QUALITY STANDARDS

Placemat for Dementia

This document is a resource for clinicians and summarizes content from the *Dementia: Care for People Living in the Community* quality standard.

Assessment and Diagnosis

Quality Statement (QS) 1: Comprehensive Assessment and Diagnosis

People suspected to have mild cognitive impairment or dementia receive a comprehensive assessment when signs are first identified. If diagnosed with either condition, they are then reassessed on a regular basis or when there is a significant change in their condition.

If you suspect that your patient has symptoms of mild cognitive impairment or dementia, perform a comprehensive assessment to ensure accurate diagnosis and to collect baseline information on your patient's status. Complete regular reassessments for patients diagnosed with either condition.

Individualized Care Plan

QS 2: Interprofessional Care Team

People with dementia have access to community-based dementia care from an interprofessional team with expertise in dementia care, of which the person with dementia and their care partners are integral team members.

Your patient should be cared for by an interprofessional team with expertise in dementia care. Your patient and their care partners should be involved in decisions about their care plan.

QS 3: Individualized Care Plan

People with dementia have an individualized care plan that guides their care. The plan identifies their individual needs, those of their care partners, and goals of care. The plan is reviewed and updated on a regular basis, including documentation of changing needs and goals and the person's response to interventions.

Work with your patient and their care partners to create an individualized care plan. The care plan should be based on their life history and social, cultural, and family circumstances, and should be reviewed and updated based on the needs and preferences of your patient every 6 to 12 months.

QS 4: Named Point of Contact

People with dementia, their family, and their care partners have 1 or more named interprofessional care team members who serve as a point of contact to facilitate care coordination and transitions across settings.

There should be 1 or more named contact from the interprofessional care team responsible for transferring information and coordinating care among the patient, clinicians, health care team, and care partners. Share the name and contact information of this team member with your patient and their care partners.

Education and Training

QS 5: Education and Training for People With Dementia and Their Care Partners

People with dementia and their care partners have access to education and training on dementia and available support services.

Connect your patient and their care partners with education and training programs and services to help them better understand dementia, its progression, treatment options, and available support. Education and training should align with your patient's stage of dementia and their current needs.

Ontario Health

QS 6: Education and Training for the Health Care Team

People with dementia receive care and services from health care team members who have education and training in dementia care.

Complete education and training to effectively provide care for people with dementia. Understand your role and responsibilities in addressing the complex needs of your patient.

Access to Support and Services

QS 7: Access to Support Services

People with dementia and their care partners have access to support services that are individualized and meet their ongoing goals and needs.

Offer support services to your patient and their care partners. Services should consider the goals of care of your patient and their care partners, and should be timely, responsive, easily accessible, and tailored to their needs, strengths, capabilities, and individual choices.

QS 8: Care Partner Assessment and Support

Care partners of people with dementia are assessed on an ongoing basis and offered supports to address their individual needs.

Complete regular assessments for care partners providing support and assistance to your patient. Care partners should be offered a range of tailored support and training opportunities that are responsive to their needs and your patient's stage of dementia.

QS 9: Safe Living Environment

People with dementia have access to a safe living environment that meets their specific needs, including design modifications and a range of housing options.

Your patient should have access to a safe living environment. The environment should have appropriate stimuli and address potential safety and security hazards inside and outside their place of residence. Connect your patient with members of the health care team who can ensure safe housing for them.

QS 10: Access to Primary Care

People with mild cognitive impairment or dementia have regular visits with a primary care physician or nurse practitioner who provides effective primary care that meets both their general health care needs and their specific needs related to cognitive impairment or dementia.

Have regular visits with your patient to address their general health needs and specific needs related to symptoms of mild cognitive impairment or dementia. Provide person-centred, comprehensive, and coordinated primary care.

Resources

- *Dementia: Care for People Living in the Community* quality standard and patient guide
- *Behavioural Symptoms of Dementia* quality standard and patient guide
- *Medication Safety* quality standard and patient guide
- *Palliative Care* quality standard and patient guide
- Non-Pharmacological Assessment and Management of Behavioural and Psychological Symptoms of Dementia in Primary Care (Mount Sinai Hospital)
- Provincial Geriatrics Leadership Ontario

Additional tools and resources are on Quorum.

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Need this information in an accessible format?
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