The *KOMI* Senile Dementia Grading System and Standard Care Planning Guide

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[Abstract]

In order to establish a care system for senile dementia sufferers, it is indispensable to first observe such sufferers and systematically understand their symptoms and behavior from a "caring" viewpoint, rather than simply an analytical viewpoint. However, it is also important to present objective and scientific guidelines for care in order that the carers can share the same understanding about the sufferers' needs and thus provide consistent care.

This study attempts to seek the analytic criteria for senile dementia sufferers from such a care-oriented viewpoint. We have developed a chart called the "KOMI Chart" and utilized it to observe and collect data about the sufferers' symptoms and behavioral patterns. For example, the maximum score for the cognitive check points in this chart is set at 77; achieving this score would suggest that the individual has sound cognitive functions. According to the degree of cognitive malfunctioning, the sufferers can be categorized into six groupings: Groups A to F, depending upon the scores achieved. In the trials that we conducted, we categorized the sufferers into these six groups using the KOMI chart. Next, we focused on both their lost abilities and remaining abilities, which can also be determined by the use of KOMI Chart, and finally structured a Standard Care Plan for each of the six groups. The effectiveness of these Standard Care Plans is now being verified, and we are hoping to utilize the Chart and Plan set for all senile dementia sufferers in care.

[Key Words]

Dementia, KOMI chart, Grading system, Standard Care Plan

Preface

Purpose of the KOMI Senile Dementia Grading System

Senile Dementia is a typical illness of geriatric regression. In the current situation where the elderly population is rapidly increasing, among the various geriatric illnesses senile dementia in particular requires urgent investigation concerning its development. No specific treatment has been developed for this illness, nor has any specialized care approach been clearly proposed, despite high social expectations. At present, care for dementia sufferers wholly relies upon the individual carer's skills and approach.

The criteria currently used to determine the degree of dementia have all been developed by doctors. Although these criteria are useful to theoretically diagnose the level of dementia, they cannot provide a great deal of help to carers in planning the everyday schedules for dementia sufferers and their family

members.

A national insurance system for elderly care has now been launched in Japan, and an official designation system for public care requirements has been introduced. However, the coverage of such a designation system is not sufficient for practical care requirements. Senile dementia does not have such a significant effect on the sufferer's physical freedom, unless the illness is at an advanced stage. Thus, sufferers often appear to be healthier and more self-controlled than they actually are. Because the current care designation system focuses on support for the care recipient's physical difficulties, it cannot adequately be used to make care plans for senile dementia sufferers.

This is why specialized criteria for care planning for senile dementia sufferers is essential.

This publication offers a grading system for senile dementia sufferers that makes use of the conventional KOMI Chart. This KOMI Senile Dementia Grading System enables us to determine 6 grades of dementia by referring to the number of marks in the Cognitive Condition in the KOMI Chart. Details are also provided about the grading system, and the process of establishing the standard care plans for each grade of senile dementia sufferer through utilizing the information provided by the grading system, the associated Standard Care Planning Guide, and the conventional KOMI Radar Chart.

By working through this process, appropriate care plans based on common objective criteria can be created by anyone involved in the care of dementia sufferers.

Direction and Expectations concerning Research into the Care System for Senile Dementia Sufferers

I am confident that our research on the development of a grading system for senile dementia and the standardization of care planning introduced in this publication will make a significant contribution to the care environment in Japan. The direction and expectations of our research can be summarized as follows:

1) In Japan, senile dementia has been generally categorized into three levels: *mild*, *moderate*, and *severe*. The KOMI Senile Dementia Grading System introduces 6 levels or grades, from A to F, thus enabling more individually-tailored care services.
2) Although the KOMI Senile Dementia Grading System is designed to indicate the level of dementia, it does not mean that each individual's dementia condition always follows a course of decline from A to F. Each grade simply indicates the current state of the individual. If appropriate care is given, the grade should improve. The KOMI Senile Dementia Grading System provides a visual scale that presents the positive correlation between appropriate care and the sufferer's condition, and, accordingly, the importance of such care.
3) The KOMI Senile Dementia Grading System can be applied to anyone who has been diagnosed with senile dementia. It also can be used in any situation – it does not matter whether the individual is at home, in hospital, or in a care home. It therefore provides a common standard that can be used in a variety of situations.
4) After determining the grade of dementia, a standard care plan can be easily created using the Standard Care Planning Guide, which is provided as part of the KOMI Senile Dementia Grading System.

5) This system does not require any specialized knowledge, nor does it insist upon a certain type of professional to define the care plan.
6) Marking the Cognitive Condition in the KOMI Chart is an important prerequisite of the KOMI Senile Dementia Grading System. Also, the general use of the KOMI Radar Chart for practical care planning for sufferers is essential.
   The KOMI Senile Dementia Grading System only requires that its users have a certain systematic understanding of KOMI theory and the KOMI Chart System.
7) To provide care for a senile dementia sufferer, it is essential to have an overall awareness of the lifestyle of the sufferer and his or her family members. In addition to such observations, a sufficiently specialized knowledge of senile dementia is important in order to make appropriate use of the KOMI Senile Dementia Grading System. The right care for senile dementia sufferers can be achieved only with this thorough background.

We believe that the findings obtained through our research are already at the stage where they can be applied in practice. We sincerely hope that our KOMI Senile Dementia Grading System and its associated Standard Care Planning Guide will be utilized and its effectiveness verified by carers themselves.

