HOW PERSON-CENTRED ARE WE?
ENHANCING PERSON-CENTRED CARE PRACTICE IN AN ASSISTED LIVING UNIT FOR PEOPLE WITH DEMENTIA

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Background of Project

• In 2015, Apex Harmony Lodge had embarked on a lodge wide transformation process, to embed the person-centred approach throughout their organisation

• ADA was approached to provide consultation and evaluation of their current state of care, and provide recommendations

• Focused on enhancing the care provided to 30 male residents in the Assisted Living Unit (Lily Home), in Apex Harmony Lodge
Objectives

• Collect baseline data and evidence of current practice
• Train AHL staff to be able to administer the assessment tool, and surveys
• Make recommendations for enhancing Person-Centred Care
• Implement action plans developed based on areas identified
• Review the well-being of same cohort of residents (1 year later)
• Re-evaluate care practices focusing on 3 domains: Activities, Care Plans and Environment
Methods

• Dementia Care Mapping (DCM) was done for the assisted living unit residents at baseline and 1 year later.
• Surveys were administered with 22 residents and 15 family members.
• 10 nursing home staff representing a range of work roles were interviewed to assess their understanding of person-centred care, and current person-centred care practice with residents, staff, and with the management.
• Person-Directed Dementia Care Assessment Tool (PDDCAT/Wisconsin) (9 domains) was administered with the nursing home staff, to identify key strengths and potential areas for improvement in the assisted living unit.
<table>
<thead>
<tr>
<th>METHOD</th>
<th>Focus Areas</th>
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<tbody>
<tr>
<td>Dementia Care Mapping</td>
<td>Environment, Communication, Social engagement, Know the resident,</td>
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<tr>
<td>PDDCAT</td>
<td>Environment, Communication, Team structure and roles, Care plans, Policy &amp; Procedures</td>
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<tr>
<td>FAMILY SURVEY</td>
<td>Environment (furniture), Ask for their preferences, food that looks good</td>
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<tr>
<td>RESIDENT SURVEY</td>
<td>Staff keep me informed, Activities that are an interest to me, variety of food</td>
</tr>
<tr>
<td>STAFF INTERVIEWS</td>
<td>Environment (furniture), staffing and workload, relationships, competing priorities</td>
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SUMMARY of PDDCAT Ratings

1 = NOT PRESENT or a problem area,
2 = Is PRESENT but could be IMPROVED
3 = PRESENT & SATISFACTORY could become a strength
4 = STRENGTH that can be used to implement more

1 = 1
2 = 1.5
3 = 2
4 = 2.5
5 = 3
6 = 3.5
7 = 4

- **ENVIRONMENT**: 2.6
- **LANGUAGE & COMMUNICATION**: 2.8
- **CARE PLANS**: 2.0
- **ACTIVITIES**: 2.9
- **PROBLEM SOLVING PROCESSES FOR WORKING WITH PEOPLE WITH DEMENTIA’S BEHAVIORAL COMMUNICATION**: 2.6
- **COMMUNICATION AND LEADERSHIP**: 2.9
- **TEAM STRUCTURE AND ROLES**: 2.8
- **STAFF KNOWLEDGE AND TRAINING**: 2.5
- **POLICIES AND PROCEDURES**: 2.2
Recommended Improvements

Environment

Modify the environment to improve the ambience and promote social engagement among residents.

Activities

- Keep the residents informed regarding the activities in the home
- Increase the variety of activities to meet individual interests and strengths
- Train the staff to use person-centred language and positive ways to communicate with the residents

Care Plans

- Care plans should focus more on the resident’s abilities rather than problem areas.
- There should be documentation of each resident’s life story by the staff who work with the resident closely.
- A systematic process for gathering information, sharing findings, and documentation, so that the use of care plans is less fragmented.
Highlights of Actions Taken - Environment

- Modifications to the ward environment to enhance the ambience, activity engagement and social interaction

Wall Repainted

Mural Decoration
Highlights of Actions Taken - Environment

• Personalisation of bedside area
Highlights of Actions Implemented – Care Plans

• New Individualised Care Plan template – ability centred goals/outcomes, use of “I” statements, focused on the persons’ perspectives

• Structured MDT for all new Residents – team-based approach between nursing and psycho-social team, learning and growing together as “ours” not “yours” or “mine”

My Life Story

My name is Lxx Sxx Hxxx John, most people just call me John. I was born on January 27, 1951 and I am now 65 years of age. I got married with two children, but I have been living apart from family for a few years before I was admitted to IMH in 2006. My religion is Buddhism. I can speak Malay but I mainly converse in English. I have worked as a carpenter for only about 2-3 years, as my father has supported me financially. My wife worked as a factory girl back then. I have three elder sisters; Sally who is in Australia, Mary who is a retired lawyer, and Jane who is a housewife.

I used to smoke and drink a lot, maybe that’s the reason why my sister Mary had to bring me to IMH to help me kick out the habit. I only stayed there for a period of time then my sister transferred me to Winsor Home. I only stayed there for a brief 5-6 months as I did not really like staying there. I’ve already lost contact with my wife and children; they seem to have abandoned me, after my wife used my money to buy an HDB flat somewhere in Sengkang and took all my savings and even closed our joint accounts.

Now I am currently residing at Apex Harmony Lodge where I’ve made a few friends whom I can call my family.
Highlights of Actions Implemented - Activities

- Training of staff in Person Centred Care and DCM
- Increase in variety of planned group and individual activities
- Review programs to increase engagement in the ward and during outdoor activities
- Use of tablets for video or games where resident could engage independently in the ward
- Involve the residents in personalized activities such as playing mini billiards, sweeping the garden, dishing food for lunch, Chinese calligraphy
2016 DCM findings – Average ME value

Comparison of Average Mood & Engagement (ME) values by Residents (n=21)

14 out of 21 residents had an increased average ME in the 2016 maps
At post 1-year DCM:

- 10% increase in the number of high potential BCCs
- 11% decrease in low potential BCCs

- Occupational diversity across BCCs:
  - Total of 18 high potential BCCs
  - Average of 8 high potential BCCs per map

- Top 4 high potential BCCs across all maps:
  1) V vocational activity
  2) L leisure
  3) F food
  4) K walking / standing
2016 DCM findings – PEs & PDs

Compared to the 2015 maps:
1) Personal Enhancers (PE)
   • 48% increase in the number of episodes of PEs observed

2) Personal Detractors (PD)
   • 14% reduction in the number of episodes of PDs that erode well-being

Tom Kitwood’s Psychological Needs
attachment occupation
comfort inclusion
identity
Learning Points

- Clear leadership and communication
- Staff empowerment and training – encouraged staff to take ownership
- Adopting a person-centred approach to care planning has enhanced the wellbeing of residents
- Dementia Care Mapping has deepened staff understanding of positive person work as seen by the increase in Personal Enhancers
- The Person-Directed Dementia Care Assessment Tool was useful guide in the implementation of Person-Centred Care practice