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Care Models

Learning and Teaching Resources

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CARE MODELS

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1. DESCRIPTION OF CARE MODELS

a) Medical model

The medical model views dementia as a clinical syndrome characterised by cognitive impairment. It focuses on the disease and the treatment rather than the individual. Treatments are decided by professionals whose knowledge focuses on a medical approach to manage the disease. The person has little control and choice in the decisions. The medical model maintains exclusion and creates dependency of the person.

b) Social and Person-centered Models

The Social model views Dementia as an impairment, focusing on the individual, ensuring that their skills and capabilities are retained. The social model recognises the importance of support for individuals, to allow them to have a quality of life in their own environments. The model understands the emotions and behaviors of the person with Dementia, and knowledge of the individual's background and personal history can help shape their support and care.

As Dementia affects functions such as memory, orientation, understanding and judgement it is therefore important to focus on the person rather than the disease. Care workers should ensure that care is person centred, and Kitwood suggests that "we should take the perspective of how the person with Dementia views their life, rather than our perspective of how they should lead their lives" Kitwood's concept of person centred care is "personhood" Personhood is a recognition of the value of all human beings, and is a status that one individual bestows upon another.

Personhood can be supported by a variety of different methods, and interventions, to enable individuals to live independently. Care workers need to have an understanding then, of what is important to the person, their life history, how they communicate, their preferences and beliefs.

In the following lines you will find some examples of different social care models:

Snoezelen

The Snoezelen method works as a self-care methodology. It is a philosophy of working with people with dementia and can also be applied when there is no disease with the aim of providing physical and psychological well-being.

The method concerns from adapting spaces and their conditions (lighting, temperature, noise etc) in such a way that it provides tranquility, going through each and every one of the activities of daily life (way of awakening the person with dementia, of grooming him /

her, not breaking routines, know how to feed him/her stimulating and promoting his/her appetite, stimulating with elements of daily life etc ...), to become a concrete method of sensory stimulation thanks to psychostimulation rooms.

An essential resource for the development of this methodology is the SNOEZELEN stimulation room:

The main objective of this multisensory space is to learn to "re-encounter" with the person suffering from some type of dementia by creating verbal and non-verbal relationships. Thus, Snoezelen, as an environment of multisensory stimuli, allows you to enjoy the stimulation of the senses and enjoy a time specifically dedicated to relaxation and self-search.

They allow to treat mainly recreational, therapeutic, social and educational aspects. There are three types of Snoezelen Room:

- the white room, which is characterized by the absence of color to highlight the elements on which we want the person to focus their attention and whose main objective is stimulation;

- the Black Room, which aims to facilitate learning, movement and stimulation by means of black light and the different colors that shine under its focus;

- the Adventure Room, where perceptivomotor and sensory stimulation is worked through the different materials present in the room, ropes, balls, panels and other instruments that encourage movement and exploration.

The SNOEZELEN environments offer a multitude of sensory experiences:

- Effects of light (eg bubble tubes, optical fibers, etc.)

- Variety of sounds

- Stimulating aromas

- Tactile experiences (eg interactive panels, etc.)

- Vibrational sound sensations

- Massage and vibration

- Smooth movement

- Different and numerous activities

- Opportunities to encourage interaction and participation

In people who suffer from some type of dementia, cognitive components such as memory, attention or language are worked; sensory components (primary senses, vestibular and proprioceptive sense); motor components such as fine and gross motor, as well as coordination or laterality; and psychosocial components, thanks to which a clear decrease in anxiety and aggression is achieved, while promoting social skills.

The sessions are conducted individually or in small homogeneous groups, and have an approximate duration of between 30 and 40 minutes. The stimuli are added one by one, creating new sensations, mainly using nonverbal language to give meaning to the situational context of each session.

The expected results include:

- Relaxation and stress reduction in anxious and / or altered patients.
- Creation of a safe environment for patients, where they can express themselves without limitations
- Improvements in terms of communication channels in patients.
- Improvement in the relationship between family and / or caregiver and patient.
- Greater understanding of the sensory perception of the individual.
- Modifications in difficult behaviors.
- Better concentration and cognitive integration
- More social interaction.
- Improvement in the mood and the perception of the pleasant, simultaneously reducing sadness and fear.
- Reduction of altered behavior.
- Positive effects on the staff's mood.

