

Dementia Care Mapping

Finding Trends & Future Thinking

In Mature Company Year 1

By Lily Craig and Lauren Clarke

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1) Methodology

Mapping session length

A typical mapping session is between 1-2 hours in length. The mapping session begins before the creative session starts and continues after the session ends.

Mappers position in the space

The mappers sit in close proximity to the residents being mapped. Mappers do not include themselves in the session and wear dark clothing to avoid attracting attention or distracting the residents.

Identifying which residents to map

In year 1 the mappers identified which residents to map through a conversation with the artistic team on the day of the session. The mappers then sit in the space to observe the residents before the session begins. The mappers then introduce themselves to the residents to gain their consent.

Mapping methodology

Each mapping session measures:

1. Individual and group levels of wellbeing and ill-being throughout a creative session.
2. Care staff and artist interactions which either promote or undermine person-centred care and wellbeing.

These two aspects are observed and coded against 4 categories:

1. **Behaviour Category Codes (BCC)** – 23 alphabetised codes representing what a person is doing. These have varying potentials for wellbeing: high, moderate, low and last. For example, Geoffrey is drinking a cup of tea. This is coded as the BCC “F” for “Food”. (See appendix 1).
2. **Mood and Engagement Value (ME)** – 6 levels that represent how negative, neutral or positive a person’s mood and engagement. For example, Geoffrey is clapping along to an Elvis CD. He is smiling and tapping his feet. This is coded as +3; his mood is content, happy, relaxed; his engagement is considerable. (See appendix 2).
3. **Personal Enhancers (PE)** – 17 interpersonal skills that can be used by a person to support or enhance the personhood of a resident. PEs can be recorded at two levels, E = enhancing, HE = highly enhancing. For example, Geoffrey is crying and reaches out to a care worker who is passing. The care worker takes Geoffrey’s hand and asks him what’s wrong. They sit together quietly until Geoffrey has stopped crying. This is coded as PE 2: “Holding” (providing safety, security and comfort) at level “E” (enhancing).
4. **Personal Detractors (PD)** – 17 interpersonal skills that can be used by a person to undermine the personhood of a resident. PDs can be recorded at two levels, D = detracting, HD = highly detracting. For example, Geoffrey is crying and reaches out to a care worker who is passing. The care worker says “*stop attention seeking; you’re only doing this because you know I’m busy*”. This is coded as PD 2: “Withholding” (refusing to give asked for attention or to meet an evident need for contact) at level “HD” (highly detracting).

Feedback to inform artistic practice

Observations are collated into an individual resident report and a group report. The mappers compile a series of questions and points of discussion about individual residents or the group as a whole. The mappers share these reports with the artistic team and facilitate an open discussion about the findings.

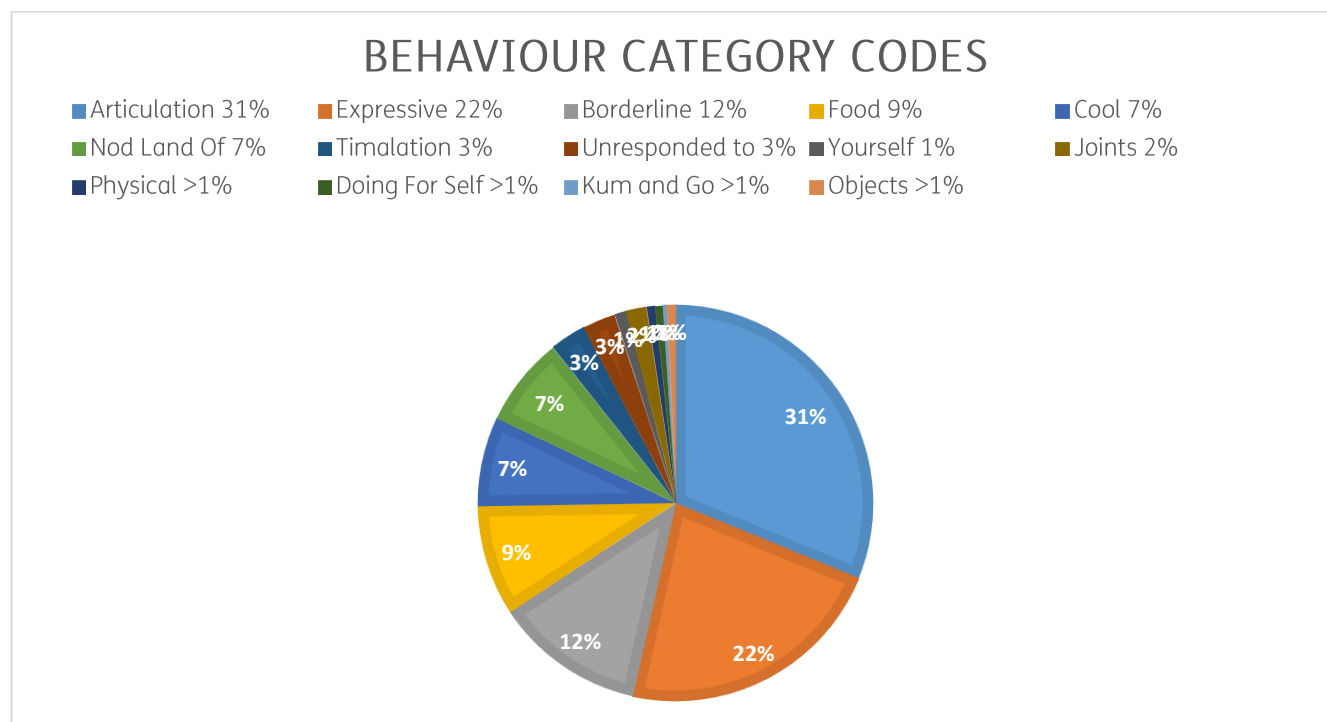
The artists use this feedback to evaluate and develop the sessions going forward.

