Introduction

Consistency in the care of people with dementia is difficult to achieve in most residential facilities, yet without it already confused people are subject to a variety of ways of dealing with their problems. This can confuse them more and reduce the effectiveness of their care.

Time is short in most residential facilities. Working out a care plan is sometimes seen as a luxury or a burden imposed from above.

Residential facilities are staffed by people from a variety of backgrounds. Some highly trained, some hardly trained at all.

These Model Care Plans (MCPs) are offered as an aid to busy staff from all backgrounds in the expectation that they can be a starting point for a brief, focussed discussion that will result in a practical care plan that can be implemented consistently.

They have been developed by a process of careful consultation with the staff of Sinclair Home, a 72 bed nursing home specialising in the care of the dementing. This is not a purpose built nursing home. It is, structurally, a very ordinary nursing home. It is funded in exactly the same way as the great majority of nursing homes in Australia. Apart from the determination of the staff and management to do an excellent job of caring for the dementing it is an ordinary nursing home. The MCPs are therefore based on approaches that can, and are, being applied in an everyday setting. They do however also bear the stamp of 8 years of experience of working with people with dementia in the highly specialised settings of the NSW Department of Health CADE Units. These units for the Confused and Disturbed Elderly (CADE) were established to provide care for those dementing people who could not be managed in an ordinary nursing home (Fleming and Bowles, 1987; Fleming, Bowles and Mellor, 1989). John Bowles personified this experience and used it in chairing the meetings with the Sinclair Home staff that resulted in the writing of the first draft.

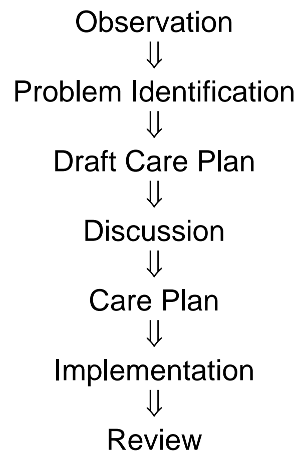
The usefulness of the MCPs as a training tool has been tested in Sinclair Home and in two National Action Plan on Dementia Care demonstration programmes (Fleming and Kramer, 1995). They have repeatedly been found to provide an excellent starting point for training staff in how to approach the most common problems of people with dementia. They provide two important guides to their users. The first is what to do and the second is how to do it at the appropriate level, so that the residents are always encouraged to do as much as possible for themselves.

The MCPs were also influenced by a thorough review of recent nursing literature. This was greatly helped by the meticulous work of Margaret Gray, who found it, photocopied it and made it available to us.

The ultimate goals are to ensure that all staff dealing with people with dementia are competent in a basic approach to the most common problems and that the approach adopted maximises the independence of the resident.

Model Care Plans: What are they and where do they fit?

The MCPs fit into an approach that has the following parts:



A brief description of these components is provided here. They will be familiar to many as the components of the nursing process. We have simply tried to make this process accessible to all staff working in residential settings by providing them with some support in making their observations, reporting them and deciing on an appropriate course and level of intervention. We use the word care plan throughout in place of terms such as action plan, primary nurse plan, key worker plan etc. Similarly the word case manager is used to cover the meanings of key worker, primary nurse etc.

From **Observation to Problem Identification**

Most people find that observing a resident with a view to developing a care plan is made a lot easier when a comprehensive, easy to use assessment scale is provided to help them structure their observations. The assessment scale that supports the MCPs is the Revised Elderly Persons Disability Scale (Fleming and Bowles, 1994).

It provides a comprehensive overview of:-

- Physical problems
- Self help skills
- Confusion
- Behaviour problems
- Social problems
- Psychiatric symptomatology
- Dependency on nursing care.

It has the advantage over other scales of being supported by computer software that facilitates reporting, care planning, communication and monitoring of the resident and the service.

A case manager intending to use the REPDS to help prepare for a case review would take the following steps:

1. The week before the case review the case manager would check her roster and identify the three working days prior to the review day.

