UNIVERSITY OF ALBERTA

SPECIAL CARE DEMENTIA UNITS: WHAT MAKES THEM "SPECIAL"?

by

Dorothy E. Phillips 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

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Abstract

Special care dementia units have been widely studied in the United States. This study represents the first of its kind in Alberta to study special care dementia units. The purpose of this study was to estimte the number of existing units, and to describe the units at one point in time, and to further identify the variability between units. In this study, a survey questionnaire was mailed to all continuing care facilities.

Òverall, the findings of this study were remarkably similar to the findings of studies conducted in the United States. In Alberta the number of special care dementia units increased dramatically since the late 1980s. Existing units were described as a separate, secure area, where special programs were provided, and the environment was modified in terms of the physical environment, staffing, and philosophy. Existing units varied in almost every respect including their underlying philosophy, physical design, staffing, programs and treatment practices. It is the opinion of the investigator that more research must be conducted before additional resources are allocated to the development of additional special care dementia units.

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CHAPTER 1: INTRODUCTION

One of the major health problems of the elderly is Alzheimer's disease and other related dementias. This topic is important to nursing practice because the number of elderly clients with dementia is increasing rapidly (Andiel, 1993), and has resulted in a definite shift in client population in continuing care facilities. Data compiled by Andiel (1993) and Alberta Health (1993) suggests that this number will only continue to increase in the future. In continuing care facilities, approximately 44 per cent of individuals with dementia have been admitted because of behavioral problems such as wandering, agitation, and aggression (Alberta Health, 1993). Although the neuropathological changes of dementia cannot be arrested, there have been many advances in the treatment and management of dementia over the past decade. Despite the availability of research findings related to the care of individuals with dementia, there has been limited objective evaluation in the clinical setting.

Providing optimum care for persons with dementia presents a significant challenge to the continuing care sector. The physical design, organizational milieu, programs, staff selection and training of traditional continuing care facilities often fail to meet the needs of this population. In traditional continuing care facilities the focus has historically been on custodial rather than restorative, therapeutic or rehabilitative. This focus was based on the belief that once marked deterioration sets in, there is little that can be done for the person with dementia other than to provide basic personal care. This trend continues today in many settings, as nurses attempt to control behavioral problems with the use of psychotropic drugs and restraints (Andiel, 1993). When these interventions are found to be ineffective, or not desirable,

the individual with dementia is usually transferred to a special care dementia unit.

It is the belief of many that special care dementia units offer opportunities for supporting a high quality of life for the person with dementia. Quality of life is dependent on the staff's ability to meet the individual's social, intellectual, spiritual, physical, and medical needs (Alberta Health, 1993). Consistent with this belief, Alberta Health introduced a provincial program and approved funding for three special care units located in Edmonton, Calgary, and Grande Prairie. These units, are referred to as Mentally Dysfunctional Elderly (MDE) Units and are intended for individuals with dementia and other related disorders. However, with the increase in numbers of cognitively impaired, Alberta Health (1993) reports that the demand for special care dementia units has exceeded available resources. In an effort to meet the constantly growing demand for institutional care for persons with dementia, many other facility operators have designed and implemented special care dementia units, that at least in theory, attempt to respond to the needs of this special group of people.

Statement of Purpose

There is no doubt that excellence of care and the manner in which it is given have much to do with the quality of life for the person with dementia. To date, however, few researchers have attempted to measure empirically the effects of special care dementia units on the individual with dementia. The major obstacle to empirical research in this setting is that there is no description of the typical special care dementia unit. Without a description of the typical special care dementia unit it will remain difficult for researchers to account for any differences which may exist among existing units. Because there is no

description, the task of describing the typical special care dementia unit is of critical importance.

Development of a description of the typical special care dementia unit requires a thorough exploration of the phenomenon (Brink and Wood, 1989). How special care dementia units are defined will directly determine the number of existing units and ultimately pave the way for researchers to measure the effects of these units empirically. The purpose of this study was to estimate the number of special care dementia units in Alberta, and describe the typical special care dementia unit in terms of size, length of operation, admission/discharge criteria, physical environment, staff selection and training, and programs for residents and family.

Statement of Problem and Research Question

Individuals with dementia have been widely studied over the past decade. The majority of these studies have focused on behavioral problems, assessment techniques and tools, measurement instruments, interventions, and the cost of care. Little is known about special care dementia units. Most of what is known about special care dementia units has come from anecdotal reports and case studies (Leon & Siegenthaler, 1994). To date there is no description of a typical special care dementia unit. Given the current stage of knowledge development, a study designed to explore the phenomenon "special care dementia unit" is appropriate. How special care dementia units are described will ultimately determine the number of existing units and pave the way for researchers to measure the effects empirically. The research question for this study is: What makes a special care dementia unit "special"?

Definition of Terms

At the present time there is no standard definition of a special care dementia unit. For the purpose of this study, the term special care dementia unit is defined as an area identified by respondents as a special care dementia unit.

CHAPTER 2: REVIEW OF THE LITERATURE

A review of the relevant literature was undertaken to determine the nature of existing knowledge on special care dementia units. Several strategies were employed to obtain published and unpublished work which met the inclusion criteria. Inclusion criteria were: (1) written and/or published within the past ten years wherever possible, (2) primarily North American in origin, (3) Canadian content wherever possible, and (4) relevant to the topic. Sources included the Cumulative Index of Nursing and Allied Health Literature (CINAHL)online computer search, authors' reference lists, and informal networks.

Dementia Care

Providing optimum care for the person with dementia presents a significant challenge to health care professionals. Continuing care facilities have been the major resource for care of this group of individuals, but it is a well known fact that their design and approaches to care may not be the best (Sand, Yeaworth and McCabe, 1992). The very nature of dementia calls for a special type of care (Williams, Doyle, Feeney, Lenihan, and Salisbury, 1991). Earlier thinking favoured the traditional unit based on the assumption that cognitively intact residents would have a stabilizing effect on persons with dementia (McCracken and Fitzwater, 1989). Traditional continuing care units were designed to meet the needs of the frail, cognitively alert individual. More recently, the trend has shifted toward the segregated unit based on the theory that this type of unit would be less stimulating and have more highly trained staff (McCracken and Fitzwater, 1989).

Armstrong-Esther and Browne (1986) and Wanich, Sullivan-Marx, Gottlieb and Johnson (1992) suggest that activities aimed at maintaining normalcy through

mobilization, social interaction, prevention of hazards, environmental and sensory modifications, and monitoring of medications can lead to improved functional and cognitive status of the individual with dementia. Special care dementia units have been developed in an attempt to provide improved care, to improve the quality of life, and reduce stress in the individual, family members, and staff (Berg et al. 1991). However, Williams et al. (1991) contended that special care dementia units have grown in number more than in design because in many facilities these units are "special" in name only. If they are to be effective, Williams et al. (1991) recommended that the focus of care must be different than that of traditional continuing care units.

The term special care dementia unit is often used to identify an area that is self-contained and self-sufficient in terms of services, staffing and congregate space (Coons, 1992). Congregate space includes areas such as dayrooms, dining rooms, and activity areas (Coons, 1992). The major goal of special care dementia units is to provide a supportive environment. The term supportive, according to Spak (1993) means to sustain, provide for, furnish with necessities, to advocate, to maintain and give strength. However, with the proliferation of units that claim to be special care dementia units, a problem exists in that there are no standards established to guide development (Sand et al. 1992). In order to be considered a special care dementia unit, Berg et al. (1991) and Sand et al. (1992) suggest that a unit should be different in terms of the following aspects: (1) physical environment, (2) admission/discharge criteria, (3) staff selection and training, (4) resident care and therapy programming, and (5) family programming. In other words, individuals with dementia require some unique environmental characteristics and care approaches (Boling and Gwyther, 1991).

Family Experience

Living with dementia is a difficult journey. Many families are unprepared for the behavioral changes that can occur, and as a result, experience a great deal of emotional stress throughout their relative's illness (Chenoweth and Spencer, 1986). The demands faced by family members are often influenced by the severity of cognitive impairment and the level of functional disability (Sudbury and Mayhew, 1994). Coping with the devastation and the emotional stress has been found to severely tax family resources (Quayhagen and Quayhagen, 1988). However, admission to an institution does not necessarily eliminate the burden to the family. The decision to institutionalize is often very painful. Most families experience guilt when care is turned over to the institution (Quayhagen and Quayhagen, 1988), and prefer to remain actively involved in the caregiving process (Spencer, 1992). Because of this, interventions targeted for family members were also considered to be of vital importance (George and Gwyther, 1988).

Families tend to choose a special care dementia unit because they believe their relative will get the best care in that setting (Spencer, 1992). However, Neufeldt (1991) suggests that the greatest single source of support for the individual with dementia comes from family members. Because interventions which help family members cope more effectively can also improve the life of the individual with dementia, Neufeldt (1991) and Almeida (1991) suggest that a key measure of the quality of a service is the extent to which it supports the family. Consistent with this view, family members are considered to be an important component of dementia care (Sudbury and Mayhew, 1994), and because of this, maintaining good relationships with family members is thought to be vital (Orr-Rainey, 1991).

Many of these families have experienced drastic changes in their relationship with the individual with dementia and

as a result, may need support and guidance in establishing new protective-kin roles (Hansen, Patterson and Wilson, 1988). The challenge is to create an atmosphere that helps ensure family involvement (Spencer, 1992), and involves families in support groups (Boling and Gwyther, 1991). Beyond visiting, it is up to the staff to clarify the roles that families can play on a day-to-day basis. Hansen et al. (1988) suggest that the quality of relationships between staff and family members depends on institutional policies which may or may not encourage involvement. As one might expect, Spencer (1992) found that the quality of relationships between staff and family members varied between units.

Descriptive Accounts of Special Care Dementia Units

According to Williams et al. (1991) and Sand et al. (1992) descriptive accounts of special care dementia units in the United States revealed wide variations in philosophies, therapeutic approaches, protocols for behaviour management, staff education, and environmental design. Gold (1991) conducted a study which sampled 31 special care dementia units in five states. In this study, data collection included a half-day site visit, a telephone survey, and an administrative questionnaire. From the analysis of the data, six distinct care-setting types emerged (Gold, 1991). While the typology developed is not hierarchical in nature, Gold (1991) contended that each type represented a unique category that is distinct from other categories.

In this typology, Gold (1991) described the ideal unit as a unit which is supervised by administrative staff who are knowledgeable about dementia and the various care options. The ideal unit was also found to have a therapeutic rather than a maintenance philosophy in which activities and other sources of cognitive and interpersonal

stimulation were provided. The primary difference between the ideal unit and the other types of special care dementia units was found to be at the administrative level. Instead of knowledgeable people to direct the overall administration of the unit, directors on the other types of special care dementia units were found to have little dementia-specific training, and were primarily concerned with monitoring working hours and keeping costs down (Gold, 1991). As a result, differences also existed in terms of staffing and staff-resident interactions. For example, Gold (1991) found that staff-resident interactions on these units were positive for the most part, but staffing ratios were not sufficient to meet the needs of the residents. As a result, staff rarely initiated touching or conversation, and activity programs if they existed, were limited (Gold, 1991). While residents on these units appeared to receive high-quality physical and psychosocial care, Gold (1991) found that family members tend to bypass these types of units if at all possible.

Gaps in the Literature

Individuals with dementia have been widely studied over the past decade. However, most of what is known about special care dementia units has come from anecdotal reports and case studies (Leon and Siegenthaler, 1994), which are considered to be insufficient for characterizing unit features or care practices. Consequently, only tentative conclusions based on experiences to date can be made (Meyer, Dorbacker, O'Rourke, Dowling, Jacques, and Nicholas, 1991). Abraham and Neundorfer (1990) contend that the momentum experienced over the past decade must be sustained and expanded. For example, more substantive research focusing on a description of the typical special care dementia unit and measurement of the effects of these units on the individual with dementia (Berg et al. 1991; Neufeldt, 1991)

must be undertaken. Without this information, policy makers will continue to make decisions strictly on the basis of cost (Spector, 1991).

Descriptive accounts of special care dementia units in the United States reveal wide variations. Such diversity poses a challenge to those who seek to evaluate their effectiveness and has been cited as a major limitation of previous research (Sand et al., 1992). Overall, special care dementia units appear to constitute a distinct care setting in the continuing care sector, but given the diverse characteristics of these units, and the limitations of the research, it remains difficult to predict the benefits with any certainty. Whether the situation in Alberta is similar remains largely unknown at this time.

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CHAPTER 3: CONCEPTUAL FRAMEWORK

The conceptual framework for this study was the Neuman Systems Model. The Neuman Systems Model views clients in continuing care facilities as living within an environment which frames their experiences in continuing care. With this framework, the study was focused on understanding the various components of the environment which affect clients. There are two major components of the model: the client, and the environment, viewed in the context of a system.

The Client System

Utilizing the Neuman Systems Model, the client system in the continuing care facility can be defined as all individuals involved with the facility, including the clients, staff, volunteers, family members and friends, other clients' visitors, and people in the community who may use the facility for respite care or day programs (Health and Welfare Canada, 1991). The Neuman Systems Model views the client as a total person who is a dynamic composite of psychological, physiological, sociocultural, developmental, and spiritual variables which are interrelated and determine the client's state of well-being (Neuman, 1989). Viewed as an open system, the client is believed to be in constant interaction with the environment (Neuman, 1989).

The Environment

Neuman (1989) defined the environment as all internal and external factors surrounding the client in terms of three components: internal, external, and created environment. The internal environment is considered within the boundaries of the individual; the external environment contains all forces outside the individual; and the created environment signifies the individual's unconscious mobilization of structural components such as energy

factors, stability, and integrity (Neuman, 1989). While the components of the environment are related and interdependent, the characteristics of the components are determined by the whole in which they exist. This view supports the notion that the environment consists of three major components: (1) the physical environment, (2) the organizational climate, and (3) the social-psychological milieu (Kayser-Jones, 1991; Kolanowski, Hurwitz, Taylor, Evans and Strumpf, 1994). The components of the environment using the Neuman Systems Model is shown in Appendix A. Kayser-Jones (1991) contends that all of these components are in constant interaction, and therefore, influence one another.