2) Data

In Year 1 mapping took place in two care homes: The Grove/Red Court and Halcyon Court. A total of seven mapping sessions produced 7 care home maps and 31 individual maps.

The Grove/Red Court hosted two group sessions, both of which were mapped. For the purpose of this report the two groups are evaluated separately.

Red Court (3 maps)

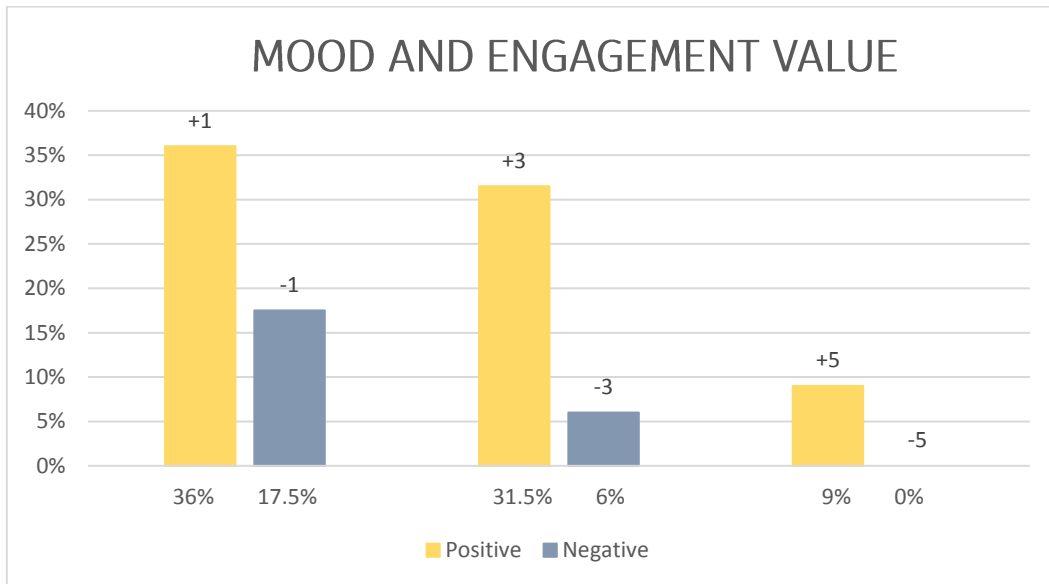


The two most prevalent behaviour category codes (BCC) were “Articulation” (interacting with others verbally or otherwise) and “Expressive” (expressive or creative activities). These BCCs account for 53% of mapped time. Both BCCs have a high potential for wellbeing.

Other BCCs mapped with a high potential for wellbeing included “Food” (eating or drinking), “Timalation” (direct engagement of the senses), “Yourself” (interaction in the absence of any observable other), “Joints” (exercise or physical sport), “Physical” (receiving practical, physical or personal care), “Doing for self” (self-care), “Kum and go” (walking, standing or moving independently), and “Objects” (displaying attachment to or relating to inanimate objects). These BCCs account for a further 17% of mapped time.

The third most prevalent BCC was “Borderline” (being engaged but passively – watching) accounting for 12% of mapped time. This BCC has a moderate potential for wellbeing.

BCCs with a low potential for wellbeing made up 10% of the map. These included “Cool” (being disengaged, withdrawn) and “Unresponded to” (attempting to communicate without receiving a response). The final BCC mapped was “Nod land of” (sleeping, dozing) which is the lowest possible BCC with potential for any wellbeing.

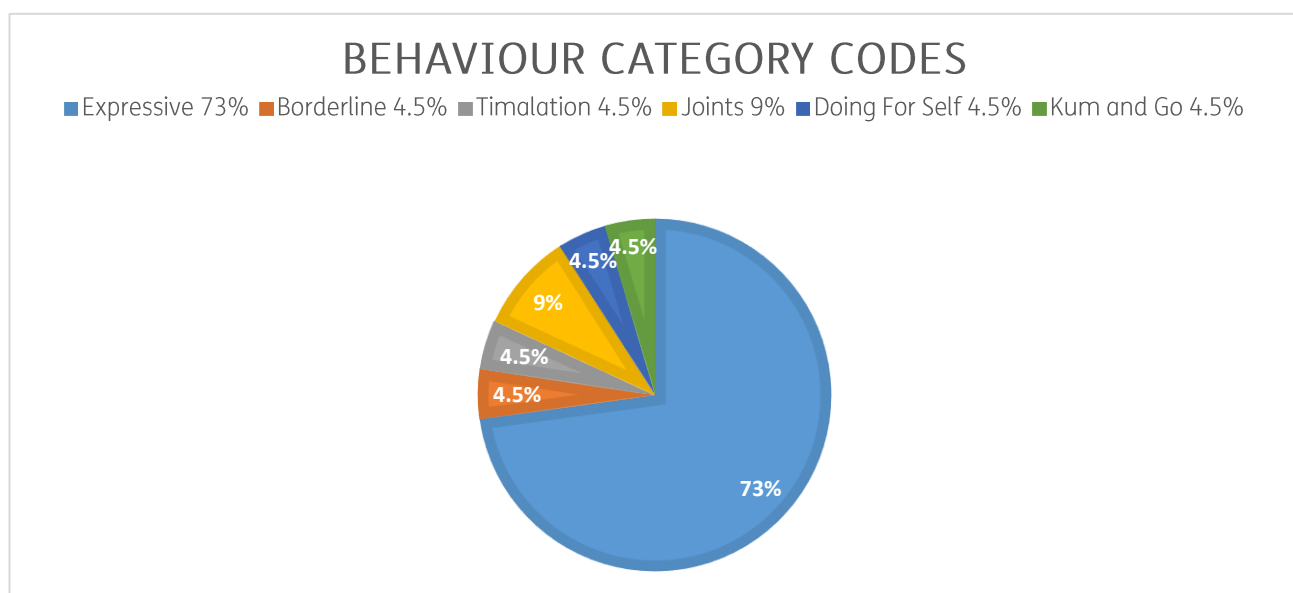


The most prevalent mood and engagement value (ME), making up 36% of mapped time, was +1 (mood = neutral, absence of overt signs of positive or negative mood / engagement = alert and focussed on surroundings, brief or intermittent engagement).

