Person-centered dementia care

Old hats and new brooms

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A pair of old hats....
Person Centred Care & BPSD
<table>
<thead>
<tr>
<th>Pharmacological interventions</th>
<th>Non-pharmacological interventions</th>
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A pair of old gloves
Person centred Dementia Care

- Roots in Martin Buber, Carl Rogers and Tom Kitwood
- “Dementia Reconsidered: the person comes first” 1997
- Supporting personhood
- Malignant social psychology & positive person work
- The enriched model of dementia
Person centred care & Personhood...

Person Centred Care are the processes by which we maintain the Personhood of those who have dementia.....

“Personhood is a standing or status that is bestowed on one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust....”

Kitwood, Dementia Reconsidered 1997
Person Centred Dementia Care

Shift from

The Person with DEMENTIA

To

The PERSON with dementia

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That old hat PCC

- Its a complex head-piece that has many bits stuck onto it.
- There are a number of different models – all complex and fussy but look similar.
- Is it too much? Would less be better?
- Still gets interpreted as just individualised care.
Behavioural & Psychological Symptoms of Dementia BPSD

IPA Consensus Conference in 1996 task force on behavioural disturbance in dementia.

“the term (BPSD), defined as:

Symptoms of disturbed perception, thought content, mood or behaviour that frequently occur in patients with dementia.” (Finkel & Burns, 1999)
Behavioural & Psychological Symptoms of Dementia BPSD

- **Behavioural symptoms** including physical aggression, screaming, restlessness, agitation, wandering, culturally inappropriate behaviours, sexual disinhibition, hoarding, cursing and shadowing.

- **Psychological symptoms** including anxiety, depressive mood, hallucinations and delusions. A psychosis of Alzheimer’s disease has been accepted since the 1999 conference.
That old hat BPSD

• Few people outside psychiatric services know what it means.
• It is seen as a uniform black hat that lends itself to the “prescription” of an intervention.
• Underplays the complex dynamic nature of problems in context.
• Makes it seem these problems are an inevitable consequence of dementia.
Hold onto the BPSD hat

- BPSD is not a single entity.
- Has enabled focus of treatment and research into the most troubling aspects of dementia.
- They cause enormous suffering; are very common and require careful analysis to identify optimal treatment (Lawlor, 2002)
- Factor analysis of NPI (Petrovic et al, 2007) identified four factors.
Hold on to the person centred care hat

• There is a difference between person centred care and an intervention
• PCC it is not a single intervention
• Person centred care provides a set of guiding principles for our actions that enable people with dementia to maintain their personhood.
• Person centred care makes the occurrence of BPSD less likely
Person Centred Care Practice

V = Values people
I = Individual’s needs
P = Perspective of service user
S = Supportive social psychology


NICE-SCIE Guidelines on Dementia
2006 Person centred care

- Values and promotes the rights of the person
- Provides Individualised care according to needs
- Understands care from the Perspective of the person with dementia
- Social environment enables the person to remain in relationship
Guiding Principles

- Do my actions show that I respect, value, and honour this person?
- Am I treating this person as a unique individual?
- Am I making a serious attempt to see my actions from the perspective of the person I am trying to help? How might my actions be interpreted by them?
- Do my actions help this person to feel socially confident and that they are not alone?
PCC: It’s what you do and it’s the way that you do it ...

V = **Values** people

I = **Individual’s needs**

P = **Perspective** of service user

S = **Supportive** social psychology

- A music group
- Aroma therapy
- Helping someone eat
- Inserting a catheter
- Running a care home
- Running a memory clinic
- Doing an assessment
### The Person-Centred Care Provider

<table>
<thead>
<tr>
<th>VALUING</th>
<th>INDIVIDUALISED</th>
</tr>
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<tbody>
<tr>
<td>V1 vision</td>
<td>I1 care planning</td>
</tr>
<tr>
<td>V2 human resource management</td>
<td>I2 regular reviews</td>
</tr>
<tr>
<td>V3 management ethos</td>
<td>I3 personal possessions</td>
</tr>
<tr>
<td>V4 training &amp; staff development</td>
<td>I4 individual preferences</td>
</tr>
<tr>
<td>V5 the service environments</td>
<td>I5 life history work</td>
</tr>
<tr>
<td>V6 quality assurance</td>
<td>I6 activity &amp; occupation</td>
</tr>
</tbody>
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<table>
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<tr>
<th>PERSPECTIVE</th>
<th>SOCIAL/PSYCHOLOGICAL</th>
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<tbody>
<tr>
<td>P1 communication</td>
<td>S1 inclusion</td>
</tr>
<tr>
<td>P2 empathy &amp; acceptable risk</td>
<td>S2 respect</td>
</tr>
<tr>
<td>P3 physical environment</td>
<td>S3 warmth</td>
</tr>
<tr>
<td>P4 physical health needs</td>
<td>S4 validation</td>
</tr>
<tr>
<td>P5 challenging behaviour</td>
<td>S5 enabling</td>
</tr>
<tr>
<td>P6 advocacy</td>
<td>S6 part of family &amp; community</td>
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Our new broom?

