

QUALITY OUTCOME
MEASURE FOR INDIVIDUALS
WITH DEMENTIA
(QOMID)

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INSTRUCTION BOOKLET

What is the QOMID?

The Quality Outcome Measure for Individuals with Dementia (QOMID) has been designed to measure the quality outcomes for any person with dementia. It is easy to use, and in initial analysis, has good internal consistency as a measure of quality outcome.

The QOMID consists of 17 domains which explore the key areas that ensure that the person with dementia is experiencing a good quality experience.

The QOMID is staged for the three main stages of dementia – suspected/ early; mid and late stage. Although the domains are the same for each stage, the description of quality outcomes may change across the stages to reflect the different requirements as dementia progresses.

The QOMID must be used in its entirety, and should not be amended.

The QOMID is available free of charge from: http://dcp-ld.bps.org.uk/dcp-ld/useful-links-and-info/useful-links-and-info_home.cfm

We would like to collect further data on its use so that we can do further analysis on its usefulness and statistical properties. Each time you complete it, please could you upload anonymised data to:

<https://www.surveymonkey.com/s/K6LB3ZD>

When to use the QOMID

The QOMID should be used sequentially to rate the quality outcome of the person as their dementia progresses. The QOMID should be used as part of a regular review of the person's care to ensure that the person maintains good quality experience through the course of their dementia.

Who should complete the QOMID?

- The QOMID should be completed by the professional in discussion with relevant people for each stage of dementia.
- It is particularly effective when completed as part of a review of the person's care.
- Wherever possible, and depending on ability, the person with dementia should be asked how they would rate their experience in each domain.
- Additional information for the professional to make an inclusive judgement may come from family, support staff, advocates, care managers or anyone else involved with the person and their support.
- The person completing the QOMID should record the evidence for their decision for each domain.

How to use the QOMID

1. **Staging of dementia:** The professional completing the QOMID needs to use a combination of results from formal assessments together with their professional judgement to decide which stage of dementia the person is currently experiencing.

Suspected / Early stage

Early stage dementia is usually characterised by gradual minor changes in the person's abilities or behaviour, especially loss of short term memory. The person may also start to become anxious and agitated. They may experience distress over their failure to manage tasks, and will need reassurance and emotional support. People who fall into Care Cluster 18 (Cognitive Impairment- Low Need) may fall into this group.

Mid stage

Mid stage dementia is characterised by the changes becoming more marked. The person will need more support to help them manage their day-to-day living. They may need frequent reminders or help to eat, wash, dress and use the toilet. They are likely to become increasingly forgetful - particularly of names - and may sometimes repeat the same question or phrase over and over because of the decline in their short-term memory. They will also experience loss of long-term memories resulting in them failing to recognise people or confuse them with others, and for older memories to become more vivid. Some people at this stage become very easily upset, angry or aggressive - perhaps because they are feeling frustrated - or they may lose their confidence and become very clingy. People who fall into Care Clusters 19 (Cognitive Impairment- Moderate Need) or Care Cluster 20 (Cognitive Impairment or Dementia Complicated- High Need) may fall into this group.

Late Stage

Late stage dementia is when the person with dementia will need even more help, and will gradually become totally dependent on others for nursing care. Loss of memory may become very pronounced, with the person unable to recognise familiar objects or surroundings or even those closest to them, although there may be sudden flashes of recognition. The person may also become increasingly frail. They may start to shuffle or walk unsteadily, eventually becoming confined to bed or a wheelchair. People who fall into or Care Cluster 21 (Cognitive Impairment or Dementia- High Physical or Engagement) may fall into this group.

Use the column for that stage of dementia and rate each domain using the following rating scale:

1	2	3	4
<p>This is rarely achieved for this person</p>	<p>This is sometimes achieved for this person</p>	<p>This is mostly achieved for this person</p>	<p>This is completely and consistently achieved for this person</p>

For each domain, enter the rating at this current time onto the **Scoring Sheet**. All domains should be completed. If the domain is rated less than 4, specify what needs to happen to improve the person’s quality outcome in that area of their life as an action in the **Scoring Sheet**.