The second most prevalent ME is +3, making up 31% of mapped time (mood = content, happy, relaxed. Considerable positive mood / engagement = concentrating but distractible. Considerable engagement).

Residents were mapped as either -1 or -3 for 23.5% of mapped time. This indicates residents were in a negative mood, withdrawn and out of contact. -5 was not mapped at all meaning residents were not considered to be very distressed or showing signs of a very negative mood.

The remaining 9% of mapped time had an ME value of +5. This is the highest ME value indicating residents are very happy, cheerful, in a very high positive mood, very absorbed and deeply engrossed/engaged.



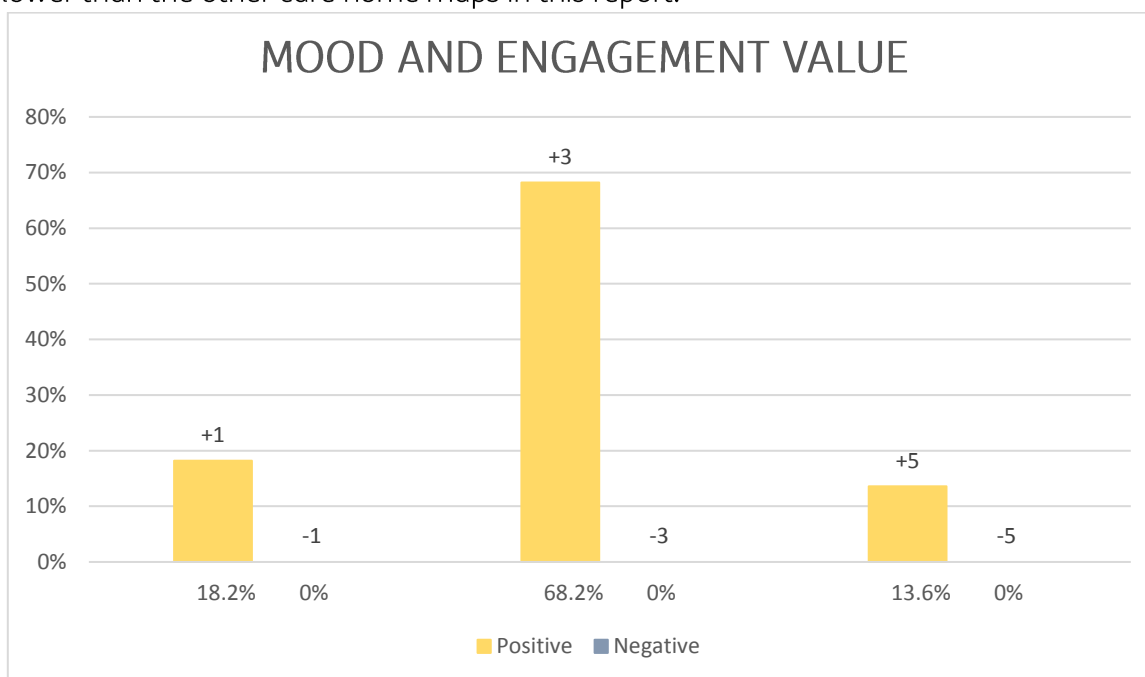
The Grove (1 map)

The most prevalent behaviour category code (BCC) was “Expressive” (expressive or creative activities), making up 73% of mapped time. This BCC has a high potential for wellbeing.

Other BCCs mapped with a high potential for wellbeing included “Joins” (exercise or physical sport), “Timalation” (direct engagement of the senses), “Kum and go” (walking, standing or moving independently), and “Doing for self” (self-care). These high potential BCCs make up 22.5% of the map.

The only other mapped BCC was “Borderline” (being engaged but passively – watching) making 4.5%. This BCC has a moderate potential for wellbeing.

It is worth noting that this data is taken from one map conducted at the Grove therefore the variety of BCCs is lower than the other care home maps in this report.