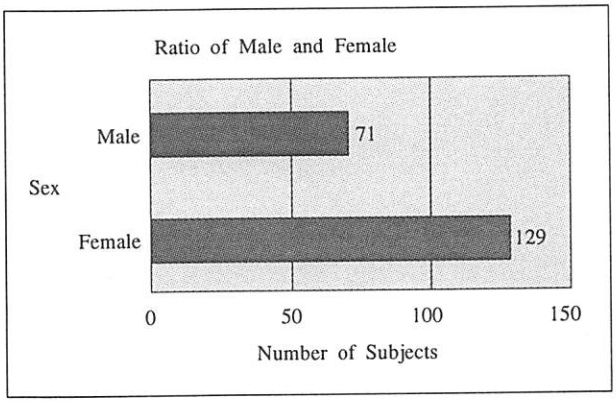
1. Method of Investigation

The following method was used for our investigations:

(1) Divide the senile dementia sufferers into groups according to their score in the Cognitive Condition chart and the characteristics of their mental behavior. Study each group in detail to determine whether there is any significant correlation between the score and their symptoms.
(2) Through the study, attempt to understand how the marked Cognitive Condition in the KOMI Chart can define the state of dementia sufferers, and establish the pathway to utilize this information to create care plans for individual sufferers.
(3) Establish a Standard Care Planning Guide that enables the creation of care plans that are suitable to each group of sufferers.

2. Subjects

Subjects were selected by opportunity sampling throughout Japan. All selected subjects were patients who were medically diagnosed as suffering from dementia; however, the cause of their dementia was ignored.



3. Results

(1) Details of Subjects

- Valid number of subjects: 200
- Ratio of male and female:
  71 males: 129 females

- Age Range

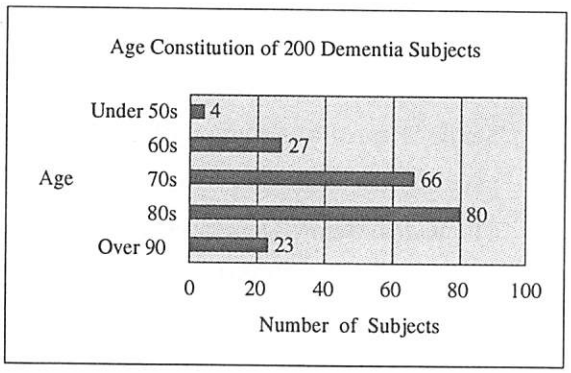
  Under 50: 4

  60s: 27

  70s: 66

  80s: 80

  Over 90: 23

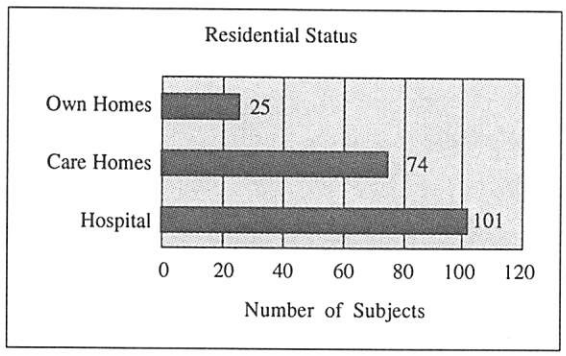


- Residential Status

  Own Homes: 25

  Residential Care Homes: 74

  Hospital: 101



(Residential care homes include health facilities for the elderly, nursing and welfare facilities for the elderly, and sheltered accommodation)

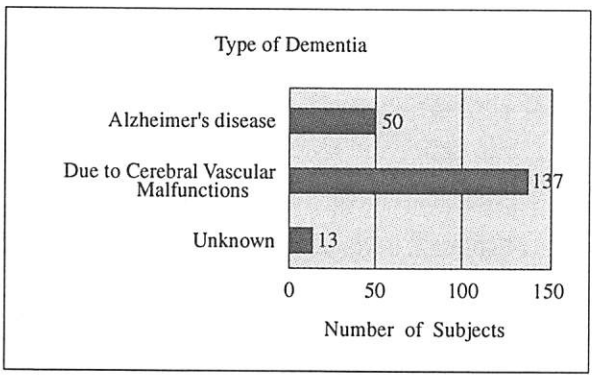
- Type of Dementia

  Alzheimer's disease: 50

  Due to Cerebral Vascular

  Malfunctions: 137

  Unknown: 13



- Period of Affliction

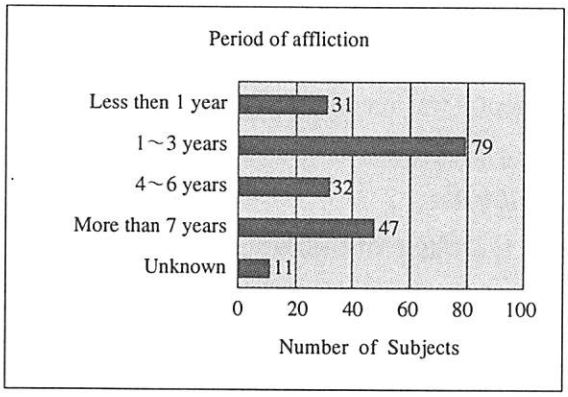
  Less than 1 year: 31

  1-3 years: 79

  4-6 years: 32

  More than 7 years: 47

  Unknown: 11



(2) Categorization of Dementia Sufferers

In order to categorize the subjects into groups according to their current cognitive ability, we first focused on the amount of blank marks in the Cognitive Condition chart included in the KOMI Chart. Such blank marks indicate that a subject cannot understand or perform a certain activity by themselves. The Cognitive Condition chart consists of 15 check lists, and each list comprises 5 checkpoints. We focused on the subjects whose 5 checkpoints were all marked as blank, which indicates that a series of activities are severely affected by their dementia. Next, we divided these subjects into 6 groups according to the total number of such totally blank check lists.