From a planning point of view, Neufeldt (1991) contends that it is important to understand that the environment, the services provided, and the planned programs have a direct influence on the well-being of the person with dementia. However, the administrative and professional leadership and the philosophy of care is cited as being far more important than the physical structure of the building (Kayser-Jones, 1991), because the rate of deterioration has been found to be affected by the care persons with dementia receive (Dawson, Kline, Wianko and Wells, 1986). Niemoller (1990) suggests that the philosophy of care should be to enhance the quality of care and dignity of life for these individuals by allowing them an opportunity for participation and decision making in activities of daily living. With this philosophy, care is centred around supporting the existing level of functioning, assisting with instrumental and functional activities of daily living, and maximizing the individual's well-being (Burgener and Barton, 1991). While special care dementia units have been developed in an attempt to address the unique needs of individuals with dementia, the literature suggests that they vary in almost every respect. This study will describe the

environment of the typical special care dementia unit as it exists in the province of Alberta.

CHAPTER 4: METHODOLOGY

Study Design

An exploratory-descriptive design utilizing a survey approach was used to answer the research question: What makes a special care dementia unit "special"? The survey approach was an appropriate method for use in this study because (1) little was known about the phenomenon "special care dementia unit" as it exists in Alberta; (2) it provided access to a widely dispersed population; (3) it was cost-efficient in terms of time and human resources; and (4) it provided the opportunity to ask a battery of standardized questions of all respondents (Fowler, 1993). Descriptions of the target population, instrumentation, data collection procedures, and data analysis procedures are outlined below.

Target Population

The target population for this study consisted of all existing special care dementia units in the province of Alberta. Because there was no list of existing special care dementia units in Alberta, the survey was sent to all continuing care facilities in the province of Alberta (n=155). Sample size was not a concern for this study because the target population consisted of all special care dementia units in Alberta. To ensure that all continuing care facilities were surveyed, a current listing of all continuing care facilities in the province of Alberta was obtained from Alberta Health one week prior to the mailing of the survey packages. However, because of the changes occurring in the health system at the time of the study, it was possible that some continuing care facilities were not included in the study.

Data Collection Procedures

A cross-sectional study design in which all units were surveyed once was used to collect data. The instrument used in this study was a mailed, self-administered questionnaire developed by the investigator for the purpose of the study. Neuman's definition of the environment was used as a framework for the development of the questionnaire. The questionnaire included questions about the demographics, the physical environment, admission and discharge criteria, staffing, and programs for residents and family members (Appendix B). The questionnaire consisted of closed-ended questions requiring a "yes" or "no" answer, fixed alternative questions in which respondents were asked to choose one of the given alternatives, and open-ended questions.

Utilizing Alberta Health's current listing of continuing care facilities, the survey package was addressed and mailed out to all continuing care facilities on the list. Only one survey package was mailed to facility operators who operated more than one continuing care facility in a single community. The survey package consisted of a cover letter (Appendix C), a questionnaire (Appendix B), and a pre-stamped envelope which was pre-addressed to the investigator. No names or numbers appeared on the questionnaire or the envelopes to ensure that the investigator had no knowledge of the name of the respondent or the facility. To ensure an adequate response rate, a second survey package was mailed four weeks following the first mailing. The second survey package was similar to the first survey package with the following exceptions: it contained a reminder letter (Appendix D), and a questionnaire marked "second mailing". The second survey package provided an opportunity for the investigator to thank those who had returned the survey and remind those who had not responded.

The first survey package was mailed September 1, 1995. After four weeks, the response rate was 63.9% (n = 99). The second survey package was mailed October 1, 1995. More specific instructions were included in the reminder letter (Appendix D) to ensure respondents understood what was expected of them. In the reminder letter, respondents were instructed to complete the first section of the questionnaire and follow the instructions included on the questionnaire for additional questions to be answered. To ensure that only one questionnaire was completed per facility, respondents were also instructed to return the blank questionnaire if one had already been completed and returned. Because the response time after the second mailing was much longer in comparison to the first mailing, data collection was extended to November 30, 1995.

A total of 158 questionnaires were completed and returned. The response rate was 102%. One questionnaire was discarded because the respondent attached a note to advise the investigator that two questionnaires had been completed by the respondent, leaving a total of 157 valid responses. While the response rate was much higher than anticipated, it was not surprising given the climate in the health care system. The timing of the study coincided with restructuring of the health system. As a result of the restructuring process, rapid changes were occurring, particularly at the administrative level. A change in administrative staff between the arrival of the first and second survey package could have had an impact on the response rate because two questionnaires may have been completed by different individuals in the same facility. With the survey approach, it is also possible that individuals in the facilities could have photocopied the questionnaire, which would also have resulted in two questionnaires being completed in a facility. Because all questionnaires were returned in the pre-addressed enveloped

provided by the investigator, this was not a factor. For the purpose of analysis, responses were included if the respondent reported that there was a special care dementia unit in the facility.

Data Analysis

Data generated from this study were coded using the Statistical Package for Social Sciences (SPSS) computer program, analyzed and reported using descriptive statistics. To facilitate analysis, numerical codes were assigned to the responses. Content analysis was used to analyze the data obtained from the open-ended questions. Main themes were identified and descriptive summaries were completed. In the first stage of analysis, responses were tabulated. This information, together with the descriptive information on the other variables was summarized in tables.

In the second phase of analysis, non-parametric statistical tests were used to test for associations between responses (Brink & Wood, 1989). The Chi-square test was used for nominal level data; Spearman's rho was used for ordinal level data; and Pearson's r was used for interval level data (Brink & Wood, 1989). Logistic regression was used to predict relationships between the demographic variables. The results of the statistical analysis are described in the following chapter.

Protection of Human Rights

Ethical approval from the Faculty of Nursing and University of Alberta Hospitals was obtained on May 3, 1995. In a covering letter (Appendix C) to the respondents, they were informed about the purpose of the study and that they had the right to refuse to participate. If respondents completed and returned the survey, implied consent was assumed.

With the survey approach, the major ethical concern is with confidentiality of the data and anonymity of the respondents. This issue was also addressed in the covering letter. Respondents were advised that data would only be reported in aggregate form. To ensure anonymity, the investigator also instructed respondents to make requests for findings by telephone or letter, separate from the survey.

Because this study was specifically designed not to require any direct interaction with respondents or involve any changes in the delivery of care there were no perceived risks to respondents who choose to participate. While there were no tangible benefits to respondents, it was anticipated that the information obtained would be beneficial to respondents, other practitioners, and researchers. Respondents were informed that a summary of results would be provided upon request.

CHAPTER 5: RESULTS

Introduction

To answer the research question What makes special care dementia units "special" the findings generated from an analysis of the responses are presented. Because a standardized instrument was not available the validity of the questionnaire developed by the investigator was assessed. A discussion about the validity of the questionnaire is presented in the following section.

Validity of the Instrument

The validity of the questionnaire developed by the investigator was assessed because with the survey approach, the instrument is the central issue in determining the validity of the data obtained (Fowler, 1993). In this study, face and content validity were established by having the questionnaire critiqued by individuals who have expertise in both the content area and measurement. These individuals were asked to evaluate the questionnaire in terms of the appearance, adequacy of content, format and use of language. Following revisions, the questionnaire was pretested on the three Mentally Dysfuntioning Elderly (MDE) Units. The MDE Units were selected for the pretest because they provided services to a similar client population. To ensure that the pretest had no affect on the target population, the MDE units were excluded from the study.

In the pretest, respondents were asked to answer the questions and rate each question according to the following criteria: (1) easy to read, (2) understand as written, and (3) can answer accurately (Fowler, 1993). Respondents were also instructed to add categories if they felt that a question had insufficient or inaccurate response categories. To assess the time required to complete the questionnaire, respondents were asked to document the exact time they began

answering questions and the time they completed the questionnaire.

In the pretest, two of the three respondents indicated that questions were easy to read, understood as worded, and could be answered accurately. The third respondent did not rate the questions. The respondents also reported a typographical error in one question, and suggested that another response category be added to two questions. The time taken to complete the questionnaire ranged from 25 to 35 minutes. This was considered appropriate since in an attempt to increase the response rate, the questionnaire was deliberately designed to ensure that respondents could complete it in approximately 30 minutes. Following the pretest, the questionnaire was revised to incorporate the suggested changes.

Characteristics of the Target Population

Demographic Variables

Approximately one-third (29.9%, n = 47) of the respondents indicated that there was a special care dementia unit in their facility (Table 1.0). Of the 47 respondents who indicated that there was a special care dementia unit in their facility, 8.5% (n = 4) reported that there was more than one special care dementia unit in their facility(Table 2.0). All four of these respondents reported that there were two special care dementia units in their facility. Based on the information reported, it was estimated that there were fifty-one special care dementia units in the province of Alberta.

Facility size was tabulated and the breakdown is presented in Table 3.0. Of the 47 respondents who indicated that there was a special care dementia unit in their facility, the majority (83.0%) were located in facilities exceeding 50 beds. Over one-half (59.6%, n = 28) were located in facilities exceeding 100 beds, 23.4 % (n = 11)

were in facilities operating 51-100 beds, 14.9% (n = 7) were in facilities operating 25-50 beds, and 2.1% (n = 1) were in facilities operating less than 25 beds. There was no relationship between the size of facility and the number of special care dementia units (Chi-square = 0.46, df = 3, p = 0.93).

The target population was also assessed in terms of length of operation (Table 4.0). The majority of respondents (91.5%, n = 43) reported that their special care dementia unit had been in operation for more than one year, and only four respondents (8.5%) indicated that their unit had been in operation for less than one year. Of the 91.5%, 29.8% (n = 14) had been in operation for more than five years, 38.3% (n = 18) had been in operation for more than two years, but less than five years, and 23.4% (n = 11) had been in operation more than one year, but less that two years.

Location of facility was also examined in this study. Location was divided into three variables in an attempt to examine the distribution in terms of the distance, urban/rural split, and region. Distance was assessed in terms of the number of miles to the nearest special care dementia unit. The distribution by distance to the nearest special care dementia unit is presented in Table 5.0. The majority of respondents (80.0%, n = 28) reported that the distance to the nearest special care dementia unit was less than 50 miles. Of the remaining 20.0%, 11.4% (n = 4) reported a distance of 50-100 miles, and 8.6% (n = 3) reported a distance of more than one hundred miles. While there was no relationship between the number of special care

Table 1.0

Distribution of special care dementia units (SCDU)

SCDU	Frequency	Percent
yes	47	29.9
no	110	70.1
Total	157	100.0

Table 2.0

Distribution of special care dementia units(SCDU) within facilities

More than one SCDU	Frequency	Percent
yes	4	8.5
no	43	91.5
Total	47	100.0

Table 3.0

Distribution of special care dementia unit by Size of facility

Size of facility	Frequency	Percent
less than 25 beds	1	2.1
25 - 50 beds	7	14.9
51 - 100 beds	11	23.4
100 + beds	28	59.6
Total	47	100.0

Table 4.0

Distribution of special care dementia units by Length of Operation

Length of Operation(Years)	Frequency	Percent
< one	4	8.5
> one, < two	11	23.4
> two, < five	18	38.3
> five	14	29.8
Total	47	100.0

dementia units and the distance to the nearest special care dementia unit (Chi-square = 1.13, df = 2, p = 0.57), there was a relationship in terms of the existence of a special care dementia unit and the distance to the nearest special care dementia unit (Chi-square = 14.79, df = 2, p = 0.0006). Thus, where there is a special care dementia unit, it is more likely that there will be another special care dementia unit within fifty miles.

The distribution by location in terms of urban/rural split is presented in Table 6.0. There was little disparity in terms of the urban/rural split. Slightly more than one-half (57.4 %, n = 27) of the special care dementia units were reported to be located in urban areas, and 42.6% (n = 20) in rural areas of the province. There was no significant difference between urban and rural facilities (Chi-square = 0.55, df = 1, p = 0.46).

Region was arranged in five categories corresponding to the seventeen regional health authorities created by the Minister of Health in April 1994. For the purpose of analysis, South includes regions 1, 2, 3, and 5; Central includes regions 6, 7, 8, and 9; Calgary area includes region 4; Edmonton area includes region 10; and North includes regions 11, 12, 13, 14, 15, 16, and 17. The distribution by region is presented in Table 7.0. As anticipated, nearly one-half (48.9%, n = 23) of the special care dementia units were located in the Calgary and Edmonton areas. Of the remainder, 21,3% (n = 10) were located in Central Alberta, 19.1% (n = 9) were located in Southern Alberta, and 10.6% (n = 5) were located in Northern Alberta. There was a significant difference between regions. (Chi-square = 25.03, df = 4, p = 0.0005).

Table 5.0

Distribution of special care dementia units by Distance to nearest special care dementia unit

Distance(miles)	Frequency	Percent
< 50	28	80.0
50-100	4	11.4
100+	3	8.6
missing	12	0
Total	47	100.0

Table 6.0

Distribution of special care dementia units by Location

Location	Frequency	Percent
rural	20	42.6
urban	27	57.4
Total	47	100.0

Combined Effect of Demographic Variables

Considering special care dementia units as a dependent variable, the combined effects of demographic variables such as size of facility, location (urban/rural), region, and distance were examined using a regression analysis (Table 8.0). Using a forward stepwise logistic regression model with the level of significance at entry set at 0.05, and removal set at 0.10, only size of facility was found to be a significant predictor of the existence of a special care dementia unit (Chi-square = 24.69. df = 1, p = 0.00). Thus, the larger the facility, the more likely it would have a special care dementia unit.

Table 7.0

Distribution of special care dementia units by Region

Region	Frequency	Percent
South	9	19.1
Central	10	21.3
Calgary	14	29.8
Edmonton	9	19.1
North	5	10.6
Total	47	100.0

Table 8.0

Regression Analysis of Demographic Variables

Total number of cases: 157 (Unweighted)
Number of selected cases: 157

Number of cases rejected because of missing data: 13
Number of cases included in analysis: 144

- - - - - - - - - Variables in the Equation - - - - - - - -

Variable	Score	df	Significance
FACSIZE	24.6878	1	0.0000

- - - - - - - - Variables not in the Equation - - - - - - -

Variable	Score	df	Significance
LOCATION	.7282	1	0.3935
REGION	5.5385	4	0.2364
DISTANCE	1.9622	1	0.1613

The Physical Environment

The physical environment was sub-divided into sixteen components. The number of beds on special care units was also investigated (Table 9.0). Over one-half (61.7%, n = 29) of the respondents indicated that their special care dementia unit contained 21 beds or more. Of the remaining 38.3%, 31.9% (n = 15) consisted of 11-20 beds, and 6.4% (n = 3) consisted of less than 10 beds. While there was a significant correlation between facility size and number of beds per unit (r = 0.36, $p \geq 0.013$) there was no significant difference between urban and rural facilities (Chi-square = 2.74, df = 2, $p \geq 0.25$).