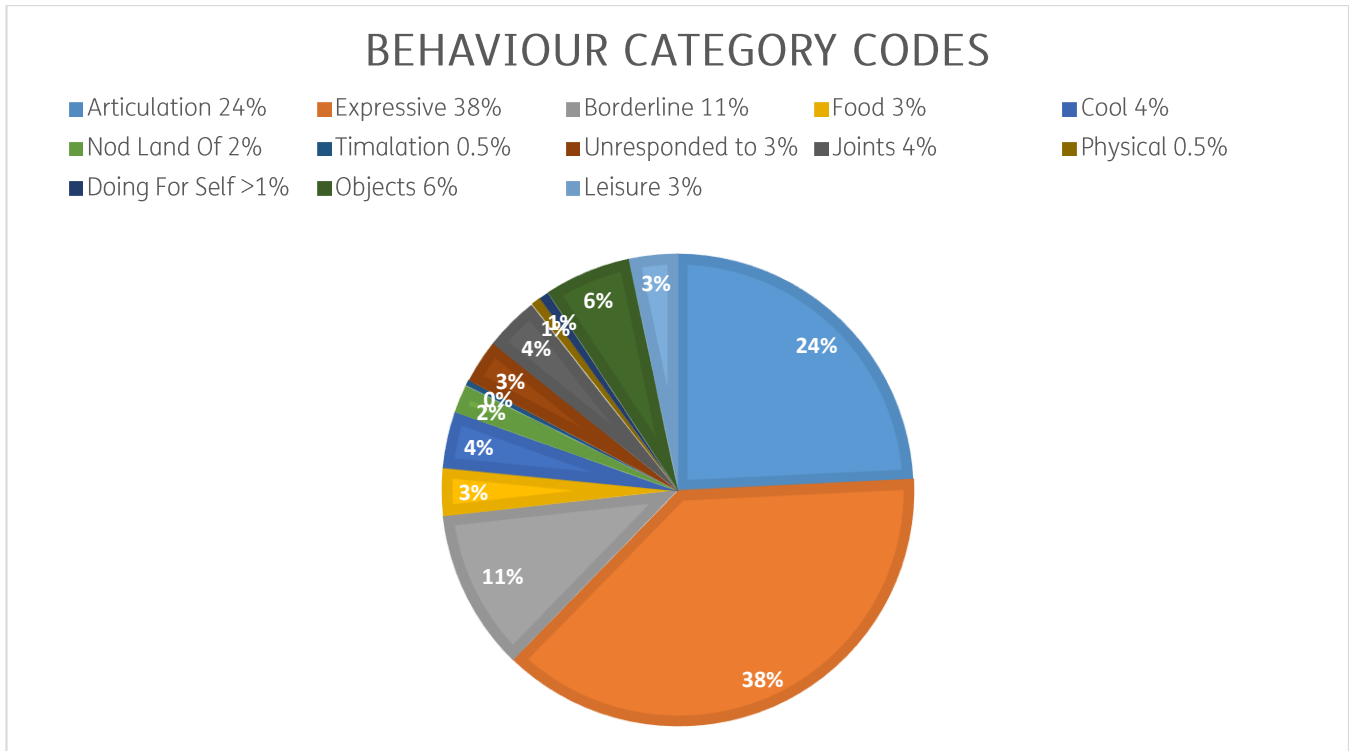


The most prevalent ME value was +3 (mood = Content, happy, relaxed. Considerable positive mood/ engagement = Concentrating but distractible. Considerable engagement) which makes up 68% of mapped time.

The second most prevalent ME value was +1 making up 18% of mapped time (mood = Neutral. Absence of overt signs of positive or negative mood/ engagement = Alert and focussed on surroundings. Brief or intermittent engagement).

The remaining 14% of mapped time was +5. This is the highest ME value and indicates residents are very happy, cheerful, in a very high positive mood, very absorbed and deeply engrossed/engaged.

Halcyon Court (3 maps)

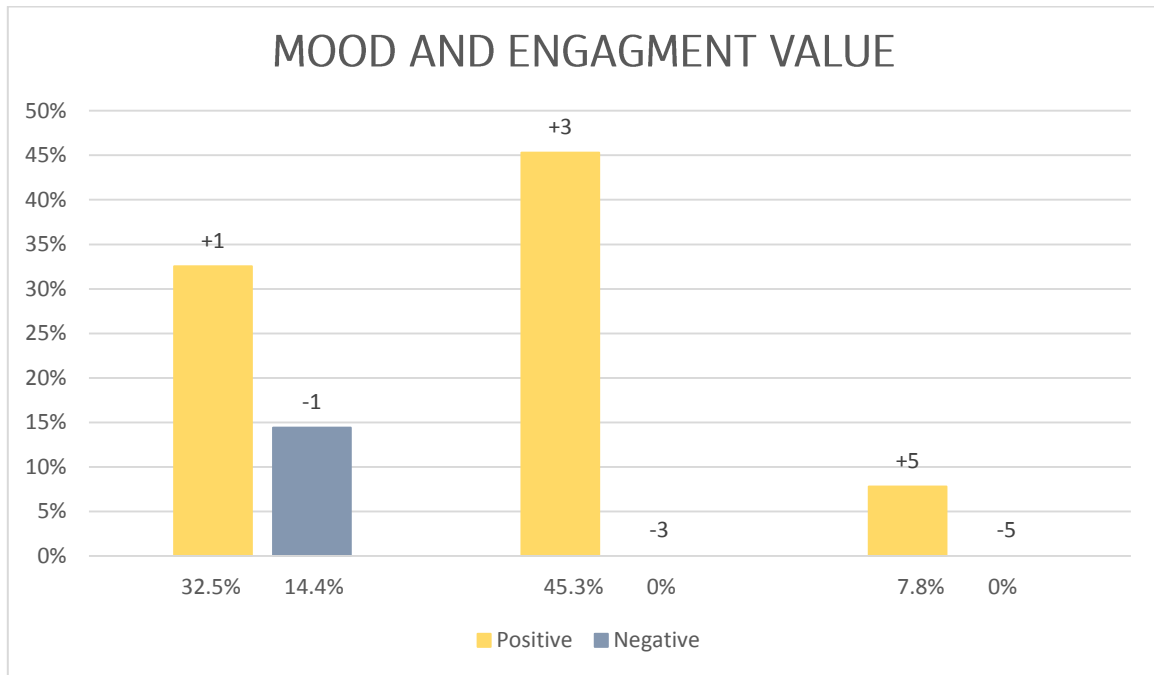


The two most prevalent behaviour category codes (BCC) mapped were “Expressive” (expressive or creative activities) and “Articulation” (interacting with others verbally or otherwise). These make up 62% of mapped time. Both of these BCCs have a high potential for wellbeing.