Table 1 shows the percentage of subjects who have at least one fully-blank check list in each group and the names of the check lists that marked the highest number of full blanks.

Table 1

Groups (Number of Subjects)	First Sector	Check List Name	Second Sector	Check List Name	Third Sector	Check List Name
Group A (37)	0%		0%		0%	
Group B (40)	0%		0%		48%	Change*1 Tasks*2 Finance*3 Health*4
Group C (45)	7%	Excretion*5 Movement*6 Sleep*7	26%	Cleanliness*8 Clothing*9 Appearance*10	77%	Change Tasks Finance Health
Group D (41)	15%	Respiration*11 Excretion Movement	70%	Cleanliness Clothing Appearance	90%	Change Tasks Finance Health
Group E (21)	71%	All lists	90%	All lists	100%	All lists
Group F (16)	94%	All lists	100%	All lists	100%	All lists

Note: The formal names of the check lists and their corresponding number in KOMI Chart are as follows:

*1) 12. Making Changes in Daily Life
*2) 13 Daily Tasks
*3) 14 Financial Administration
*4) 15 Health Management
*5) 3 Excretion
*6) 4 Physical Movement
*7) 5 Sleep
*8) 6 Physical Cleanliness
*9) 7 Clothing and Laundry
*10) 8 Attention to Appearance
*11) 1 Respiration

(3) Raw Data concerning Cognitive Condition and Physical Condition Scores

Tables 2 to 5 shows the lists of Cognitive Condition scores and Physical Condition scores for each subject. These are the number of shaded marks, which means that the patients can understand and perform those particular tasks or functions unaided. Table 2 shows the total scores of the Cognitive Condition and the Physical Condition for all subjects. Tables 3 to 5 are for those who reside at home, in care homes, and in hospitals, respectively.

Table 2

Cognitive and Physical Condition Scores

for All Subjects

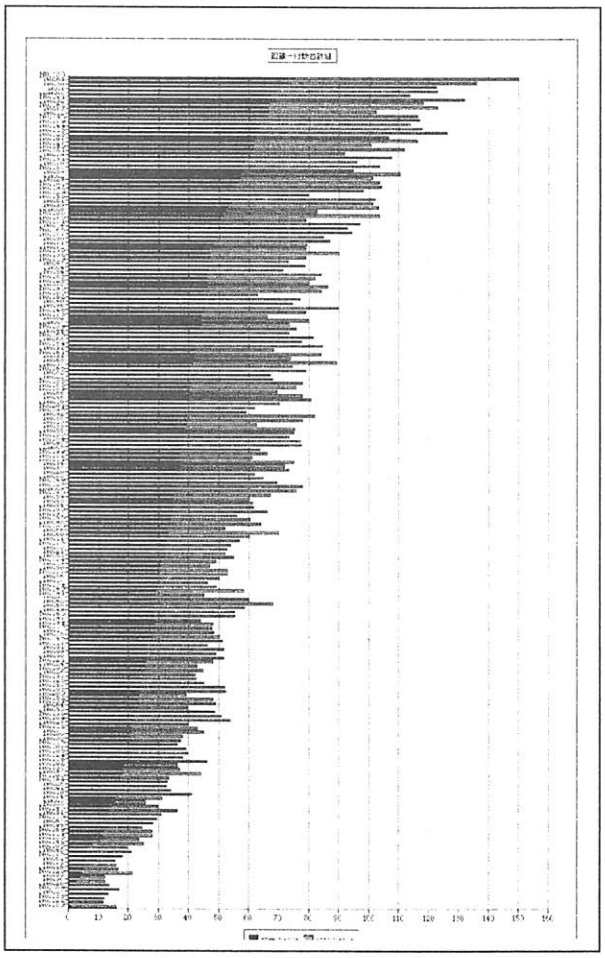
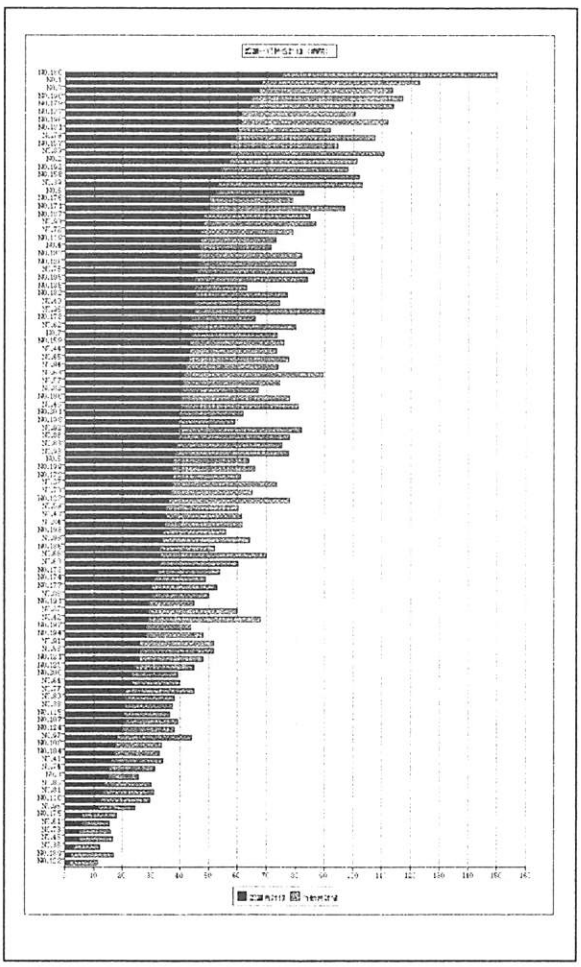


Table 3:

Cognitive and Physical Condition Scores

of Hospital Residents



■ Total of Cognitive Condition Scores □ Total of Physical Condition Scores

Table 4:

