UNIVERSITY of BRADFORD
School of Dementia Studies

Introduction to Dementia Care Mapping™ (DCM™)

Dementia Care Mapping™ is an established approach to achieving and embedding person-centred care for people with dementia. For over 20 years it has been used by care practitioners to improve quality of life for people living with dementia in a range of care settings, including care homes and hospitals.

An established approach to practice development

DCM™ is recognised in key national policy and guidance. The Social Care Institute for Excellence and National Institute for Health and Clinical Excellence (2006) *Guideline on supporting people with dementia and their carers in health and social care* discusses the role of DCM™ in changing practice. The National Audit Office (2010) report on *Improving dementia services in England* recognises DCM™ as a method for measuring quality of life. The UK's Audit Commission (2000) in their *Forget me not report on mental health services for older people* underscored its role in improving quality care.

The benefits of DCM™ include the improvement of people's well-being and helping staff see care from the point of view of the person living with dementia, leading to evidence-based feedback and action planning that motivates staff and helps them to feel more confident in implementing person-centred care.

In collaboration with the University of Bradford, the British Standards Institute (BSI 2010) has published the first Publically Available Specification (PAS) in the *Use of Dementia Care Mapping™ for improved person-centred care in a care provider organisation*. This PAS provides a guide to the principles involved in using DCM™ to improve the lived experience for people living with dementia.

The University of Bradford has partnerships with organisations in Australia, Belgium, Denmark, Germany, Hong Kong, Italy, Japan, Netherlands, Norway, Singapore, Spain, Switzerland and the United States to provide training in DCM™.

Purpose of DCM

Dementia Care Mapping™ is designed to empower staff teams to engage in evidence-based critical reflection in order to improve the quality of care for people living with dementia. It provides a direct and ongoing evidence base for practice and practice change and can be used in a number of different ways including:

Quality monitoring and improvement

DCM™ was primarily developed to be used as part of a continuous quality improvement process to develop the quality of person-centred care over time. Through a process of preparation and feedback, staff are encouraged to consider care from the point of view of the person living with dementia. On the basis of these observations, changes can be made to care plans and to care practice generally. DCM™ data can provide evidence about whether change in care practice has had an impact on the person's experience of care. They can help to monitor change at individual, group and organizational levels. It has a lot in common with continuous quality improvement cycles and PDSA (plan, do, study, act) quality cycles that underpin many of the systems for clinical governance and quality audit in health and social care settings.

Individual assessment and care planning

DCM™ can be used to improve well-being and quality of life for people living with dementia at an individual care-planning level. The analysis of individual maps provides information about how to optimise an individual's well-being over the day. Small things that engender happiness or distress are highlighted in the process of mapping. This can be built upon to ensure that people have the opportunity to experience well-being more often during their day.

Organisation of key events over the day

At a group level DCM™ can be used to improve the organisation of care during key events in the day – such as meal times or activity sessions or handovers. DCM™ data can indicate where changes can be made that will improve levels of well-being of the whole group of people living within the care setting.

Training needs and staff development

DCM™ data can help to identify training needs and opportunities for staff development. DCM™ can help to identify staff skills that support and promote levels of well-being. It can be useful in tailoring training and staff development programmes around specific examples from the experience of people living with dementia.

The DCM practice development cycle

DCM™ is an observational tool used within a practice development cycle in care settings. It includes five phases:

- Preparation and briefing;
- Observation;
- Analysis;

- Feedback – written report and verbal feedback;
- Action planning.

This developmental evaluation cycle can be repeated every 4-6 months to monitor and revise action plans. The cycle may need to be repeated more frequently for individualised person-centred care planning.

Once mappers complete their initial training and skills development they can then conduct cycles of mapping independently of external input. As such, DCM™ is an empowering methodology for care staff teams and is closely aligned with real world dementia care practice.

