• Include knowledge of the person in care plan and re-assessment
• Share knowledge of person with all staff

**Recommendations in Action**

**PERSON CENTERED FOCUS**

**DETECTION AND DIAGNOSIS**

Information about brain health and cognitive aging
• Signs and symptoms of cognitive impairment
• Concerns, observation and changes
• Routine procedures for assessment and referral
• Brief mental status test when appropriate
• Diagnostic evaluation follow-through
• Better understanding of diagnosis

Signs and symptoms of cognitive impairment; diagnostic evaluation is essential
• Educate staff about signs and symptoms
• Develop process for referral to qualified professional for diagnostic evaluation
ASSESSMENT AND CARE PLANNING

Recommendations
• Regular, comprehensive, person-centered assessments and timely interim assessments
• Information gathering, relationship building, education and support
• Collaborative, team approach
• Accessible documentation and communication systems
• Advance planning

Comprehensive PCC Assessment

Experience of the person/care partner
Function and Behavior
Health Status and Risk Reduction

Experience of the Person/Care Partner
• Neurocognitive function
• Decisional capacity
• Physical function (including activities of daily living [ADL], instrumental activities of daily living [IADL])
• Psychological, social and spiritual activity and wellbeing
• Everyday routines, activities (including personal care, exercise, recreational activity, sleep)
• Behavioral changes, symptoms
Regular comprehensive person-centered assessments and timely interim assessments:
- Perform initial assessment at intake
- Conduct when person is at peak performance and distraction-free
- Conduct interim assessment at least every 6 months and/or when changes occur
- Tailor frequency for individual and family

ASSESSMENT AND CARE PLANNING

MEDICAL MANAGEMENT

Recommendations
- Holistic, person-centered approach
- Role of medical providers
- Common comorbidities of aging
- Non-pharmacologic interventions
- Pharmacological interventions when necessary
- Person-centered plan for possible medical and social crises
- End-of-life care discussions

Recommendations in Action
- Educate staff about common comorbidities
- Develop protocol for when MD should be contacted
- Have discussion about types of acute care that cannot or be provided
INFORMATION, EDUCATION AND SUPPORT

Recommendations

• Preparation for the future
• Work together and plan together
• Culturally sensitive programs
• Education, information and support during transition
• Technology to reach more families

Early Stage: Becoming Familiar

Education and Information
- Disease
- Symptoms
- Treatment
- Prognosis

Support
- Support groups
- Technology-based
- Care planning for future
- Driving

Middle Stage: Increased Care and Support Needs

Education and Information
- Family-centered
- Behaviors
- IADLs and PADLs

Support
- Support groups
- Counseling
- Care coordination
- Technology-based
Late Stage: Relocation and End of Life Care

**Education and Information**

- Care needs
- Continue in home care or relocate to an alternate care setting

**Support**

- Support groups or counseling
- End of life and hospice care
- Palliative care approach

**Recommendations in Action**

- At orientation, assess knowledge and build a plan
- Within 30 days, provide basic education about types of dementia, common symptoms, diagnosis, and current treatments

**ONeGOING CARE: ADLS**

- Support for ADL function
- Person-centered care practices
- Dressing — dignity, respect, choice, process, environment
- Toileting — also health and biological considerations
- Eating — also adaptations and functioning; food, beverage, and appetite
Person-centered care practices when providing ADL support:

- Know personal preferences
- Learn and honor preferred daily schedule
- Use positive reinforcement for encouragement
- Encourage independence - graded approach

ONGOING CARE: ADLs

Recommendations in Action

- Social and physical environmental triggers
- Non-pharmacological practices
- Investment for implementation
- Protocols
- Evaluation of effectiveness

ONGOING CARE: Dementia Related Behaviors

Recommendations

- Sensory Practices

<table>
<thead>
<tr>
<th>Practice</th>
<th>Evidence</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aromatherapy</td>
<td>Moderate</td>
<td>Positive effect on agitation</td>
</tr>
<tr>
<td>Massage</td>
<td>Small</td>
<td>Positive effects on agitation, aggression, anxiety, depression, disruptive vocalizations</td>
</tr>
<tr>
<td>Multi-sensory stimulation</td>
<td>Large</td>
<td>Positive effects on agitation, anxiety, apathy, depression</td>
</tr>
<tr>
<td>Bright light therapy</td>
<td>Moderate</td>
<td>Mixed effects</td>
</tr>
</tbody>
</table>
Psychosocial Practices

<table>
<thead>
<tr>
<th>Practice</th>
<th>Evidence</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validation therapy</td>
<td>Small</td>
<td>Positive effects on agitation, apathy, irritability, night-time disturbances</td>
</tr>
<tr>
<td>Reminiscence therapy</td>
<td>Moderate</td>
<td>Positive effects on mood, depression symptoms</td>
</tr>
<tr>
<td>Music therapy</td>
<td>Moderate</td>
<td>Positive effects on a range of BPSDs, including anxiety, agitation, and apathy, particularly with personalized music practices</td>
</tr>
<tr>
<td>Pet therapy</td>
<td>Small</td>
<td>Preliminary positive effects on agitation, apathy, disruptive behavior</td>
</tr>
<tr>
<td>Meaningful activities</td>
<td>Moderate</td>
<td>Mixed—some positive effects on agitation; larger effects for activities that are individually tailored</td>
</tr>
</tbody>
</table>