Cognitive and Physical Condition Scores

of Care Home Residents

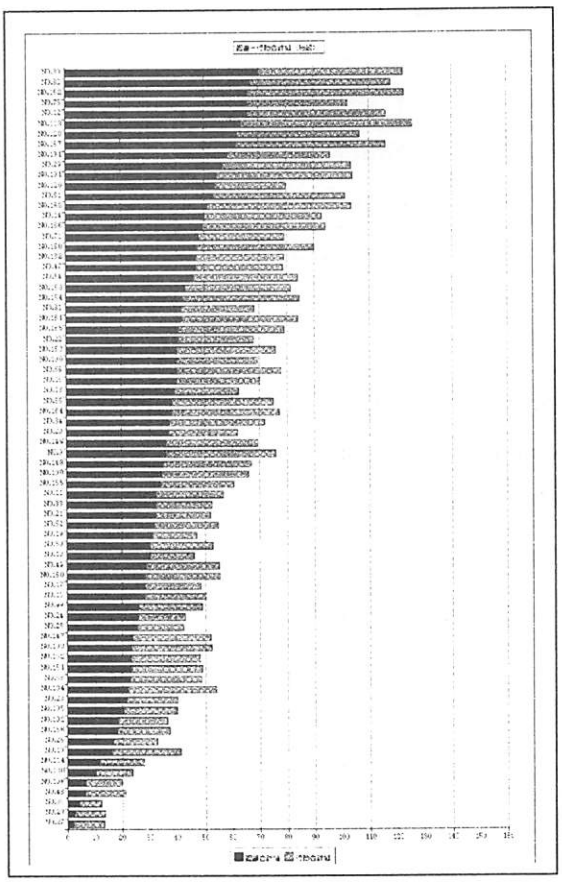
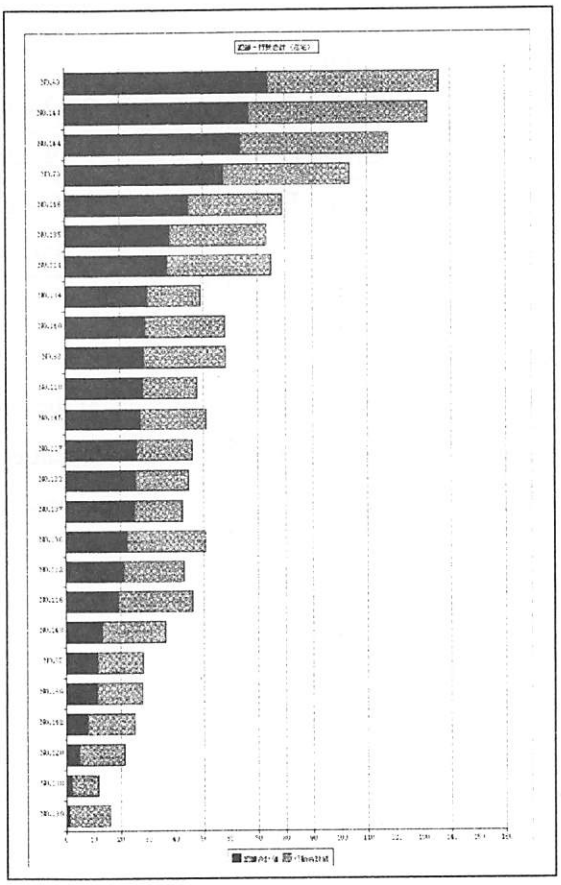


Table 5

Cognitive and Physical Condition Scores

of Home Residents



■ Total of Cognitive Condition Scores ▨ Total of Physical Condition Scores

(4) Categorization of Dementia Sufferers

This section shows the grouping of the dementia sufferers based on the number of shaded marks in the Cognitive Condition in KOMI Chart.

Table 6 *KOMI* Senile Dementia Grading System

Group	Number of Shaded Marks	Grade Names
Group A	77.0 - 50.0	Memory-Loss Period
Group B	49.9 - 40.0	Toilet-Accident Period
Group C	39.9 - 30.0	Confused Period
Group D	29.9 - 20.0	Disoriented Period
Group E	19.9 - 10.0	Withdrawn Period
Group F	9.9 - 0	Deranged Period

(5) Group Features

Here we focused on the following aspects of the subjects and listed the features of each group:

- Symptoms that affect the subjects' independence in their daily lives.
- Symptoms that affect the support from carers and family members.

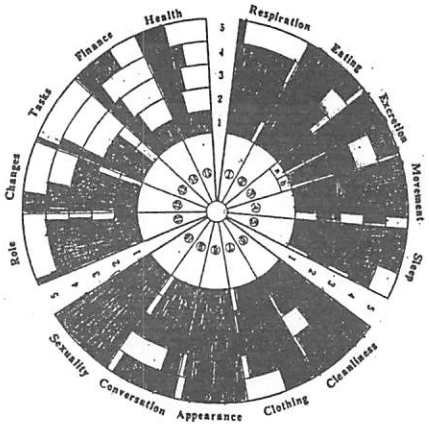
Table 7 Disturbing Symptoms and Their Percentages in Each Group