- 2. **Expected scoring:** The aim, in supporting the person with dementia, is for them to have an excellent quality outcome throughout the progression of their dementia.

As dementia is a progressive condition, it is vital to ensure that the person’s changing needs are recognised and met. This means that as the person moves into each stage of dementia, the quality outcome score for each domain may start at 2 or 3, but as people work together to improve the person’s quality outcome, the scores should reach the maximum of 4 in each domain.

Scores may fluctuate during the course of the dementia as support ‘catches up’ with the person’s changing needs. Scores should be entered onto the **Scoring sheet**, putting the evidence for the rating.

- A score of 60 – 68 indicates that the person has an excellent quality outcome.**
- A score of 51 – 59 indicates that the person has a good quality outcome.**
- A score of 43 – 50 indicates that the person has an adequate quality outcome.**
- A score of 34 – 42 indicates that the person has a poor quality outcome.**
- A score of 33 or less indicates that the person has an unacceptable quality outcome.**

3. **Forward planning:** The QOMID is designed to help the support team and the professionals to work with the person to both prevent deterioration in quality and to forward plan effective care.

For each domain that is scored at less than 4, the support team is asked to specify what needs to be put in place to improve the person's quality outcome for that domain. These actions should be entered into the **Scoring Sheet** and can then be included in the person's support plan.

In addition, by looking at the descriptions for the next stage of dementia, the professional can begin to help the person and their supporters to think about what needs to be put in place to maintain their quality experience.

For further information please contact: Karen Dodd – DrKaren.dodd@sabp.nhs.uk

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DOMAIN REFERENCE BOOKLET

AREA	SUSPECTED / EARLY STAGE DEMENTIA	MID STAGE DEMENTIA	LATE STAGE DEMENTIA
1. PERSON CENTRED APPROACHES TO SUPPORT	<p>The person experiences support which is underpinned by planning based on:</p> <ul style="list-style-type: none"> • the person's own wishes, • their capacity (maximising their decision making wherever possible), • their needs and history as shown in their individualised support plan which includes <ul style="list-style-type: none"> ○ their person centred plan, ○ health care plan, ○ communication passport, ○ life story book, ○ advanced directives, and ○ end of life planning. 	<p>The person experiences support which is underpinned by planning based on:</p> <ul style="list-style-type: none"> • the person's own wishes, • their capacity (maximising their decision making wherever possible), • their needs and history as shown in their individualised support plan which includes <ul style="list-style-type: none"> ○ their person centred plan, ○ health care plan, ○ communication passport, ○ life story book, ○ advanced directives, and ○ end of life planning. 	<p>The person experiences support which is underpinned by planning based on:</p> <ul style="list-style-type: none"> • the person's own wishes, • their capacity (maximising their decision making wherever possible), • their needs and history as shown in their individualised support plan which includes <ul style="list-style-type: none"> ○ their person centred plan, ○ health care plan, ○ communication passport, ○ life story book, ○ advanced directives, and ○ end of life planning.
2. POSITIVE RISK TAKING	<p>The person is supported to take appropriate risks that enhance their opportunities to live an independent, fulfilled life.</p>	<p>The person is supported to take appropriate risks that enhance their opportunities to live an independent, fulfilled life.</p>	<p>The person is supported by people who take positive action to ensure that the person still has a range of fulfilling life experiences.</p>