Other BCCs mapped, with a high potential for wellbeing, included “Food” (eating or drinking), “Timalation” (direct engagement of the senses), “Joints” (exercise or physical sport), “Physical” (receiving practical, physical), “Doing for self” (self-care), “Objects” (displaying attachment to or relating to inanimate objects), and “Leisure” (leisure, fun and recreational activities). These high potential BCCs make up 18% of mapped time.

The third most prevalent BCC was “Borderline” (being engaged but passively – watching) with 11%. This BCC has a moderate potential for wellbeing.

BCCs with a low potential for wellbeing made up 9% of the map. These BCCs included “Cool” (being disengaged, withdrawn) and “Unresponded to” (attempting to communicate without receiving a response). The final BCC mapped was “Nod land of” (sleeping, dozing) which is the lowest possible BCC with potential for any wellbeing.



The most prevalent ME value was +3 (mood = content, happy, relaxed. Considerable positive mood / engagement = concentrating but distractible. Considerable engagement), making up 45% of mapped time.

The second most prevalent ME value mapped 33% of the time was +1 (mood = neutral, absence of overt signs of positive or negative mood / engagement = alert and focussed on surroundings, brief or intermittent engagement).

Residents were mapped as -1 for 14% of the mapped time. This indicates that residents were in a negative mood, were withdrawn and out of contact. -5 was not mapped indicating that residents were not very distressed or showing signs of a very negative mood.

The remaining 8% of mapped time was +5 meaning residents were very happy, cheerful, in a very high positive mood, very absorbed and deeply engrossed/engaged.

3) Trends

Seven trends were highlighted by the group mapping data. The number next to each heading represents how many times the trend has occurred across the 31 individual maps and 7 care home maps.

Trend 1 - 1:1 Interactions (13 occurrences)

1:1 interactions with another person (artist, care worker, resident or external visitor) are the most frequent example of how resident's wellbeing can increase from a lower ME value to a higher ME value. Mapping data indicates that residents who find it more difficult to engage during group activity are more likely to experience higher levels of wellbeing when interacted with on a 1:1 basis during the session.

For example: Barbara is sat back in her wing backed chair with her eyes closed but not sleeping. She displays a behaviour category code (BCC) of "Cool" (being disengaged, withdrawn) and mood/engagement (ME) level of -1 (withdrawn and out of contact). The artist approaches Barbara and begins a conversation. The artist reaches out their hand, which is received by Barbara. Barbara sits forward and responds to the artist. Following this interaction, she is coded with a BCC of "Articulation" (interacting with others verbally or otherwise) and an ME level of +1 (neutral with brief or intermittent engagement). As the artist walks away, Barbara sits back in her chair and in the following two time frames, she exhibits the BCC "Borderline" with intermittent engagement, followed by the BCC "Cool" with no interest in others or the surroundings.

During this 1:1 interaction, Barbara displayed a BCC with a high potential for health and wellbeing. This suggests that with increased frequency of 1:1 interactions Barbara can sustain a higher level of mood and engagement.

Trend 2 - Agency within the session (7 occurrences)

It was observed that the artists empowered residents who display high ME values (very happy and deeply engrossed) to go beyond the activity laid out in the session and take ownership. Where this occurred residents ME value increased to the highest possible level.

For example: Pat displays a consistently high ME value and is almost always involved in the creative activity. After noticing Pat's enthusiasm and sustained level of engagement, the artist says to Pat "I need a hand here". They encourage Pat to her feet and lead her over to Donald, who is sat in his chair. Pat is encourage to take Donald's hand and leads a sway in time with the music. Thus increasing Donald's engagement within the session by initiating a 1:1 interaction.

This was mapped as a personal enhancer of "Empowerment" (assisting the participants to discover or employ abilities and skills) where some control and agency was passed over to Pat. She displayed the highest possible ME value at this time, +5. Following this interaction when Pat sits back down in her chair, she returns to her consistent ME value of +3.

Trend 3 - Touch and Comfort (5 occurrences)

The first year of the project focused on exploring the impact of touch. The artists use touch in different ways throughout the session, for example they use touch at the start and end of the sessions to communicate their arrival and departure to individual residents. Touch also occurred during group movement activities. Mapping data indicates that touch within the sessions upholds the psychological need for comfort and thus results in a high ME value. It was observed that touch has the greatest impact on ME values when used during 1:1 interactions.

For example: An artist approaches Terry and bends to his eye level. The artist asks how he is and smiles. Terry mumbles a response. The artist asks if Terry is going to do some singing and if he likes the song playing. They are holding hands and Terry says that the artist's hands are warm. In response to this the artist puts their hands around Terry's and rubs together to gently warm them up. This was mapped as a personal enhancer of "Warmth" (demonstrating genuine affection, care and concern for the participant). The warmth that Terry feels is translated into his mood and engagement value which is mapped as a +3 (content, happy and relaxed). In the following timeframe, Terry's ME remained at a +3 showing the lasting impact of this PE. However in the next time frame, his ME drops back down to a +1.

Trend 4 - Signifiers that show resistance to being in the room / sleeping (3 occurrences)

It was observed that a small number of residents display signifiers associated with the desire to leave the session. Their actions and language were often coded with a negative ME value or with the BCC "Unresponded to".

For example, during an individual map of Edna her calling out indicated that she did not want to be in the session. Sometimes Edna was responded to and sometimes she was not. It is important to note that each time frame is 5 minutes; these examples were picked out from within those timeframes, therefore other behaviours reinforced the coding.

