

How do you determine if a dementia care program is improving the quality of life and meeting the needs of the residents; or, if management, staff, family members and other stakeholders are sufficiently aware of the goals and objectives for the program to be successful? You don't, unless you have a viable process of evaluation - - - like the one described in this article.

By Nancy Gnaedinger, Janice Robinson, and Fiona Sudbury

Evaluating a dementia care program

Purpose, process and practical advice for the successful initiation and completion of a Dementia Care Program evaluation

The Lodge at Broadmead, a nursing home in Victoria B.C., accommodates veterans with a primary diagnosis of dementia, at moderate to severe levels. They live in three dedicated lodges: Palm North, Palm South and Magnolia. Within these three lodges, a multi-faceted Dementia Care Program has been on-going since August, 2003, thanks to funding from Veterans Affairs Canada as part of its National Dementia Care Initiative.

Program enrichment

There are four major components of program enrichment at The Lodge at Broadmead:

1. Clinical expertise was elevated by hiring a full-time Clinical Nurse Specialist in dementia care. In addition, enhancements to staffing included: a half-time occupational therapist, a half-time physical therapist, a full-time rehabilitation assistant (com-

binning occupational and physical therapy skills), a second full-time activity worker and a second half-time social worker.

2. Staff mix was enriched by increasing the number of hours of hands-on-care per resident/day by 35 percent.

3. Special in-service education and training in dementia care were delivered to staff from all areas, as well as to family members and volunteers.

4. Major renovations were completed to reduce the size and institutional atmosphere, and to increase the home-like character of the three dedicated lodges.

The overall goal of the changes was to improve quality of care and quality of life for veterans with dementia.

Program evaluation

This article focuses on the purpose and process of the Dementia Care Program evaluation at The Lodge at

Broadmead (TLAB). It also offers some practical advice for planning and implementing a program evaluation in a residential care facility. Actual results of the evaluation will be published in future articles.

Purpose of evaluation

The Lodge at Broadmead established a *Dementia Care Program Steering Committee* led by the Director of Care, with individual participants responsible for renovation planning, program development, education and staffing. This committee met weekly for most of two years during renovations, program and staff development.

From the outset, the *Steering Committee* recognized that quality improvement through program evaluation was an essential component of program development, and that a structured evaluation would allow the committee and other staff members to

track the process, changes based on evaluation, and publish and present outcomes over time.

At the outset, the *Steering Committee* set clear goals for program development, as they wanted a solid method of assessing how well the goals would be met. In addition, it was recognized that an evaluation should stimulate learning in the organization; thus, it needed to be participatory, engaging staff, families, volunteers and other stakeholders.

By March, 2004, the *Steering Committee* had established an evaluation plan and secured a contract with an evaluation consultant for the next two years. The Clinical Nurse Specialist (CNS) was assigned responsibility for day-to-day liaison with the evaluation consultant, who was to design and facilitate the evaluation of the Dementia Care Program.

The evaluation of the Program had three main purposes:

1. record changes in the Program;
2. evaluate both the process and impact of changes; and
3. encourage and facilitate reflective practice among all participants in the Program.

Process of evaluation

• Preparation

Between January and March, 2004, the evaluation consultant researched the relevant literature on evaluation in dementia care; reviewed over a dozen data collection tools; scrutinized documents, records, and data collection tools already in use at TLAB; visited and spent time observing residents and staff in Palm and Magnolia Lodges; interviewed senior management to obtain a clear picture of the staff, residents and care programs in the lodges; clarified and articulated the stated objectives of the Dementia Care Program; consulted with staff about

A profile of the residents and The Lodge at Broadmead

The Lodge at Broadmead is a 10-year old, 225-bed, non-profit residential care facility (nursing home) owned and operated by the Tillicum and Veterans Care Society. It is located in a residential neighbourhood of Victoria, B.C. The facility receives base operational funding from the Vancouver Island Health Authority.