AREA	SUSPECTED / EARLY STAGE DEMENTIA	MID STAGE DEMENTIA	LATE STAGE DEMENTIA
3. RESPECT FOR HUMAN RIGHTS	<p>The person's human rights are fully respected by ensuring that there is full compliance with:</p> <ul style="list-style-type: none"> • Prescribed medication is in line with NICE guidelines • Mental Capacity Act- choice and decision making. The person is supported to make as many decisions for themselves as is possible • Best Interest Decisions that are made on behalf of the person are fully documented • Absence of inappropriate restrictions <p>If the person tends to wander, this is managed through respectful and positive approaches that do not impact on their human rights</p>	<p>The person's human rights are fully respected by ensuring that there is full compliance with:</p> <ul style="list-style-type: none"> • Prescribed medication is in line with NICE guidelines • Mental Capacity Act- choice and decision making. The person is supported to make as many decisions for themselves as is possible • Best Interest Decisions that are made on behalf of the person are fully documented • Absence of inappropriate restrictions <p>If there is a need to deprive somebody of their liberty, the appropriate Deprivation of Liberty Safeguards are in place.</p>	<p>The person's human rights are fully respected by ensuring that there is full compliance with:</p> <ul style="list-style-type: none"> • Prescribed medication is in line with NICE guidelines • Mental Capacity Act- choice and decision making. The person is supported to make as many decisions for themselves as is possible • Best Interest Decisions that are made on behalf of the person are fully documented • Absence of inappropriate restrictions <p>If there is a need to deprive somebody of their liberty, the appropriate Deprivation of Liberty Safeguards are in place.</p>
4. CONSISTENCY OF APPROACH	<p>The person experiences consistency of approach in all settings e.g.</p> <ul style="list-style-type: none"> • They are supported by familiar people • Family /Staff fully understand the content of their support plan • New staff are properly introduced to the person before they start working with them • The use of unfamiliar or agency staff is minimised and staff are well briefed about the person before they start to support them. 	<p>The person experiences consistency of approach in all settings e.g.</p> <ul style="list-style-type: none"> • They are supported by familiar people • Family /Staff fully understand the content of their support plan • New staff are properly introduced to the person before they start working with them • The use of unfamiliar or agency staff is minimised and staff are well briefed about the person before they start to support them. • They are not moved unnecessarily because of funding issues (e.g. need for waking night staff) 	<p>The person experiences consistency of approach in all settings e.g.</p> <ul style="list-style-type: none"> • They are supported by familiar people • Family /Staff fully understand the content of their support plan • New staff are properly introduced to the person before they start working with them • The use of unfamiliar or agency staff is minimised and staff are well briefed about the person before they start to support them. • They are not moved unnecessarily because of funding issues (e.g. need for waking night staff)

AREA	SUSPECTED / EARLY STAGE DEMENTIA	MID STAGE DEMENTIA	LATE STAGE DEMENTIA
5. INTERACTION WITH OTHERS	The person experiences calm and constructive interaction with family, staff and friends, who adapt the amount of language used and use symbols and pictures as required to ensure the person experiences positive interactions.	The person experiences calm and constructive interaction with family, staff and friends, with no confrontation; no time pressures; and validation of roll back memories. The person experiences positive interactions and is always approached from the front to prevent surprise and panic.	The person experiences calm and constructive interaction with family, staff and friends, with protected 1:1 time each waking hour to ensure that the person experiences positive interactions.
6. EMOTIONAL REASSURANCE TO COPE WITH THE CHANGES	The person receives explanations about their dementia and reassurance about the effects of the disease as appropriate to their wishes and level of ability.	The person is reassured about the changes they are experiencing through both verbal and non verbal interaction.	The person is reassured about their condition by the way people interact both verbally and through appropriate touch.
7. ORIENTATION	The person is oriented to time and place through approaches that are appropriate to their level of ability. Their support plan describes routines that are likely to be important to the person as the dementia progresses. There is evidence that the team has made plans to ensure that any future changes that are envisaged for the person are properly considered and take account of possible effect on the person's orientation	The person is able to understand their daily routine through the use of appropriate cues and aids e.g. daily picture timetable, picture menus, picture staff rotas. There is evidence that the team has made plans to ensure that any future changes that are envisaged for the person are properly considered and take account of possible effect on the person's orientation	The person feels safe in having a consistent and familiar routine.
8. DAILY LIVING	The person is able to complete personal care and daily living activities as much as they are able, but without pressure. The person's abilities and additional assistance required to help maintain independence are recognised, and the person is supported appropriately e.g. having increased prompting.	The person is able to complete parts of personal care and daily living tasks that they can do and are assisted as necessary so they do not fail. Their support plan details the additional assistance required to help maintain as much independence as possible in a failure free manner.	The person experiences care that is dignified and respectful of them as a person for all their personal care and daily living activities.