	Group-a	Group-b	Group-c	Group-d	Group-e	Group-f
Number of Shaded Marks in Cognitive Condition	75-55	49.9-40	39.9-30	29.9-20	19.9-10	9.9-0
Number of Subjects /Total (200)		**40**	**45**	**41**	**21**	**16**
Symptoms						
Memory Confusion (Short Term)	95%	85%	87%	98%	90%	75%
Memory Confusion (Long Term)	51%	65%	67%	66%	90%	69%
False Cognition	51%	65%	73%	73%	67%	63%
Incontinence (Urine)	19%	45%	67%	63%	81%	81%
Incontinence (Feces)	5%	43%	60%	56%	81%	81%
Wandering	3%	23%	31%	32%	24%	25%
Public Urination	3%	10%	22%	10%	29%	0%
Toying with Feces	3%	8%	20%	12%	24%	0%
Irrational Demand to "go home"	24%	13%	27%	5%	10%	0%
Refusal of Family Support	11%	15%	9%	27%	4%	13%
Lack of Voluntary Actions	19%	15%	31%	32%	43%	50%
Lack of Sleep	24%	15%	27%	24%	14%	13%
Lack of Motivation	24%	8%	22%	44%	52%	25%
Unable to Respond	0%	0%	2%	2%	10%	44%
Unable to Recognize People	0%	10%	16%	29%	62%	75%
Bedridden	0%	3%	7%	15%	19%	38%
Bedridden,Unable to Recognize People,and Unable to Respond	0%	0%	0%	0%	0%	25%

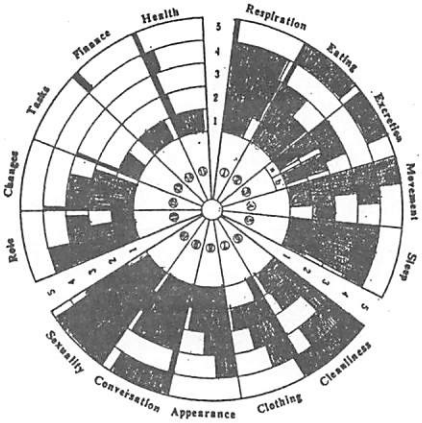
(6) Average Scores in the Cognitive Condition of KOMI Charts Corresponding to Each Group

(Figure 1)

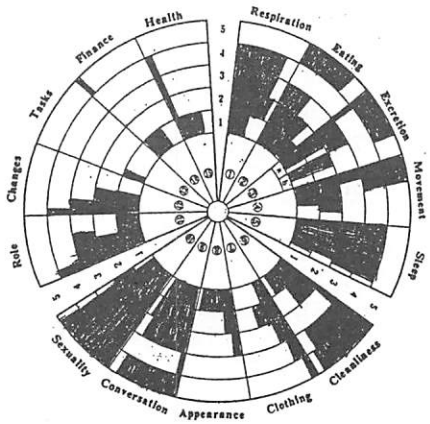
Group A



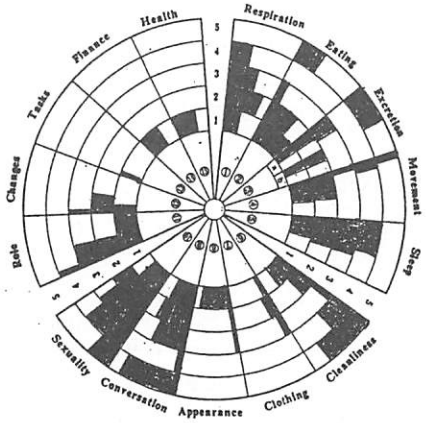
Group B



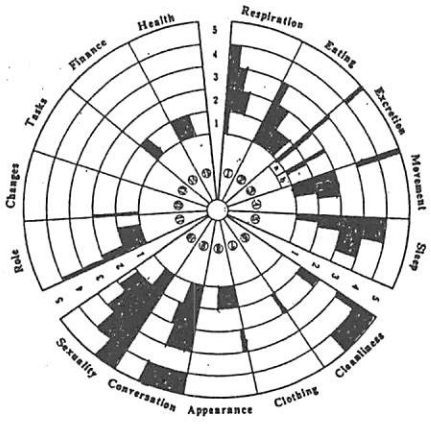
Group C



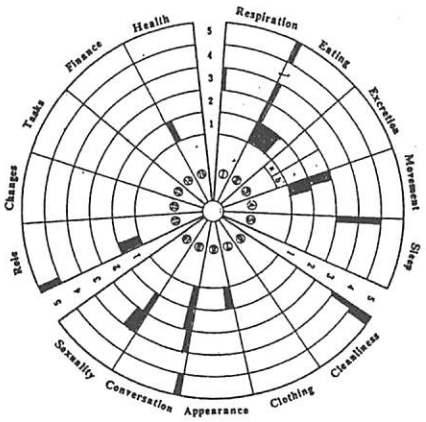
Group D



Group E



Group F



4. Findings

Through our studies to date, we have identified the following points:

1) Using the number of shaded marks in the Cognitive Condition of the KOMI Chart, it is possible to grade the progress of senile dementia into 6 different levels.
2) This grading is based on the percentage of dementia sufferers who have at least one completely blank check list among the 15 different check lists in the Cognitive Condition of KOMI Chart in each group.
3) We also found that there was an order in the appearance of completely blank check lists. We found that completely blank lists tend to appear first in the Third Sector of the Cognitive Condition. Within the Third Sector, "(13) Daily Tasks" is most likely to be first marked totally blank. Next, "(14) Financial Administration," "(12) Making Changes in Daily Life," and "(15) Health Management" tend to follow. This order of appearance was the same in both groups that had a high independence factor in their lives and in the group with a low independence. After this, completely blank lists are likely to appear in the Second Sector. Within the Second Sector, the order of appearance is "(6) Physical Cleanliness," "(7) Clothing and Laundry," and "(8) Attention to Appearance."
4) The following cognitive functions are relatively well-preserved through the progress of senile dementia.
    - Able to feel comfortable in sunlight
    - Able to understand about food
    - Able to feel hunger
    - Eager to move or walk
    - Able to feel refreshed after having bathed.
    - Able to feel pleasure when hairstyles or clothes are praised
    - Eager to talk or express.
    - Able to understand own sex.
    - Feels physical contact comfortable
    - Able to understand themselves
    - Able to notice problems in physical or mental condition
5) As the grade develops from A to F, the number of shaded marks in the Cognitive Condition in the KOMI Chart decreases and the number of blank marks increases.
6) The number of shaded marks in the Cognitive Condition in KOMI Chart can be an indicator of the level of dementia.
7) Because there is some regularity in the order of appearance of the symptoms for each group, the progress of dementia can be predicted by grasping the current symptoms and condition. In other words, the symptoms of dementia increase through the groups (grades) A to F.
8) Attributes of each groups can be described as follows:
   95% of subjects in Group A showed short-term memory loss, and more than 50% of subjects showed long-term memory loss or confusion, and/or false cognition (memory-loss period).
   Group B's main attribute was toilet problems as well as sharing the same attributes as Group A.