2. If he/she was unfamiliar with the REPDS she would read it thoroughly. This would bring to her attention the 7 questions that need to be incorporated into conversation with the resident. They appear in the Confusion section. (Detailed instructions and definitions for completing the REPDS are to be found in Appendix 2)

3. During the three working days prior to the case review he/she would observe the resident with the REPDS questions in mind. He/she would also interact with the resident in a way that allowed the specific questions to be asked gently and unobtrusively.

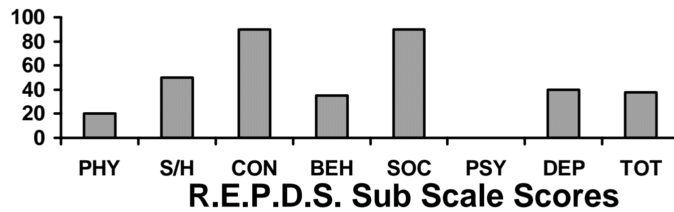
4. At the end of the third day he/she would sit down and fill in the REPDS by putting the date at the top of the column and then writing in the number indicating the description that best fits the resident in the box next to the question.

   If the case manager knows that a colleague has been in a better position to observe a problem he/she should consult with that colleague. This is sometimes necessary for problems that are most apparent to staff on the night shift.

   Steps 3 and 4 can take as little as 15 minutes.
5. Where the case manager has access to the computer with the REPDS system on he/she should then enter the data.

6. The case manager should then produce the Programme Development Report and Monitoring Report to assist in the preparation of the presentation for the next days case review. xamples of these reports are provided below.

Programme Design   Assessment Date 08/01/93



DATE OF BIRTH: 4 / 9 / 1914 .   COUNTRY OF BIRTH: England .

RELEVANT MEDICAL HISTORY: .

Susceptible to chest infections.

RELEVANT SOCIAL HISTORY, E.G. OCCUPATION, INTERESTS, ACHIEVEMENTS, FAMILY

Interested in trains. Worked on the railways
Family not interested following a long separation.

DETAIL PROGRAMME OBJECTIVES AND CARE PLAN - IF REQUIRED.
(BASE ON PROBLEMS AND INTERVENTIONS SUMMARISED ON NEXT PAGE.)

1. Maintain mobility   involve in house hold activities
   accompany on daily walk

2. Improve self help skills   implement Model Care Plan SH(2) for bathing

3. Reduce disruptive behaviors   implement Model Care Plan B(1)
   redirect to help with making a cup of tea.

REVIEW DATE: 9 / 9/ 1993   SIGNED: J. Bowles   POSITION: P.D.O.

PROBLEMS ASSESSED ON 8-1-1993	RECOMMENDED INTERVENTIONS
PHYSICAL PROBLEMS: P4. POOR HEARING	*Speak slowly and clearly.* *Approach from the front.*
SELF HELP PROBLEMS: SH2. BATHING SH3. DRESSING SH5. ROOM TIDY SH6. LOOKING AFTER HEALTH	*Use Model Care Plan SH(2)* *Observe for signs of chest infection.*
CONFUSION: C1. DOESN'T KNOW NAME C2. DOESN'T KNOW STAFF C3. DOESN'T KNOW DAY C4. DOESN'T KNOW ADDRESS C5. LOSES WAY C6. POOR SHORT TERM MEMORY C7. POOR LONG TERM MEMORY C8. DOESN'T KNOW DAYS OF WEEK	*Accept his reality.* *Use first names in conversation.* *Put picture of a train on his door.* *Use his 'life history' to reminisce - particularly about railways.*
BEHAVIOURAL PROBLEMS: B1. AGITATED, RESTLESS B3. DISTURBS OTHERS B5. ABSCONDS, WANDERS B6. UNCOOPERATIVE	*Use Model Care Plan B(1)* *Early intervention reduces disturbance* *Maintain secure perimeter.* *Use Rule of Thumb for "Non-Compliance.'*
SOCIAL PROBLEMS: S1. NO HOBBY, PASTIMES S2. RARELY READS S3. RARELY JOINS IN ACTIVITIES S4. RARELY HELPS OTHERS S5. NO FRIENDS S7. RARELY LEAVES AREA AROUND ROOM	*Involve in the daily routine- dish washing.* *Read newspapers with him.* *Invite him to morning tea.* *Take for daily walk.*
STAFF DEPENDENCY: SD1. REFUSES MEDICATION SD3. PROBLEM BEHAVIOUR SD4. PROBLEMS WITH FEEDING, DRESSING, ETC.	*Accepts medication when put in a drink or a sandwich.*