'Why can't you take me home?' Coded as: "Unresponded to" -3

'Shut up, I'm going home. Leave me alone, please.' Coded as: "Articulation" -3

'I don't want to be here, no-one loves me, never.' Coded as: "Articulation" -3

'May I leave the room? Please, yes.' Coded as: "Unresponded to" -1

During this map there are examples of Edna sleeping, mostly just for a minute or so, but once for a whole 5 minute timeframe. Edna's resistance to being in the room is reinforced by the fact she becomes so disengaged that she falls asleep.

In Halcyon Court, Jean was mapped for a total of 1 hour (12 time frames). At the start of the session, Jean told a mapper that she didn't enjoy the previous week's session due to the loud drumming music. When the session began, Jean appeared to be agitated and angry, which is coded as "Unresponded to" -1.

The artist led the "hello song" (which includes the lyrics; "it's good to see you"), where each resident is addressed individually. When it is Jean's turned to be sung to, she responds with; ***'no, it's not good to see you'***. Throughout the remainder of the session, Jean is only coded with a negative or neutral mood

and engagement (-1 or +1). When an artist attempted to engage with Jean on a 1:1 basis she refused and remained disengaged.

The mappers observed additional signifiers including: attempts to stand up and leaving the room; calling out for care staff; crying; shouting; withdrawal; agitation; and anger. These are clear signs of ill-being and potentially indicate a desire to leave the session.

Trend 5 - Inclusion of history and biography (4 occurrences)

The Enriched model of Dementia Care recognises the multiplicity of factors which affect a person's experience of dementia and includes the individual's biography or personal history. Understanding and referencing a resident's personal history is likely to increase ME values.

The mapping identified a number of missed opportunities for using a resident's biography and personal history and therefore a missed opportunity to raise ME values and increase wellbeing. For example, when Scarborough is mentioned at the Grove, Margaret says aloud, '*ahhh, childhood memories!*' but this is unacknowledged within the session.

Trend 6 - Pace of session / clarity of instruction (4 occurrences)

Within the sessions, set verbal instructions are not always followed by the residents. The mappers questioned whether this is due to the pace of the activity and clarity of these instructions. In relation to pace, it was observed residents becoming either less engaged or disengaged when the pace of the session was either too slow or too fast.

For example at the Grove, Dorothy joins in with a marching movement, raising her arms in the air. As this exercise continues for a few minutes, Dorothy looks at her watch to check the time. She continues to raise her left arm and with her right arm, takes a book out of her pocket and starts to read it. She manages to multi-task and read whilst still staying involved in the activity at a certain level. During this timeframe, Dorothy's ME value is a +1 as her engagement is brief and intermittent. During the rest of the map, both before and after this particular timeframe, Dorothy's ME is a +3. Dorothy was potentially more distractible during this timeframe because the pace of the session during this particular activity was too slow for her.

However in other instances residents did not take part in an activity either because they did not understand the verbal instruction, the pace of the activity was too fast for them to keep up, or there was a personal/individual reason why they did not join in. For example, at Halcyon Court, Margaret doesn't join in the call and response rhythm when holding her bells. She taps her foot but keeps the bells in her hand and just watches other residents do the call and response with their various percussion instruments. The verbal instruction was given by the artist: "repeat what I do". Potentially Margaret did not understand what was expected during this particular exercise. Margaret did however follow verbal instructions during the rest of the session, therefore the mapping report questioned why she did not actively engage in this specific task. Margaret's ME value did not change from a +3 and she remained in a positive mood.

Lack of clarity and appropriate pace can have a negative impact on ME values but not consistently. More data is needed to draw conclusions around this trend.

Trend 7 - Attachment to Objects / Props – (4 occurrences)

Some residents displayed an attachment to objects which were unrelated to the session, e.g. Jean's toy dog and Anna's doll. These residents tended to remain less engaged within the sessions. The mappers questioned whether these objects could be included more within the creative sessions to increase the ME value of the resident.

For example: Anna (resident) is holding Annabel (the baby doll), she is smiling and keeps looking at Annabel. The artists sing the welcome song to Anna and she is passively engaged. The mappers questioned whether including a welcome to Annabel in the song would increase her ME value.

4) Conclusions

Reducing Loneliness and Isolation

In year 1 Dementia Care Mapping was used to measure levels of well-being and ill-being as an indicator of whether the In Mature Company programme was effective in reducing loneliness and isolation. Mapping data demonstrates that the creative sessions are having a positive impact and consistently engaging approximately 80% of residents through expressive activity and verbal or non-verbal communication.

The three most prevalent BCCs across all 7 care home mapping sessions, making up 70% of mapped time, were "Expressive" (36%), "Articulation" (24%) and "Borderline" (10%). "Expressive" and "Articulation" are BCCs which are not necessarily present in everyday care and have a higher potential ME value. The BCC "Borderline" refers to a resident who is engaged but is passively watching. It is possible to map a "Borderline" BCC with a +5 ME value however a B+5 coding did not occur across the 7 mapping sessions. This was because "Borderline" was normally observed in the same time frame as another BCC with a higher potential for wellbeing, such as "Expressive" or "Articulation" so the timeframe was coded with the BCC with high ME value potential.

In the mapping time frames before the creative session began residents were mapped with BCCs such as "Borderline" and "Cool" which indicate passive engagement or no engagement. Whereas during the sessions residents were mapped with BCCs with a higher potential ME value.

One of the features of good person centred care is giving residents freedom for self-expression and recognising the individual. The programme is enhancing person-centred care because opportunities for creativity and participation are embedded within the sessions.

The Impact of Touch

In year 1 the project focused on exploring the use of touch to reduce loneliness and isolation. Touch was present during the creative sessions, however, using the standard DCM approach meant that mapping did not differentiate between different types of touch (i.e. functional, communicative, creative, etc.) and so no conclusions could be drawn about when touch has the greatest impact.