The Dementia Care Mapping™ Practice Development Cycle

Preparation and Briefing

Briefing involves providing information about DCM™ to staff, people living with dementia, family members, and visitors so they are aware of the process that will take place, and their role and involvement in that process. It provides all concerned with an opportunity to ask questions.

Observation

During the observation period, a trained observer (mapper) records the care experience of up to eight people living with dementia for a length of time determined by the purpose of the observation (map). This can be short focussed maps (for example over mealtime periods), up to longer maps of six or more

hours to gain a broad picture of the participants' day and evening time experience.

A trained observer (often a member of staff in the care setting) records the care experience of up to eight people living with dementia for up to six consecutive hours. The length of the time observing will depend upon the reason for the map, and this can be shorter or longer than 6 hours. For example, some care settings have found it useful to perform a 24-hour map using several mappers in the organisation to observe this mapping period.

Observation takes place in communal areas of care settings.

After each-five minute period the observer records:

- a Behaviour Category Code (BCC) which represents what each person was mainly doing for that five minute period.
- a Mood and Engagement (ME) Value, which represents how engaged the person is and whether their mood is positive or negative.

It is the combination and interpretation of the ME data which allows the mapper to make an assessment of the level of relative well or ill-being of the person living with dementia.

The mapper also records the quality of interactions with staff for each person they are observing through Personal Enhancers and Personal Detractions, as and when they occur. Personal Enhancers are times when a member of staff interacts with a person in a way which has the potential to uphold her/his psychosocial needs. Personal Detractions are times when an interaction 'puts down' a person with dementia and undermines her/his psychosocial needs. In addition, field notes are made to provide information about the context.

Analysis

Analysis of data recorded using the DCM™ tool provides in depth detail about the following:

- How individual and group levels of well-being and ill-being vary across the day.
- Which participants have relatively high well-being, which participants experience low well-being, and whether there are significant changes in this over time.
- How people living with dementia spend their time and how this is linked to relative well and ill-being.
- Staff interactions that promote person centred care and well-being, and staff interactions that undermine person centred care and well-being.

Report writing and feedback

Once the data have been analysed, the mapper provides written and verbal feedback to staff teams.

Action planning

Following verbal feedback of the written report, the staff team develop action plans for individuals or groups of individuals. In some instances this may be facilitated and supported by the mapper.

Policy context

Improvement in care quality and staff knowledge and skills are identified as key priorities for England within the Department of Health (2009) National Dementia Strategy, *Living well with dementia*. Developing an informed and effective workforce is a strategic component of improving care quality.

The All Party Parliamentary Group on Dementia report in 2009 recognised that working with people living with dementia requires knowledge and skills as well as empathy and compassion. The Prime Minister's Challenge (2012) recognised the need to improve health and social care. Alongside these political imperatives, there is a strong desire on an individual level to provide health and social care that enables people to live their lives to the full.

Although we would advise against the use of DCM™ during a safeguarding investigation, DCM™ can help care team to understand some of the care practices that can lead to safeguarding concerns being raised. Equally following a safeguarding investigation DCM™ can be used with care to support a care team to reflect on and begin to change their practice (Crossland, 2010).

Development of DCM

DCM™ was developed at the University of Bradford by the late Professor Tom Kitwood and his colleague, Dr Kathleen Bredin. The impetus for the development of DCM™ came from a request for a University of Bradford evaluation of a new dementia care initiative in the mid 1980's. At that time there were no evaluation instruments that looked at care from the point of view of the person living with dementia. This sparked Tom Kitwood's interest in people living with dementia and the way in which they were marginalised in society.

Since its first edition in 1992, DCM™ has been revised and updated at regular intervals. Each period of review has drawn on the experience and expertise of practitioners, researchers and academics.

Using DCM requires organisational support

Using DCM™ to maximum effect requires organisational commitment and support. Key elements which need to be in place include:

- An understanding of person-centred care;
- An understanding of the aims and objectives of DCM™;
- Leadership;
- Staff teams ready for change;
- Staff teams sufficiently stable and secure to engage in change process;
- Staff time released for mapping;
- Supervision and support for mappers;
- Sufficient number of mappers.

