The Dementia Training & Education Strategy for Gloucestershire

Appendices
# APPENDICES

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</table>
## Checklist: Gathering Background Information About The Person

Use the checklist in collaboration with carers and key people in the person’s life. Include the person. This is a guide about things to explore, and not an exhaustive list.

<table>
<thead>
<tr>
<th>Things to consider:</th>
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</thead>
</table>
| **Type of dementia** | ● How does it affect communication?  
   ● How does it affect everyday tasks?  
   ● How does it affect memory?  
   ● Are there any odd thoughts the person is having? |
| **Life story** | ● Work / Children / Marriage  
   ● Childhood anxiety / trauma or separation  
   ● The person’s passions and traumatic / significant events  
   ● What was / is the person’s view of the above?  
   ● What was / is important to the person? |
| **Personality** | ● Quiet and shy / outgoing and confident  
   ● Angry and bad tempered / laid back & passive  
   ● Disorganised & chaotic / very organised  
   ● Jokers |
| **Physical and Mental Well-Being** | ● Chronic or acute pain  
   ● Any long standing physical disabilities / mental health issues  
   ● Other long term conditions  
   ● Any sight or sensory impairments  
   ● Any addiction issues  
   ● Did the person have an interest in alternative therapy  
   ● What did the person use in the past |
| **Relationships** | ● Who were the person’s friends and are they still around  
   ● What were relationships like: good / bad / indifferent  
   ● Are there any spiritual relationships? |
| **Environment** | ● What are the routines?  
   ● What is it like living where the person is living?  
   ● Where does the person prefer to spend their day?  
   ● Opportunities for engagement?  
   ● Does it make sense for the person?  
   ● Can the person move about if they want?  
   ● Can the person have a cup of tea when they wish? |
Person Centred Care working across cultures

- Check that appointment times do not clash with religious holidays, festivals, rituals
- Check if English is the service users or carer’s (family, friend) first language and if you need an interpreter.
- Find out how the person wishes to be addressed
- Be aware of diversity of food preparation and choices
- Consider privacy and dignity needs in relation to person’s culture and faith.
- Remember cultural background may affect understanding and context of particular words
## Personal Profile

### My Name:
I like to be called:

<table>
<thead>
<tr>
<th>People who were and are important to me:</th>
<th>Significant Places for me:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My working life:</th>
<th>Social Activities Interests and Hobbies:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

I really like:

<table>
<thead>
<tr>
<th>Any other Information About me:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Antecedent (What was happening directly before)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
</tr>
<tr>
<td><strong>Primary Location:</strong></td>
</tr>
</tbody>
</table>
| **Time:** late evening  
**Date:**                      | **What did the person do/say:**                              | **What assisted the person to calm (interaction with staff etc)?** |
<p>| <strong>Staff Present:</strong> |                                                              | <strong>How long did it take for the person to appear calm?</strong> |
| <strong>Service Users Present:</strong> |                                                             | |
| <strong>Others Present:</strong> |                                                           | |
| <strong>Contributing factors (eg. physically unwell, or poor night sleep etc):</strong> |                                                             | |
| <strong>Setting conditions (What was going on in the environment directly before the incident):</strong> |                                                             | |</p>
<table>
<thead>
<tr>
<th></th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A = Activating Event (Triggers)</strong></td>
<td>(what led to the person behaving in a certain way, what was happening to them or around them at the time, where did the event take place, what time did it happen)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B = Behaviours</strong></td>
<td>(What happened name and describe the behaviour. Was the person trying to communicate using this behaviour, are there any risks? Please state them)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C = Consequences</strong></td>
<td>(What happened as a result of the behaviour? What did you do that worked / did not work)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Model of Enriched Care

Type of dementia

Personality

Physical health

Life Story

Behaviour Causing Distress

Environment

Relationships
Life Story

82 year old Peter was brought up on a dairy farm by his adopted family after being evacuated to Gloucester from the East End of London during WWII (Peter’s mother and father died in a bombing raid over London).

Peter competed in ploughing competitions in vintage tractors and with shire horses. His proudest achievement was in helping to ensure the breed survival after the war.

Peter secretly called his pet pig Myrtle after his adopted sister (they never got on well!) it still raises a laugh for him.