50% of subjects suffered from incontinence and 23% of subjects suffered from wandering (toilet-problem period).

Group C shared the attributes of Group A and B, and thus the following groups incrementally shared the same attributes as the previous groups. Subjects in Group C revealed a variety of problems that are commonly observed in the progress of dementia, such as frequent wandering, irrational demand to "go home," lack of sleep, public urination, toying with feces, and lack of voluntary actions (confused period).

Group D was in the period when the subjects showed various types of problematic behavior frequently. The main attribute of this group was that the subjects could not recognize their family members and refused support from them. Their loss of motivation was also particularly significant. Care at home becomes difficult in this stage (disoriented period).

In Group E, the increase of mental regression, such as lack of voluntary actions and motivation were observed, in addition to the remaining problems such as memory loss and physical decline, including incontinence. 19% of Group E were in a state in which they could not leave their beds.

25% of subjects of Group F showed the three symptoms simultaneously: bedridden, unable to recognize others, and unable to respond. However, as shown in Table 7, Group F subjects showed a lower percentage for the appearance of short-term memory confusion compared to Group A. Also, the percentages for other symptoms, such as long-term memory confusion, false cognition, and lack of motivation were less than Group F and closer to those figures of Group A. This gives the impression that the subjects' symptoms had improved; however, this may only be due to a lack of attention to those symptoms by the recorders. It is more likely that the subjects who have the symptoms of being bedridden, unable to recognize others, and unable to respond, also have basic problems such as memory confusion and lack of motivation (deranged period).

9) Distribution of different groups of senile dementia sufferers were approximately the same for all residential situations: homes, care homes, and hospitals.

10) The percentages of subjects who belonged to the highly independent grades (Groups A and B: 77 people) in each residential situation were 32% at home, 40% at care homes, and 42% at hospitals. This suggests that the distribution of highly independent dementia sufferers is relatively even for all residential situations.

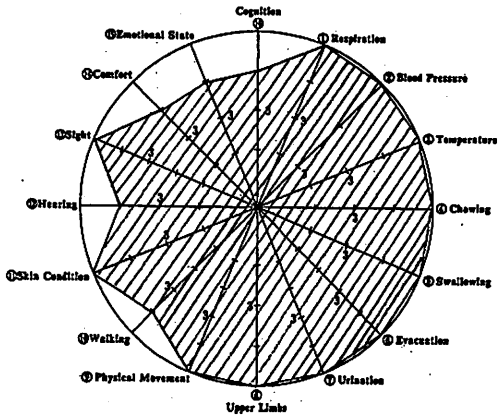
11) The percentages of subjects who belonged to the highly dependent grades (Groups E and F: 37 people) in each residential situation were 20% at home, 15% at care homes, and 18% at hospitals. These figures suggest that even highly dependent sufferers can remain at home as far as they and their family members can receive appropriate care support.

12) The percentages of subjects who belonged to Group C (45 people) in each residential situation were 22% at home, 40% at care homes, and 55% at hospitals. In this stage, the subjects were experiencing the most disoriented period, with frequent symptoms such as false cognition, wandering, and irrational demand to "go home." From these figures we can see that this is the most difficult period in which to provide sufferers with care at home.

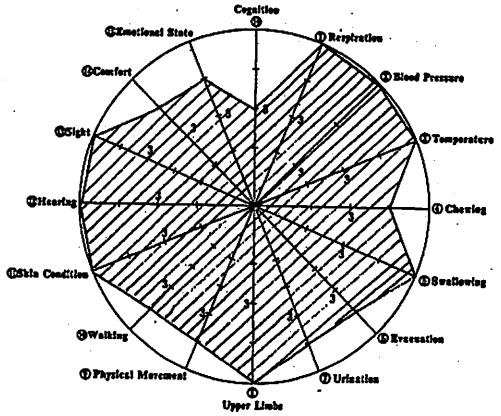
5. Establishment of Standard Care Planning Guides for Each Group

(1) Characteristics of Each Group's KOMI Radar Chart Distribution (Figure 2)