More than half of the facility's residents are Veterans eligible for priority-access bed status. The majority (67%) of veteran residents have moderate-to-severe levels of dementia and all require 24 -7 supervision and care. Ambulatory veterans, for whom dementia is a primary diagnosis, are accommodated in three special lodges: Palm North, Palm South, and Magnolia.

These veterans are the primary beneficiaries of a multi-faceted Dementia Care Program funded by Veterans Affairs Canada since 2003 as part of their National Dementia Care Initiative.

Objectives of the National Dementia Care Initiative

The outcome objectives of the national initiative are threefold:

1. improve quality of care and quality of life for veterans with dementia;
2. enhance capacity among care providers; and
3. enhance support for family members of veterans.

their preferred methods of participating in the evaluation; identified key informants for the evaluation study; and, wrote a detailed two-year evaluation plan. The evaluation plan was reviewed and approved by the TLAB Research and Ethics committee.

• Approach to evaluation

The approach to evaluation was inclusive and respectful of all participants. Suggestions regarding content and methods of evaluation were welcomed from all stakeholders, including staff and family members.

Evaluation activities were specially designed to minimize interference with service delivery and not unduly burden respondents. For example, surveys were designed to be completed in approximately ten minutes.

Survey instruments developed by the evaluation consultant were field tested with select respondents, discussed, and modified as required before distribution.

It should be noted that all study instruments (surveys, results) were printed on the same gold-colour pa-

per. This helped staff recognize evaluation documents in a world of paper.

• Methods of data collection

The evaluation study was multi-method and reflected a broad spectrum of perspectives. Confidential survey questionnaires were specially developed, tested with, and distributed to, staff, family members, volunteers, companions and regular visitors.

Group interviews were developed in consultation with senior nursing staff and were conducted with a wide array of staff members who work in the Dementia Care Program, including housekeepers, food service workers, maintenance workers, health care aides, nurses, social workers, occupational and physical therapists, dietitian, the clinical resource nurse and the clinical nurse specialist.

Face-to-face interviews were conducted with the clinical nurse specialist, the director of volunteer services, and the social worker.

Two data collection instruments found during the literature search were employed as part of the evaluation. One is a tool for measuring quality

of life of persons with dementia, developed by Logsdon and colleagues (2002). This one-page questionnaire was completed as an interviewer-administered survey of the 11 veterans in the Dementia Care Program capable of responding. It takes approximately 15 minutes to administer.

A different version of this data collection instrument, the family version, was completed by 25 family members or friends, one for each resident. Thus, this evaluation tool, administered twice, one year apart, was one method used to assess the quality of life for each resident in the Dementia Care Program.

The second tool selected for the evaluation is derived from a 65-item checklist developed by Zeisal and colleagues (2003). It was designed to assess the appropriateness of the built environment for dementia care residents. An adapted version of Zeisal's checklist has been used at The Lodge at Broadmead to evaluate the renovated environments in the Palm and Magnolia Lodges.

Photographs were taken of the lodges, before and after renovations, as a visual record of environmental change.

Ad hoc documentation of successes, by staff members who wished to do so, were entered in brightly coloured notebooks called "Hurrah" journals. These were left in a convenient place for staff in each lodge. The commentaries were reviewed and recorded by the evaluation consultant.

In summary, the evaluation consultant designed, conducted, analyzed and reported results from the following:

- three staff surveys (six months apart), with some questions repeated in all surveys in order to assess changes in self-rated knowledge of dementias as a result of the education and training provided;

- two written, "Family and Friend Surveys" (six months apart, with some questions repeated) to assess change in such variables as their ratings of residents' quality of life;
- six group interviews with different staff groups (where staff were able to express themselves candidly, without the presence of supervisors);
- one group interview with volunteers (as it was discovered early in the process that volunteers are an important element in the program);
- three one-to-one interviews (to clarify the depth and breadth of certain professional roles, such as the social worker's role in the program); and
- two content analyses of staff's voluntary entries in "Hurrah!" journals.