When asked what makes a special care dementia unit "special", the majority of respondents (65.9%, n = 29) indicated that the special care dementia unit was special because it was a separate, secure area, with special programs, and an environment supporting the cognitive abilities of residents (Table 10.0). Of the remaining respondents, 22.7% (n = 10) reported that the special care dementia unit was special because it was a separate, secure area, and 11.4% (n = 5) reported that it was special only because it was located in a separate area. There was n significant difference between urban and rural facilities (r = - 0.006, p = 0.97), and there was no relationship between the special features and facility size (r = 0.029, p = 0.85) or length of operation (r = -0.112, p = 0.47).

When asked how the special care dementia unit differed from other units in the facility, the majority (92.7%, n = 38) reported that the unit was modified in terms of physical design, staffing and philosophy. The distribution by differences is presented in Table 11.0. Three respondents (7.3%) reported no difference between the special care dementia unit and other units in the facility. There was no

Table 9.0

Distribution of special care dementia units by Number of beds

Number of beds/unit	Frequency	Percent
< 10	3	6.4
11-20	15	31.9
> 21	29	61.7
Total	47	100.0

Table 10.0

Distribution of SCDU by special features

Special Features	Frequency	Percent
separate area	5	11.4
separate, secure area	10	22.7
separate, secure area, special programs	29	65.9
missing	3	0
Total	47	100.0

Table 11.0

Distribution of SCDU by differences

Difference	Frequency	Percent
no difference	3	7.3
modified environment	38	92.7
missing	6	0
Total	47	100.0

Table 12.0

Distribution of SCDU by Design differences

Design differences	Frequency	Percent
no difference	10	25.6
minor modifications	23	59.0
major modifications	6	15.4
missing	8	0
Total	47	100.0

significant difference between urban and rural facilities (r = 0.13, $p \geq 0.42$), and there was no relationship between the differences and facility size (r = 0.62. $p \geq 0.90$) or length of operation (r = 0.07, $p \geq 0.65$).

In terms of design differences (Table 12.0), over one-half (59.7%, n = 23) reported that minor modifications had been made, and 15.4% (n = 6) reported that major modifications had been made, ie. the physical structure was specifically modified to support the cognitive abilities of the residents. The remaining 25.6% (n = 10) reported no differences between the special care dementia unit and other units in the facility. There was no significant difference between urban and rural facilities (r = -0.15, p = 0.36), and no relationship between the design differences and facility size (r = 0.06, $p \geq 0.74$) or length of operation (r = -0.01, $p \geq 0.94$).

The physical environment was also examined to find out if special care dementia units were self-contained and self-sufficient. This component was split into three components: services, staffing, and congregate space. The distribution by services is presented in Table 13.0. Over one-third of the respondents (36.2%, n = 17) reported that their special care dementia unit was self-contained and self-sufficient in terms of services, while 63.8% (n = 30) reported that they were not. There was no significant difference between urban and rural facilities (Chi-square = 0.22, df = 1, p = 0.64), and there was no relationship between self-sufficiency of services and size of unit (Chi-square = 3.95, df = 2, p = 0.14), facility size (Chi-square = 2.28, df = 3, p = 0.52), or length of operation (Chi-square = 1.04, df = 3, p = 0.79).

The distribution by self-sufficiency of staffing is presented in Table 14.0. In terms of staffing, over two-thirds of the respondents (70.2%, n = 33) reported that their unit was self-contained and self-sufficient, while

29.8% (n = 14) reported that their unit was not. There was no significant difference between urban and rural facilities (Chi-square = 0.0008, df = 1, p = 0.98), and no relationship between self-sufficiency of staffing and size of unit (Chi-square = 3.85, df = 2, p = 0.15), facility size (Chi-square = 1.79, df = 3, p = 0.62), or length of operation (Chi-square = 1.26, df = 3, p = 0.74).

The distribution of self-sufficiency of congregate space is presented in Table 15.0. While over three-quarters of the respondents (82.6%, n = 38) reported that their unit was self-contained and self-sufficient in terms of congregate space, 17.4% (n = 8) were not. There was no significant difference between urban and rural facilities (Chi-square = 0.14, df = 1, p = 0.71), and no relationship between self-sufficiency in terms of unit size (Chi-square = 2.05, df = 2, p = 0.36), facility size (Chi-square = 3.24, df = 3, p = 0.36), or length of operation (Chi-square = 1.38, df = 3, p = 0.71).

Specific design features and room configuration were also examined by the investigator. The distribution by specific design features is presented in Table 16.0. Over one-half of the respondents (51.1%, n = 23) reported that the design of the special care dementia unit was similar to other units in the facility with the addition of wallpaper, art and furnishings to give it a different atmosphere. Of the remaining 48.9%, 28.9% (n = 13) reported that the design was similar to other units in the facility, and 20.0% (n = 9) indicated that the design was different than other units. There was no significant difference between urban and rural facilities (Chi-square = 0.19, df = 2, p = 0.91), and there was no relationship between the specific features and size of unit (r = -0.09, p = 0.55), facility size (r = 0.06, p = 0.69), or length of operation (r = -0.16, p = 0.31).

Table 13.0

Distribution of SCDU by self-sufficiency of services

Self-sufficient	Frequency	Percent
yes	17	36.2
no	30	63.8
Total	47	100.0

Table 14.0

Distribution of SCDU by self-sufficiency of staffing

Self-sufficient	Frequency	Percent
yes	33	70.2
no	14	29.8
Total	47	100.0

Table 15.0

Distribution of SCDU by self-sufficiency of congregate space

Self-sufficient	Frequency	Percent
yes	38	82.6
no	8	17.4
missing	1	0
Total	47	100.0

Table 16.0

Distribution of SCDU by Specific design features

Specific design	Frequency	Percent
similar to other units	13	28.9
addition of wallpaper, art and furnishings	23	51.9
completely different	9	20.0
missing	2	0
Total	47	100.0

Distribution by room configuration is presented in Table 17.0. Eight respondents (17.0%) reported that the room configuration on their unit was similar to other units, ie. standard, semi-private, and private rooms. Of the remaining 83%, 78.7% (n = 37) reported that the special care dementia unit had both semi-private and private rooms, and 4.3% (n = 2) reported that the special care dementia unit had private rooms only. There was a significant difference between urban and rural facilities (Chi-square = 5.83, df = 2, $p = 0.05$). Urban facilities did not have any units comprised of private rooms only. There was no relationship between room configuration and size of unit (Chi-square = 1.44, df = 4, $p = 0.84$), facility size (Chi-square = 5.26, df = 6, $p = 0.51$), or length of operation (Chi-square = 2.20, df = 6, $p = 0.90$).

The use of redundant cueing was also examined by the investigator. Redundant cueing is where the same information is presented via several sensory modalities. Redundant cueing was sub-divided into two components: decor, and other visual cues. Distribution by decor is presented in Table 18.0. Only ten respondents (21.3%) reported that the special care dementia unit in their facility was distinctive in design, color and furniture. The remaining 78.7% (n = 37) reported that the decor was not distinctive. There was no significant difference between urban and rural facilities (Chi-square = 0.03, df = 1, $p = 0.85$), and there was no relationship between the size of unit (Chi-square = 2.86, df = 2, $p = 0.24$), facility size (Chi-square = 3.66, df = 3, $p = 0.30$), or length of operation (Chi-square = 2.45, df = 3, $p = 0.48$).

The distribution by additional visual cues is presented in Table 19.0. Over three-quarters of the respondents (76.6%, n = 36) reported that additional visual cues were provided to assist with orientation. Eleven respondents (23.4%) did not report the use of visual cues. There was no

Table 17.0

Distribution of SCDU by Room configuration

Room Type	Frequency	Percent
private	2	4.3
private, semi-private	37	78.7
standard/semi/private	8	17.0
Total	47	100.0

Table 18.0

Distribution of SCDU by Decor

Distinctive Decor	Frequency	Percent
yes	10	21.3
no	37	78.7
Total	47	100.0

significant difference between urban and rural facilities (Chi-square = 0.844, df = 1, p = 0.36). There was no relationship between additional visual cues and size of unit (Chi-square = 3.35, df = 2, p = 0.19), facility size (Chi-square = 4.11, df = 3, p = 0.25), or length of operation (Chi-square = 2.76, df = 3, p = 0.43).

Other features of the physical environment were separated into six components: lighting, security systems, wandering areas, direct access to outdoors, overhead paging systems, and traffic flow. The distribution by lighting features is presented in Table 20.0. Only eleven respondents (23.9%) reported that the special care dementia unit had additional lighting in comparison to other units, while over three-quarters (76.1%, n = 35) indicated that the lighting was similar to other units in the facility. There was no significant difference between urban and rural facilities (Chi-square = 3.19, df = 1, p = 0.07), and there was no relationship between lighting and size of unit (Chi-square = 0.48, df = 2, p = 0.79), facility size (Chi-square = 2.73, df = 2, p = 0.26), or length of operation (Chi-square = 1.99, df = 3, p = 0.57).

The distribution by security systems is presented in Table 21.0. The majority of respondents (80.9%, n = 38) reported that there was a security system on their special care dementia unit. Less than one-quarter (19.1%, n = 9) reported that there was no security system. There was no significant difference between urban and rural facilities (Chi-square = 0.39, df = 1, p = 0.53), and there was no relationship between security system and size of unit (Chi-square = 1.33, df = 2, p = 0.52), or facility size (Chi-square = 0.84, df = 3, p = 0.84). There was, however, a relationship between the existence of a security system and length of operation (Chi-square = 7.99, df = 3, p = 0.05). Thus, the longer a special care dementia unit has been in operation, the more likely it was to have a security system

Table 19.0

Distribution of SCDU by Additional visual cues

Additional cues	Frequency	Percent
yes	36	76.6
no	11	23.4
Total	47	100.0

Table 20.0

Distribution of SCDU by Lighting features

Lighting features	Frequency	Percent
similar to other units	35	76.1
additional lighting	11	23.9
missing	1	0
Total	47	100.0

Table 21.0

Distribution of SCDU by Security System

Security System	Frequency	Percent
yes	38	80.9
no	9	19.1
Total	47	100.0

preventing wandering out of the area.

The distribution of wandering areas is presented in Table 22.0. The majority of respondents (93.5%, n = 43) reported that their special care dementia unit had an area where residents could wander freely. Only three respondents (6.5%) indicated that their unit did not have a wandering area. There was no significant difference between urban and rural facilities (Chi-square = 2.26, df = 1, p = 0.13), and there was no relationship between wandering area and size of unit (Chi-square = 1.75, df = 2, p = 0.42), facility size (Chi-square = 2.26, df = 3, p = 0.52), or length of operation (Chi-square = 4.75, df = 3, p = 0.19).

The distribution of special care dementia units with direct access to the outdoors is presented in Table 23.0. While over one-half of the respondents (57.4%, n = 27) indicated that there was direct access to the outdoors at ground level, twenty respondents (42.6%) indicated that their unit did not. There was a significant difference between urban and rural facilities (Chi-square = 4.39, df = 1, p = 0.04). Rural facilities were found to have more units with direct access to the outdoors at ground level. However, there was no relationship between direct access to the outdoors and size of unit (Chi-square = 1.30, df = 2, p = 0.52), facility size (Chi-square = 2.25, df = 3, p = 0.51), or length of operation (Chi-square = 1.49, df = 3, p = 0.69).

The distribution of special care dementia units with overhead paging systems is presented in Table 24.0. The majority of respondents (89.4%, n = 42) reported that there was an overhead paging system on their unit. The remaining 10.6% (n = 5) indicated that there was no overhead paging system. There was no significant difference between urban and rural facilities (Chi-square = 3.21, df = 1, p = -0.07). While there was no relationship between the existence of an overhead paging system and length of

Table 22.0

Distribution of SCDU with Wandering areas

Wandering area	Frequency	Percent
yes	43	93.5
no	3	6.5
missing	1	0
Total	47	100.0

Table 23.0

Distribution of SCDU with Direct access to the outdoors

Direct access	Frequency	Percent
yes	27	57.4
no	20	42.6
Total	47	100.0

Table 24.0

Distribution of SCDU with Overhead paging system

Paging system	Frequency	Percent
yes	42	89.4
no	5	10.6
Total	47	100.0

Table 25.0

Distribution of SCDU with restricted traffic

Restricted traffic	Frequency	Percent
yes	24	52.2
no	22	47.8
missing	1	0
Total	47	100.0

operation (Chi-square = 1.32, df = 3, p = 0.72), there was a relationship between the existence of an overhead paging system and the size of unit (Chi-square = 9.13, df = 2, p = -0.01), and facility size (Chi-square = 9.26, df = 3, p = -0.03). Facilities operating more than 100 beds were more likely to have an overhead paging system than smaller facilities. Similarly, the larger the size of unit, the more likely there will be an overhead paging system.

The distribution of special care dementia units with restricted traffic is presented in Table 25.0. There was little variation in terms of this variable, with slightly over one-half (52.2%, n = 24) of the respondents reporting restricted traffic flow, and 47.8 % (n = 22) reporting no restriction of traffic flow through the unit. There was no significant difference between urban and rural facilities (Chi-square = 0.87, df = 1, p = 0.35), and no relationship between restricted traffic flow and size of unit (Chi-square = 3.69, df = 2, p = 0.16), facility size (Chi-square = 13.36, df = 3, p = 0.34), or length of operation (Chi-square = 1.54, df = 3, p = 0.67).

The Organizational Climate

The organizational climate is collapsed into thirty-one variables. These variables are further divided into the following topic areas: philosophy, admission/discharge criteria, staffing, and programs. The findings generated from an analysis of the responses are presented in the following paragraphs.

