

**Personal and Possible:  
Achieving Quality Dementia Care  
in Residential Aged Care Services**

**Alzheimer's Association Australia**

**June 2002**

## Personal and Possible: Achieving Quality Dementia Care in Residential Aged Care Services

*The aim of effective care is to support quality of life that respects the dignity, identity, and needs of both the person in care and the care giver. This kind of care is possible only in the context of a trusting, mutually respectful relationship. In the presence of such a relationship caring can be an enriching experience; in its absence, it becomes a custodial affair.*

(Zgola 1999)

**Prepared for the Commonwealth Department of Health and Ageing by  
Maggie Cecchin, Flinders University SA  
Sue Jarrad, Policy Unit Alzheimer's Association (SA) Inc on behalf of  
Alzheimer's Association Australia**

**June 2002**

# CONTENTS

Executive Summary	1
1. Introduction	4
1.1 Aim of the study	4
1.2 Significance of the study	4
1.3 Approaches to care	4
2. Findings	6
2.1 Context of care	6
2.2 Process of care	11
2.3 Outcomes of care	13
3. Analysis	15
3.1 Measuring quality care	17
3.2 Links between quality and accreditation	18
3.3 Introducing key elements into care practice	19
3.4 Next steps	20
Bibliography	21
Appendices	
1 Research process	23
2. Profile of the residential aged care services	26
3. Excerpt from Quality Dementia Standards, UK	28
4. A case study, UK	29
5. Person-centred care	31

## EXECUTIVE SUMMARY

In March 2001, the Department of Health and Ageing funded the Alzheimer's Association to conduct a project exploring quality dementia care in residential aged care services.

The aim of the project was to:

- identify systems and practices that contribute to quality of life;
- analyse the ability to document these factors as measurable quality standards ;
- identify links and relationships with accreditation standards;
- explore potential to recreate and introduce these elements in other Residential Aged Care Services and
- recommend ways that these may be implemented in other residential aged care services.

Approaches to care in literature purports variable approaches including medical and behavioural. The person-centred care approach was identified as a model that involved an individualised approach and focus on quality of life.

Three residential aged care services located in three states were selected for the study. Each of the three services had received a commendable rating in areas relating to dementia care in the first accreditation round and were also perceived by peers in the aged care industry as providing quality care. The three services selected were coincidentally, all dementia units, but it is considered that the findings would be applicable to the care of all residents with dementia.

The findings focussed primarily on shared themes and systems observed in dementia units in the three residential services participating in the study. Themes identified included:

- *shared values* that valued the uniqueness of the individual and had a culture of enabling and learning
- *physical environment* included homelike settings and ranged in size from six to fifteen residents
- *emotional environment* – warm relationships were evident, activities that promoted familiarity and fun were encouraged and family relationships were nurtured
- *leadership* was identified as a key factor in all settings with different leadership styles evident but with the common element and sharing the vision and empowering staff to create change
- *organisation of work* – care was structured around needs of residents and demonstrated a strong team ethic
- *management systems* and documentation supported rather than detracted from care, accreditation was seen to have clarified rather than improve practice
- *staffing* was a major issue for all three residential services particularly around staffing levels, recruitment and training
- *information gathering and assessment* about the individual was continuous and contributed to regular review of care and activity planning
- *maintaining identity and dignity* was viewed as the cornerstone of quality care in the three settings with a requirement to reduce 'busyness' around tasks to a listening and enabling approach

- *maintaining and maximising* ability occurred through making opportunities in everyday activities for meaning and participation
- *relationships between staff and residents indicated respect, trust, warmth and mutual affection; families were made to feel welcome*
- *communication skills were demonstrated in the settings – a high proportion were tasks orientated, others dedicated to individual relationship building, promoting well-being*
- *behavioural responses showed staff viewing behaviour as indicative of need rather than a 'problem' and responding creatively*
- *residents and family expressed high levels of satisfaction with the care they received, verbally and non-verbally*
- *staff viewed their work as hard but felt appreciated and supported; volunteers felt valued in their contribution.*

The study confirmed that quality dementia care is possible and currently occurring in Australia. Five dimensions that are key components to creating change were identified:

- *philosophy / culture* of care dictated the outcomes of care. The person centred approach was identified clearly in each setting which had led to a new model of care that valued each resident, and also created high staff morale
- *management* support was seen as crucial to the implementation of the philosophy of care and in enabling full participation at each level of the organisation
- *leadership* ensures that the vision for quality is shared and integrated and with an empowering and transformational approach, enables creativity, commitment and co-operation
- *staff* – skilled staff rather than numbers of staff was seen as an essential element to quality care with congruence between the values of the organisation and each individual. Personal qualities of initiative and intuition are important, supported by competency based training.
- *environment* – the emotional environment was considered as highly significant to quality care, with good building design enhancing the ease of care but not essential to it. Dementia specific units were the identified models in each of the three settings. These quality factors, as identified in the study, are well confirmed in the literature, demonstrating international agreement on the quality approach to dementia care.

Following from these five dimensions are key elements that form a hierarchy in implementation. A Quality Dementia Care Framework containing these key elements of quality dementia care has been developed. Measurement, however, is best based on measuring *outcomes* rather than measuring key elements. A number of measurement tools are available that provide objective feedback.

Analysis on the relationship for quality care to accreditation confirmed that quality care was independent of accreditation but that the process of accreditation assisted in reflection and articulation of care. There was much relevance of the various outcomes to the key quality components. It was identified that objective measures of outcomes could be utilised to assist with concerns over interpretation of outcomes in the accreditation process as well as checklists for assessors. To guarantee greater attention to providing care around the person's needs, the addition of a new Person-Centred Outcome is proposed.

A service excellence model for introducing the person-centred quality approach is outlined, with an example of possible performance indicators, which can assist in working towards a change in care culture.

To enable a structured approach to the implementation of quality dementia care, the development of a person-centred workbook is proposed, complementing Accreditation Standards.

Additional strategies to assist this process include strategic change leadership courses, the sharing of innovative models and ideas, and staff exchanges.

# 1 Introduction

In recent years there have been concerns regarding the quality and appropriateness of care provided for residents with dementia in hostel and nursing home accommodation. Under the Aged Care Act 1997, Standards and Guidelines for Residential Aged Care Services have been developed to assist service providers to comply with their obligations and criteria, though dementia specific care is not distinguished in the standards.