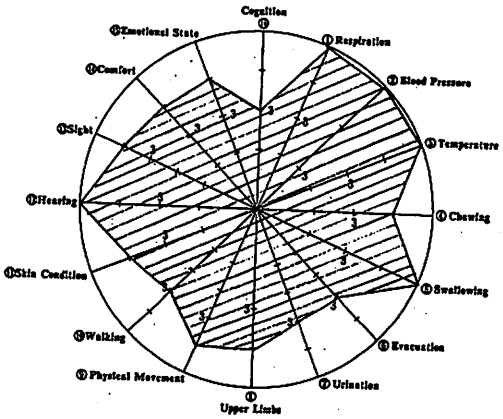
Group A



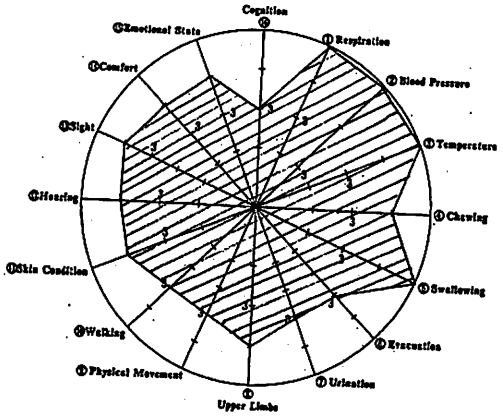
Group B



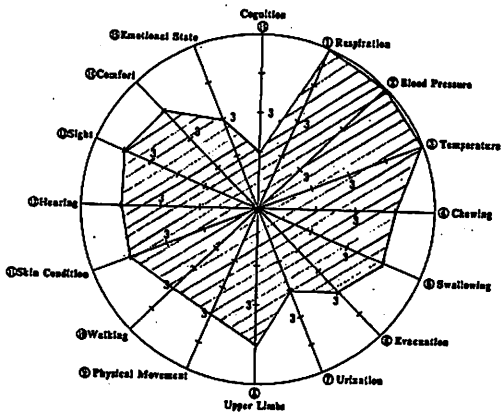
Group C



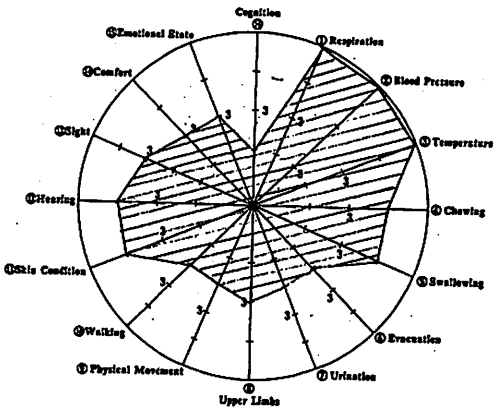
Group D



Group E



Group F



(2) Missing Cognition and Remaining Abilities

1) Group A

(i) Missing Cognition

- Many cannot understand how to use electric appliances, such as vacuum cleaners and air conditioners.
- Many cannot understand what is the best food for their health.
- Many cannot manage themselves when they have excretory problems.
- Many cannot understand what to do about their sleeping problems.
- Weak motivation for washing clothes.
- Confused memories.
- Decrease in ability for daily tasks and chores.
- Lack of financial competence.
- Decrease in ability to manage their health.

(ii) Remaining healthy abilities

- Physically in good condition.
- Cognitive abilities are sufficient to carry out daily routines.
- Able to socialize through conversation or going out.
- Interested in their appearance and able to express themselves through their appearance.
- Show consideration to the others.
- Maintain their independence and help themselves.
- Enjoy small changes in daily life and show a desire for such changes.
- Able to handle daily money and purchase what they need.
- Able to report their health problems and have a desire to maintain their health.

2) Group B

(i) Missing Cognition

- No interest in the quality and quantity of food and tend towards over- or under-eating.
- No understanding of the right place for their toilet requirements and tend to have toilet accidents.
- Decrease in desire to move, or start wandering.
- Unconcerned about cleanliness of their bodies or about bathing.
- No interest in appearance, therefore unable to express themselves through their looks.
- Confused memories causing conversation to be incomprehensible.
- No ability concerning daily judgments and daily problem solving.
- No ability to perform calculations and increased difficulty in daily finance management.
- Loss of health-management ability.

(ii) Remaining healthy abilities

- Just able to manage daily routines.
- Sufficient awareness of comforts such as enjoying the sunlight and feeling refreshed.
- Healthy appetite.
- Upper limbs are free to move (although the lower limbs are weak).
- Desire for communication and show consideration to others.
- No auditory or visual problems.
- Able to notice problems in physical or mental condition.

3) Group C

(i) Missing Cognition

- Eats only when fed. No voluntary intention to eat.
- No recognition of requirement for excretion. Increase in toilet accidents and other problematic behavior related to excretion.
- Increase in wandering or self-confinement.
- Decrease in the will to change clothes and increased indifference to appearance.
- Often becomes distressed when holding a conversation. Communication becomes difficult.
- Significant drop of interest in keeping room tidy, financial management, and health management.

(ii) Remaining healthy abilities

- Cognitive ability enough to maintain ability of daily life (ADL).
- Able to swallow.
- Able to distinguish day from night and have the will to get up.
- Desire to bath and able to feel refreshed after a bath.
- Despite lack of interest in appearance, still feels happy when their appearance is praised.
- Normal interest in sexuality.
- Clear self-recognition.
- Able to feel boredom or discomfort in uneventful periods and has a desire for changes.
- Able to understand concept of money and retain an interest in shopping.

4) Group D

(i) Missing Cognition

- Cognitive ability has declined to about one-third of a normal adult's cognitive ability.
- Problems are observed in a wide range of areas in daily life.
- Individuality is completely lost.
- Uncontrollable wandering or self-confinement.
- No voluntary ability to communicate or socialize.

(ii) Remaining healthy abilities

- One-third of healthy abilities is left.
- Able to understand food and feel hunger.
- Able to swallow.
- Many still feel embarrassment to receive support for cleaning body or excretion.
- Able to feel refreshed after having bathed.
- Able to feel happy when praised.
- Conversation is hard to hold, but still have a relatively strong desire to communicate.
- Many still understand the concept of money.