Philosophy

When asked to describe the philosophy practiced on the special care dementia unit, three themes emerged: philosophy similar to other continuing care units, philosophy identifies unique needs of individuals with dementia, and philosophy is based on the use of a specific conceptual model. The distribution by theme is illustrated in Table 26.0. While the majority of respondents (88.2%, n = 30) provided a response indicating that the philosophy identifies the unique needs of individuals with dementia, only 58.8% (n = 20) described the use of a particular conceptual model, ie. Gentle Care, PLST (Progressively Lowered Stress Threshold). The remaining 11.8% (n = 4) provided a description of philosophy similar to other continuing care units, ie. "we treat our residents with respect and dignity, and include them in regular programs". There was no significant difference between urban and rural facilities (Chi-square = 1.49, df = 2. p = 0.48), and there was no relationship between the philosophy practised and other demographic variables (Unit size: Chi-square = 6.0, df = 4, p = 0.20; Facility size: Chi-square = 9.74, df = 6, p = 0.14; Length of operation: Chi-square = 10.80, df = 6, p = 0.10).

When asked how the beliefs stated in the philosophy were expressed, only one theme emerged. All respondents who chose to respond to the question (n = 15) indicated that programs and services were adapted to meet the needs of the

Table 26.0

Distribution by Philosophy
(Major theme)

Philosophy	Frequency	Percent
similar to other units	4	11.8
identifies unique needs	10	29.4
identifies unique needs, specific conceptual model	20	58.8
missing	13	0
Total	47	100.0

Table 27.0

Distribution by Major Focus

Major Focus	Frequency	Percent
promote independence	5	10.6
highest level of functioning	41	89.1
missing	1	0
Total	47	100.0

individual resident. Further examination revealed that on the majority of units (89.1%, n = 41) the major focus was the use of individual care plans, and a variety of activities to help each resident remain involved and functioning at the highest possible level. The remaining 10.6% (n = 5) reported an emphasis on the need to help residents remain as independent as possible. A breakdown of the responses is presented in Table 27.0. There was no significant difference between urban and rural facilities (Chi-square = 1.05, df = 1, p = 0.31), and no relationship was found between the major focus and other demographic variables (Unit size: Chi-square = 0.77, df = 2, p = 0.68; Facility size: Chi-square = 1.32, df = 3, p = 0.72; Length of operation: Chi-square = 3.32, df = 3, p = 0.34.

Admission/Discharge Criteria

The use of admission/discharge criteria was also investigated. A breakdown by the use of admission/discharge criteria is presented in Table 28.0. While the majority of respondents (80.9%, n = 38) indicated that admission/discharge criteria were specified, nine respondents (19.1%) reported that admission/discharge criteria were not specified. There was no significant difference between urban and rural facilities (Chi-square = 0.39, df = 1, p = 0.53), and there was no relationship between admission/discharge criteria and size of unit (Chi-square = 0.76, df = 2, p = 0.68), size of facility (Chi-square = 1.68, df = 3, p = 0.64), or length of operation (Chi-square = 0.96, df = 3, p = 0.81).

Further examination revealed some major differences in terms of the specified admission/discharge criteria(Table 29.0). While all respondents reported that the admission/discharge criteria included a diagnosis of Alzheimer's disease and other dementias, 10.6% (n = 5) included Psychiatric disorders, 19.1% (n = 9) excluded

Table 28.0

Distribution by Specified Admission/Discharge Criteria

Specified Criteria	Frequency	Percent
yes	38	80.9
no	9	19.1
Total	47	100.0

Table 29.0

Distribution by Type of Admission/Discharge Criteria

Type of Criteria	Frequency	Percent
AD, other dementias, no Psychiatric disord.	9	19.1
AD, other dementias, Psychiatric disord.	5	10.6
AD, other dementias, behavioral problems	33	70.2
Total	47	100.0

Psychiatric disorders, and 70.2% (n = 33) included behavioral problems that could not be managed on other continuing care units. There was no significant difference between urban and rural facilities (Chi-square = 2.26, df = 2, p = 0.32), and there was no relationship between the specific admission/discharge criteria and other demographic variables such as unit size (Chi-square = 2.89, df = 4, p = 0.58), facility size (Chi-square = 8.15, df = 6, p = 0.23), or length of operation (Chi-square = 5.02, df = 6, p = 0.54).

The type of unit is presented in Table 30.0. The majority of respondents (80.9%, n = 38) reported that their unit was best described as a long term placement unit. Of the remaining 19.1%, 2.1% (n = 1) indicated that their unit was best described as a short term assessment and treatment unit, and 17.0% (n = 8) reported that their unit was both a short term assessment and treatment unit, and a long term placement unit. There was no significant difference between urban and rural facilities (Chi-square = 1.44, df = 2, p = 0.50), and there was no relationship between type of unit and the other demographic variables (Unit size: Chi-square = 3.14, df = 4, p = 0.54; Facility size: Chi-square = 0.99, df = 6, p = 0.99; Length of operation: Chi-square = 5.46, df = 6, p = 0.49).

Further examination revealed a wide range in terms of average length of stay. The distribution by average length of stay is illustrated in Table 31.0. Only two respondents (4.5%) reported an average length of stay of less than one year. Of the remaining 95.5%, 27.3% (n = 12) reported an average length of stay ranging from one to two years, and 68.2% (n = 30) indicated that the average length of stay on their unit was over two years. There was no significant difference between urban and rural facilities (Chi-square = 0.43, df = 2. p = 0.81). While there was no relationship

between the length of stay and unit size (r = 0.07, p = 0.65), or length of operation (r = -0.02, p = 0.90), there was a relationship between the length of stay and facility size (r = -0.32, p = 0.03). However, the strength of the relationship was not strong enough to enable the investigator to make predictions.

The discharge protocol was also examined by the investigator. The distribution by discharge protocol is illustrated in Table 32.0. Over one-half of the respondents (58.1%, n = 25) indicated that residents were transferred to other units when they could no longer benefit from the programs offered on the special care dementia unit. Only one respondent (2.3%) reported that residents were transferred to other units once stabilized, and seventeen respondents (39.5%) indicated that residents remained on the unit until death occurs. There was no significant difference between urban and rural facilities (Chi-square = 1.95, df = 2, p = 0.38). While there was no relationship between the discharge protocol and unit size (Chi-square = 2.24, df = 4, p = 0.69), or facility size (Chi-square = 2.84, df = 6, p = 0.83), there was a relationship between discharge protocol and length of operation (Chi-square = 13.30. df = 6, p = 0.04). Thus, the longer the length of operation, the more likelihood residents would be transferred to other units when they could no longer benefit from the programs offered on the special care dementia unit.

Table 30.0
Distribution by Type of Unit

Unit Type	Frequency	Percent
short term	1	2.1
long term	38	80.9
both	8	17.0
Total	47	100.0

Table 31.0
Distribution by Average Length of Stay(ALOS)

ALOS	Frequency	Percent
>90 days, < 1 yr	2	4.5
1 - 2 yr	12	27.3
< 2 yr	30	68.2
missing	3	0
Total	47	100.0

Table 32.0

Distribution by Discharge Protocol

Protocol	Frequency	Percent
transferred once stable	1	2.3
transferred when no longer benefits	25	58.1
remains until death occurs	17	39.5
missing	4	0
Total	47	100.0

The use of specialized assessment screening tools was also investigated. The distribution by use of specialized assessment screening tools is presented in Table 33.0. Nineteen respondents (40.4%) reported that highly specialized assessment screening tools were used on their unit, while the remaining 59.6% (n = 28) reported that they were not. No significant difference was found between urban and rural facilities (Chi-square = 0.002, df = 1, p = 0.96), and no relationship was found between the use of specialized assessment screening tools and other demographic variables (Unit size: Chi-square = 2.27, df = 2, p = 0.32; Facility size: Chi-square = 3.09, df = 3, p = 0.38, Length of operation: Chi-square = 5.01, df = 3, p = 0.17).

Further examination revealed that a variety of specialized assessment screening tools were being used. The distribution by type of specialized assessment screening tools is illustrated in Table 34.0. The majority of respondents (60.0%, n = 18) reported that mental/cognitive/behavioral assessment screening tools were used. Of the remaining 40.0%, nine respondents (30.0%) indicated that both functional and mental/cognitive/behavioral assessment screening tools were used, while only three respondents (10.0%) reported the use of functional assessment screening tools only. No significant difference was found between urban and rural facilities (Chi=square = 4.0, df = 2, p = 0.14). While there was no relationship found between the type of specialized assessment screening tool used and unit size (Chi-square = 8.10, df = 4, p = 0.09), or length of operation (Chi-square = 2.84, df = 6, p = 0.83), a relationship was found between the type of specialized assessment screening tool and facility size (Chi-square = 13.23, df = 6, p = 0.04). Thus, the larger the facility, the more likely both functional and mental/cognitive/behavioral assessment screening tools were

Table 33.0

Distribution by Use
of Specialized Assessment Screening Tools

Screening Tools	Frequency	Percent
yes	19	40.4
no	28	59.6
Total	47	100.0

Table 34.0

Distribution by Type of Assessment Screening Tool

Type of Tool	Frequency	Percent
functional	3	10.0
mental/cognitive/ behavioral	18	60.0
Both	9	30.0
missing	17	0
Total	47	100.0

used.

The protocol for assessment review was also examined by the investigator. Distribution by frequency of assessment review is illustrated in Table 35.0. Only three respondents(6.8%) indicated that assessment reviews were conducted on a weekly basis. Of the remaining 93.2%, 59.1% (n = 26) reported that assessment reviews were conducted on a monthly basis, while 34.1% (n = 15) reported that assessment reviews are conducted on a semi-annual basis. There was no significant difference between urban and rural facilities (Chi-square = 0.27, df = 2, p = 0.87), and there was no relationship between the protocol for assessment review and the other demographic variables (Unit size: r = 0.08, p = 0.63; Facility size: r = -0.11, p = 0.50; Length of operation: r = 0.07, p = 0.70).

Placement of residents on the unit was also investigated. The distribution by method of placement on the unit is illustrated in Table 36.0. Over one-half of the respondents (56.5%, n = 26)indicated that residents were placed in clusters with other residents who had similar capacities, while 43.5% (n = 20) did not place residents in such clusters. The investigator found no significant difference between urban and rural facilities (Chi-square = 0.58, df = 1, p = 0.45), and no relationship between the method of placement on the unit and unit size (Chi-square = 2.66, df = 2, p = 0.27), facility size (Chi-square = 1.67, df = 3, p = 0.64), or length of operation (Chi-square = 0.13, df = 3, p = 0.99).

Staffing

Staffing was sub-divided into seven components. When asked if the special care dementia unit had designated medical staff, only 27.7% (n = 13) of the respondents said "yes", and 72.3% (n = 34) said "no". There was no significant difference between urban and rural facilities

Table 35.0

Distribution by Protocol for Assessment Review

Protocol	Frequency	Percent
weekly	3	6.8
monthly	26	59.1
semi-annually	15	34.1
missing	3	0
Total	47	100.0

Table 36.0

Distribution by Method of Placement on Unit

Cluster according to level of functioning	Frequency	Percent
yes	26	56.5
no	20	43.5
missing	1	0
Total	47	100.0

(Chi-square = 0.095, df = 1, p = 0.76), and there was no relationship between the existence of designated medical staff and unit size (Chi-square = 1.39, df = 2, p = 0.49), facility size (Chi-square = 4.80, df = 3, p = 0.19), or length of operation (Chi-square = 2.51, df = 3, p = 0.47). The distribution of special care dementia units with designated medical staff is presented in Table 37.0.

An examination of the qualifications of medical staff involved in the special care units revealed that 62.9% (n = 22) were General Practitioners, and 31.4% (n = 11) were General Practitioners who had a demonstrated interest in dementia. Of the remaining 5.8%, 2.9% (n = 1) had a Certificate in Gerontology, and 2.9% (n = 1) had a Certificate in Psychogeriatrics. The distribution by qualifications of medical staff is illustrated in Table 38.0. There was no significant difference between urban and rural facilities (r = 0.18, p = 0.30), and there was no relationship between the qualifications of medical staff and unit size (r = 0.16, p = 0.35), facility size (r = 0.09, p = 0.60), or length of operation (r = 0.06, p = 0.72).

When asked about the qualifications of staff employed on the special care dementia unit, 67.4% (n = 31) of the respondents indicated that staff were required to have special knowledge and skills, while 32.6% (n = 15) did not. The distribution of special care dementia units requiring staff to have special knowledge and skills is presented in Table 39.0. There was no significant difference between urban and rural facilities (Chi-square = 0.93, df = 1, p = 0.33), and no relationship between facilities requiring staff to have special knowledge and skills and unit size (Chi-square = 2.09, df = 2, p = 0.35), facility size (Chi-square = 4.85, df = 3, p = 0.18), or length of operation (Chi-square = 4.28, df = 3, p = 0.23).

Table 37.0

Distribution of special care dementia units by designated medical staff

Designated Medical Staff	Frequency	Percent
yes	13	27.7
no	34	72.3
Total	47	100.0

Table 38.0

Distribution of Medical Staff by Qualifications

Qualifications	Frequency	Percent
GP	22	62.9
GP, interest in dementia	11	31.4
Gerontology Certificate	1	2.9
Psychogeriatrics Cert.	1	2.9
missing	12	0
Total	47	100.0

Further examination revealed that 73.8% (n = 31) of respondents desired staff who had a demonstrated interest in dementia. Nine respondents (21.4%) indicated that the desired qualifications of staff included completion of special education courses. Only two respondents (4.8%) reported that they desired staff who have completed a Certificate Program. The distribution by staff qualifications is illustrated in Table 40.0. There was no significant difference between urban and rural facilities (r = -0.24, p = 0.13), and there was no relationship between the qualifications of staff and unit size (r = -0.10, p = 0.50), facility size (r = -0.17, p = 0.30), or length of operation (r = -0.07, p = 0.67).

The educational needs of staff was also investigated. The distribution by educational needs of staff is illustrated in Table 41.0. Over one-half (51.1%, n = 24) of the respondents indicated that staff employed on the special care dementia unit required on-going education related to basic knowledge and skills. The remaining 48.9% (n = 23) reported that staff also needed education about restorative theories and strategies. There was no significant difference between urban and rural facilities (Chi-square = 0.51, df = 1. p = 0.47), and no relationship between the educational needs of staff and unit size (Chi-square = 5.27, df = 2, p = 0.07), facility size (Chi-square = 2.49, df = 3, p = 0.48), or length of operation (Chi-square = 4.82, df = 3, p = 0.19).