In January 2001, the former Minister for Aged Care, established the *Lessons Learned from Accreditation : Working Group* consisting of five members of the National Aged Care Forum to examine the lessons learned from the first round of accreditation of residential aged care services. With acknowledgment of the need for specialist knowledge and skills regarding dementia care, a discussion about the nature of high quality care of people with dementia between the Alzheimer's Association Australia (AAA) and the Department of Health and Ageing in March 2001 resulted in AAA being funded to conduct a project to contribute to this exploration by ascertaining quality dementia care.

## 1.1 AIM OF THE STUDY

The aim of the study was to explore and describe quality care for persons with dementia in residential aged care services in order to:

- identify systems and practices that contribute to quality of life;
- analyse the ability to document these factors as measurable quality standards ;
- identify links and relationships with accreditation standards;
- explore potential to recreate and introduce these elements in other residential aged care services and
- recommend ways that these may be implemented in other residential aged care services.

## 1.2 SIGNIFICANCE OF THE STUDY

The significance of this current research project is its ability to identify (observe), describe and document factors as measurable standards of quality dementia care in residential care in Australia. Understanding of how quality care for people with dementia is achieved enables the development of a framework to recreate these in residential aged care services and thus improve the quality of care and quality of life for persons with dementia and their caregivers. While the services in the study were all dementia units, the findings would apply to the care of all residents with dementia.

## 1.3 APPROACHES TO CARE

While for some, caring for people who have dementia is considered the same as caring for other frail elderly, this view does not acknowledge the underlying disease process that leads to degeneration of cognitive functioning. While many physical care needs are similar to those of the frail elderly, recognition of personhood<sup>1</sup> is essential for the physical and emotional well being of persons who have dementia and is central to enactment of ethically ordered care (Clarke 1999a). The aim of effective care is to support a quality of life that respects identity as well as dignity (Zgola 1999).

People living with dementia are rendered not only physically dependent but are also emotionally dependent on the environment, including other people, for their well-being (Zgola 1999). The importance of physical but especially the social needs are

---

<sup>1</sup> Personhood is a term used to encompass the uniqueness of individuals - 'the standing bestowed upon one human being, by others, in the context of a relationship and social being. It implies recognition, respect and trust'. (Kitwood,1997)

demonstrated in a recent report on challenging behaviours (Bird 2001) with physical disorders or discomfort potential contributors, but staff attitudes, environment and emotions of equal or greater significance. Understanding the cause of behaviours usually allows successful intervention or ideally, prevention of many of these behaviours. Quality dementia care enables the person to feel supported, valued and socially confident (Younger and Martin 2000).

Quality of life is defined in a variety of ways depending on the context in which it is used (Logsdon, Gibbons et al. 2000). Recent advances in the understanding of quality of life for persons with dementia has included new concepts and assessment of quality of life of persons with dementia (Brod, Stewart et al. 2000). Quality of life and quality care are inextricably linked. Poor care may impair an individual more severely than is necessary by compounding cognitive impairment with emotional distress, whereas quality care provides compensation and reassurance as abilities fail (Fares 1997).

There are a number of approaches to provision of care, including medical, an approach which focuses on the disease process and identifying dysfunction (Berrios 1994; Clarke 1999a; Shenk 2001); behavioural, an approach focusing on 'problem' behaviours (Fares 1997) and infantilisation, an approach that views the person as dependent and helpless, unable to do or say anything meaningful (Kitwood 1997).

A culture of care that incorporates a person-centered approach is well documented as being necessary for quality of life for persons with dementia (Fares 1997; Zimmermann 1998; Tolson, Smith et al. 1999; Dewing 2000). This was described by Kitwood (1997; 1997a) as a "new culture of dementia care" replacing models that have not been adequate to meet the needs of the person with dementia. Person-centered care is based on the recognition of the uniqueness of the person. It takes into account past and present lifestyle in conjunction with a person's physical health needs. It involves a relationship between the persons with dementia, the family and significant others of the person and the formal care system (Adams 1998).

Quality dementia care is complex and involves a series of interrelated interactions and interventions, and requires a learning culture together with management and leadership that actively nurtures person-centred care (Dewing 2000). A recent Australian study of 44 residential aged care services concluded "best practice dementia care is driven by a strong philosophical approach that emphasises personalised care with the resident as the central focus" (Rosewarne et al. 2000). This study determined that this approach requires dynamic, supportive leadership integral to the organisational structure and applied to all day to day practices. It determined the requirement for staff to feel valued and be given freedom to use initiative within their role.



## 2 FINDINGS

Three dementia specific residential aged care services located in Victoria, New South Wales and South Australia were selected to participate in the study. This section presents the findings and discussion of broad key elements as defined within the framework of context, process and outcome of care identified in this study.

### 2.1 CONTEXT OF CARE

Context of care describes the way care was structured within the residential aged care services, including such areas as management, staffing and values.

#### *SHARED VALUES*

Shared values were the foundation of every aspect of care in the three settings. The mission and value statements were living elements that permeated structures and practices. Values emphasised inclusiveness, recognition of the uniqueness of each individual through enabling lifestyle choice, and recognising and utilising ability.

An enabling and learning workplace culture was observed in each service by which staff members were able to experience the espoused values and reflect them in their practice.

Staff workshops to develop or review mission and value statements encouraged staff to hold them as their own. Statements were accessible and displayed in written form and they were visible in practice. Staff reflected the values in the way they knew and understood the life and care needs of individual residents, in the planning and provision of care that centred on the person and in their communication and daily interactions.

The ability to embrace and share the values of the facility also determined the “fit” of a person as a member of the staff, which was of high consideration in each setting. Observations confirmed that values are the key to the establishment of a culture of care that promotes well being and quality of life for persons with dementia

#### *PHYSICAL ENVIRONMENT*

The size of the units, in terms of the number of residents, ranged from 6 to 18. While staff considered the optimal number of residents to be 8 to 10 the management in two settings had determined that, because of staffing, it was not an economically viable size. A unit of 6 residents and one of seven residents were co-located at one site to make staffing efficient.

All units had secure exits and garden areas to prevent residents from wandering away from the unit. Security systems were unobtrusive and there was minimal restriction of movement within the secure area.

One of the units incorporated a traditional Victorian style house while the other two had centrally located public spaces with private areas in wings extending from the centre. All units included a kitchen that was used for meal preparation or cooking with residents. Utility areas were not prominent and space for writing or storing information folders was either incorporated into the living space or in a small unobtrusive separate space.

There was clear visibility and access to common areas such as dining and lounge rooms, and exits to the garden. Furniture arrangements did not interrupt pathways through areas and provided for both social interaction and quiet places. Carpets and soft furnishings provided a “lived in” feel. Regardless of residents having a single or shared room their private spaces were personalised.