The evaluation study included numerous and varied data collection activities so that all professional and non-professional perspectives would be tapped, and change could be tracked. Written surveys provided quantitative data, while group and personal interviews, observation, and entries in the "Hurrah!" journals provided qualitative data. Each shored up the other.

• Reporting

Throughout the process, the evaluation consultant reported the results of each evaluation activity to the Clinical Nurse Specialist and Director of Care in a timely manner, usually within one week to 10 days (or longer for written surveys), so that modifications could be made immediately to the Dementia Care Program or to the evaluation plan, if necessary.

Summaries of findings were made available to all staff members by posting the results in the team centre. This method served to recognize staff members' input and kept them involved in the evaluation process. Although evaluation activities focused

primarily on the questions in the evaluation plan, unsolicited findings were recorded and reported as well.

Additional evaluations

Additional evaluation activities, directed by the Clinical Nurse Specialist, were conducted by the Interdisciplinary Team. These included:

• Implement Best Practices

Since one objective of the Dementia Care Program was to gather, collate, and implement Best Practice Principles in Dementia Care, an interdisciplinary committee (including the clinical nurse specialist, clinical resource nurse, registered nurse, registered psychiatric nurse, occupational and physical therapists, dietician and social worker), collaborated to develop guidelines for Best Practice in Dementia Care that were to be followed.

The guidelines cover 20 Best Practice Principles, such as person-centred care, flexible scheduling of care provision, staff training/education, interdisciplinary assessment, etc. These guidelines were adopted and are being applied.

A strategic plan was also devised to ensure that every aspect of each of the principles was put into practice. Almost all of the activities listed in this strategic plan were completed by March, 2006, two years after the implementation of the program. The strategic plan is currently used to develop the clinical program document.

• Create and maintain comprehensive resident profiles

Another goal of the Dementia Care Program was to create a comprehensive resident-profile data capture form, including information in physical, functional, cognitive, behavioural, medical and social domains.

This form was used to document

scores from a variety of resident assessments completed by members of the interdisciplinary team. Detailed resident data on veterans with dementia have been collected four times (every six months) so far. Baseline data were collected between August and September, 2004, before major renovations and staff education projects were started, and before staffing/human resource enhancements were completed. Information was recorded for all veterans with dementia living on Palm and Magnolia Lodges.

The second data collected was six months later, Feb., 2005, after the most disruptive renovations, and almost all staff education, had been completed. The third was July and Aug., 2006, and the fourth, Feb., 2006.

- **Ensure a holistic approach to care**

An interdisciplinary *Resident Admission Assessment Form* was developed by the Clinical Nurse Specialist in charge of the Dementia Care Program, in consultation with an interdisciplinary committee. It was tested in Palm and Magnolia Lodges, with the intention that it will be utilized throughout The Lodge. Categories of information include financial, spiritual, physical, cognitive, behavioural and functional care.

Guidelines for the completion of this assessment tool were also developed and include a list of responsibilities for the social worker, activation worker, RN or RPN, licensed practical nurse, occupational and physical therapists, and dietician.

Practical advice

Following is some practical advice based on the experience of designing and conducting program evaluation in residential care:

- 1) Establish and support a**

culture of evaluation and enquiry

The organization needs to “buy in” to the importance of the contributions of all staff members.

During team-building meetings, staff embraced the idea that they would provide input into the evaluation before the process began. Maintaining enthusiasm for participation requires on-going effort by leaders.

- 2) Find an external consultant and the budget to fund the evaluation**

It is unrealistic to do an *internal evaluation* in today’s nursing home environment, characterized by increasingly frail residents, shorter lengths of stay, a shortage of nurses and other health professionals, changes in knowledge and approaches in dementia care, and myriad other challenges. Nobody “on the inside” has the time.

- 3) Find someone very familiar with LTC and dementia care**

This individual should be someone who has done data collection in a nursing home before. This will increase the chances that the questions will be pertinent, methods will be appropriate to the environment and to respondents, the analysis will be meaningful, and informants will be treated with understanding.

- 3) Start the evaluation early**

The evaluation should be initiated as soon as you start the new program or the changes to an existing program, or shortly thereafter.