Structured Care Protocols

<table>
<thead>
<tr>
<th>Practice</th>
<th>Evidence</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mouth Care</td>
<td>Small</td>
<td>Preliminary: positive effects on care-resistant behaviors</td>
</tr>
<tr>
<td>Bathing</td>
<td>Small</td>
<td>Positive effects on agitation</td>
</tr>
</tbody>
</table>

Dementia Related Behaviors

Characteristics of social and physical environmental triggers:
- Identify situations where social or physical environment:
  - Evokes behavioral response
  - Produces stress
  - Evokes behavior that expresses unmet need

Recommendations in Action

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**WORKFORCE**

**Recommendations**
- Orientation and training, and ongoing training
- Person-centered information systems
- Teamwork and interdepartmental/interdisciplinary collaboration
- Caring and supportive leadership team
- Relationships
- Continuous improvement

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**Long-Term Care Workforce Principles**

- **Staffing levels** should be adequate to allow for proper care at all times—day and night.
- Staff should be sufficiently **trained** in all aspects of care, including dementia care.
- Staff should be adequately **compensated** for their valuable work.
- Staff should work in a supportive atmosphere that appreciates their contributions to overall quality care. Improved working environments will result in reduced turnover in all care settings.
- Staff should have the opportunity for **career growth**.
- Staff should work with **families** in both residential care settings and home health agencies.

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**WORKFORCE**

**Recommendations in Action**

- Thorough staff orientation and training, including:
  - Set an expectation that all staff welcome, serve, and respond
  - Provide information that all staff welcome, serve, and respond
  - Develop strategies to maintain high expectation standards
  - Create a strong, collaborative work experience
  - Staff should work with **families** in both residential care settings and home health agencies.

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• Sense of community
• Comfort and dignity
• Courtesies, concern and safety
• Opportunities for choice
• Meaningful engagement

**SUPPORTIVE AND THERAPEUTIC ENVIRONMENT**

Recommendations

- Provide cues and tools to support functioning
- Consider a secured perimeter or technology that is non-limiting
- Use design to minimize fall risk
- Provide sufficient lighting

**Recommendations in Action**

- Education about common transitions in care
- Timely communication of information between, across and within settings
- Preferences and goals of the person living with dementia
- Strong inter-professional collaborative team to assist with transitions
- Evidence-based models
Common Transitions

Care Coordination Interventions

<table>
<thead>
<tr>
<th>Author</th>
<th>Setting</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naylor et al. (2014)</td>
<td>Hospital to home</td>
<td>Transitional Care Model (TCM)</td>
<td>Augmented Standard Care versus Resource Nurse Care versus TCM</td>
<td>Time to first rehospitalization was longest for those in the TCM, and rehospitalization or death was accelerated for both other groups</td>
</tr>
<tr>
<td>Samus et al. (2014)</td>
<td>Home</td>
<td>MIND at Home</td>
<td>Dementia care coordination versus usual care</td>
<td>Significant delay in time to transition from home and remained in home 51 days longer</td>
</tr>
<tr>
<td>Bass et al. (2014)</td>
<td>Home</td>
<td>Partners in Dementia Care (PDC)</td>
<td>Care coordination program versus usual care</td>
<td>Fewer hospitalizations and fewer emergency department visits</td>
</tr>
<tr>
<td>Bellantonio et al. (2008)</td>
<td>Assisted living</td>
<td>Geriatrics Team Intervention (GTI)</td>
<td>Four systematic interprofessional geriatric team assessments</td>
<td>Reductions in risk of unanticipated transitions, including hospitalizations, ED visits and nursing home placement, as well as death</td>
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Recommendations in Action

- During orientation, have discussions about types of and criteria for transitions
Perspectives from Individuals living with Dementia

- Encourage early detection and diagnosis
- Share appropriate information and education
- Get to know the person
- Maximize independence
- Practice patience and compassion
- Personalize care to meet individual needs and preferences
- Adjust care approaches to reflect day-to-day needs and abilities
- Provide ongoing opportunities for engagement that have meaning and purpose
- Ensure coordination among those who provide care
- Train staff on the most current disease information and practice strategies
- Inform and include the individual in new interventions as appropriate
- Create a safe and supportive environment that reflects the person

Dementia Care Practice Recommendations

- Person-Centered Focus
- Medical Management
- Information, Education and Support
- Ongoing Care for Behaviors
- Supportive and Therapeutic Environment
- Transition and Coordination of Services
- Person-Centered Focus

Putting It All Together

- Develop a Plan
- Create short and long-term goals
- Include staff
- Take small steps
- Get help if needed
- Build support
- Recognize and celebrate accomplishments
Next Steps: Get Involved

- Connecting with local chapter
- alz.org/qualitycare

Quality Care in Long-Term & Community-Based Care

Questions?

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