Outside spaces in two of the three residential aged care services included gardens of lawns, trees, shrubs and flowers, an aviary of birds, and a garden shed; the other had not had time to establish a garden and was lawned. All gardens contained a clothesline and sitting areas.

The design and décor of each unit with small size and low profile of utility areas together with a domestic kitchen and personal details were key factors in creating a nurturing, calm and homelike environment.

#### *EMOTIONAL ENVIRONMENT*

While the building and facilities made a significant contribution to quality care, the environment of emotional warmth and stability was a major factor.

Mealtime rituals were important in creating and maintaining an emotional environment that contributed to well being of residents. One unit had breakfast tables set with butter and jam in bowls for residents to spread their toast as desired and teapots, milk and sugar on the table. Staff subtly enabled or assisted residents, rather than served them. This represented an every day opportunity for residents to engage in activity that was familiar and maintained their ability, sense of self worth and independence.

Each unit valued positive stimuli such as sounds and smells of cooking in the kitchen. Volunteers in each of the units contributed by cooking scones, pikelets, cakes or a roast lunch with residents "participating" as possible.

Laughter was a frequent sound and music also contributed. Residents sang along to familiar songs or tapped their feet in time to piano music. Calming music was used to reduce anxiety. Staff spoke of their pleasure in seeing residents' responses to music. Each setting tended to avoid unfavourable stimuli such as television.

Stability and familiarity of people were acknowledged as contributing to a supportive emotional environment. With unavoidable staff turnover, conscious attempts to aid continuity was made by accessible brief care plans containing key information and where possible teaming the casual worker with a regular staff member. Emphasis was also placed on sustaining family and other significant relationships to ensure continuity in the life of the resident.

#### *LEADERSHIP*

Leadership was a key factor in all of the residential aged care services. The vision of each of the Directors of Nursing/Managers was clearly focussed on quality of life for residents and despite the barriers experienced in some areas, all were clear that they were the drivers of change. Strategies to communicate and implement their vision and the style of leadership differed but all were willing to step outside of the accepted boundaries to explore opportunities, to take risks and attempt new initiatives. All had achieved success as evidenced in the accreditation evaluation and also by their staff. Staff spoke highly of their leaders and saw them modelling values and care practices. Changing the culture of care had involved showing the staff that care focused on the resident improved the quality of life for residents and for staff. Leaders worked together with staff to enable change to occur. Each leader had high expectations of staff, but also held their staff in high regard, recognising the contribution they made to the achievements of the unit. Staff felt valued and trusted by leaders.

Leadership was team orientated and sought to empower rather than direct. Participation in decision making, coordination and team leader roles, and portfolios of responsibility provided staff with a sense of ownership and pride in their contribution to their unit and an opportunity to show leadership in their team. Staff expressed pride and satisfaction in achievements.

#### *ORGANISATION OF WORK*

The three residential aged care services all structured care according to the lifestyle habits, preferences and health needs of residents.

One service had recently re-organised work from routines that centred on completion of tasks within staff timeframes, to being focussed on residents lifestyle and habits and health needs. Problems associated with care, such as anxiety and aggressive

behaviour of residents had reduced, as did untoward incidents and worker's compensation claims.

Structures focussing on residents' needs eliminated concentrated frenetic activity around tasks such as hygiene. Residents preferences' had been identified in a range of ways and planned accordingly, for example, instead of daily showers, some showered once a week, some three times, some preferred to shower before breakfast others after breakfast or in the evening. A "shower list" provided this information at a glance and assisted with consistency and ensuring residents did not miss their day. Staff reported that such strategies had not created an additional demand on staff hours and that the systems in place were easy to follow.

Both residents and staff had benefitted by the changed pace of work and had reduced the tendency to view residents' behaviour as 'problems' – instead staff were able to analyse how they could adjust their actions to reduce stressors and improve the quality of life for residents.

One service structured unit staff in teams, which enabled stability and cohesion of small work groups. Each team had a team leader and individuals within the team were given portfolios of responsibility to ensure best practice in areas of policy and care delivery. Staff in all of the settings worked cooperatively and talked of the work group having a team spirit and of common objectives.

Organisation of work differed according to the constraints imposed by the size and structure of the facility, but regardless of differences all had a strong teamwork ethic.

#### *MANAGEMENT SYSTEMS AND DOCUMENTATION*

Management systems and documentation in the three residential aged care services were observed to support rather than detract from care.

One service had recently examined and streamlined its documentation process. Care planning, evaluation and documentation was scheduled so that the process was a continuous part of daily routine. Staff felt that the documentation provided an accurate record of individual care. One service included additional regular assessments for feedback on mental state, weight gain or loss, blood pressure and blood sugar levels and level of participation in activities, observations of which guided care planning and programming of activities.

Innovative use of technology had proven advantageous to residents and staff in one facility for overnight monitoring.

An unobtrusive monitoring system with movement sensors had been installed in residents' rooms and ensuite. The system set according to each individual resident's pattern and was activated during the night. The system also had capacity for a mattress monitor that could record restlessness and incontinence patterns. Staff considered that the system made a significant contribution to well being of residents, such as reducing need for staff to disturb residents when they entered their room for routine checks.

Some managers appreciated the opportunity accreditation had provided to reflect on care and systems (quality process). They had used the preparation to review and record what currently occurred but had considered it had clarified rather than improved practice.

Overall it was observed that efficient care delivery and record systems, and creative uses of technology enhanced the potential to provide high quality care.

#### *STAFFING*

Staffing matters were presented as a crucial issue for all residential aged care services in regards to providing quality of care.

### *Staffing levels and skill mix*

Staffing levels and skill mix differed in each of the units. Staffing levels varied at different times of the day and according to specific care needs. The ability of the service to reallocate staff to meet times of extra demand depended on factors such as the size of the service, overall staffing and the demands in other parts of the service. Family and volunteers also made a significant contribution to many care activities as well as assisting to create an emotionally secure environment that reduced stressors and supported well being of residents.

All three residential aged care services studied expressed concern that staff members were stretched to capacity. They perceived that demands had increased both as a consequence of high care levels of residents and with new requirements from the aged care reforms. For instance, new projects as part of the continuous improvement approach created additional time demands on staff.

Staff were employed in both full time and part time schedules and agency staff were required on a shift by shift basis particularly over the weekends. Many staff worked additional unpaid hours on a regular basis, particularly those staff who were team leaders or had taken additional portfolio responsibilities.