5) Group E

(i) Missing Cognition

- Excretion is not self-supported. Not able to feel the need for excretion, nor the end of excretion. Do not understand the toilet and may be totally incontinent.
- However, the radar chart usually shows that the condition of defecation is better than urination.
- Will to move has declined and tendency is to confine themselves.
- Lack of desire to bath.
- No interest in appearance or cleanliness.
- Decrease in desire to communicate.
- Loss of self-recognition.

(ii) Remaining healthy abilities

- Basic life mechanisms such as respiration, blood pressure, and temperature.
- Able to feel comfortable in sunlight and fresh air.
- Able to understand food.
- Slight desire for movement and getting up.
- Conversation is difficult, but still responsive.
- Able to understand their sex and enjoy physical contact.
- Slight ability to notice problems in physical or mental condition.

6) Group F

(i) Missing Cognition

- 95% of abilities have been lost.
- Bedridden or self-confined.
- No self-expression.
- No conversation.
- All the decisions necessary to maintain their life rely upon others.

(ii) Remaining healthy abilities

- Normal breathing, blood pressure and temperature. Life is self-supporting.
- Able to understand food.
- Barely able to feel refreshed after having cleaned.
- Able to hear voices and sounds.
- Occasionally able to recognize themselves and others.

6. Establishment of Standard Care Planning Guide

(1) Principles of Standard Care Planning

1) Do not focus only on the missing abilities

2) Make the best use of remaining healthy abilities

3) Support clients' human dignity

4) Provide comfortable stimuli

5) Maintain a familiar environment and lifestyle

(2) Standard Care Planning Guide for Each Group

1) Group A

- They are able to maintain their life as long as it is within a familiar environment and lifestyle. Support their voluntary will for an independent life.
- Encouragement is important to maintain their confidence. (Do not blame or scold.)
-Identify concrete tasks for which the client needs support, and provide help only for those tasks and in a casual manner

2) Group B

- Create a daily program that will enhance the client's remaining abilities to the maximum within the range of the client's familiar environment and lifestyle.
- Create occasions when they can communicate with people in a friendly atmosphere.
- Create occasions when they can enjoy nature or touching animals.
- Listen carefully to their complaints about health issues.

3) Group C

- Create a daily program that enables the client to perform the tasks that they still can manage in order to encourage their independence.
- Provide support in such a manner that the client can appreciate their participation and importance to society.
- Do not take a negative attitude to their problematic behavior, or criticize them for it.
- Their voluntary participation may be low, but they are still responsive to external stimuli. Provide comfortable stimuli such as conversation that recalls their past, music, humorous chat and jokes.

- Encourage social involvement.

4) Group D
- Create an environment in which the client can feel secure and stable.
- Remove dangers from their environment.
- Do not dwell on the effects of the client's problematic behavior. Focus on their healthy abilities and program daily tasks to suit their remaining powers.
- Do not isolate, restrain, or leave the client alone.
- Do not overuse medicines.

5) Group E
- Provide a safe and comfortable environment, keeping the client's life cycle regular and at their own pace.
- Dementia sufferers lose their motivation in this stage, but continue to provide moderate stimulus to maintain their attention and prevent them from becoming isolated.
- Maintain regular physical contact so that they can feel secure through human contact.
- Plan small strolls and outings so that they can enjoy the sunshine and fresh air.
- Prepare processed foods so that they can continue to enjoy eating.
- If the client is fond of some particular things, keep them in the client's environment.

6) Group F
- Create a comfortable environment where the client can keep a close contact with the client's family so that he/she can spend a peaceful time right up to the last moments.
- Pay close attention to the quality of contact with the client. Do not neglect their human dignity.
- Appreciate any remaining abilities and support them positively.

7. Findings from Establishing the Standard Care Planning Guide

(1) The six groups categorized by the KOMI Senile Dementia Grading System showed clear characteristics in the Cognitive Condition of the KOMI Chart. It was relatively easy to describe their characteristics in words.

(2) It was found that contrasting the KOMI Radar Chart with the Cognitive Condition in the KOMI Chart was helpful, because the state of the physical condition shown in the KOMI Radar Chart revealed a correspondence with the state of the Cognitive Condition in KOMI Chart at each stage of senile dementia.

(3) Through the study of contrasting the KOMI Radar Chart with the Cognitive Condition in the KOMI Chart, it was found that the clients' physical conditions stay relatively healthy compared to

their cognitive state. The clients graded as Groups C and D in the KOMI Senile Dementia Grading System experience a confused or disoriented period in the aspect of cognition, and therefore require a significant amount of support. However, their physical conditions are generally healthy and this tends to create the inaccurate impression that they do not need much support. Careful overall observation is essential to provide the right level of support.

(4) Through developing the Standard Care Planning Guide, five principles of care planning emerged. These five principles can be applied to each group of clients.

(5) The Standard Care Planning Guide was established based on the characteristics of each group, as identified using the Cognitive Condition of the KOMI Chart and the KOMI Radar Chart. This Standard Care Planning Guide can be used as soon as the grade of the client has been determined using the KOMI Senile Dementia Grading System.

(6) The Standard Care Planning Guide is merely a basic guideline for creating a care plan for each group of clients. The actual care plan should of course be tailored to suit the individual requirements of the client's situation.

8. Conclusion

A summary of the order of making care plans for senile dementia sufferers is shown below:

(1) Accurately mark the Cognitive Condition in the KOMI Chart.

(2) Mark the KOMI Radar Chart.

(3) Count the fully-shaded lists of the Cognitive Condition of the KOMI Chart and refer to the KOMI Senile Dementia Grading System to determine a grade for the client.

(4) Based on the Standard Care Planning Guide that matches the determined grade, create a care plan taking into consideration the client's individual conditions.

Reference

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