Peter loved country and farming life but it was also a hard life and in the main he is happy to be retired and put his feet up for a well-earned rest.

Peter enjoys music especially Dolly Parton.

Type of dementia

Alzheimer’s disease – Peter relies on carers for his personal care needs.
Expressive dysphasia – Peter’s sentences can take time to form and in his words, come out all wrong.
Milder receptive dysphasia – It takes time for Peter to process information. He can understand clear short sentences.

Personality

Peter is polite and accommodating – he is happy to be retired and in his words “put his feet up for a well-earned rest”
Peter has what he calls old fashioned values of good manners and respect.
He is a little shy with female carers but does prefer to receive care from women. Peter is happy in his own company.
He retires to bed early because he still likes to get up at 4.00 a.m.

Behaviour Causing Distress

Peter will at times resist personal care.
He has been known to shout loudly and angrily at care staff.
He has pushed staff away from him and two days ago struck a male carer on the shoulder.

Relationships

Peter’s wife died 4 years ago
Peter has a good relationship with his son who also farms.
Peter enjoys a joke with carers and it is obvious that he is well liked (although his height makes providing care feel a little intimidating for some staff).

Physical health

Peter is 6 foot 2 – he has arthritis in his knees and hips which makes walking painful.
Occasionally he gets gout in his left foot which is excruciatingly painful. Peter is reluctant to walk at these times.

Environment

Peter is happiest sitting in his favourite arm chair and looking out of the window.
He has a table next to his chair preferably with a cup of tea and the newspaper on it.
He is very proud of his ploughing photographs which are kept on his table.
Peter enjoys mealtimes and comfort food.
He takes a long time to eat his meals and requires adapted cutlery due to arthritis in his fingers.
He does not like a lot of noise around him especially at mealtimes (except for his music which he likes to have playing in the background).
### Gloucestershire Mental Capacity Act Governance Group (MCAGG)

**MCA1 Form - Day-to-Day Decisions - Health & Treatment Needs (1.1)**

This form must be used to record the outcome of a Mental Capacity Assessment conducted with the service user in accordance with the MCA (2005).

<table>
<thead>
<tr>
<th>Name of Service User</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Assessment</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Has the Service User got an impairment of or a disturbance in the functioning of, the mind or brain?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If yes describe the impairment:</th>
</tr>
</thead>
</table>

**HEALTH & TREATMENT NEEDS**

<table>
<thead>
<tr>
<th>Decision – please identify care plan(s) or specific proposed care provision</th>
</tr>
</thead>
</table>

For Example:
- Treatment for leg ulcers
- Administering medication

Check whether for any of the separate elements there might be a need for an individual capacity assessment. For example a person may not have capacity in one area (ie stoma care) but may have capacity in another area.

Explain to the service user the purpose of this assessment and associated proposed care. Explain the available options and the pros and cons of each.

**Can the service user………**

- Understand the information relevant to the care plan(s)? Yes / No
- Retain this information long enough to make a decision? Yes / No
- Weigh up the information? Yes / No
- Or, Communicate their decision? Yes / No / N/A
If the answer to one or more of the questions is ‘no’ then the person lacks capacity to make this decision. The first 3 (U,R,W) should be applied together. If a person cannot do any of these 3 things they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way.

Overall Outcome of Assessment (tick one)

| This person has capacity to make this specific decision for themselves |
| This person lacks capacity to make this specific decision for themselves |

If the person lacks capacity, you will be making the decision for them in consultation with family / friends / other professionals, and by involving the service user as much as possible.

Detail below the action you will be taking, evidencing why this is in the person’s best interests. Also make a note of who else you have consulted, and what their feelings were.

If you decide that the person cannot make the decision for themselves, you should review this assessment along with the associated care plan(s), or if anyone raises concerns that the person’s capacity may have changed.

Assessment/ to be reviewed on

Name of assessor

Signature of assessor

Details of others involved: (Include relatives / informal carers)
Gloucestershire Mental Capacity Act Governance Group (MCAGG)

MCA1 Form - **Day-to-Day Decisions – Safety Needs (1.6)**

This form must be used to record the outcome of a Mental Capacity Assessment conducted with the service user in accordance with the MCA (2005).