The move from

The death that leaves the body behind

to

Living well with dementia
Bio-Psycho-Social Models

• To achieve these outcomes we need to work from a biomedical, a psychological and a societal model in combination

• We need to understand the impact of the dementia syndrome on the individual’s health and well-being over time in the context of their family, their community and the health and social care interventions they receive.
D = NI + B + P + H + SP

The enriched model...

NI Neurological Impairment
B Biography - life story
P Personality
H Health
SP Social Psychology

All these effect how a person with dementia behaves, feels and thinks......

By understanding NI, B & P and optimising H & SP we can help people live well with dementia
New language: Same concepts
The Enriched model

Cognitive ability & profile
Life story
Personality & Coping
Physical Fitness
Positive Social & Psychological Support

Photographs of people living with dementia taking part in
The Enriched Opportunities Programme
Gloves Off!

Pharmacological & Non-pharmacological interventions....... 

Is this a useful pair?

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Gloves off to heal suffering in BPSD

- NON implies dominance of one over another
- Lumps all pharma together
- Dichotomies limit possibilities.
- There is a place for multi-pharmacological and psychological and social and physiological and nutritional and spiritual and creative and humanistic and systemic and public health interventions
New brooms sweep up better

- What is necessary in our general person centred care to minimise the escalation of problems into BPSD (Ballard et al, 2009; Cohen-Mansfield et al, 2007 & 2010)
- Stepped approaches (Brodaty, 2003, Alzheimer’s Society, 2011) including a range of interventions.
- Specific functional analysis-based interventions & approaches to BPSD (Bedard et al, 2007; Moniz Cook et al, 2009)
Being Competent at Core business?

Care homes and hospitals should provide a good enough quality of person-centred care so that the chances of a person with dementia experiencing BPSD is minimal. If a person does develop BPSD the staff know what action to take to minimise suffering.

Patient with dementia on acute medical ward, New Cross Hospital 2011

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The processes involved in making this core business?

1. Clear processes that the staff do in order to minimise chances of BPSD occurring (person centred care?)
2. What type of staff competencies are needed to deliver this?
3. What training, education and ongoing support is needed for this to occur?
4. What processes are needed so they can access help in more severe cases (liaison psychiatry?)
5. How to enable leaders in these services to see this as core business and priority?
The Enriched Opportunities Programme (Brooker et al, 2011)

1. Staff tasks – Use enriched model to care plan and problem solve, regular engagement in pleasurable activity.

2. Staff type – Locksmith works with residents and staff team

3. Training – awareness, specialist and leadership

4. Help – in house coach, active engagement with primary and secondary care

5. Management – Improves occupancy, regulation reports, fewer complaints
“all needs, no mobility, not eating”

6 days after admission to a care home.....

Mrs May Williams, Lady Forester Home
“all needs, no mobility, not eating”

1 month later
– baking

Mrs May Williams, Lady Forester Home
“all needs, no mobility, not eating”

1 month later – baking

Mrs May Williams, Lady Forester Home
“all needs, no mobility, not eating”

6 weeks later
– Italian meal

.....
“all needs, no mobility, not eating”

6 weeks later

tea and teddy
“all needs, no mobility, not eating”

2 months later – head massage.
“all needs, no mobility, not eating”

2 months later – old skills returning.....
“all needs, no mobility, not eating”

2 months later – silk scarves.....
“all needs, no mobility, not eating”

3 months later – dancing to music....
“all needs, no mobility, not eating”

3 months later Mexican celebration
Interventions to reduce BPSD for May Williams

- **Interventions:** Person centred animal therapy, baking, eating, knitting, teddy, dressing up, silk scarves, head massage, dancing, pain relief

- **Outcomes:** Alive, weight gain, happy, active, having fun, no BPSD
Useful websites

Association for Dementia Studies, University of Worcester
- http://www.worc.ac.uk/discover/association-for-dementia-studies.html

Care fit for VIPS
- www.carefitforvips.co.uk

Interdem: European Early & Timely Interventions in dementia research network
- http://www.interdem.org/

Evidem: Evidence based Interventions in Dementia
http://www.evidem.org.uk

Lifestory network
- http://www.lifestorynetwork.org.uk/

Social Care Institute for Excellence: Dementia Gateway
- www.scie.org.uk/publications/dementia

Memory Bridge:
- www.memorybridge.org
Thank you for listening!

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Photographs of people living with dementia taking part in The Enriched Opportunities Programme