From Draft Care Plan to Implementation

The case manager will move from the identification of the problems (as described in the Programme Development Report) to the presentation of a detailed description of an approach to the problem by selecting a MCP and modifying it to fit the resident and the circumstances in the facility.

What is a Model Care Plan?

A Model care plan is a basic approach to reducing an identified handicap which may be caused by dementia, physical impairment or some other cause. **It is assumed that reversible medical causes for the handicap have been addressed, or are being addressed, before the use of the Model care plan is considered.**

The Model Care Plan is only standard for a particular facility with its own peculiar set of resources. In so far as facilities differ in their philosophy of care and resource availability the Model Care Plans must be modified if they are to be used by them.

The Model Care Plans are provided as models that need to be modified for the individual residents. Having identified the problem to be dealt with the case managers task then becomes to decide on the level(strength) of the intervention. The MCPs are organised into 5 levels of intervention:-

1. Avoid the problem
2. Provide the opportunity for the task to be carried out
3. Non-dirctive prompts
4. Directive prompts
5. Doing it yourself (with the resident)

These, and the layout of the MCPs, are explained in detail below.

The title:-

MODEL CARE PLAN

PROBLEM: (SH2)
DIFFICULTY IN BATHING/HYGIENE

gives the name of the problem followed by the REPDS question number, in this case SH2 standing for Self Help question 2. The unique question number is used as the reference number when Problem Oriented records are used.

In some cases this is followed by:-

DETAILED ASSESSMENT:

1. Bathing: Including Undress, Washing Body & Drying Body

2. Shaving

3. Shampooing Hair

4. Oral Hygiene

5. Nails

a list of sub-problems that could be the cause of the major problem identified by the REPDS. The case manager is asked to consider this list and select the sub-problem, or problems, most relevant to the resident. The availability of this list greatly increases the specificity of the REPDS. The case manager then selects the care plan for that sub-problem.

The care plan begins with a list of common situations in which the chosen problem occurs. These are paired with some simple suggestions for avoiding the problem. If simple interventions are sufficient to avoid it then there is no need for the detailed care plan to be put into effect. The presentation of strategies for avoiding the problem may stimulate the case manager to devise a new strategy. If this is successful and simple it should be added to the list for the benefit of other case managers.

SH2. Shaving

Avoiding the problem

WHEN DOES IT OCCUR?	HOW IS PROBLEM AVOIDED?
• Due to skin irritation when shaven.	• In consultation with resident and/or relatives, employ skin conditioners to alleviate irritation or discuss the option of growing a beard.
• Where anti-coagulant therapy is used and resident is unfamiliar or agitated by an electric razor.	• Discuss in consultation with resident and/or relative the option of growing a beard.
• Where agitation is caused by the use of an electric razor.	• Use a safety razor.
• Where agitation is caused when using a safety razor blade.	• Discuss with resident and/or relatives the option of growing a beard. This will minimise shaving. Maintenance of neatness and trimming of the beard can be organised through a hairdresser. This is necessary on a much less frequent basis than shaving.
• Where skin on face is difficult to shave due to sunken cheeks.	• If dentures are worn, ensure that they are in place before commencing procedure.

The care plan continues with the provision of a set of staged interventions, the underlying philosophy being to only provide the residents with the level of assistance that they require to engage in the task for themselves.

The first level of intervention is to ensure that the opportunity to engage in the task is being provided. If a resident does not have access to a razor, soap and water he cannot shave himself. This can appear to be his problem when in fact it is an environmental or policy problem. A rationale is given for each intervention so that the case manager is reminded of the reasons for the action.