In one service Registered Nurses worked between the dementia care unit and other parts of the facility requiring them to supervise the care of large number of residents. With the complexity of care required by many of the residents, a view was held by some that having a RN in the unit all of the time would improve the quality of care.

Enrolled Nurses tended to have a mixed role, some provided direct care, and some like Registered Nurses worked between the dementia unit and other parts of the facility. Assistants in Nursing and Personal Care Workers comprised the greatest number of staff in all units and their roles also varied greatly – some held coordination roles or were responsible for a portfolio area, some were team leaders.

Support services staff were enabled to contribute to activities such as talking to residents and assisting with resident transfers, along with volunteers. For example, the support staff in one of the residential aged care services assisted with meals.

It was recognised in the services studied that dementia care required well-trained staff with high levels of creativity and insight. However, the majority of staff came into these settings with little or no specialist training, often learning 'on the job'.

### *Staff recruitment*

Staff recruitment was a particular challenge in two of the three services. Managers indicated that the shortage of qualified staff made it particularly difficult to employ Registered Nurses or Enrolled Nurses, despite Enterprise Agreements that eliminated the pay differential between aged care and acute care.

It was perceived that the work demand contributed to the reasons why many staff exited from this sector, and why it was often difficult to recruit new staff.

Many staff interviewed experienced a high level of work satisfaction, and expressed commitment to their work but staff attrition was also a reality. Achieving the right number of the right skill mix of staff was reported as an increasing challenge over recent years. Employing new staff in the three sites involved rigorous screening throughout the application and appointment process but this did not always guarantee the desired result. It was general practice for new staff to be employed initially on a casual basis to ascertain how they fitted the culture of the unit and it was important that new staff were integrated into the team.

Employing new people involved not only the selection of the right person but the time and resources necessary for a new employee to integrate the culture of the service and

also the basic knowledge and skills required for the role. This training placed an additional demand on already scarce resources.

#### *Staff training and development*

The three residential aged care services encouraged a learning culture in which staff development was a priority and all committed considerable resources to training and development. One facility had undertaken a comprehensive training program for all staff that had increased everyone's skill and sense of professionalism. Staff were encouraged to share their knowledge, and one of the roles of team leaders was to ensure current information was available to all staff. Staff undertaking further education felt supported in their learning and appreciated the opportunities afforded to them. They stated that continued learning contributed to their enthusiasm and satisfaction.

The residential aged care services reported that they had provided programs for new employees who had little or no prior education or training related to caring for people with dementia and workplace preceptors assisted their learning and in-service opportunities.

## 2.2 PROCESS OF CARE

The findings presented in this section focus on the processes of care specific to the provision of quality dementia-related care: how the person is valued, and how her/his lifestyle choices, abilities, identity and dignity are maintained.

#### *INFORMATION GATHERING AND ASSESSMENT*

Resident assessment linked to the determination of the level of care for funding purposes occurred at admission and at regular intervals. However, because of the progressive nature of dementia continuous assessment in these settings ensured care and activities were tailored to the individual.

Assessment focusing on what the person is able to do highlighted retained abilities and gave the information necessary to create an environment which respected independence in dignity and identity. Collecting information and knowing life patterns were important aspects of assessment. Information gathering often began before admission when possible, usually from the family and doctor. This continued in a dynamic ongoing way with all staff constantly identifying what was happening to the person and planning care around this information. One residential aged care services weighed residents each month and took blood pressure and blood sugar checks regularly as a monitoring tool. One resident's weight following admission had dropped sharply and the resident was agitated and would not sit to eat. A plan was developed including supplements and finger foods.

#### *MAINTAINING IDENTITY AND DIGNITY*

Maintaining identity and dignity of each resident was viewed as a cornerstone of quality care and was underpinned by the values of each residential aged care services and achieved through a person centred approach. Maintaining identity and dignity was stated to be achieved by an approach that respects who the person is, does not treat them like children, values their past contribution, provides opportunities to participate, maintains the person's individuality, lets the person make the choice, not forcing standards on them. These principles were observed as being implemented in practice in a variety of ways.

Spiritual care was another enabling dimension that provided for the person to maintain her/his identity.

It was seen as important to have opportunities to be with individuals to allow them to tell their story, not always being busy trying to shower or do some activity – a different way of being with a person, enabling that person to maintain her sense of who she

was. Different approaches were used; one service brought residents together around a table to talk about different events, looking and talking about photographs, for instance. Opportunities were taken to relate in a meaningful way to individuals as a natural part of other day-to-day activities.

#### *MAINTAINING AND MAXIMISING ABILITY*

There was a major focus on activities in the three residential aged care services. It was recognised that every day activities provided opportunities for maintaining and maximising a resident's ability and self-worth.

For one resident who was not actively able to participate, something as simple as *“putting the brush into her hand so that she can brush her hair”* provided a way of maximising ability. This process took more time than the staff doing it for the resident but it did not make sense to them to rush the resident through these daily personal activities so that they could participate in programmed activities.

Residents who were able to participate in every day activities such as setting the table or wiping the dishes after the meal were encouraged to do so – these activities were often in high demand. Staff arranged activities according to the background, interests and ability of residents. Others participated through engaging with the sounds and smells of cooking scones or a roast lunch.

Special activity programs were numerous and included listening to music, or playing an instrument, dance, sensory stimulation, beauty therapy, nature walks, reading and many more. The diversity provided the opportunity for residents' preferences and abilities to be considered and a program tailored to individual needs. Participation promoted enjoyment and well being through engagement in physical and social activity. Socialising and having fun was given high value.

#### *RELATIONSHIPS*

It was evident that staff had developed strong relationships with residents and knew the residents well. They talked of the things that had meaning in residents' lives and how they endeavoured to incorporate those into their current life, such as simply knowing the colour a resident loved to wear. Staff recognised the significance of their role in the resident's life and the intimacy of knowing the resident's life and daily contact. Relationships of respect, trust and warmth enabled mutual affection and the provision of care centred on the person.

Residents' personal relationships were maintained such as sisters who had lived together all of their lives had rooms next to each other. Involvement of family and friends was actively encouraged. Family members who had made the selection of the facility had done so primarily because of the staff's warm relationships and the environment they had created. Families felt welcome.

#### *COMMUNICATION*

Communication was pivotal to all activities of care and staff used many communication skills such as making eye contact, smiling, speaking slowly in a calm tone and giving time for residents to process and respond to questions or requests. Communication included staff using a look or a touch to reassure someone who did not understand what was said. Non-verbal cues were also used and observed by staff, such as body language.