AREA	SUSPECTED / EARLY STAGE DEMENTIA	MID STAGE DEMENTIA	LATE STAGE DEMENTIA
9. CARRYING OUT PREFERRED ACTIVITIES	The person continues to access and enjoy activities which build upon on their lifelong interests and preferences and are appropriate to their level of ability and dementia. Activities are adapted to meet their changing needs.	The person continues to access and enjoy activities which build upon their lifelong interests and preferences and are appropriate to their level of ability and dementia. Activities are adapted to take account of their attention span and memory and ensure that the person is not stressed or experiences failure.	The person continues to access and enjoy activities appropriate to their level of ability and dementia. The person has opportunities to interact with people / objects which give them enjoyment and in ways that take full account of their preferences and attention span.
10. FLEXIBILITY OF SUPPORT	The person continues to attend familiar social, leisure, work, respite and recreational activities in their local community, with adjustments made as appropriate to meet their needs.	The person continues to enjoy familiar social, leisure, work, respite and recreational activities in their local community through flexible supports e.g. short days, flexible transport, 1:1 support following the person.	The person continues to access and enjoy the community as much as their dementia allows and as agreed in their support plan.
11. ENVIRONMENT	The person lives and spends their time in environments that are familiar to them and can find their way around easily with depth perception problems minimised. e.g. flooring colour is consistent.	The person lives and spends their time in environments that are familiar to them and have all the necessary aids/adaptations to help them find their way around and meet their needs, and minimises risks of falls. e.g. red toilet doors, red toilet seats, colour contrasts, good signage, handrails, chairs at right height.	The person lives and spends their time in environments that are familiar to them and have all the necessary adaptations to meet their needs. e.g. hoists, adapted bath / shower, special bed, appropriate wheelchair and armchair, changing facilities.

AREA	SUSPECTED / EARLY STAGE DEMENTIA	MID STAGE DEMENTIA	LATE STAGE DEMENTIA
12. BEHAVIOUR	<p>Behavioural issues are minimised by ensuring that the person experiences support that:</p> <ul style="list-style-type: none"> • Understands the context of their behaviour • responds with compassion and • avoids confrontation. <p>If the person needs support from services because of their behaviour this is underpinned by:</p> <ul style="list-style-type: none"> • a comprehensive assessment of the person, their care and the environment, • a formulation that enables carers or staff to understand the likely reasons for the behaviour, • a proactive support plan that includes triggers to be avoided, • reactive strategies that are non-restrictive and the effectiveness of the approach is reviewed regularly. 	<p>Behavioural issues are minimised by ensuring that the person experiences support that:</p> <ul style="list-style-type: none"> • Understands the context of their behaviour • responds with compassion and • avoids confrontation. <p>If the person needs support from services because of their behaviour this is underpinned by:</p> <ul style="list-style-type: none"> • a comprehensive assessment of the person, their care and the environment, • a formulation that enables carers or staff to understand the likely reasons for the behaviour, • a proactive support plan that includes triggers to be avoided, • reactive strategies that are non-restrictive and the effectiveness of the approach is reviewed regularly. 	<p>Behavioural issues are minimised by ensuring that the person experiences support that:</p> <ul style="list-style-type: none"> • Understands the context of their behaviour • responds with compassion and • avoids confrontation. <p>If the person needs support from services because of their behaviour this is underpinned by:</p> <ul style="list-style-type: none"> • a comprehensive assessment of the person, their care and the environment, • a formulation that enables carers or staff to understand the likely reasons for the behaviour, • a proactive support plan that includes triggers to be avoided, • reactive strategies that are non-restrictive and the effectiveness of the approach is reviewed regularly.