The mappers identified that touch occurred mostly within 1:1 interactions and was used to build relationships between artists and residents. The mapping shows that this use of touch is effective in creating Personal Enhancers of "Warmth" and "Comfort" for residents which is reflected in their mood

and engagement levels. However when a Personal Enhancer or Personal Detractor was not recorded, it was difficult to pinpoint where touch moments occurred. This is because touch does not have its own behaviour category code which makes it challenging to not only code within a map, but also to quantify.

When touch was observed, it resulted in something being changed experientially for an individual. For example, a participant is disengaged and becomes engaged as a result of an artist holding their hand. These examples of touch directly impacted BBCs and ME values so touch is coded as “Articulation” or “Expressive”, rather than the actual act of touch.

Early data indicates that touch has a positive impact on wellbeing however entering into year 2 the DCM mappers need to look at new ways of mapping, coding and analysing touch. More specific coding of touch will allow the DCM reporting to quantify whether touch has a lasting impact on those who experience it and also whether touch has more or less impact in different group sizes.

Dementia Care Mapping year 1 methodology

Different people were mapped during each session and in some sessions a different number of residents were mapped (ranging from 2 to 4 people per mapper per session). Whilst the year 1 mapping reports indicate the positive impact of the programme across a large number of residents it has not been possible to track or evaluate the impact of the 20 week programme on a single resident’s wellbeing.

The number of maps carried out within each care home was inconsistent creating a question around the validity of comparing the raw data of different care homes.

Time of day is another variable which impacted on the validity of comparing results between care homes. Some creative sessions took place in the morning and some in the afternoon. If a session takes place just before lunch residents may be hungry, whereas if a session takes place straight after lunch, residents may be full and potentially sleepy. Sessions directly after a meal sometimes started late resulting in a shorter session and less mapping time. Controlling the time of day variable is challenging however one way of mitigating against sessions starting late is to always map for the same length of time regardless of when the session starts. This will include a mapping period before and after the creative session.

In year 1 the two DCM mappers worked independently to analyse their individual maps and produce a report for the mapping session. At the end of the year the two mappers worked together to identify trends across all 31 individual maps and 7 sessions. This way of working reduced the mappers’ ability to identify trends throughout the year and to actively respond to this by taking corrective action.

5) Recommendations

The following 11 recommendations are intended to improve both Dementia Care Mapping and session delivery in year 2 of the project:

1. 1:1 interactions have the greatest impact on increasing wellbeing, it is therefore recommended that the number of 1:1 interactions within sessions are increased to enable every resident within a session to experience a 1:1 interaction with either an artist, a volunteer or member of care staff. This could be achieved by increasing the number of facilitators, such as volunteers, in the space and providing appropriate training on working with a resident 1:1.
2. To encourage agency, it is recommended that artists continue to actively look for residents demonstrating enthusiasm and engagement and invite them to play a more active role in interacting with other residents, props; helping with tasks (e.g. giving out instruments); or contributing a movement.
3. To increase quantifiable data around the impact of non-functional touch in sessions the mappers should identify a method of coding touch. This could be a new BCC code or attaching touch to a pre-existing BCC code, for example, "Articulation with touch". The ongoing evaluation of touch could be supported by artists, care staff and visitors increasing the use of touch within sessions.
4. To enable the mappers to quantify whether there are clear signifiers that a resident wishes to leave the session it is recommended that if a resident displays one of the signifiers of distress identified by Dementia Care Mapping™ (i.e. attempts to stand up and leaving the room; calling out for care staff; crying; shouting; withdrawal; agitation; and anger) the artists should trial: acknowledging the resident, asking if the resident wishes to leave, speaking with care staff to ascertain potential reasons for the behaviour or potentially supporting the resident to leave the room.
5. To increase ME values by shaping session content with the history and biography of individuals, it is recommended that the team work with the care homes to access profiles of the residents and artists use 1:1 interactions to build their knowledge of a resident's personality, likes, dislikes, background, etc. Any session content developed based on personal histories should actively acknowledge the resident (e.g. "*Margaret loves Scarborough so we're doing...*")
6. To test whether clarity and pace impact on ME values the artists should communicate all instructions non-verbally as well as verbally. Increasing non-verbal communication will support pace and clarity for residents who cannot communicate verbally, therefore enabling the mappers to quantify the potential impact of lack of clarity and appropriate pace on resident's well-being.
7. To improve the ME values for residents who like to hold objects, we recommend artists explore how they can use and refer to these unrelated objects differently within the session.
8. To improve ongoing analysis and allow for corrective action throughout the year, the Dementia Care Mappers should allocate more time to planning, analysis and reflection.
9. To increase the validity of DCM data, an equal number of mapping sessions and individual maps of the same standard length should be completed for each care home. Dementia Care Mappers should also map a control session to act as a comparison to the creative sessions.
10. To increase understanding of the impact of the sessions the DCM mappers should map the same participants in each mapping session over a 20 week period. This will provide more in depth and richer data relating to an individual resident for feedback and discussion.
11. To increase understanding of the mapping data structured time should be allocated for both mappers to code, analyse and plan together and feed back to the artists and care team.

6) Future Thinking

Dementia Care Mapping Focus Area in year 2

In year 2 non-functional touch will continue to be mapped. The mappers will contact Lisa Heller for advice on how to code touch. The mappers will also begin to investigate the pathways between 1:1s, small groups and large group sessions looking at the impact on residents' wellbeing of moving between different group sizes.