It was observed that a high proportion of communication between staff and residents was “task talk”, functional directives related to accomplishing care such as giving medication. The main exceptions were during programmed activities when time was spent with volunteers or others who had a specific role such as the aromatherapist or pastoral counsellor, who gave dedicated time for one to one therapeutic communication that promoted well being and quality of life.

### *BEHAVIOURAL RESPONSES*

Behaviour was viewed by staff as an expression of the resident's need and staff observed and analysed behaviours, and looked for relevant interventions and responses.

For instance, in one service staff had been challenged by one resident who each morning insisted in pouring jam, sugar, milk into her cereal bowl which often overflowed and then stirred it with a spoon so that much of the content spilled onto the tablecloth and floor. Staff tried many unsuccessful ways to prevent this. Then one day one of the staff thought to inquire of the resident what she was doing – she said she was making a cake. So rather than stop this activity they provided her with small dishes of “ingredients” so that each day she could make her cake and leave the table emotionally content.

In another service, there was one resident who had frequently hit out at staff when woken early in the morning. It was decided to leave him to sleep later and was given time to wake properly before being assisted out of bed. As a consequence the resident was more content and no longer hit out, the incident reports had ceased and staff satisfaction had increased.

Practices such as physical or chemical restraint were considered incompatible to the care approaches used in the three settings and were not used. Significant care was taken to prepare residents for sleep and enhance their relaxation, using strategies such as evening sensory sessions and the regular use of warm neck packs. Known triggers to challenging behaviours were avoided, and knowledge about each individual allowed appropriate and personal responses in the case of restlessness or confusion.

### 2.3. OUTCOMES OF CARE

Outcomes of care refer to how care is experienced by the care recipients and other stakeholders. Outcomes can be determined by subjective and objective forms of measurement although such tools were not utilised in this study.

### *RESIDENTS AND FAMILY*

The methods of this study did not provide for in-depth evaluation from the perspective of the person with dementia. However, it was possible to observe positive responses of residents to care activities, to see their faces light up, to see their feet tapping to music, to see the warmth of a hug and the positive response to respectful requests. It was also possible to gain an impression of well being or levels of agitation and frustration. Family and friends of residents expressed high levels of satisfaction with the facility and the care provided.

They were perceptive about the challenges related to caring for people who have dementia and felt that generally staff “*do a remarkable job under the circumstances*”. There was, however, concern expressed about the difficulty of maintaining the same level of care when casual or agency staff do not have the same knowledge of the resident's needs.

For some family members participation in the residential aged care services facility had become so much part of their life that when their relative died they continued to contribute as a volunteer.

The three services had succeeded in providing positive outcomes for residents and in so doing had also provided family and friends with a sense of satisfaction. Quality of care had provided a visible sense of well being for residents and their family and friends.

### *STAFF*

While staff expressed a great deal of enjoyment and satisfaction in their work they also spoke of the work being “*hard and stressful*” because of physical demands, repetition,

and emotional involvement. Financial rewards did not attract them to this area of work and many staff had chosen this area of work because they found the work innately fulfilling.

Many contributed more than was expected both in effort and time. Staff spoke of being supported by the by the facility and appreciated the opportunity for participating in staff development activities. They also felt support by each other particularly in times of grief when a resident has died.

Volunteers contributed because they loved what they did, they felt valued and supported by the staff, residents and families. Without exception they said that they got more than they gave.



### 3 ANALYSIS

The observation of cultures, care practices and their systems in three residential aged care services has confirmed that *quality dementia care is possible* and is currently occurring in Australia. In some sites this quality care has been present before the aged care reforms and accreditation process. The following five dimensions were identified during analysis of the findings as key components to creating change in care.

#### *Philosophy*

The philosophy of care and accompanying shared values and culture within the residential care facility will dictate the outcomes. The philosophy of care favoured as best in achieving a quality dementia care outcome is that of the person-centred approach. This includes the belief that the facility is the person's home and that all activities need to reflect that principle. It views that each resident is unique and is treated individually; that the development of meaningful relationships between the resident and staff who care for them is given high importance; and has the focus of enabling the person in care to maximise their abilities and identity. Extensive work on the person-centred care model has occurred in Bradford, UK and itemises key definitions and principles (See Appendix 3).

This person-centred care approach requires a new model of care. The traditional bio-physical model of care, based on physical diagnostics with accompanying care practices ritualised into set physical care tasks, has been the historical basis for nursing home care. This model is no longer appropriate if quality care is to be achieved. The new model has a person centred culture of care and focuses on holistic health and well being. Flexibility around care tasks occurs, and skilled nursing responses are integrated within the care relationships that are central in the model. It includes awareness by staff to physical changes and emotional states of residents with timely and appropriate individual response, with subsequent reduction in challenging behaviours. Knowledge of each person is essential and meaningful activities are integrated into care.

#### *Management*

For this philosophy to be enacted requires ownership of the philosophy by every member and part of the facility, including management and supporting systems. Management would ensure that the new philosophy of care is implemented through strategic planning, resource allocation and support of those implementing the changes.

An outcome of such ownership would be observed in a practice and management model that encourages and achieves full participation by all staff in achieving and maintaining this culture. Staff would exhibit motivated and autonomous behaviour, high moral and work satisfaction with the confidence of management support with feedback.

#### *Leadership*

Leadership is a powerful determinant of a successful team and quality dementia care would not be possible without this leadership. In a complex and changing environment a transformational approach to leadership supports development of a team and promotes creativity and a spirit of cooperation and commitment.

The leader may have different titles or roles dependent on the facility (such as DON, Manager or CEO), but they would have the authority to lead the philosophy of person-centred care, implement and maintain it. The leader would provide inspiration and motivation to those in the facility. Some of the responsibilities and initiatives of the person in the leadership role would be to:

- provide appropriate physical environment and equipment, skills training and knowledge

- hold personal and professional values congruent to and supportive of the philosophy
- provide the system to assist the organisation to achieve best practice in quality dementia care.

The person in the leadership role would need to receive support in their role by a Board / CEO or senior managers to whom they are responsible. Style of leadership would vary and is not prescriptive though strategies may be similar.

### *Staff*

Staff will be valued as important resources in the organisation and provided with support. This would be demonstrated by congruence between the staff person's and the organisation's values. The staff person may hold these values already and then be attracted to the organisation for these reasons or will be socialised to these values as a clear expectation in recruitment / appointment. Staff losses would be expected where this congruence is not achieved.