SH2. Shaving

INTERVENTIONS	RATIONALE
1. Provide Opportunity	
• Provide, in consultation with the resident/ relatives, equipment necessary to perform the task according to the usual habit and/or desire of resident and/or relatives.	• Ensure that the resident has the opportunity to express wishes and demonstrate ability to care for self. Avoids reduction of self-help abilities.
• Allow this equipment to be easily accessible to the resident.	• Encourages continuation of familiar habits, providing security.
• Whenever the opportunity arises, compliment the resident on his fresh appearance.	• Maintains motivation to shave self and improves self-image.

Many residents require more than the provision of the opportunity. The next level of prompting is to gently remind them of the task and to do no more if this is successful.

INTERVENTIONS	RATIONALE
2. Non-Directive Prompt	
• At the appropriate, pre-arranged time (usually after or before bathing) remind the resident by saying, “Do you think you need to shave today?”	• Draws resident’s attention to memory of old habits and encourages him to take appropriate action.
• If the resident responds, support by allowing the resident to independently take steps to begin and complete the task.	• Allows resident to remain in charge while helping him to succeed.
• Praise and encourage whenever the resident responds or takes a step towards and completion of the task.	• Success will increase the chances of the resident’s continued co-operation, as will praise and encouragement.

When gentle reminding is not sufficient, and this is often the case, the staff must be more directive. Their intervention must be structured and they must prepare themselves and the resources required before beginning.

INTERVENTIONS	RATIONALE
3. Directive Prompt	
• Collect equipment needed when collecting bath necessities and place appropriately in the bathroom.	• Maintains continuity of task. Allows for greater concentration on task.
• After or before bathing (use the time that is the usual habit of the resident according to previous consultation with relative and/or resident) say, “It would be nice to have your shave now”.	• Maintains usual habit (time). Orientates the resident to the task. Allows for greater response from the resident, therefore maintaining self-help abilities.
• Approach the task in a step-by-step manner, allowing the resident to hold and use the razor as appropriate, only intervening with physical assistance when verbal prompts and modelling cues are unsuccessful.	• Avoids over-whelming the resident with impossible demands. Encourages success in simple step tasks. Promotes self-esteem and self-help abilities.
• Praise and/or say thank you whenever the resident takes a step towards completing the task.	• Improves the chances that the resident will be co-operative the next time. Provides a calm, friendly experience of success.

Some residents will require physical guidance and assistance with the tasks. This level of intervention is almost the last resort. The last resort is doing the task for the resident but even then the resident must be involved by having task explained to them and being asked to contribute as much as possible, even if that is only to agree that "That's better."

INTERVENTIONS	RATIONALE
4. Physical Assistance/Do-It-Yourself.	
• Collect equipment needed with bath necessities before bringing the resident to the bathroom	• Maintains continuity of task.
• Communicate the need for a shave for the resident, at a pre-arranged time that coincides with normal habits when the resident was independent.	• Maintains dignity and orientates the resident to the task. Encourages confidence and memory of an old habit.
• Explain every step of the process as you do it.	• Provides a calm environment with greater chance of co-operation.
• Praise and/or say thank you to the resident as each step is completed and/or when the resident responds with co-operation.	• Encourages feelings of success. Increases chances of co-operation.

The headings for the level of intervention vary from topic to topic but they all contain the concept of a graded set with the least active being the preferred option.

Having selected and modified the MCP the case manager then uses it as the basis for a discussion with those responsible for the care of the resident. The more points of view that can be brought into this discussion the better, particularly if they include a relatives, external experts (e.g. physiotherapists, occupational therapists, etc) and registered nurses. The ideal setting for this discussion is a well managed case review (Fleming and Kramer, 1995). The purpose of this discussion is to come to an agreement on the application of the care plan as it has been presented, its modification or its abandonment in favour of another approach. This should lead on to an agreed plan, a care plan that has the support of all who will be involved in the care of the resident. Consistent care should result.