Staffing levels and method of assignment was also examined by the investigator. When asked about the staffing ratio, over one-half of the respondents (55.3%, n = 26) reported that staffing ratios were similar to other units in the facility. The remaining respondents (44.6%, n = 21) indicated that there was a higher staff ratio on the special care dementia unit. On five of these units, respondents (10.6%) indicated that there was a higher ratio of

Table 39.0

Distribution of special care dementia units requiring staff to have special knowledge and skills

Special knowledge/skills	Frequency	Percent
yes	31	67.4
no	15	32.6
missing	1	0
Total	47	100.0

Table 40.0

Distribution by staff qualifications

Desired Qualifications	Frequency	Percent
Interest in dementia	31	73.8
Special education	9	21.4
Certificate Program	2	4.8
missing	5	0
Total	47	100.0

professional staff, and on the remaining sixteen units, respondents reported that there was a higher ratio of non-professional staff. The distribution by staffing ratio is presented in Table 42.0. There was no significant difference between urban and rural facilities (Chi-square = 0.32, df = 2, p = 0.85), and there was no relationship between staffing ratio and unit size (Chi-square = 6.21, df = 4, p = 0.18), facility size (Chi-square = 10.98, df = 6, p = 0.09), or length of operation (Chi-square = 6.61, df = 6, p = 0.36).

The method of staff assignment is illustrated in Table 43.0. The majority of respondents (78.3%, n = 36) reported that consistent staff were assigned to the special care unit. Only ten respondents (21.7%) reported that staff floated between units. There was a significant difference between urban and rural facilities (Chi-square = 3.66, df = 1, p = 0.05). Urban facilities were more likely to use consistent staff assignment than rural facilities. While there was no relationship between the method of staff assignment and unit size (Chi-square = 2.34, df = 2, p = 0.31), and length of operation (Chi-square = 1.15, df = 3, p = 0.76), there was a relationship between the method of staff assignment and facility size (Chi-square = 7.84, df = 3, p = 0.05). Thus, the larger the facility, the more likely consistent staff were assigned to the special care dementia unit.

The Social Psychological Milieu

The social psychological milieu included variables related to the delivery of programs and services. This component was divided into twelve components which included: programs, policies and procedures, and routines. When asked to describe the programs on the special care dementia unit, 65.8% (n = 25) of the respondents reported that the special care dementia unit provided a program of activities enabling

residents to maintain continuity with the past and continue in normal social roles appropriate to adults. Eleven respondents (29.0%) indicated that individual or small group programs were provided, with 23.7% (n = 9) focused on social activities, and 5.3% (n = 2) focused on increasing the functional ability of the residents. Only two respondents (5.3%) indicated that programs on the unit were similar to those for other units in the facility. The distribution by type of program is illustrated in Table 44.0. There was no significant difference between urban and rural facilities (Chi-square = 2.05, df = 3, p = 0.56), and no relationship between the type of program and other demographic variables such as unit size (Chi-square = 10.56, df = 6, p = 0.10), facility size (Chi-square = 15.51, df = 9, p = 0.10), or length of operation (Chi-square = 10.14, df = 9, p = 0.34).

Table 41.0

Distribution by Educational needs of staff

Educational needs	Frequency	Percent
basic knowledge/skills	24	51.1
restorative theories/ strategies	23	48.9
Total	47	100.0

Table 42.0

Distribution by Staffing ratios

Ratio	Frequency	Percent
similar to other units	26	55.3
↑ professional staff	5	10.6
↑ non-professional staff	16	34.0
Total	47	100.0

Table 43.0

Distribution by method of Staff assignment

Method of assignment	Frequency	Percent
consistent assignment	36	78.3
float between units	10	21.7
missing	1	0
Total	47	100.0

The distribution by type of family programs is illustrated in Table 45.0. The majority of respondents (62.2%, n = 23) reported that family support and/or counselling was available. Of the remaining 37.8%, six respondents (16.2%) indicated that additional education and information sessions for family members were scheduled on a regular basis, and eight respondents (21.6%) reported that family programs on the special care dementia unit were similar to programs offered on other units in the facility. There was no significant difference between urban and rural facilities (Chi-square = 5.04, df = 2, p = 0.08). While there was no relationship between the type of family program and facility size (Chi-square = 9.71, df = 6, p = 0.14), or length of operation (Chi-square = 4.08, df = 6, p = 0.67), there was a relationship between type of family program and unit size (Chi-square = 9.37, df = 4, p = 0.05. Thus, the larger the unit size, the more likely family support and counselling would be available.

An examination of family roles revealed that on the majority of special care dementia units (57.8%, n = 26) family members were viewed as a partner in care and a client requiring intervention. Over one-third of the respondents (37.8%, n = 17) viewed family members as partners in care, and 4.4% (n = 2) indicated that family members provided support for the resident. The distribution by role of family members is illustrated in Table 46.0. There was no significant difference found between urban and rural facilities (Chi-square = 1.47, df = 2, p = 0.48), and no relationship between the role of family members and unit size (Chi-square = 7.39, df = 4, p = 0.12), facility size (Chi-square = 5.18, df = 6, p = 0.52), or length of operation (Chi-square = 5.26, df = 6, p = 0.51).

Routines were also examined by the investigator. The distribution by type of ward routine is illustrated in Table 47.0. Over one-half of the respondents (59.5%, n = 25)

Table 44.0

Distribution by Type of Activity Program

Type of Program	Frequency	Percent
similar to other units	2	5.3
individual/small group focused on 1 function	2	5.3
individual/small group focused on social activities	9	23.7
focused on maintaining continuity with past etc	25	65.8
missing	9	0
Total	47	100.0

Table 45.0

Distribution by Type of Family Program

Type of Program	Frequency	Percent
similar to other units	8	21.6
additional education/ information sessions	6	16.2
family support/counselling	23	62.2
missing	10	0
Total	47	100.0

reported that the times by which certain tasks had to be completed by staff were flexible. Fourteen respondents (33.3%) indicated that the routine was individualized according to the needs of the residents. Only three respondents (7.1%) reported that the routine was similar to the routine on other units in the facility. The investigator found no significant difference between urban and rural facilities (Chi-square = 0.10, df = 2, p = 0.95), and no relationship between type of ward routine and unit size (Chi-square = 1.16, df = 4, p = 0.89), facility size (Chi-square = 3.73, df = 6, p = 0.71), or length of operation (Chi-square = 7.52, df = 6, p = 0.28).

When asked to describe the "typical day" on the special care dementia unit, three themes emerged. One-half of the respondents (50.0%, n = 15) reported that the routine varied depending on the resident's routine. Six respondents (20.0%) provided a description of a routine which was structured but has some flexibility. The remaining 30.0% (n = 9) provided a description of a routine which was highly structured, and was common among traditional continuing care facilities. The distribution by structure of a typical day is illustrated in Table 4[illegible]6. The investigator found no significant difference between urban and rural facilities (Chi-square = 1.60, df = 2, p = 0.45), and no relationship between the structure of a typical day and unit size (Chi-square = 7.47, df = 4, p = 0.11), facility size (Chi-square = 9.02, df = 6, p = 0.17), or length of operation (Chi-square = 1.92, df = 6, p = 0.93).

Activities of daily living were also examined by the investigator. Activities of daily living were divided into two components: view held by staff, and actions taken. The distribution by view held by staff is illustrated in Table 49.0. The majority of respondents (91.5%, n = 43) indicated that staff held the view that activities of daily living provided an opportunity for sharing with residents

Table 46.0

Distribution by View of Role of Family Member

View	Frequency	Percent
support resident	2	4.4
partner in care	17	37.8
Partner in care, client requiring care	26	57.8
missing	2	0
Total	47	100.0

Table 47.0

Distribution by Type of Routine

Type of Routine	Frequency	Percent
similar to other units	3	7.1
individualized to resident needs	14	33.3
Flexibility in terms of times tasks completed	25	59.5
missing	5	0
Total	47	100.0

and helping them continue in tasks or parts of tasks they were still able to manage alone or with help. Only four respondents (8.5%) reported that staff viewed activities of daily living as tasks to be accomplished as quickly as possible. There was no significant difference between urban and rural facilities (Chi-square = 0.55, df = 1, $p = 0.46$), and there was no relationship found between view held by staff and other demographic variables such as unit size (Chi-square = 0.82, df = 2, $p = 0.66$), facility size (Chi-square = 0.46, df = 3, $p = 0.93$), or length of operation (Chi-square = 2.15, df = 3, $p = 0.54$).

Further examination revealed that if a resident had difficulty completing a task, the majority of respondents (52.4%, n = 22) indicated that staff employed strategies in the order of least intrusive to most intrusive. Of the remaining 47.6%, 31.0% (n = 13) reported that staff made daily reassessments of the resident's ability to complete a task, and 16.7% (n = 7) reported that staff completed the task for the resident if there was difficulty completing a task. The distribution by actions taken by staff is illustrated in Table 50.0. The investigator found no significant difference between urban and rural facilities (Chi-square = 0.16, df = 2, $p = 0.92$), and no relationship between actions taken by staff and unit size (Chi-square = 3.85, df = 4, $p = 0.43$), facility size (Chi-square = 4.79, df = 6, $p = 0.57$), or length of operation (Chi- square = 5.36, df = 6, $p = 0.50$).

Policies and procedures were also investigated. Policies and procedures were sub-divided into five major areas of concern: restraints, psychotropic drugs, toileting, dietary, and feeding. The distribution by restraint policy is presented in Table 51.0. Over two-thirds of the respondents (67.4%, n = 31) indicated that restraints were used as a last resort only. The remaining 32.6% (n = 15) reported that their

Table 48.0

Distribution by Structure of a Typical Day

Typical Day	Frequency	Percent
highly structured	9	30.0
structured, some flexibility	6	20.0
routine varies depending on needs of resident	15	50.0
missing	17	0
Total	47	100.0

Table 49.0

Distribution by view held by Staff

View	Frequency	Percent
ADL to be completed as quickly as possible	4	8.5
ADL viewed as therapeutic intervention	43	91.5
Total	47	100.0

special care dementia unit had no restraint policy. There was no significant difference between urban and rural facilities (Chi-square = 0.11, df = 1, p = 0.74), and no relationship between the type of restraint policy and size of unit (Chi-square = 0.007, df = 2, p = 0.996), facility size (Chi-square = 4.69, df = 3, p = 0.20), or length of operation (Chi-square = 0.37, df = 3, p = 0.95).

The distribution by psychotropic drug use policy is illustrated in Table 52.0. The majority of respondents (65.9%, n = 29) reported that psychotropic drugs were used as a last resort only. Ten respondents (22.7%) reported that psychotropic drugs were given on a regular basis. There was no significant difference between urban and rural facilities (Chi-square = 1.09, df = 2, p = 0.58), and no relationship between the psychotropic drug use policy and size of unit (r = 0.05, p = 0.76), facility size (r = 0.11, p = 0.49), or length of operation (r = -0.27, p = 0.07).

The distribution by toileting policy is illustrated in Table 53.0. The majority of respondents (82.9%, n = 34) reported that an individual toileting schedule is developed for each resident on the special care dementia unit. Of the remaining 17.1%, 12.2% (n = 5) reported that residents were taken to the toilet every two hours during the daytime, and 2.4%, (n = 1) reported that residents were taken to the toilet every two hours throughout the twenty-four hour period. Only one respondent (2.4%) indicated that there was no toileting routine for incontinent residents. There was no significant difference between urban and rural facilities (Chi-square = 5.98, df = 3, p = 0.11), and there was no relationship between the toileting policy and other demographic variables such as size of unit (r = - 0.22, p = 0.16), facility size (r = - 0.30, p = 0.06), or length of operation (r = - 0.26, p = 0.10).

Table 50.0

Distribution by Actions taken by Staff

Actions	Frequency	Percent
complete task for resident	7	16.7
reassess ability on daily basis	13	31.0
Employ strategies from least to most intrusive	22	52.4
missing	5	0
Total	47	100.0

Table 51.0

Distribution by Restraint Policy

Policy	Frequency	Percent
used as last resort	31	67.4
no restraint policy	15	32.6
missing	1	0
Total	47	100.0

The distribution by dietary policies is illustrated in Table 54.0. One-half of the respondents (50.0%, n = 21) reported that food and fluids were provided at scheduled mealtimes and every two hours. Of the remaining 50.0%, 40.5% (n = 17) indicated that food and fluids were provided at mealtimes and upon request, while 7.1%, (n = 3) reported that food and fluids were provided at scheduled mealtimes and during social activities. One respondent (2.4%) reported that food and fluids are provided at scheduled mealtimes only. There was no significant difference between urban and rural facilities (Chi-square = 0.98, df = 3, $\underline{p}$ = 0.81), and there was no relationship between the dietary policies and size of unit ($\underline{r}$ = 0.03, $\underline{p}$ = 0.86), facility size (r = -0.08, $\underline{p}$ = 0.60), or length of operation ($\underline{r}$ = 0.16, $\underline{p}$ = 0.30).

Further examination of dietary policies revealed that on over one-half of the units (58.5%, n = 24), staff feed residents as a last resort only. When a resident experienced difficulty using utensils properly, 29.3% (n = 12) of the units provided finger food. Only five respondents (12.2%) indicated that staff would feed residents who have difficulty. The distribution by feeding policy is illustrated in Table 55.0. There was no significant difference between urban and rural facilities (Chi-square = 0.87, df = 1, $\underline{p}$ = 0.65). There was no relationship between feeding policy and size of unit ($\underline{r}$ = - 0.20, $\underline{p}$ = 0.20), facility size ($\underline{r}$ = - 0.03, $\underline{p}$ = 0 83). There was a relationship between feeding policy and length of operation ($\underline{r}$ = - 0.37, $\underline{p}$ = 0.01). However, the strength of relationship was not sufficient to allow the investigator to make any predictions.