Staff would be equipped with competency-based dementia care training, that is, linked to skill outcomes, and congruent with the person-centred care model. Staff would need to have a thorough understanding of each individual and require the ability to critically reflect on and interpret information to ensure that the implementation of individualised care will be a matter of choice not design. Staff would be encouraged to show initiative and autonomy in their individual tasks and intuition and care in their relationship building with residents.

All of facility training would be desirable in achieving quality care. Staff would work in teams with team building and team trust will be crucial. These teams, ideally, would reflect the range of skills and specialised knowledge required and would be responsible for a group of residents, dependent on size of unit.

The ratio of staff to resident would not be rigid but constantly changing and extremely responsive to the needs of the individuals in the care unit. This encompasses residents' level of care, complexity of care, size, organisation of work and other systems that support care and reduce demand on staff time. Increases in staff time by itself do not necessarily improve the quality of care; conversely, there is a limit to expectations that can be placed on staff without compromise to care and staff morale. The use of volunteers can have a significant influence on emotional well being of residents but there needs to be caution in relying on their contribution in order to achieve quality care. Time would be given to enable important communication to occur between staff, between staff and family and staff and resident.

### *Environment*

The environment would have a warm and homelike feel not dependent on physical design. This emotional environment of warmth, psychological security and physical comfort would be created by the relationships within the residential aged care service, which are congruent with the philosophy. This welcoming emotional environment would be extended to family, friends and volunteers of the facility, providing a sense of welcome, inclusion and partnership in care.

Physical environment is seen as assisting and enhancing with the emotional environment through good design, small sized units (e.g. alone or in clusters) and appropriate furnishing. However, it is acknowledged that these factors by themselves will not create the more important emotional environment.

The three sites were all dementia specific units even though they were not chosen on this basis. While having a dedicated secure area for dementia care does not always ensure that care is dementia specific (Rosewarne, 2000), the specialised person-centred approach in the three residential services in the study demonstrated the

achievement of quality care in such an environment. The findings are also applicable to the care of all residents with dementia.

Analysis of the observable culture practices and systems in three settings, while a small sample, has provided in depth qualitative material. The key dimensions emerging from this field research is supported by literature and confirms there is a congruent specific approach and body of knowledge both academically and anecdotal, to achieving quality dementia care. Mary Marshall, international dementia consultant from the Dementia Services Development Centre, Scotland, in *Putting Quality First* (Alzheimer Scotland, 1996) outlines four crucial factors that emerge from the literature view on quality dementia care – specialist dementia training for staff, leadership and management support, multi-disciplinary assessment, and rigorous care planning and review.

### 3.1 MEASURING QUALITY CARE

The key elements in the *context of care* are seen as crucial to achieve before the *process of care* can take place, and subsequently, the *outcomes* of quality care. These form a hierarchy of steps that can be taken in order to achieve change.

The following table sets out this quality framework of the key elements found in this study, to which performance indicators can be prescribed, in achieving quality dementia care.

#### Quality Dementia Care Framework

Philosophy	Management	Leadership	Staff	Environment
Context of care (care is structured)		<ul style="list-style-type: none"> <li>shared values</li> <li>physical environment</li> <li>emotional environment</li> <li>leadership</li> <li>organisation of work</li> <li>management systems and documentation</li> <li>staffing</li> </ul>		
Process of care (care is delivered)		<ul style="list-style-type: none"> <li>information gathering and assessment</li> <li>maintaining identity and dignity</li> <li>maintaining and maximising ability</li> <li>relationships</li> <li>communication</li> <li>behavioural responses</li> </ul>		
Outcomes of care (care is experienced)		<ul style="list-style-type: none"> <li>quality of life of resident and family</li> <li>quality work outcomes for staff</li> </ul>		

Similar frameworks have been developed elsewhere, most notably the Quality Dementia Care in Care Homes: Person-Centred Standards (2001) in the UK. These standards are complementary to statutory standards and could be adapted for use in Australia. An example of topics presented in these Standards is in Appendix 3.

Such standards and frameworks do not, however, provide measurement of quality. It would be possible to measure progress on integrating new practices; that is, measuring the key elements in the *context* and *process of care*, but these practices may not necessarily achieve the *outcome* of quality. A case example in Appendix 4 illustrates this point.

Measurement of quality is best based on measuring outcomes, that is, quality of life. This is the customer satisfaction equivalent in service excellence frameworks. A number of tools have been specifically developed to measure quality of life for people with dementia, notably, Logsdon's Quality of Life Questionnaire (2000), Emotional Responses as Quality Indicators in Dementia Care (ERIC) and Dementia Care Mapping (see Appendix 5). Feedback from these tools provides impetus for new strategies to be implemented to improve these scores, and without the application of such tools relies on subjective assessment of outcomes.

### 3.2 LINKS BETWEEN QUALITY AND ACCREDITATION

Information from the observations indicated that for at least one residential aged care services, the accreditation process was independent of their pursuit of quality, even though the accreditation processes assisted them in some instances to articulate and reflect on practices.

The study has found that there was much relevance to various outcomes within the accreditation standards to the key quality principles and elements, such as staff education (3.3), emotional support (3.4), and leisure activities (3.7), for instance. Many of these standards, if met, would be indicative of quality care. It is also noted that greater evidence based material will be required in this next round of accreditation.

However, an issue was identified regarding the *interpretation* of outcomes and *measurement* of outcomes attained in accreditation with shortcomings in objective measurement. Similar conclusions were drawn in the Two-Year Review of Aged Care Reforms, when it was noted that 'capacity to provide objective information around care outcomes is limited' (Gray, 2001).

Tools that provide an objective assessment of positive engagement or withdrawal of the person with dementia and quality of life measures, such as *Dementia Care Mapping*, or *Dementia Quality of Life* questionnaires have been raised earlier. Such tested tools provide methodology for more accurate and objective measurement of such outcomes and may need to be integrated into the accreditation process to provide a further safeguard to assessor variability. The development of criteria and checklists for assessors would also assist to elicit objective information.

It was concluded that the standards were not always specific enough in regards to quality dementia care practices. For example, for those who are significantly impaired physically and mentally, 'encouragement to participate' (3.7 Leisure interests and activities) is irrelevant. For this seriously impaired group, pleasurable activities that are person-centred could be identified and integrated into care and relationship activities. One example is that of classical music played to sooth a resident who has always loved this music before the onset of dementia.

In these instances Accreditation Standards could be reworded to assist a more appropriate application for dementia care; alternatively adjuncts to the Accreditation Standards could be adopted.