The Snoezelen method can be applied in any area of care of the elderly, from residential centres, day centres to even in-home care.

To be able to apply it correctly, it is essential to adapt the work methodology of the caregiver, the conditioning of the space and the correct use of resources or supports.

In relation to the caregiver's methodology, we would be referring to the way in which the caregiver performs his care functions. The method implies that the caregiver respects the time of the patient, be a "companion" of the elderly person not only responsible for care (grooming, feeding etc.), provide a relaxed atmosphere (adequacy of voice tone, times, movements soft, care of non-verbal communication ...) and become, within the times of care, a stimulating resource suited to the individual needs of each patient and each specific moment (use of toilet for the memory of the parts of the body, the experimentation of odours with soaps or reminiscence through food could be examples of this).

In reference to the conditioning of the space, to follow this method, it is essential that the space is an orientation for the elderly person and that it promotes the maintenance of the routines of the person in the most autonomous way possible (placement of orientation posters, signage and labeling, elimination of architectural barriers such as wide furniture or carpets, placement of personal items keeping the same routine etc). For a correct adaptation of the spaces, this method makes a special emphasis in the maintenance of temperature and adequate light promoting the maximum comfort of the person. Starting from the basis that we must first feel good to be able to develop and put into practice our cognitive and sensory capacities. Within this point we would also find the conditioning of a multisensory stimulation room as we have explained in the description of the method, in order to develop to the maximum, the aforementioned capacities of the elder person at all levels.

Finally, it is not only important to have resources that can facilitate the work of the caregiver and promote the desired sensory stimulation of the elderly (lights, projectors, water bed, rolling objects etc ...) but it is necessary to use them correctly to achieve the appropriate results. For this, the training of the caregiver is important. This training would include the training of the caregiver to understand the individuality of the person, since not all people benefit from all the resources. In this way, many resources can be used as relaxing or stimulating elements; according to the needs the use of those should be adapted. At the same time, the caregiver must pay special attention not to fall into overstimulation, knowing how to control times and making correct interpretations of patient reactions.

Montessori

The Montessori method tries to adapt all space and the form of care to how the person wants to be cared for, treated. Starting from its possibilities and favoring the capabilities of the person. Maintain and improve the skills for daily life in a comfortable, known, predictable environment. Use real-life materials that are aesthetically pleasing to generate motivation and interest for interaction. It is based on the development of activities that progress from the simple to the complex.

A key point is the structuring of materials and procedures so that participants can work from left to right and from top to bottom in a progressive manner. Usage of patterns that are parallel to the movements of the eyes and the hand in reading and writing (in Western cultures).

Based on this method, we would also take into account the arrangement of the materials used in the activities developed with the person. From the largest to the smallest and

from most to least quantity. Chop the activities into smaller components and practice with one element at a time.

The Montessori method focuses on people's abilities in this way. It is essential to ensure that participants have the physical and cognitive capacity to manipulate the objects and understand what is required to carry out the task. It is very important to minimize the risk of failure and maximize success. Control the speed of both the language and the movements you use in demonstrating the activity and try to adapt them to the patient's needs.

Butterfly Model

In the UK the Butterfly Model is applied within many care settings. Developed in 1995, by Dr David Sheard, his philosophy is “feelings matter most” and the core belief that people living with Dementia are more “feeling beings” than “thinking beings”. Care homes in this model are divided into small domestic households, to reduce stress and increase wellbeing. This model focuses on emotions and understanding “expressive behaviours” of individuals, replicating home like environments, for example, colours, sensory items and open spaces, including life story profiles and activities related to people’s past lives and interests, looking to create connections and memories.

As Dr David Sheard (2013) states, beginning with Kitwoods original theory of person centredness, the model also draws on ideas from neuro linguistic programming about personal congruence in leadership and emphasizes the need to embed dementia care training in the development of staffs’ emotional connection and emotional intelligence. The Feelings Matter Most model centres on eight key components:

BEING person centred involves helping staff to shift their focus from only doing ‘tasks’ to being able to reach people on the inside.

ENABLING quality of life starts with really seeing, hearing, feeling the lived experience of people. This also involves measuring the minute by minute experiences of people and being determined to improve the moment.

INSPIRING leadership means guiding people away from detached management to a new professionalism of attached leadership. Attached leadership is where people lead from the heart and not just by the hand.