Staff teams need to understand person-centred care

Staff teams need to have an understanding of the key concepts in person-centred care. It is usually necessary to have this as part of training and induction prior to the commencement of DCM™. Without this there is a risk that staff will feel intimidated by the use of DCM™ rather than being clear about its purpose.

Staff teams need to know the aims and objectives of DCM™

Staff and management teams need to have a general awareness of DCM™, its aims and objectives and the need for follow-on work from the results of the evaluation. They need to know that DCM™ is a complex and powerful agent for change and is best used as part of a change process.

Leadership

The person or persons taking a lead on the process of using DCM™ for developmental evaluation need to work at an appropriate level within the organisation to provide support and governance. Furthermore, the lead person in DCM™ should be sufficiently trained to ensure:

- They have enough knowledge and experience to manage mapping activity within the organisation.
- They have sufficient credibility with direct care workers and management staff to be able to deal with feedback from the maps.
- They are able to lead action planning and change management.

Staff teams need to be ready for change

Staff teams need to be open to the concept of change and development. DCM™ can be a good way of helping build teams following a merger, or building on lessons learnt from investigations.

Staff teams need to be stable and feel secure

If members of staff are undergoing disciplinary action or where there is an investigation into poor practice or where the care setting is under threat of closure, then it may not be an appropriate time to introduce DCM™.

Staff time will need to be covered

There will need to be provision agreed to cover staff time for those involved in all stages of the mapping cycle: briefing, mapping, data analysis, feedback and action planning. By scheduling mapping activity in advance, disruption to care delivery can be minimised.

Mappers will need support and supervision

Mappers need supervision and mentorship. Mapping can be an emotional, and, at times, frustrating experience. This is particularly the case when poor care is observed, feedback sessions have been difficult, motivation and enthusiasm on the unit mapped is low and the prospects for developing care seem small. Supervision is also useful to identify times when what has been observed has been inspiring and motivating. It is therefore vital that mappers have access to regular supervision to discuss their experiences and seek advice. This can be achieved in a number of ways:

Supervision of new mappers

New mappers often need a period of mapping under the supervision of a more experienced mapper to ensure that their coding is accurate and that their practice is sound. This supervision is equally important during the practice of mapping as well as carrying out briefing sessions and feeding back results.

Debriefing sessions

Following mapping or feedback sessions, having the opportunity to debrief can be useful for mappers to discuss their observations as well as considering the messages that they might want to feed back to the rest of the staff.

Support groups

Where there are a number of mappers within an organisation, it is often a good idea for mappers to come together in a formalised way for mutual support, skills sharing and updating.

Buddy systems

Where mappers are working in relative isolation, it may be more difficult to achieve supervision and support in this area. Buddy systems between mappers in different organisations can meet some of these needs. The Bradford

Dementia Group may be able to put you in touch with mappers working in your area

Trainer status and networks

In organisations where there are a large number of mappers, developing one or two mappers as DCM™ trainers may be a consideration for the organisation. This has a financial advantage as it is more cost effective to train staff in-house. It also brings with it a support and network of DCM™ expertise at a very high level.

Sufficient number of mappers

The number of mappers needed will depend upon the size of the organisation and how many facilities there are to be mapped and on the size of the individual facilities. It is recommended that mappers map in pairs where possible because more participants can be observed overall and the mappers can support each other. However, in some small facilities two mappers or more can feel very obtrusive and increase the levels of ill-being both in staff and service users, and some very small organisations may only have one mapper. It is often worth training as many people as possible in DCM™ so that it will decrease the mystery around the process and accelerate culture change. Not all those trained in DCM™ will necessarily map following training. Those responsible for resource management often value being trained in DCM™ so that they feel confident in understanding mapping data and managing change.

Further information

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