Quality dementia care standards have been developed in the UK 'to complement and support mandatory and benchmark standards...to provide impetus and motivation for homes aspiring to develop and practice their expertise' (Ray, 1999). The development of Australian quality dementia standards would enhance the Accreditation Standards in regards to dementia care.

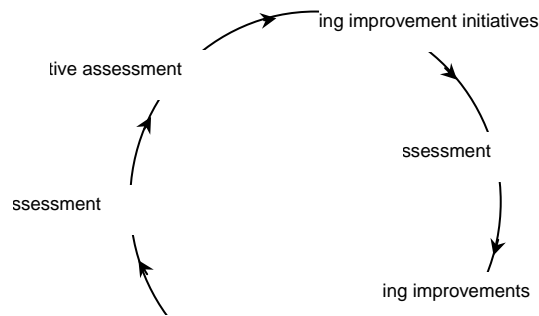
It was also concluded that care practices would be enhanced through the addition of the principle of person-centred individualised care. In studying the Accreditation Standards in detail, it was considered that an approach to person-centred care was not sufficiently guaranteed, and required a distinct standard of its own. It has a focus on *knowing* the person and *applying* this knowledge in a meaningful individualised way in every aspect of care. The person-centred quality approach, while crucial to the care of the person with dementia, is equally applicable to all residents. Such a *Person-centred Standard* would cover all four areas of Management Systems, Health and Personal Care Resident Lifestyle, and Physical Environment. Individualised information about each resident would be required, and evidence provided as to how this understanding of the individual was integrated in their care, assisting residential aged care services to integrate in practice this important principle and to organise all activities around the person.

### 3.3 INTRODUCING KEY ELEMENTS INTO CARE PRACTICE

A service excellence model is appropriate to support the implementation of quality care in a systematic way. This approach is one of action/reflection or continuous improvement and is validated by objective assessment.

A service excellence model would include:

1. a self assessment of the residential aged care service – giving evidence of how each key element is being met
2. on completion of self assessment, opportunities for planning improvement initiatives would be identified
3. implementation of improvement initiatives with support, education and training
4. a self assessment would then follow once there was evidence that all key elements were being met and practiced
5. an independent and objective assessment of quality of life (outcome) would occur using Dementia Care Mapping or an equivalent validated measure.
6. development of the next stage of planning improvement initiatives.



There would be a range of strategies utilized depending on the context and individual situation of the facility, relying on the framework or standards adopted. Such strategies may include:

- demonstrating change around a resident and extending that learning to care practices around each resident
- training staff
- think tanks and consultation at all levels
- strategic planning processes
- modelling examples of desired care
- mentorship by peers
- personal and peer reflection by staff
- staff appraisal
- objective evaluations and feedback such as Dementia Care Mapping.

Below is an example of one approach using performance indicators and strategies around development of a philosophy in the Residential Aged Care Facility.

Key element : philosophy (person-centred)

Performance indicators	Strategies
<ul style="list-style-type: none"> <li>• the residential aged care service has an observable commitment to person-centred care and makes this commitment clear to staff, residents, family and friends and statutory authorities</li> </ul>	<ul style="list-style-type: none"> <li>• a philosophy of care has been developed and written based on the values of person-centred care and made available to all staff, residents and family members in public place</li> </ul>

<ul style="list-style-type: none"> <li>• <i>the processes and systems in the home support and underpin the strengths and abilities of a person with dementia</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>the needs, preferences, abilities and strengths of each resident is known and regularly reviewed</i></li> <li>• <i>work has been organised around the needs and preferences of the residents</i></li> </ul>
<ul style="list-style-type: none"> <li>• <i>staff are supported in their day-to-day work to put the concept of person-centred care into practice.</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>staff have received training about person-centred care and can articulate this knowledge</i></li> <li>• <i>a protocol has been developed to assist staff to change care practices that are not person-centred.</i></li> </ul>

### 3.4 Next steps

To enable a structured approach to the implementation of quality dementia care, the development of a person-centred workbook suitable for the Australian context to complement existing Accreditation Standards would be the next step. Such a workbook or manual would assist the residential aged care services to work incrementally toward their goal of quality care validated by objective measurement. An example is in Appendix 3.

Another strategy to assist in this process would be strategic change leadership courses for those who are implementing person-centred change in their service. Using the workbook as a base, understanding about change management, leadership styles and change strategies would support those with the responsibility of implementing quality person-centred care.

Further support could be provided through the sharing of innovative models, technical ideas and individualised solutions. Networks or newsletters could be utilised as well as staff exchanges between residential aged care services to assist in sharing innovations in the journey toward quality dementia care.