Table 52.0

Distribution by Psychotropic drug use Policy

Policy	Frequency	Percent
given regularly	5	11.4
given prn	10	22.7
used as last resort	29	65.9
missing	3	0
Total	47	100.0

Table 53.0

Distribution by Toileting Policy

Policy	Frequency	Percent
no routine	1	2.4
q 2 h, daytime	5	12.2
q 2 h, day & night	1	2.4
individual routine	34	82.9
missing	6	0
Total	47	100.0

Table 54.0

Distribution by Meal Policy

Policy	Frequency	Percent
food/fluids at mealtimes only	1	2.4
food/fluids at mealtimes & during social activities	3	7.1
food/fluids at mealtimes & upon request	17	40.5
food/fluids at mealtimes & every 2 hours	21	50.0
missing	5	0
Total	47	100.0

Table 55.0

Distribution by Feeding Policy

Policy	Frequency	Percent
staff feed residents who experience difficulty	5	12.2
provide finger food when resident has difficulty	12	29.3
staff feed as a last resort	34	58.5
missing	6	0
Total	47	100.0

Summary of Results

The following is a summary of the important findings in the study:

1. It was estimated that there were fifty-one special care dementia units in the province of Alberta.
2. The majority of the special care dementia units were located in facilities exceeding 50 beds.
3. The majority of the special care dementia units had been in operation for more than one year.
4. The majority of the special care dementia units were located less than 50 miles from the nearest special care dementia unit.
5. There was little variation in terms of urban/rural split. Approximately one-half of the special care dementia units were located in the Edmonton and Calgary areas.
6. Only facility size was found to be a significant predictor of the existence of a special care dementia unit. The larger the facility, the more likely it would have a special care dementia unit.
7. Over one-half of the special care dementia units had 21 or more beds.
8. The majority of the special care dementia units were separate secure areas, with special programs, and an environment supporting the cognitive abilities of residents.
9. The majority of the special care dementia units were modified in terms of physical design, staffing and philosophy.

Existing units varied in almost every respect including their underlying philosophy, physical design, staffing, programs and treatment practices.

CHAPTER 6: DISCUSSION

This study represents the first of its kind in Alberta to study special care dementia units. The initial goal was to estimate the number of existing units, and describe the units at one point in time, improving basic definitions, and further identifying the variability among the units. Highlighted by the data were several components of critical importance in describing the units including the demographics, physical environment, organizational climate, and social psychological milieu. The findings relative to these components are discussed in the following paragraphs.

Demographics

Overall, the findings of this study supported the findings of similar studies conducted in the United States. Six recent surveys conducted at the state and national levels have examined the growth and characteristics of these units (Leon & Seigenthaler, 1994). In the United States, special care dementia units have mushroomed from a handful of units to become a major feature of current continuing care facilities (Sloane, P. D., Lindeman, D. A., Phillips, C., Moritz, D. J., & Koch, G., 1995). In Alberta, the number of special care units have grown from three MDE (Mentally Dysfunctioning Elderly) Units to a large number of special care dementia units located throughout the province. Based on the data, it is estimated that 29.9% (n = 47) of continuing care facilities in the province of Alberta had a special care dementia unit at the time of the study. Of these facilities, 8.5% (n = 4) reported that there were two special care units in their facility, making the total estimated number of units fifty-one. While the results from the studies conducted in the United States were remarkably similar, the percentage of continuing care facilities reported to have a special care dementia unit was small in

comparison to the findings of this study. Leon and Seigenthaler (1994) reported that approximately 10.0% of all certified nursing homes in the United States had special care dementia units in 1992. The estimates in reported studies ranged from 9.6% to 19.0%. It was suggested that the differences in estimates could be related to the way special care is defined by individual states(Leon and Seigenthaler, 1994).

In this study, the majority of special care dementia units were located in large facilities (50 beds or more), and nearly one-half were located in large urban areas. This finding was consistent with the findings of the study cited by Sand et al. (1992), and other studies cited by Leon and Seigenthaler (1994). All of these studies provide strong evidence that small facilities rarely have special care dementia units.

At the time of this study, the majority of the special care dementia units in the province had been in operation for more than one year. While this variable was not addressed in all studies conducted in the United States, the median length of operation in three of the studies ranged from two to six years (S[illegible] et al., 1995). Sloane et al. (1995) postulated that systematic differences may occur as a result of differences in length of operation. This could be an important extraneous variable that will need to be controlled for in future studies intended to measure outcomes.

The findings in this study revealed that the majority of special care dementia units in Alberta were located within 50 miles of another special care dementia unit. This finding seems logical because nearly one-half of the special care dementia units were located in urban areas. However, because distance between units had not been addressed in previous studies, this is one variable that needs to be examined further.

Physical Environment

In terms of the physical environment, the findings of this study were remarkably similar to studies conducted in the United States. Existing units varied in almost every aspect. The findings of this study showed that the number of beds on the special care dementia units in Alberta ranged from less than 10 beds to 21 beds or more. Of the units reported, over one-half had 21 beds or more. While the mean bed size of special care dementia units cited in a study by Mathew and Sloane (1991) was 35.9, some experts have suggested that the ideal unit size is between 8 and 15 beds (Sloane et al., 1995). Berg et al. (1991) suggested that small unit size may improve effectiveness, particularly in managing noise and disorientation. If unit size is indeed a determinant of effectiveness, as suggested by Berg et al. (1991), and Sloane et al. (1995), unit size could ultimately be an important extraneous variable that will need to be taken into account and addressed by researchers in future studies when measuring effectiveness.

When asked what makes the special care dementia unit **"special"**, the majority of respondents described the units as a separate, secure area. The majority of respondents in this study also reported that the special care dementia units were self-contained and self-sufficient in terms of services, staffing, and congregate space. The finding that the special care dementia unit was a separate area that was self-contained and self-sufficient in terms of services, staffing and congregate space provided support for the definition developed by Coons (1991). The finding that the special care dementia unit was a secure area provides support to the statement made by Berg et al. (1991) that individuals with dementia have a right to a secure environment. Williams et al. (1991) also considered this to be a critical feature of a special care dementia unit. According to Williams et al. (1991) the term **"secure"** refers

to a range of precautions including preventing access to a range of toxic substances or sharp objects; eliminating sites where individuals are likely to fall; and using devices to deter individuals from entering unsafe places. The definition of "secure" was not addressed in this study, it will require further investigation.

Although consistent staffing were assigned to the special care dementia unit in the majority of the facilities included in this study, urban facilities were found to use consistent staff assignment more than rural facilities. This finding was not consistent with the findings cited by Sloane et al. (1995) that it was common for staff who worked on special care dementia units in the United States to also work on other units within the facility. Williams et al. (1991) considered staffing to be a critical component of the special care dementia unit, and contended that the need for routine and continuity in observations of behaviour and the progression of the disease makes consistent staffing essential. Because of this variation, the method of staff assignment on the unit will need to be clearly described in future studies intended to measure the effectiveness of special care dementia units.

Wandering has been well documented as a potentially serious problem that presents a tremendous challenge to staff. From the time they are dressed in the morning until bedtime, many individuals with dementia wander non-stop, pausing only to eat or take a short rest (Hirst and Metcalf, 1989). Even after these individuals go to bed, many of them get up and wander during the night. In this study, the majority (80.9%)of the respondents indicated that the special care dementia unit had an area where residents could wander freely and that there was a security system which prevented wandering out of the area. This finding was similar to those cited by Riter & Fries (1992). Riter and Fries (1992) found that although nursing homes in the United

States have converted existing units into special care dementia units rather than building them specially, 85% reported having some design features that reduce the likelihood of a confused resident wandering from the unit or facility. Moreover, this finding also provided support for the statement made by Williams et al. (1991) that the physical design of the unit should cater to the individual's wandering and pacing. Eggert (1993), Sand et al. (1992), and Williams et al. (1991) also considered access to a secured courtyard on the ground level to be another essential feature. While the majority of the respondents in this study indicated that the special care dementia unit had direct access to the outdoors at ground level, this was not found to be a common feature on special care dementia units located in urban facilities. It was not known if this area was secure. Therefore, this will need to be addressed in future studies.

Special care dementia units may be considered to be state-of-the-art, but Eggert (1993) reported that developing one presents many challenges because of the physical structure of existing buildings. In this study, the majority of respondents indicated that the design of the unit was similar to other units in the facility, with only minor modifications such as the addition of wallpaper, art and furnishings intended to give it a home-like atmosphere. This finding provided support to the statement made by Cohen and Weisman (1991) that to the extent possible, all special care dementia units should hold on to the attributes of home.

Examination of room configuration (ie. standard, semi-private, private), in this study revealed little variation. The majority of the special care dementia units included in this study were comprised of both semi-private and private rooms, and a small number were comprised of private rooms only. Despite this, there was a significant difference

found between urban and rural facilities. Urban facilities did not have any special care dementia units comprised of private rooms only. While the results from studies conducted in the United States were remarkably similar, there were some differences. For example, Mathew and Sloane (1991) reported that a more substantial proportion of the bed capacity on the special care dementia unit was made available in the form of private rooms. This finding was considered to be important because some experts have suggested that private rooms are much more functional on special care dementia units than shared facilities (Meyer, D. L., Dowling, J., Jacques, J., Nicholas, M., O-Rourke, J., & Dorbacker, B. M., 1990). Cohen and Weisman (1991) also considered this feature to be a critical attribute of a home. In most homes, bedrooms are considered to be the most private area because the bedroom is the area where the activities of sleeping, grooming and dressing usually occur. If room type is indeed a determinant of functionality as suggested by Cohen and Weisman (1991), room type could be another important extraneous variable that will need to be considered in future studies to measure effectiveness of special care dementia units.

Other features identified include subtle environmental cues intended to support the individual with dementia. The majority of respondents in this study reported that additional visual cues were provided to assist individuals with orientation. This finding provided support for the findings cited by Meyer et al. (1990) and Coons (1991), that features such as redundant cueing whereby the same information is presented via several sensory modalities is an essential feature of a special care dementia unit. Because of the variation between units, this could also be an important extraneous variable that will need to be considered in future studies intended to measure effectiveness of special care dementia units.

Other subtle environmental features frequently cited in the literature include those intended to reduce noise. The finding that the majority of special care dementia units in Alberta had restricted traffic flow was similar to findings cited by Hall, Kirschling and Todd (1986), Sand et al. (1992), and Meyer et al. (1992), and provided strong support that the reduction of traffic was an essential feature. Overhead paging systems are another common source of noise frequently cited in the literature. While some experts suggest that staff should avoid using an overhead paging system (Williams et al., 1991), others suggested that the overhead paging system should be removed (Hall et al., 1986). In this study, the majority of respondents indicated that there was an overhead paging system. The researcher also found a relationship between the existence of an overhead paging system and unit size. Larger facilities and larger units tended to have an overhead paging system more than small facilities or units. One aspect not addressed by the researcher was the extent of use. Therefore, this will need to be examined in future studies.

Organizational Climate

When asked to describe the philosophy practiced on the special care dementia unit, 58.8% of the respondents in this study described the use of a particular conceptual model, ie. Gentle Care, PLST (Progressively Lowered Stress Threshold). This finding provided support for the statement that the very nature of dementia calls for a specific type of care (Williams et al., 1991) which is best approached from a conceptual perspective (Hall and Buckwalter, 1991). Coulson (1993) also considered the use of a conceptual model to be an essential feature of a special care dementia unit because it provides guidelines for staff. Despite the use of different conceptual models by special care dementia units included in this study, the major focus on the

majority of the units was the use of individual care plans to adapt programs and services to meet the needs of the individual resident, and the use of a variety of activities intended to help the individual resident remain involved and functioning at the highest possible level. This finding provided support for the findings which were cited by Dawson et al. (1986). Because different conceptual models are being used, a full description of the specific conceptual models being used as a guide, will need to be included in future studies intended to measure effectiveness of special care dementia units.

Sand et al. (1992) suggested that for a unit to be designated as "special", admission/discharge criteria must be specified. In this study, admission/discharge criteria were specified on the majority of the units. On all units reported to have admission/discharge criteria, Alzheimer's disease and other related dementias were included. This finding provided support for the statement made by Coons (1991) that although special care units are often called "Alzheimer's Units", they usually accept residents with any type of dementia. Berg et al (1991) also supported the use of admission/discharge criteria, and suggested that defining specific admission/discharge criteria would help reduce the number of confounding variables in studies intended to measure effectiveness of special care dementia units.

In terms of discharge criteria, the findings of this study were remarkably similar to findings of reported studies in the United States. It was not unusual for residents to be transferred to another unit when the person could no longer benefit from the programs provided on the special care dementia unit (Orr-Rainey, 1991). The majority of respondents in this study reported that residents were transferred to other units when they could no longer benefit from the programs offered on the special care dementia units. However, there is a minority professional opinion

that, once admitted to a special care dementia unit, the resident should stay there until death in order to promote the continuity of relationships among staff, residents, and their families (Berg et al., 1991). In addition to the controversy surrounding the practice of transferring residents to other units, Sloane et al. (1995) also cautioned researchers that the practice of transferring residents to another unit when they could no longer benefit from the programs, could be a potential source of bias because the resident population may not be the same in all facilities. Because of the controversy, and the potential for bias, this variable will need to be examined further.

Although length of operation was not addressed in studies conducted in the United States, in this study, the longer the special care dementia unit was in operation, the greater tendency there was to transfer residents to other units when they could no longer benefit from the programs offered. Despite this trend, the majority of respondents in this study described the special care dementia unit as a long term placement unit. The average length of stay reported by the majority of respondents (over one year) supported this description. However, because the relationship between discharge and length of operation, and length of stay had not been addressed in previous studies, these variables need to be examined further.

The use of specialized assessment screening tools is another essential feature of the organizational climate frequently cited in the literature. In this study, specialized screening tools were used on over one-half of the units. This finding was consistent with the findings of the study cited by McCracken and Fitzwater (1989). Although mental/cognitive/behavioral assessment screening tools were among the most commonly used, in this study larger facilities and larger units had a tendency to use both functional and mental/cognitive/behavioral assessment

screening tools. This finding supported the statement by Sand et al. (1991) and Coons (1991) that assessment of multiple domains is essential.

According to McCracken and Fitzwater (1989) the resident's preliminary score on the specialized assessment screening tool becomes part of the initial assessment data, and periodic assessment can then be used by staff to track the progression of the disease, uncover sudden declines in function, and alert staff to new pathology. In this study, the majority of the respondents reported that assessment reviews were conducted more frequently than the monthly requirement for all continuing care facilities in the province. This finding provided support for the statement made by Williams et al. (1991) and Coons (1991) that changes in function can be reversed if recognized and managed using baseline functional assessments and regular reviews.