DCM Approach

- Both mappers will map a single session together to produce 6 individual maps per session.
- Each mapping session will last for 2 hours including six 5-minute timeframes (equivalent to 30 minutes) both before and after the creative session. We will allow contingency time for observational set up/pack down and greeting residents.
- Mappers will map the same 6 residents in each care home in order to investigate the impact of the sessions across the full 20 weeks. We anticipate it may not be possible to map all 6 residents in every session however where possible we aim to map the same individuals.
- Mappers will map in 2 out of the 3 care homes in year 2. Focusing on 2 care homes allows a greater number of maps on a single resident providing richer data.
- 2 control maps will be completed in each care home before the 20 week programme commences.
- An interval of 3 weeks will be left between maps.
- The mapping reports will be fed back to the artistic teams at training sessions held during the programme breaks after week 7, week 14 and week 20.
- An end of year evaluation will be completed for March 2020.

Time Allocation

In year 2 sixty days (thirty days per mapper) is allocated to Dementia Care Mapping. We recommend that this 30 days is apportioned as follows (for a single DCM mapper):

Timescale	DCM Activity	Total Time
May 2019: Before the 20 week programme begins. NOT during a creative session.	<u>4 Control Mapping sessions</u> 10 hours of mapping (4 mapping sessions up to 2.5 hours each) 20 hours write up and analysis (5 hours per mapping session) 10 hours feedback (4 feedback sessions of up to 2.5 hours each) 10 hours of analysis (2.5 per control session)	50 hours (6.6 days)
May-Dec 2019: DCM sessions during week: 3,5,9,12,16, 19	<u>6 Mapping sessions in Care Home 1:</u> 15 hours of mapping (6 mapping sessions up to 2.5 hours each)* 30 hours of write up (5 hours per mapping session) 15 hours of feedback (6 feedback sessions of up to 2.5 hours each) 15 hours of analysis (2.5 hours per mapping session)	75 hours (10 days)
May- Dec 2019:	<u>6 mapping sessions in Care Home 2:</u> 15 hours of mapping (6 mapping sessions up to 2.5 hours each)*	75 hours (10 days)

DCM sessions during week: 3,5,9,12,16, 19	30 hours of write up (5 hours per mapping session) 15 hours of feedback (6 feedback sessions of up to 2.5 hours each) 15 hours of analysis (2.5 hours per mapping session)	
Feb- March 2020: After 20 week programmes end in year 2 care homes.	<u>1 End of Year Report</u>	3.5 days

**Each mapping session will produce 3 individual maps. This includes the one control group map, and four maps during the creative session. The total number of residents mapped across Phase 2 will be 30 residents.*

Post intervention mapping

We anticipate revisiting the year 1 or 2 care homes to map the residents after the 20 week programme ends. There may be potential to map at The Grove (Year 1 care home) where the Activities Coordinator is aiming to continue running a weekly creative session.

Index:

Dementia Care Mapping: a tool that prepares staff to take the perspective of the person living with dementia in assessing the quality of the care they provide. It empowers staff teams to engage in evidence-based critical reflection in order to improve the quality of care for people living with dementia.

Enriched Model of Dementia: asserts that all of the following affect how a person living with dementia acts, feels and thinks; neurological impairment, health and physical wellbeing, biography and life history, personality, and social psychology.

Personhood: the quality or condition of being an individual person.

BCC: Behaviour Category Codes (see appendix 1).

High Potential for Wellbeing: This relates to particular behaviour category codes that have a greater potential for an individual to experience high wellbeing. (See appendix 1. All green highlighted codes have high potential).

M/E Value: Mood and Engagement Value. This relates to what manner the behaviour category code is being displayed.

(+5 to – 5): This is the mood and engagement scale. With +5 being extreme levels of high mood and engagement and -5 being extreme levels of low mood and engagement. (See appendix 2) .

Timeframe: Refers to each 5 minute interval that an individual is mapped.

Appendix 1:

High Mod Low Last

DCM™ 8 Crib Sheet

BEHAVIOUR CATEGORY CODES

Code	Memory cue	General description of category
A	Articulation	Interacting with others verbally or otherwise
B	Borderline	Being engaged but passively (watching)
C	Cool	Being disengaged, withdrawn
D	Doing for self	Self care
E	Expressive	Expressive or creative activities
F	Food	Eating or drinking
G	Going back	Reminiscence and life review
I	Intellectual	Prioritising the use of intellectual abilities
J	Joints	Exercise or physical sport
K	Kum and Go	Walking, standing or moving independently
L	Leisure	Leisure, fun and recreational activities
N	Nod Land Of	Sleeping, dozing
O	Objects	Displaying attachment to or relating to inanimate objects
P	Physical	Receiving practical, physical or personal care
R	Religion	Engaging in a religious activity
S	Sexual expression	Sexual expression
T	Timalation	Direct engagement of the senses
U	Unresponded to	Attempting to communicate without receiving a response
V	Vocational	Work or work-like activity
W	Withstanding	Repetitive self-stimulation of a sustained nature (not of other or outside of self)
X	Excretion	Episodes related to excretion
Y	Yourself	Interaction in the absence of any observable other
Z	Zero option	Fits none of existing categories

Each colour represents the potential for well-being:

Green - High

Yellow - Moderate

Blue - Low

Pink - Last

Appendix 2:

Mood	ME value	Engagement
Very happy, cheerful. Very high positive mood.	+5	Very absorbed, deeply engrossed/engaged.
Content, happy, relaxed. Considerable positive mood.	+3	Concentrating but distractible. Considerable engagement.
Neutral. Absence of overt signs of positive or negative mood.	+1	Alert and focussed on surroundings. Brief or intermittent engagement.
Small signs of negative mood.	-1	Withdrawn and out of contact.
Considerable signs of negative mood.	-3	
Very distressed. Very great signs of negative mood.	-5	