## Bibliography

- Adams, T.(1998). The discursive construction of dementia care: implications for mental health nursing. *Journal of Advanced Nursing* 28(3): 614-621.
- Aged and Community Care (2002). *Aged Care in Australia*.  
<http://www.health.gov.au/acc/about/agedaust/agedaust/htm>
- Alzheimer's Scotland-Action for Dementia (1996). *Putting Quality First: The Need to Improve Long-Stay Care for People with Dementia*, Report.
- Alzheimer's Society UK (2001), *Quality Dementia Care in Homes: Person centred standards Report*, Sept.
- Barrett, E. (1997). Collaboration and interdependence: care as a two-way street. *State of the art in dementia care*. M. Marshall. London, Centre for Policy on Ageing: 1-12.
- Bennett, K. (1997). Cultural issues in designing for people with dementia. *State of the art in dementia care*. M. Marshall. London, Centre for Policy on Ageing: 164-169.
- Berrios, G. E. (1994). *Dementia and ageing since the nineteenth century*. *Dementia and normal aging*. F. A. Hubert, C. O. Brayne and D. W. O'Connor. Cambridge, Cambridge University Press: 15-40.
- Bird, M., Llewellyn-Jones, Smithers, Korten, *Psycho-social Approaches to Challenging Behaviour in Dementia*, Report to Government, 2001.
- Brod, M., Stewart, A. and Sands, L. (2000). *Conceptualisation of quality of life in dementia. Assessing Quality of Life in Alzheimer's Disease*. S. M. Albert and R. G. Logsdon. New York, Springer Publishing Company Inc: 3-17.
- Brooker, D, (1999) *Dementia Care Mapping and Engagement Combined to Audit Care Quality*, *Journal of Dementia Care*, May / June.
- Clarke, C. L. (1999a). *Dementia care partnerships: knowledge, ownership and exchange*. *Dementia care: Developing partnerships in practice*. T. Adams and C. L. Clarke. London, Bailliere Tindall: 5-35.
- Clarke, C. L. (1999b). *Professional practice with people with dementia and their family carers: help or hindrance? Dementia Care: Developing partnerships in practice*. T. Adams and C. L. Clarke. London, Bailliere Tindall.
- Commonwealth of Australia (1998). *Standard and Guidelines for Residential Aged Care Services Manual*. 2001.
- deLaine, M. (1997). *Ethnography: Theory and applications in health research*. Sydney, MacLennan + Petty.
- Dewing, J. (2000). *Promoting wellbeing in older people with cognitive impairment*. *Elderly Care* 12(4): 19-22.
- Downs, M (1997) *The emergence of the person in dementia research*. *Ageing and Society (Online)* 17: 597-607. Available Proquest (15 May 2001)
- Executive Summary of the Assessment Team's Report in relation to the Accreditation Decision* (<http://www.accreditation.aust.com/accreditation/audits.html>)
- Edwards S D (2000). *Defining Personhood: towards the ethics of quality in clinical care*. *Journal of Medical Ethics (Online)* 26(2): 145. Available Gale Group / Expanded Academic ASAP (28 May 2001)
- Fares, A. (1997). *Assessment and care for people with dementia*. *Nursing Standard* 11(40): 49-50.
- Ford, P. and McCormack, B. (2000). *Keeping the person in the centre of nursing*. *Nursing Standard [Online]* 14(46): 40-44. Available: OVID/Journals@OVID (31 October 2000).
- Foster, K. (1997). *Pragmatic groups: interactions and relationships between people with dementia*. London, Centre for Policy on Ageing.
- Garratt, S. and Hamilton-Smith, E. Eds. (1995). *Rethinking dementia - an Australian approach*. Melbourne, Ausmed Publications.
- Graham, I. W. (1999). *Reflective narrative and dementia care*. *Journal of Clinical Nursing* 8(6): 675-683.
- Gray, Len (2001) *Two Year Review of Aged Care Reforms*, Dept Health and Aged Care.
- Herbert, G. (1997). *Which hat should I wear today? Recruiting and developing the ideal workforce for dementia care*. London, Centre for Policy on Ageing.
- Health and Aged Care (1999) Dept of, *Emotional Responses as Quality Indicators in Dementia Care (ERIC)*.

- Innes, A., Capstick, A. and Surr, C. (2000). Mapping out the framework. *Journal of Dementia Care* March/April: 20-21.
- Jenkins D and Price B(1996). Dementia and personhood: a focus for care? *Journal of Advanced Nursing* (Online) 24(1): 84-90. Available OVID / full text Nursing Collection (19 August 1999)
- Jennings, B. (2000). A life greater than the sum of its sensations: Ethics, dementia, and the quality of life. *Assessing Quality of Life in Alzheimer's Disease*. S. M. Albert and R. G. Logsdon. New York, Springer Publishing Company: 165-178.
- Kidd, B. J. (1997). A journey with Alice. State of the art in dementia care. M. Marshall. London, Centre for Policy on Ageing: 169-175.
- Kitwood.T. (1993). Toward a Theory of Dementia Care: The Interpersonal Process, Ageing and Society: 113, 15-17.
- Kitwood, T. (1997). Cultures of care: tradition and change. *The New Culture of Dementia Care*. T. Kitwood and S. Benson. London, Hawker Publications: 7-11.
- Kitwood, T. (1997a). *Dementia reconsidered: the person comes first*. Buckingham, Open University Press.
- Kitwood, T. and Bredin K. (1992). *Person to person: a guide to those with failing mental powers*. Loughton, Gale Centre Publications.
- Kitwood, T., Buckland, S. and Tracy P. (1995). *Brighter Futures: A report on research into provision for persons with dementia in residential homes, nursing homes and sheltered housing*. Oxon, Anchor Housing Association.
- Logsdon, R. G., Gibbons, L. E., McCurry, S. M. and Teri, L.(2000). *Quality of Life in Alzheimer's Disease: Patient and Caregiver Reports*. *Assessing Quality of Life in Alzheimer's Disease*. S. M. Albert and R. G. Logsdon. New York, Springer Publishing Company Inc: 3-17.
- Long, A. and Slevin, E. (1999). Living with dementia: communicating with an older person and her family. *Nursing Ethics* 6(1): 23-36.
- Marshall, M. (2001). The challenge of looking after people with dementia: Professional carers need higher expectations and better training and support. *British Medical Journal* [Online] 323(7310, Available: OVID/Journals@OVID [26 October 2001]).
- Ray, M. (1999). Developing Person-Centred Standards, *Journal of dementia Care*: Nov/Dec.
- Rosewarne, R. C., Opie, J.R. and Ward, S. M.(2000) *Dementia-specific care in Australia: An overview and future directions*. *RAPD* 4: 45-68.
- Shenk, D. (2001). *The Forgetting: Alzheimer's: Portrait of an Epidemic*. New York, Doubleday.
- Sifton, C. B. (2000). Maximising the functional abilities of persons with Alzheimer's disease and related dementias. *Interventions in Dementia Care: Toward Improving Quality of Life*. M. P. Lawton and R. L. Rubinsteing. New York, Springer Publishing Company: 11-37.
- Stake, R. E. (1998). Case studies. *Strategies of Qualitative Inquiry*. N. K. Denzin and Y. S. Lincoln. California, Sage Publications: 86-109.
- Standards and Guidelines for Residential Aged Care Services Manual* (1998), Commonwealth of Australia.
- Tolson, D., M. Smith, and Knight, P. (1999). An investigation of the components of best nursing practice in the care of acutely ill hospitalized older patients with coincidental dementia: a multi-method design. *Journal of Advanced Nursing* [Online] 30(5): 1127-1136. Available: EBSCO Online/Blackwell Science Collection [7 December 2000].
- Whitworth, A., Perkins, L. and Lesser, R. (1999). Communication in dementia care: a partnership approach. *Dementia Care: Developing partnerships in practice*. T. Adams and C. L. Clarke. London, Bailliere Tindall.
- Younger, D. and G. W. Martin (2000). Dementia care mapping: an approach to quality audit of services for people with dementia in two health districts. *Journal of Advanced Nursing* 32(5): 1206-1212.
- Zgola, J. M. (1999). *Care That Works: A Relationship Approach to Persons with Dementia*. Baltimore, The Johns Hopkins University Press.
- Zimmermann, P. G. (1998). Effective communication with patients with dementia. *Journal of Emergency Nursing* [Online] 24(5): 412-415. Available: OVID/FullText Nursing Collection [February 1, 2000].