The creation of small groupings of people with dementia is frequently cited as an essential feature of a special care dementia unit. According to Cohen and Weisman (1991) the creation of small groupings of people with similar capabilities can reinforce group identity because these groupings can become households or family clusters which provide consistent social contact with a limited number of people. There were marked differences between the findings in this study and previous studies conducted in the United States. In this study, over one-half of the respondents reported that residents were placed in clusters with other residents who had similar capacities. Mathew and Sloane (1991) reported that little subdivision of residents was being done on special care dementia units in the United States at the time of their study. Because of the variation between units, this could also be an important extraneous variable that researchers will need to address in future studies intended to measure effectiveness of special care dementia units.

Many experts in the field believe that the level of educational qualifications of physicians and staff is another important feature of a special care dementia unit. While the majority of respondents in this study reported that physicians and staff did not have additional educational qualifications, staff were required to have a demonstrated interest in dementia. These findings were remarkably similar to the findings cited by Coons (1991), Mathew and Sloane (1991), and Sand et al. (1992). All of these studies provided strong support that persons working on special care dementia units should be carefully selected and trained to meet the demands of the setting. Selection criteria suggested include the following: (1) enjoys working with individuals with dementia in established long term relationships (Coons,1991), and (2) possesses the characteristics of patience, compassion and understanding, while being calm and flexible (Sand et al., 1992). There were however, some major differences between the findings of this study and those conducted in the United States, in relation to staff education and training. In this study, less than one half of the respondents indicated that in addition to basic skills and knowledge, staff also needed education about restorative theories and strategies. In the United States, legislation passed by Congress in 1987 requires that all staff satisfactorily complete a 75-hour state approved training program which includes basic skills, mental and social needs, basic restorative services, and resident rights (Coons, 1991). If staff training is indeed a determinant of effectiveness as suggested by the authorities in the United States, this could be one area that will need further development in this province.

Enhanced staffing ratios is another feature of a special care dementia unit that is frequently cited in the literature. The findings of this study revealed marked differences between existing special care dementia units in

this province and the United States. In this study, over one-half of the respondents reported that the staffing ratios on the special care dementia unit were similar to other units in the facility. Findings cited by Coons (1991), Mathew and Sloane (1991), and Sand et al. (1992) indicate that special care dementia units in the United States were staffed at a higher staff-resident ratio than other continuing care centres. Because of the differences, staffing ration will need to be examined further.

Social-Psychological Milieu

The social-psychological milieu refers to the programs and existing norms, values, and actions of staff employed on the unit (Kayser-Jones, 1989). In this study, the majority of the respondents reported that their special care dementia unit provided a program of activities designed to enable residents to maintain continuity with the past and continue in normal social roles appropriate to adults. In response to other questions intended to examine existing norms, values, and actions of staff, the majority of respondents indicated staff held the view that activities of daily living n opportunity for sharing with residents and continue in tasks or parts of tasks they do alone or with help. They also times by which tasks had to be completed f a resident had difficulty completing a d strategies in the order of least most intrusive. These findings were consistent with the findings cited by Boling and Gwyther (1991), Coons (1991), Dawson et al. (1986), Mathew and Sloane (1991), and Neimoller (1990). All of these studies provided strong support that activity programs should be designed to create social opportunities and make use of skills learned long ago such as activities of daily living, washing dishes, folding clothes, shelling peas, or sanding wood because they provide

fulfilment of daily needs, and enable residents to use their remaining abilities to continue activities which had meaning and purpose for them in the past. Coons (1991) and Coulson (1993) also considered this to be an essential feature of a special care dementia unit, and stated that its success depended on a flexible model of care. If flexibility is indeed a determinant of effectiveness, this may be another important variable that will need to be addressed in future studies intended to measure effectiveness of special care dementia units.

The existence of family programs is another feature of a special care dementia unit frequently cited in the literature. In this study, the majority of respondents reported that family members were viewed as a partner in care as well as a client requiring intervention. The findings in this study also showed that family support and/or counselling was available on the majority of the units. However, larger units tended to have family support and/or counselling services available more than smaller units. This finding seems feasible given the level of resources commonly found in continuing care centres at the time of the study. These findings were consistent with the findings cited by Coons (1991), Mathew and Sloane (1991), and Meyer et al. (1990). Moreover, the findings also provided support for the statement made by Hudgins (1994) and Mathew and Sloane (1991) that the family is an integral part of dementia care. A tremendous amount of staff energy is required to take care of the needs of family members (Hudgins, 1994), to help families work through placement decisions (Meyer et al., 1990), and is another way to extend the process of caring (Boling and Gwyther, 1991).

Coulson (1993) considered the policies and procedures which guide staff in the delivery of care as another important feature of a special care dementia unit. Findings in this study showed that on the majority of the special

care dementia units in this province, intrusive measures such as chemical and physical restraints were used as a last resort. These findings provided support for the finding that when interventi were required, ie. feeding and toileting, interventions were implemented on an individual basis in the order of least intrusive to most intrusive. All of these findings were remarkably similar to the reported findings of similar studies conducted in the United States. Sand et al. (1992) and Kayser-Jones (1991) reported that chemical and physical restraints were rarely used. McCracken and Fitzwater (1989) also considered toileting routines to be important, and suggested that the use of toileting routines could be responsible for overall improvements in bowel/bladder function.

When asked about dietary policies and procedures, the majority of respondents in this study reported that food and fluids were provided at scheduled mealtimes and every two hours. This practice provided support to the statement made by Jones (1996) and McCracken and Fitzwater (1989) that additional snacks and fluids are an essential feature of a special care dementia unit, and are considered useful in maintaining the resident's weight and promoting overall health and performance. If dietary policies and procedures are indeed a determinant of effectiveness, this could be another important variable that will need to be addressed in future studies.

Limitations

Overall, this study provided a snapshot of what makes a special care dementia unit "special". Contrary to the findings cited by Gold (1991), no typology emerged. While the majority of the special care dementia units included in this study appeared to have the same underlying theme (separate, secure area), each unit was different in terms of the other variables investigated. All of the studies

conducted in the United States provided strong evidence that the existence of typologies makes possible the design of intensive studies with smaller, more manageable numbers of units without sacrificing generalizability (Leon and Seigenthaler, 1994). Consequently, the description of a special care dementia unit will need to be examined further.

Findings generated in this study were also limited because with this type of study there is always a possibility that a high rate of reporting error was a significant factor in explaining differences between units. For example, control over data is limited because descriptive studies always examine the variable as it exists, without investigator interference (Brink and Wood, 1989). In this study, the response rate (102%) could also have contributed to a high rate of reporting error. The instrument is also considered by experts to be a common source of reporting error. In this study, the investigator developed and used a self-administered questionnaire that relied exclusively on responses to preset questions. Although the structure of the self-administered questionnaire gave the investigator control over the data insofar as the questions were standardized, the findings were limited because responses were limited to preset questions. Also, the investigator had no control over who answered the questions, and had no way of knowing if the responses given were accurate. With this approach there is always the potential for reporting error related to social desirability, in which people tend to answer according to what they think is the socially desirable answer rather than the actual answer. Because of these limitations, the findings can only be considered to be suggestive in nature.

CHAPTER 7: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to estimate the number of special care dementia units in the province of Alberta, and describe the typical special care dementia unit as it exists, and to identify the variability between units. The study was focused on understanding the various components of the environment, the organizational climate, and the social-psychological milieu. Overall, the findings of this study supported the findings of similar studies conducted in the United States. In Alberta, special care dementia units have increased from the three MDE (Mentally Dysfunctioning Elderly) Units originally opened in the late 1980s, to become a major feature of the continuing care sector.

At the time of this study, approximately one-third of the continuing care centres in the province were reported to have a special care dementia unit. Based on the data in this study, it was estimated that there were fifty-one (51) special care dementia units in the province. The majority of these units were located in continuing care centres which contained more than fifty beds, and had been operational for more than one year. Approximately one-half of the special care dementia units were located in the two largest urban areas of the province (Edmonton and Calgary).

Overall, this study provided insight to what makes a special care dementia unit "special". Contrary to the findings of the study cited by Gold (1991), no typology emerged. The majority of respondents who participated in this study described the special care dementia unit as a separate, secure area where special programs were provided and the environment was modified in terms of the physical environment, staffing, and philosophy. However, because existing units varied in almost every aspect including their underlying philosophy, physical design, staffing, programs and treatment practices, it was not possible to describe a

typical special care dementia unit.

Implications for Nursing Practice

Why should the description of special care dementia units be of concern to nurses? In many continuing care centres nurses are often the "gate keepers" of special care dementia units, and they also have the responsibility for the coordination and provision of formal care for individuals residing on the units. Providing optimum care for persons with dementia has been found to present a significant challenge to nurses working in the continuing care sector. Special care dementia units have developed to provide an improved standard of care, to enhance the quality of life, and to reduce stress on the resident, family members, and staff. With the proliferation of units that claim to be special care dementia units, a problem exists in that there are no operating standards for these units.

At the time of this study, existing units varied in almost every respect including their underlying philosophy, physical design, staffing, programs, and treatment practices. In order to ensure that the unique needs of residents on special care dementia units are met, it is imperative that standards be developed. Formalizing standards in this area will provide support and direction for nurses working in this area. Once the standards are developed, it will then be imperative that nurses participate in the development of written information about special care dementia units to assist individuals and their family members select a unit which will meets their needs.

Implications for Nursing Education

The number of elderly clients with dementia is increasing rapidly. As a result, there has been a definite shift in client population in the continuing care sector. Although the neuropathological changes of dementia cannot be

arrested, there have been many advances in the treatment and management of dementia over the past decade. In an effort to meet the constantly growing demand for institutional care for persons with dementia, special care dementia units have developed, that at least in theory, attempt to respond to the unique needs of this group of individuals. Because nurses in many fields of practice are involved with individuals with dementia and their families, it is imperative that the basic curriculum include information about Alzheimer's disease and other related dementias, the unique needs of this group of individuals and their family members, and concepts such as special care dementia units, restorative theories and strategies, and the various conceptual models currently in use.

It has long been thought that the very nature of dementia calls for a special type of care. Despite this, less than one-half of the respondents who participated in this study indicated that in addition to basic knowledge and skills, staff also needed education about restorative theories and strategies. Because it is important to understand that the environment, the services provided, and the planned programs have a direct influence on the well-being of the person with dementia, persons working on special care dementia units should be carefully selected and be provided with education that will enable them to meet the care demands of this vulnerable population. However, before such an educational experience can occur, there needs to be a mutual awareness that there is a need to include restorative theories and strategies in educational programs. This could be accomplished utilizing a variety of strategies including the development of standards for basic education and continuing education for nurses working in these settings, and the provision of nursing student placements on special care dementia units. Finally, in order to educate family members and the public about the needs of individuals

with dementia, and special care dementia units, nurses must be made aware of the required components of a special care dementia unit, and where family members can obtain information about these units.

Implications for Nursing Research

Special care dementia units have been widely studied in the United States. This study represents the first of its kind in the province of Alberta. Overall, this study provided an estimate of the number of existing units and an insight into what makes a special care dementia unit "special". Because of the limitations identified by the investigator, this study serves only as a preliminary effort in trying to explore special care dementia units as they exist.

Overall, the number of special care dementia units in this province have increased to become a major feature of the continuing care sector. Although the majority of special care dementia units included in this study were described as a separate, secure area, each unit was different in terms of the other variables investigated. Given the variation between these units, and the limitations of the current research, the investigator has identified the need for further research. The investigator has also identified the need to clearly describe the clinical setting in future studies intended to measure the effectiveness of special care dementia units, and some extraneous variables that will need to be addressed in these studies, ie. room configuration, visual cueing, flexibility of routines, staffing ratios, conceptual models, etc. It is the opinion of this investigator that more research examining these variables must be sought before additional resources are committed to the development of additional special care dementia units.

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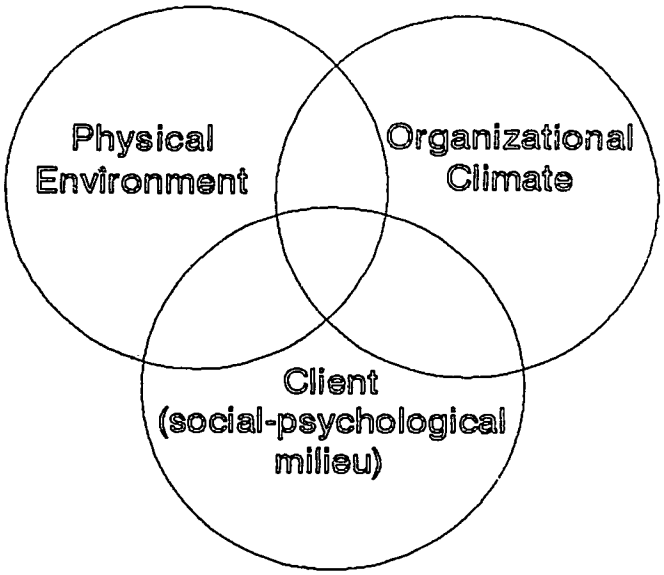
APPENDIX A

The Components of the Environment using Neuman's Systems Model

The Components of the Environment using Neuman's Systems Model



Physical Environment consists of:
- clients
- staff
- visitors
- volunteers
- people in community
- physical structure of the building

Client consists of:
- physiological variables
- psychological variables
- developmental variables
- sociocultural variables
- spiritual variables

Organizational climate consists of:
- philosophy
- policies/procedures
- services provided
- planned programs
- staff attitude

APPENDIX B

Special Care Dementia Unit Questionnaire

SPECIAL CARE DEMENTIA UNITS

100

QUESTIONNAIRE

The following are a series of questions about special care dementia units. In responding to the questions, please remember that there are no correct answers, and that you are being asked to describe your facility as it exists because the information will be important in assisting others to understand what a special care dementia unit is. For the purpose of this study, the term special care dementia unit is defined as an area that is self-contained and self-sufficient in terms of services, staffing and congregate space at least two shifts in a twenty-four hour period.

To answer questions with multiple choices (√) your response.