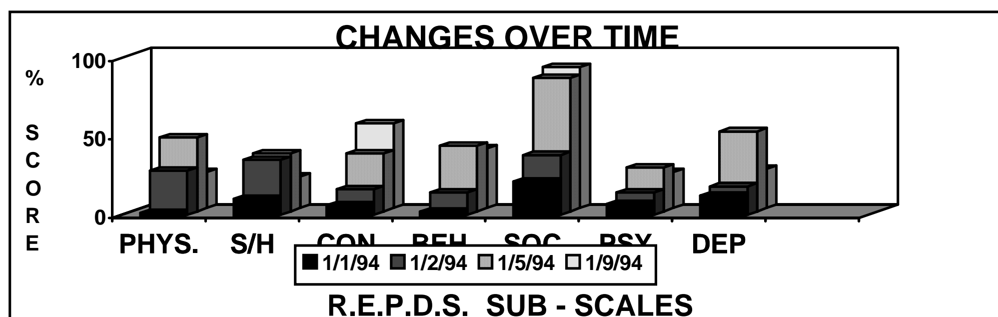
As the MCPs enable direct care staff to help formulate the care plans they help to ensure that the care plans are actually used, not just written. Direct care staff can own them and take pride in implementing them.

Review

The ownership of the care plans becomes particularly important when it comes to reviewing them because at this point the success or failure of the interventions come up for discussion. We find that doing this every 4 months or so is about as much as can be achieved in a busy nursing home but also enough to ensure that the care is responsive to changing needs. The REPDS assists the staff in this process by providing a Monitoring Report that clearly shows areas of change and provides an opportunity for staff to explain what has happened. This should be done as the first stage in the case reviews of residents who have has a care plan implemented already. Following the explanation of the changes the review continues through problem identification and discussion on care plans in the same way as before.

An example of the REPDS Monitoring Report is provided below.

ALAN ALPHA: MONITORING REPORT



USE THE SPACES BELOW TO COMMENT ON THE REASONS FOR THE CHANGES.

PHYSICAL PROBLEMS:

Physiotherapy has improved mobility.

SELF HELP PROBLEMS:

Consistent use of care plans has improved self help. Particularly bathing and shaving.

CONFUSION:

Confusion is not responding to reality orientation.

BEHAVIOUR:

Behaviour seems to be unpredictable.

SOCIABILITY PROBLEMS:

Death of friend has made Alan withdraw from social contacts.

PSYCHIATRIC CONDITION:

Marginal improvement, unknown cause.

DEPENDENCY ON STAFF:

Reduction in physical problems and improvement in self help have reduced the amount of time needed for nursing interventions.

DETAILED SCORES:

DATE	PHYS.	S/HELP	CONFUSION	BEHAVE	SOCIAL	PSYCH.	DEP.
01/01/1994	9	12	8	4	23	9	14
01/02/1994	28	35	16	14	38	14	18
01/05/1994	47	37	17	42	85	28	51
01/09/1994	23	20	54	38	30	23	25

Instructions for the use of the Model Care Plans.

1. Assess the resident using the REPDS.

Be sure to do this properly by observing the resident carefully, using a conversation to ask the questions in the Confusion section and knowing the definitions used in each question.

2. Identify the problems.

The easiest way to do this is to enter the REPDS answers into the computer and use the REPDS programme to generate the 'Programme Development Report'.

You could also scan the completed REPDS form and list the most significant problems. These will usually be scored 2 or 3.

3. Link the problems to the Model Care Plans

Each REPDS question has a number, e.g. SH2 (which refers to the question about bathing). Each Model Care Plan has a corresponding number. So to find the Model Care Plan dealing with bathing simply go to Model Care Plan SH2. The care plans are in the same order as the REPDS questions.

4. Decide the level of intervention

Each MCP has four sections each referring to a different 'strength' of intervention. Select the weakest intervention that you think will work. This will help to reduce the tendency for residents to get more and more dependent on staff.

Use this intervention as the basis for **your suggested** care plan.

5. Change the MCP to meet the individual needs of the resident

Having decided on the starting point for the care plan discuss it with your colleagues. Make sure the problem you are dealing with is of high enough priority to require a care plan, make sure they agree with the approach, make sure it is practical, make sure they will help you carry it out consistently.

Write the modified (agreed to) care plan up on the appropriate documentation.