- 4) Provide the consultant with plenty of data**

Whether or not you have the opportunity to start the evaluation early in the life of the program, be sure to provide the evaluation consultant with plenty of information before asking

for an evaluation plan (or framework). Provide references to relevant literature, access to key informants, and information about the facility’s care philosophy, physical environment, staffing, resident characteristics, and the role of volunteers or others who are not regular staff.

Also, ensure that your program’s process objectives (how you are going to do things and/or what new products you are going to develop) and outcome objectives (what changes you hope to see as a result of your program), are clear and well understood. Clarifying these objectives to an external consultant is often a very enriching process for staff members, since it can re-spark their enthusiasm.

- 5) Establish a key contact and collaborator on staff**

This individual will work with the evaluation consultant for the duration. In this case, it was the CNS

This collaboration works in several ways. It simplifies decision-making about possible changes to the evaluation plan, timing of data collection events, and so on, since only two people are involved in decisions about logistics; and it provides someone ‘on the inside,’ the CNS, to disseminate surveys and arrange group and personal interviews, thus saving the consultant considerable time (and the nursing home considerable expense).

The ‘inside person’ acts as the ‘cheerleader’ for the evaluation and can provide reminders to staff, and bouquets of thanks for participation.

A bonus of this pairing is that the collaborators can learn a great deal from each other. When decisions of major import or substance are required, the DOC is asked for input.

- 6) Introduce evaluation consultant**

Formally acquaint staff, volunteers,

family members and others with the evaluation consultant. This will help ensure that the consultant confers with them about their participation in the process of evaluation. For example, they should be asked for their preferred data collection methods, and every effort should be made to accommodate their preferences. Make it clear that the evaluation being conducted is *their* evaluation of the program; the evaluation consultant is just a designer and facilitator. The opinions and input that matter are theirs

7) Make sure there is a mix of data collection methods in the design of the study

One survey does not an evaluation make! If data collection is limited to written surveys, for example, all those who do not like completing questionnaires, or who are not confident in reading or writing English, will be at a disadvantage and may not respond.

Another weakness is that some concerns - even important ones - may not come to light if only structured, written surveys are employed. On the other hand, if only group interviews are used as a data collection method, findings may be skewed due to a few outspoken people.

Surveys provide breadth; they are good at giving a snapshot of “what,” “where” and “when.” Interviews, observations and impromptu entries in journals are methods that provide depth; they are good for explaining “how” and, most importantly, “why.” You need both quantitative and qualitative data to get the full picture.

8) Ask direct and informal questions

Another way to learn the “how and why” is to ask staff members directly how things are working, and then jot down their anecdotal feedback to share with the evaluation consultant.

9) Provide financial support

Financially support staff members’ participation in the evaluation process (for example, for participating in a two-hour group interview). This will require special funding or “time back in lieu.”

10) Ask evaluation consultant to report results in a timely manner

You should expect results of group or telephone interviews within a week or two, and results of surveys (which take longer to write up) within a month or so of their final deadline. This way, you will have the information required to make decisions, plan meetings, respond to staff concerns, etc., in a timely manner, and possibly averting crises. Gone are the days when an evaluator collects data for two years and then hands in a fat report!

11) Share the results

Share the results of all data collection activities with the respondents who took the time to provide input. Staff prefer short, bullet summaries of findings, since they tend to be pressed for time, and some are not confident readers in the English language. Volunteers and family members may prefer fuller versions of findings. Determine their preference; doing so confirms that the informants’ input has been recorded and contributes to their feelings of efficacy. They know they have been heard.

12) Do on-going, informal assessment

Use your time during clinical interdisciplinary rounds and team meetings to assess how the Best Practice Principles are being used in care practice and to celebrate successes discovered in the evaluation process.

13) Disseminate information in the field

Be prepared to share your methods and findings with others in the field through publications and presentations.

14) Remember, evaluation is not a luxury

An evaluation is an essential element of reflective practice, a method of finding out if you are doing a good job. You want to know. ■

References

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