<table>
<thead>
<tr>
<th>Name of Service User</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Date of Assessment</th>
</tr>
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<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Has the Service User got an impairment of or a disturbance in the functioning of, the mind or brain?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes describe the impairment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**SAFETY NEEDS**

<table>
<thead>
<tr>
<th>Decision – please identify care plan(s) or specific proposed care provision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>For Example: Environmental restrictions eg locked doors</td>
</tr>
<tr>
<td>Physical restrictions eg holding</td>
</tr>
<tr>
<td>Mechanical restrictions eg lap belts</td>
</tr>
</tbody>
</table>

Check whether for any of the separate elements there might be a need for an individual capacity assessment. For example a person may not have capacity in one area (ie stoma care) but may have capacity in another area

Explain to the service user the purpose of this assessment and associated proposed care. Explain the available options and the pros and cons of each.

**Can the service user………**

<table>
<thead>
<tr>
<th>Understand the information relevant to the care plan(s)?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retain this information long enough to make a decision?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Weigh up the information?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Or, Communicate their decision?</td>
<td>Yes / No / N/A</td>
</tr>
</tbody>
</table>
If the answer to one or more of the questions is ‘no’ then the person lacks capacity to make this decision. The first 3 (U,R,W) should be applied together. If a person cannot do any of these 3 things they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way.

Please give more detail – How did you support the person? How did the person respond?

Overall Outcome of Assessment (tick one)

| This person has capacity to make this specific decision for themselves | This person lacks capacity to make this specific decision for themselves |

If the person lacks capacity, you will be making the decision for them in consultation with family / friends / other professionals, and by involving the service user as much as possible.

Detail below the action you will be taking, evidencing why this is in the person’s best interests. Also make a note of who else you have consulted, and what their feelings were.

Please identify that where restrictions are being applied why they are necessary and proportionate to harm.

If you decide that the person cannot make the decision for themselves, you should review this assessment along with the associated care plan(s), or if anyone raises concerns that the person’s capacity may have changed.

Assessment/ to be reviewed on

Name of assessor

Signature of assessor

Details of others involved: (Include relatives / informal carers)
Gloucestershire Mental Capacity Act Governance Group (MCAGG)

MCA1 Form - **Day-to-Day Decisions – Personal Care Needs (1.5)**

This form must be used to record the outcome of a Mental Capacity Assessment conducted with the service user in accordance with the MCA (2005).

<table>
<thead>
<tr>
<th>Name of Service User</th>
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</table>

<table>
<thead>
<tr>
<th>Date of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has the Service User got an impairment of or a disturbance in the functioning of, the mind or brain?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>If yes describe the impairment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### PERSONAL CARE NEEDS

<table>
<thead>
<tr>
<th>Decision – please identify care plan(s) or specific proposed care provision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

- For Example: Washing and dressing
- Shaving
- Changing continence aids
- Assisting to the toilet
- Stoma care / Conveen care

Check whether for any of the separate elements there might be a need for an individual capacity assessment. For example a person may not have capacity in one area (ie stoma care) but may have capacity in another area.

Explain to the service user the purpose of this assessment and associated proposed care. Explain the available options and the pros and cons of each.

**Can the service user.........**

- Understand the information relevant to the care plan(s)? Yes / No
- Retain this information long enough to make a decision? Yes / No
- Weigh up the information? Yes / No
Or, Communicate their decision? Yes / No / N/A

If the answer to one or more of the questions is ‘no’ then the person lacks capacity to make this decision. The first 3 (U,R,W) should be applied together. If a person cannot do any of these 3 things they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way.

Please give more detail – How did you support the person? How did the person respond?

Overall Outcome of Assessment (tick one)

| This person has capacity to make this specific decision for themselves | |
| This person lacks capacity to make this specific decision for themselves | |

If the person lacks capacity, you will be making the decision for them in consultation with family / friends / other professionals, and by involving the service user as much as possible.

Detail below the action you will be taking, evidencing why this is in the person’s best interests. Also make a note of who else you have consulted, and what their feelings were.

If you decide that the person cannot make the decision for themselves, **you should review this assessment along with the associated care plan(s)**, or if anyone raises concerns that the person’s capacity may have changed.