AREA	SUSPECTED / EARLY STAGE DEMENTIA	MID STAGE DEMENTIA	LATE STAGE DEMENTIA
13. HEALTH	<p>The person's physical and mental health needs are met promptly and appropriately including attention to:</p> <ul style="list-style-type: none"> • Pain recognition and management • Thyroid function • Vision • Hearing • Blood pressure • Diabetes • Mental wellbeing <p>Medication is prescribed appropriately and reviewed regularly.</p> <p>The person experiences care with regard to Vitamin D in line with DH guidance.</p>	<p>The person's physical and mental health needs are met promptly and appropriately including attention to:</p> <ul style="list-style-type: none"> • Pain recognition and management • Thyroid function • Vision • Hearing • Blood pressure • Diabetes • Mental wellbeing <p>Medication is prescribed appropriately and reviewed regularly.</p> <p>The person experiences care with regard to Vitamin D in line with DH guidance.</p>	<p>The person's physical and mental health needs are met promptly and appropriately including attention to:</p> <ul style="list-style-type: none"> • Pain recognition and management • Thyroid function • Vision • Hearing • Blood pressure • Diabetes • Mental wellbeing <p>Medication is prescribed appropriately and reviewed regularly.</p> <p>The person has:</p> <ul style="list-style-type: none"> • No pressure sores • No aspiration • No urinary tract infections <p>The person experiences care with regard to Vitamin D in line with DH guidance.</p>
14. SUPPORT FROM WELL COORDINATED AGENCIES	<p>The person's needs are met by people from providers in primary care, secondary care, social services and voluntary sector who have a good understanding of the needs of people with dementia, and who work well together with the person and their families.</p>	<p>The person's needs are met by people from providers in primary care, secondary care, social services and voluntary sector who have a good understanding of the needs of people with dementia, and who work well together with the person and their families. Where necessary good links are made with neurology services re management of epilepsy.</p>	<p>The person's needs are met by people from providers in primary care, secondary care, social services and voluntary sector who have a good understanding of the needs of people with dementia, and who work well together with the person and their families. Good links are made with local palliative care services.</p>

AREA	SUSPECTED / EARLY STAGE DEMENTIA	MID STAGE DEMENTIA	LATE STAGE DEMENTIA
15. NUTRITION	The person enjoys a good and appetising diet and adequate hydration. The person maintains an appropriate weight which is monitored through regular weight checks.	The person enjoys a good and appetising diet and adequate hydration as appropriate to their needs over each 24 hour period. The person maintains an appropriate weight which is monitored through regular weight checks. Any swallowing difficulties are identified and support plans take these into full account	The person enjoys a good and appetising diet and adequate hydration as appropriate to their needs over each 24 hour period which also prevents dysphagia and aspiration. There is a full assessment of all eating and swallowing problems by an appropriate clinician. Any needs are well documented, a support plan is in place and staff are trained to deliver it safely. The person maintains an appropriate weight which is monitored through regular weight checks.
16. MOBILITY	The person maintains good mobility. They access regular exercise that is appropriate to their needs and interests.	The person is able to mobilise safely and has appropriate aids and adaptations in place. They access regular exercise that is appropriate to their needs and interests. Risk assessments are in place to prevent falls.	The person is supported to be moved appropriately. They access regular exercise that is appropriate to their needs and interests. Risk assessments are in place to prevent falls.
17. CONTINENCE	The person maintains their baseline level of continence.	The person maintains their baseline level of continence through environmental changes e.g. clear signage for toilets; regular prompting to use the toilet; and attention to relevant health issues where possible. Continence products are only used when the person needs them.	The person experiences dignified management of incontinence through the use of appropriate aids and continence products.