SECTION A: Background Information	***Office Use Only***
A.1 What is the number of approved long term care beds in your facility?	*A.1* *0*
( ) less than 25 beds	*1*
( ) 25 - 50 beds	*2*
( ) 51 - 100 beds	*3*
( ) 100 + beds	*4*
A.2 Which of the following best describes your location?	*A.2* *0*
( ) rural	*1*
( ) urban	*2*
A.3 In which region of the province are you located?	*A.3* *0*
( ) South (Regions 1,2,3 or 5)	*1*
( ) Central (Regions 6,7,8 or 9)	*2*
( ) Calgary Area (Region 4)	*3*
( ) Edmonton Area (Region 10)	*4*
( ) North (Regions 11,12,13,14,15,16 or 17)	*5*

Office Use Only

A.4 *Do you have a special care dementia unit in your facility?* A.4 0

( ) Yes 1

( ) No 2

(If you answered "No" to this question go to question A.9)

A.5 *Is your special care dementia unit recognized and/or approved as a provincial program by Alberta Health?* A.5 0

( ) Yes 1

( ) No 2

A.6 *Do you have more than one special care dementia unit in your facility?* A.6 0

( ) Yes - enter number:_____ 1

( ) No 2

A.7 *How many beds are there on your special care dementia unit?* A.7 0

( ) less than 10 beds 1

( ) 11 - 20 beds 2

( ) 21 beds or more 3

A.8 *How long has your special care dementia unit been in operation?* A.8 0

( ) less than one year 1

( ) more than one year, but less than 2 years 2

( ) more than two years, but less than 5 years 3

( ) more than five years 4

Office Use Only

A.9 ***What is the number of miles between your facility and the nearest special care dementia unit?*** *A.9* ***0***

( ) *less than 50 miles* ***1***

( ) *50 - 100 miles* ***2***

( ) *100 + miles* ***3***

(If you do not have a special care dementia unit go to Section G)

SECTION B: ***Physical Environment***

B.1 ***What makes the special care dementia unit "special"?*** *B.1* ***0***

_____ ***1***

_____

_____

_____

_____

B.2 ***How does the special care dementia unit differ from other long term care units in the facility?*** *B.2* ***0***

1

_____

_____

_____

_____

_____

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B.3 ***How does the design of the special care dementia unit differ from other long term care units in the facility?*** *B.3* *0* *1*

_____

_____

_____

_____

_____

B.4 ***Is your special care dementia unit self-contained and self-sufficient in terms of services?*** *B.4* *0*

( ) Yes *1*

( ) No *2*

B.5 ***Is your special care dementia unit self-contained and self-sufficient in terms of staffing?*** *B.5* *0*

( ) Yes *1*

( ) No *2*

B.6 ***Is your special care dementia unit self-contained and self-sufficient in terms of congregate space?*** *B.6* *0*

( ) Yes *1*

( ) No *2*

B.7 ***Does your special care dementia unit have a security system which prevents wandering out of the area?*** *B.7* *0*

( ) Yes *1*

( ) No *2*

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B.8 *Does your special care dementia unit have an area where residents can wander freely?* *B.8*

( ) Yes *0*

( ) No *1*

2

B.9 *Does your special care dementia unit have direct access to the outdoors at ground-level?* *B.9*

( ) Yes *0*

( ) No *1*

2

B.10 *Does your special care dementia unit have an overhead paging system?* *B.10*

( ) Yes *0*

( ) No *1*

2

B.11 *Which of the following best describes the design of your special care dementia unit?* *B.11*

( ) private rooms only *0*

( ) private and semi-private rooms *1*

( ) private, semi-private, and standard ward rooms *2*

3

B.12 *Which of the following best describes the design features of your special care dementia unit?* *B.12*

( ) design similar to other long term care units in the facility *0*

( ) design similar to other long term care units with the addition of wallpaper, art and furnishings to give unit a different atmosphere *1*

( ) design different than other long term care units in the facility *2*

3

Office Use Only

B.13 *On your special care dementia unit do you place residents in clusters with other individuals who have similar capacities?* *B.13* *0*

( ) Yes *1*

( ) No *2*

B.14 *On your special care dementia unit is each room and/or cluster distinctive in design, color and furniture?* *B.14* *0*

( ) Yes *1*

( ) No *2*

B.15 *On your special care dementia unit are additional visual cues provided to assist with orientation?* *B.15* *0*

( ) Yes *1*

( ) No *2*

B.16 *On your special care dementia unit is traffic of staff, visitors and other residents restricted?* *B.16* *0*

( ) Yes *1*

( ) No *2*

B.17 *Which of the following best describes the lighting on your special care dementia unit?* *B.17* *0*

( ) similar to other long term care units in the facility *1*

( ) additional lighting *2*

SECTION C: ***Admission/Discharge Criteria*** *Office Use Only*

C.1 *Does your special care dementia unit have specified admission/discharge criteria?* C.1 0

( ) Yes 1

( ) No 2

C.2 *Which of the following best describes the admission criteria on your special care dementia unit?* C.2 0

( ) diagnosis of Alzheimer's Disease or other Dementias, with no Psychiatric Disorder 1

( ) diagnosis of Alzheimer's Disease or other Dementias, and Psychiatric Disorders 2

( ) diagnosis of Alzheimer's Disease or other Dementias, with behavioral problems that cannot be managed in a regular long term care unit 3

C.3 *Which of the following best describes your special care dementia unit?* C.3 0

( ) short term assessment and treatment unit 1

( ) long term care placement unit 2

( ) both of the above 3

C.4 *What is the average length of stay on your special care dementia unit?* C.4 0

( ) less than 90 days 1

( ) more than 90 days, but less than one year 2

( ) 1 - 2 years 3

( ) over 2 years 4

Office Use Only

C.5 ***Are highly specialized assessment screening tools used as part of the regular assessment protocol on your special care dementia unit?***

C.5

0

( ) Yes

1

( ) No

2

C.6 ***What specialized assessment screening tool(s) do you use?***

C.6

_____ *0*

_____

_____ *1*

_____

_____

C.7 ***Which of the following best describes the protocol for assessment reviews on your special care dementia unit?***

C.7
0

( ) assessment reviews on a weekly basis *1*

( ) assessment reviews on a monthly basis *2*

( ) assessment reviews semi-annually *3*

C.8 ***Which of the following best describes the philosophy guiding your special care dementia unit?***

C.8
0

( ) offers services similar to other long term care units *1*

( ) emphasizes need to help residents remain as independent as possible *2*

( ) uses individual care plans, offers a variety of activities to help each individual remain involved and functioning at highest level possible *3*

Office Use Only

C.9 *Which of the following best describes the discharge program on your special care dementia unit?* *C.9* *0*

( ) residents are transferred once stabilized *1*

( ) residents are transferred when they no longer benefit from the program *2*

( ) residents remain on unit until they die *3*

SECTION D: ***Staffing***

D.1 *Does your special care dementia unit have designated medical staff?* *D.1* *0*

( ) Yes *1*

( ) No *2*

D.2 *Which of the following best describes the qualification of the designated medical staff?* *D.2* *0*

( ) General Practitioners *1*

( ) General Practitioners with demonstrated interest in Dementia *2*

( ) General Practitioners with additional education *3*

( ) Certificate in Gerontology *4*

( ) Certificate in Psychogeriatrics *5*

( ) Certificate in Psychiatry *6*

D.3 *Are staff employed on the special care dementia unit required to have special knowledge and/or skills?* *D.3* *0*

( ) Yes *1*

( ) No *2*

Office Use Only

D.4 ***In recruiting staff for the special care dementia unit which of the following best describes the level of qualifications desired?*** *D.4*

( ) ***demonstrated interest in Dementia*** *0*

1

( ) ***completion of specified educational course(s)*** *2*

( ) ***Certificate Program*** *3*

D.5

D.5 ***Which of the following best describes the staffing ratio on the special care dementia unit?*** *0*

( ) ***similar to other long term care units in the facility*** *1*

( ) ***higher staff to resident ratio with increased number of professional staff*** *2*

( ) ***higher staff to resident ratio with increased number of non-professional staff*** *3*

D.6 ***Which of the following best describes the method of staff assignment on your special care dementia unit?*** *D.6*

0

( ) ***consistent staff are assigned*** *1*

( ) ***staff float between units*** *2*

D.7 ***Which of the following best describes the educational needs of staff on your special care dementia unit?*** *D.7*

0

( ) ***on-going basic knowledge and skills*** *1*

( ) ***on-going, in addition to basic skills and knowledge require education on restorative theories and strategies*** *2*

SECTION E: ***Programs*** *Office Use Only*

E.1 *Describe the philosophy practiced on your special care dementia unit.* *E.1*

0

_____

1

_____

_____

_____

_____

E.2 *How are the beliefs stated in the philosophy expressed on your special care dementia unit?* *E.2*

0

1

_____

_____

_____

_____

_____

E.3 *Which of the following best describes the programs on your special care dementia unit?* *E.3*

0

( ) similar to other long term care units in the facility

1

( ) individual or small group programs focused on increasing functional abilities

2

( ) individual or small group programs focused on social activities

3

( ) provides a program of activities which enables residents to maintain continuity with the past and continue in normal social roles appropriate to adults

4

Office Use Only

E.4 *Which of the following best describes the routines on your special care dementia unit?*

E.4
0

( ) *similar to other long term care units in the facility* 1

( ) *individualized according to the needs of the residents* 2

( ) *staff have flexibility as to the times by which certain tasks must be completed* 3

E.5 *What is a "typical" day on your special care dementia unit like?*

E.5
0

_____ 1

_____

_____

_____

_____

E.6 *Which of the following best describes the restraint policy on your special care dementia unit?*

E.6
0

( ) *restraints used on a regular basis* 1

( ) *restraints used as a last resort only* 2

( ) *"no restraint" policy* 3

E.7 *Which of the following best describes the policy on use of psychotropic drugs on your special care dementia unit?*

E.7
0
1

( ) *psychotropic drugs are given on a regular basis*

( ) *psychotropic drugs are given on a prn basis* 2

( ) *psychotropic drugs are used as a last resort only* 3

Office Use Only

E.8 *Which of the following best describes the toileting routine on your special care dementia unit?*

E.8
0

- *( ) no toileting routine for incontinent residents* — *1*
- *( ) toileting every two hours during the daytime* — *2*
- *( ) toileting every two hours around--clock* — *3*
- *( ) individual toileting schedule developed for each resident* — *4*

E.9 *Which of the following best describes the view held by staff on your special care dementia unit?*

E.9
0

- *( ) activities of daily living routines are to be accomplished as quickly as possible* — *1*
- *( ) activities of daily living provide the opportunity for sharing with residents and helping them continue in tasks or parts of tasks they are still able to manage alone or with help* — *2*

E.10 *If a resident has difficulty completing a task, which of the following best describes the actions taken by staff?*

E.10
0

- *( ) complete the task for the resident* — *1*
- *( ) reassess ability to complete task on a daily basis* — *2*
- *( ) employ strategies in the order of least intrusive to most intrusive* — *3*

Office Use Only

E.11 ***Which of the following best describes the dietary routine on your special care dementia unit?*** *E.11* *0*

( ) food and fluids are provided at scheduled times only *1*

( ) food and fluids are provided at scheduled mealtimes and during social activities *2*

( ) food and fluids are provided at scheduled mealtimes and upon request *3*

( ) food and fluids are provided at scheduled mealtimes and every two hours *4*

E.12 ***Which of the following best describes the policy on feeding residents on your special care dementia unit?*** *E.12* *0*

( ) staff feed residents who have difficulty *1*

( ) staff provide finger food when resident has difficulty using utensils properly *2*

( ) staff feed residents as a last resort only *3*

SECTION F: Family Programs

F.1 ***Which of the following best describes the family programs on your special care dementia unit?*** *F.1* *0*

( ) similar to other long term care units in your facility *1*

( ) additional educational/information sessions scheduled on a regular basis *2*

( ) family support and/or counselling available *3*

Office Use Only

F.2 Which of the following best describes the role of family members on your special care dementia unit? F.2

( ) *family members provide support for the resident* 0

( ) *family members are viewed as partners in care* 1

( ) *family members are viewed as a partner in care and a client who requires intervention* 2

( ) *family members are viewed as a partner in care and a client who requires intervention* 3

SECTION G:

G.1 Which of the following best describes your present position? G.1

( ) *Administrator* 0

( ) *Director of Nursing/Patient Care* 1

( ) *Unit Supervisor* 2

( ) *Front-line Care giver (Staff Nurse, LPN, etc)* 3

( ) *Front-line Care giver (Staff Nurse, LPN, etc)* 4

Thank you for taking the time to complete this questionnaire. Please return the completed survey to:

Dorothy Phillips
11525 - 86 Street NW
Edmonton, Alberta
T5B 3J4

Phone: (403) 474-9755

APPENDIX C

Letters to Facility Operators

Dear Facility Operator/Director of Nursing:

As a graduate student in the Faculty of Nursing, University of Alberta, I am conducting a research study on Special Care Dementia Units. The enclosed questionnaire will provide all of the information for the study. Please take 30 minutes to fill out the questionnaire, and return it in the self-addressed, stamped envelope provided.

Because little is known about Special Care Dementia Units in Alberta, this questionnaire has been mailed to all long term care facilities in Alberta. Topics covered include background information about your facility, the physical environment, admission and discharge criteria, staffing, and programs for residents and family members.

Participation in this study is voluntary. Should you choose to fill out the questionnaire, your responses will be confidential. If there are any questions you prefer not to answer, just skip them. The data will be reported in aggregate form for the sole purpose of the study.

If you have any questions or concerns please call me or contact my supervisor.

Sincerely,

Dorothy E. Phillips, RN. BScN
(403)474-9755

Thesis Supervisor: Dr. Janet Ross-Kerr, PhD
(403)492-6253

Dear Facility Operator/Director of Nursing:

Re: Special Care Dementia Unit Questionnaire

A few weeks ago a questionnaire about Special Care Dementia Units was mailed to you. Because the sample in this study is expected to be small, the success of this project is directly dependent upon your response.

If you have not already done so, please fill out the enclosed questionnaire and return it in the self-addressed, stamped envelope provided.

If you do not have a Special Care Dementia Unit, please fill out the first section of the questionnaire and follow the instructions for any additional questions to be answered.

If you have already completed and mailed the questionnaire, return the blank questionnaire.

Thank you to everyone who has responded to date.

If you have any questions or concerns please call me or contact my supervisor.

Sincerely,

Dorothy E. Phillips
(403)474-9755

Thesis Supervisor: Dr. Janet Ross-Kerr, PhD
(403)492-6253