Assessment/ to be reviewed on

Name of assessor

Signature of assessor

Details of others involved: (Include relatives / informal carers)
<table>
<thead>
<tr>
<th>Green Behaviours</th>
<th>Possible Reasons Why?</th>
<th>What Might Help? How to Respond?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amber Behaviours</td>
<td>Possible Reasons Why?</td>
<td>What Might Help? How to Respond?</td>
</tr>
<tr>
<td>Red Behaviours</td>
<td>Possible Reasons Why?</td>
<td>What Might Help? How to Respond?</td>
</tr>
</tbody>
</table>
### Green behaviours

- Peter responds positively to requests and prompts when being supported with care.
- Enjoys food and drink when he is supported.
- He prefers traditional food such as; porridge
- ‘sausage and mash’
- Fish and chips
- Enjoys gravy with most meals
- Responds to conversation with short sentences. Peter’s sentences may not always be easy to understand.
- Peter enjoys music, especially Dolly Parton.
- Peter likes to reminisce.
- Peter enjoys his armchair and a newspaper.

### Possible reasons why?

- Peter:
  - Feels safe
  - Feels comfortable
  - Feels in control
  - Is pain free
  - Feels respected

### What might help? How to respond?

- Where possible care to be provided by female carers. Continue to explain to Peter what is happening at all times when undertaking any care tasks
- Be consistent and respectful in your approach. Peter is happy to be called by his first name.
- Don’t rush Peter- give him plenty of time to respond to requests and questions. Give Peter time to eat his meals and relax with a cup of tea.
- Talk to Peter about his interests: farming, cows, music (Dolly Parton).
- Be consistent using staff with whom Peter has a positive relationship.

### Amber behaviours

- Peter is reluctant to get out of bed.
- Peter raises his voice and tells carers to ‘go away’.
- Peter reluctant to receive personal care.
- Peter finds it increasingly difficult to make himself understood.

### Possible reasons why?

- It’s possible that Peter is in pain
- Too many / difficult demands
- Environment busy or noisy
- Male carers
- Overwhelmed at what is happening
- Has been offended by perceived impoliteness

### What might help? How to respond?

- Gain eye contact and move to Peter’s level
- Be quiet and calm in your approach
- Do not crowd Peter
- Support to be provided by someone with whom Peter has a positive relationship.
- Try use of favourite music to help Peter to relax
- Use short sentences to explain what you are doing. Apologise if you feel you have inadvertently offended Peter. Remember manners…
- Try pain relief as prescribed if Abbey Pain scale indicates possibility of pain or there are other indicators.

### Red behaviours

- Peter has struck a male member of staff on the shoulder
- Raised voice
- Resistive to support with care tasks

### Possible reasons why?

- Peter may be in pain / discomfort
- Peter may struggle with too much information
- Feelings of frustration that he can’t convey his meaning in words.
- Anxiety and fear that care approaches will result in pain.
- Peter may be overwhelmed and reacting to too many people talking to him / touching him at the same time.
- Peter is offended by what he perceives as impolite behaviour.

### What might help? How to respond?

- Remain calm and polite in approach (be aware of body language and tone and pitch of voice).
- Use minimal language & allow processing of information
- One, preferably female, carer, with whom Peter has a good relationship to communicate with Peter.
- Allow time for situation to calm and leave Peter alone if safe to do so.
- Report and communicate situation for future review.
End of Life Considerations: 
Supporting People with Dementia and their Carers

The care plan needs to incorporate the following elements:

**Physical changes**

Page 12 of the Gloucestershire 5 Step Approach Booklet sets out the physical and psychological changes associated with dying with dementia. This transition can take place over weeks, months or years, so it is essential that care plans record patterns of change to evidence a terminal phase, allowing appropriate Advance Care Planning.

**Communication**

It is important to maintain good, clear and transparent communication between the person, the professional and the family/friend/carer. The Triangle of Care (Hannan et al, 2013) is a useful model.

The best practice approaches to communicating with people with dementia remain relevant: smiling, eye contact, open body language and at the same eye level, particularly in a care environment, where background noise and poor lighting can have a negative impact.
Pain

Pain can be physical, emotional and psychological; all aspects of these need to be considered when addressing pain. Talk to the family about how they have supported the person with discomfort or distress, manages pain. They may have developed coping strategies to use in conjunction with medication. The Abbey Pain Scale [Appendix 10](#) is a useful tool in identifying pain, it is an observational tool that is effective with limited communication.