NURTURING staffs' emotions in dementia care, recognises the need to support peoples emotional labour. This centres on fostering positive team relationships whilst requiring the development of an emotion led organisational strategy.

GROWING training that works signals a move away from tick-box courses and awareness level competency training. The new focus is on the development of peoples emotional intelligence through reflection, modelling and coaching.

ACHIEVING real outcomes is all about focusing on policies, procedures and systems as the secondary focus. Balancing and measuring quality of service and quality of life as the primary goal becomes the new focus.

SUPPORTING nurses in dementia care to modernise and to restore compassionate cultures of care is critical. This involves nurses being developed to merge clinical best practice with the new focus of nurses knowing how to lead and personally model person centred care and relationship focused support.

MATTERING in a dementia care home involves centring on the core skills in staff of Feel, Look, Connect and Occupy whilst creating culture change through developing a community based on Share, Reach, Relax and Matter.

2. ADVANTAGES AND DISADVANTAGES OF EACH MODEL

a. Medical Model

The medical model is the model in which the greatest number of disadvantages could be highlighted since it is not designed with the person in mind, therefore, their individual needs would not be covered. This model does not take care of the individuality and does not develop the stimulation of the person, therefore it would be "treated as a better work object" losing the opportunity to develop and keep growing and learning. Of course, the emotional development and adaptation of an accessible and comfortable environment for the person is also not important, which would negatively affect the physical, mental and social well-being of the elderly person.

The only advantage that we can extract from this model is that, not having personal resources with specific qualifications, nor adapted material resources, it would be economically more accessible. Of course, this idea is absolutely irrelevant when we talk about working with people.

b. Social and Person-centered models

Snoezelen

The Snoezelen method, in conforming a methodology of work with the patient, implies both advantages and disadvantages. In this way the method would conform all the philosophy of the workplace with the elder person. This implies the difficulty of being assumed by all workers in a regularized manner and therefore a proper training and involvement on the part of the entire staff is necessary. On the other hand, if a homogenization of the method of care is achieved, the results that have been observed are very positive, especially in relation to levels of relaxation, stimulation, perceived sensation of well-being and improvements in cognitive processes such as perception / attention / memory.

We cannot ignore that one of the most significant disadvantages responds to the economic issue, since this methodology implies the use of resources that unfortunately are not economically accessible by all the centers of attention (multisensory resources, water bed, lighting, image projector etc ...)

Montessori

In the same way as with the Snoezelen method, the Montessori method presents application difficulties since it involves the global restructuring of the traditional method of care that is sometimes complicated to assume by all workers, and the ideal qualification is essential for it. At the same time, the results that can be obtained with this method are very remarkable, especially in the cognitive-perceptive-sensory field.

Although the Montessori method does not imply a priori the acquisition of new resources, but rather a new perspective of the use given to existing ones, the method does involve a restructuring of spaces and times of work that is sometimes difficult to assume within the work routines of the centers where attention is given to elderly people with dementia.

Butterfly Model

In addition to own advantages and disadvantages of the rest of the social methods centered on the person, this model has an added feature that gives it a special advantage. This model ensures that the person does not lose their links when they begin to go to a specialized care center. The customs, the material aspects of the environment where the person lived are maintained and a less level of disconnection with the previous environment and a greater link with the resources and the memory of the past events is reached.

3. LEARNING EVIDENCES

Once we have deepened in relation to the care models, we will reflect in relation to a real case.

The case of Anthony is exposed:

Anthony is an 82-year-old man who has just entered a nursing home because Anthony has Alzheimer's dementia in the initial phase and needs supervision to perform the basic activities of daily life.

Anthony, a retired maths teacher, has always been very sociable, belonged to different social groups in his town and was in charge of organizing different fun events with the help of his grandson Joe. Until about 2 years ago, Anthony has been a very active person, a sports fan (watching and practicing) and music. He collects small model planes (he has a showcase full of models in his house) and has a close relationship with his two daughters (Alice and Mia).

Regarding the case:

What care model do you think is the most suitable to work with Anthony?

Within social models, which one would you choose and Why?

What advantages and disadvantages does each model have regarding Anthony's attention?

What characteristics do you think are necessary in relation to this case?

How could Anthony continue to develop actively despite his illness?

References:

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