Nutrition and Hydration

People living with dementia may lose weight as a consequence of cognitive and physical impairment. Maintaining nutrition, hydration, oral health and bodily functions such as elimination are important aspects of palliative care. Work with the family to understand how they have supported the individual with eating and drinking, seeking advice from the Speech and Language Team or Dietician as appropriate.

Carers’

Spiritual, emotional psychological needs should be equally addressed when considering end of life care for a person living with dementia. Again, the Triangle of Care offers a model to think about the family’s psychological support needs: has this been included in the care plan? Have the difficult conversation about dying been initiated? Has carer support been offered?

Dame Cicely Saunders founder of the hospice movement stated “perhaps one of the most challenging and important needs to address well for the person, are spiritual needs as this is central to the experience of death and to the observation of death”.

Reference


https://www.carers.org/triangle-care
Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6.

Name of resident: ................................................................................................................................

Name and designation of person completing the scale: ...........................................................................

Date: .................................................................................................................................. Time: ..................................................

Latest pain relief given was ........................................................................................................... at .......... hrs.

Q1. Vocalisation
   eg whimpering, groaning, crying
   Absent 0   Mild 1   Moderate 2   Severe 3
   Q1

Q2. Facial expression
   eg looking tense, frowning, grimacing, looking frightened
   Absent 0   Mild 1   Moderate 2   Severe 3
   Q2

Q3. Change in body language
   eg fidgeting, rocking, guarding part of body, withdrawn
   Absent 0   Mild 1   Moderate 2   Severe 3
   Q3

Q4. Behavioural Change
   eg increased confusion, refusing to eat, alteration in usual patterns
   Absent 0   Mild 1   Moderate 2   Severe 3
   Q4

Q5. Physiological change
   eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
   Absent 0   Mild 1   Moderate 2   Severe 3
   Q5

Q6. Physical changes
   eg skin tears, pressure areas, arthritis, contractures, previous injuries
   Absent 0   Mild 1   Moderate 2   Severe 3
   Q6

Add scores for 1 - 6 and record here

Total Pain Score

Now tick the box that matches the Total Pain Score

<table>
<thead>
<tr>
<th></th>
<th>0-2</th>
<th>3-7</th>
<th>8-13</th>
<th>14+</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Finally, tick the box which matches the type of pain

Chronic  Acute  Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 -2002
(This document may be reproduced with this acknowledgement retained)
### Clinical Frailty Scale*

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Very Fit</strong> – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Well</strong> – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Managing Well</strong> – People whose medical problems are well controlled, but are not regularly active beyond routine walking.</td>
</tr>
<tr>
<td>4</td>
<td><strong>Vulnerable</strong> – While not dependant on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.</td>
</tr>
<tr>
<td>5</td>
<td><strong>Mildly Frail</strong> – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.</td>
</tr>
<tr>
<td>6</td>
<td><strong>Moderately Frail</strong> – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.</td>
</tr>
<tr>
<td>7</td>
<td><strong>Severely Frail</strong> – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).</td>
</tr>
<tr>
<td>8</td>
<td><strong>Very Severely Frail</strong> – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.</td>
</tr>
<tr>
<td>9</td>
<td><strong>Terminally Ill</strong> – Approaching the end of life. This category applies to people with a life expectancy &lt;6 months, who are not otherwise evidently frail.</td>
</tr>
</tbody>
</table>

#### Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

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# Feedback Form

<table>
<thead>
<tr>
<th>About the booklet:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspects that worked well?</td>
</tr>
<tr>
<td>Areas that didn’t work?</td>
</tr>
<tr>
<td>Is there anything missing?</td>
</tr>
<tr>
<td>Is there anything you would like to see changed?</td>
</tr>
</tbody>
</table>

## Anonymised stories:
Please attach where relevant any anonymised personalised care planning. This will help others identify strategies which can support people with dementia.

Please return to
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* tina.kukstas@glos.nhs.uk
Sherbourne House, Charlton Lane, Cheltenham GL53 9D2