

Shifting from a Medical Model of Dementia Care to a New Culture of Person-Directed/Centered Care

Disease vs. Disability

In order to provide true quality of life for people with dementia, it is necessary for us to shift our way of thinking from focusing on dementia as a disease that is degenerative without a cure - to focusing on the whole person, and seeing dementia as a disability of certain parts of the person's brain. In this way we can still have the whole person to work with where improvements in the person's abilities are possible, and continued use of their strengths essential.

The following model was developed by Christa Monkhouse, a Swiss nurse, as a way to present this concept visually and factually in a way that depicts how eldercare is being handled in most world countries from a medical perspective. The model also shows the rationale for shifting how care is focused in the future. Please refer to the visual depiction of the model as you read the next section.

1. **Acute/Intensive Care:** Imagine that you have just been in a terrible accident and are near death. You will need the most intensive care that you can get. There will be a need for expert doctors, nurses, technologies, medications, etc., and you will probably either be unconscious or barely able to interact with others. This means that your need for medical care is very high, and your need for life (shown at the bottom of the column) is very tiny (maybe only a five minute visit is all you could handle).
2. **Medical Floor Care:** Now that you have recovered a bit and are able to get up, walk, talk, eat, etc. you are transferred to a medical floor. At this point you may still be very weak and need close monitoring by doctors and nurses, but you can also begin to tolerate a little more visiting, phone calls, etc. so your need for life increases - as in the second column (though it is still small).
3. **Rehabilitation Care:** In this phase of your healing you are beginning to resume some of your daily routine and prepare for going back to your life outside of the medical facility. Now the focus is on therapy much more than on the doctors, nurses and medical monitoring you once needed. As you can see by the column number three, your need for life increases dramatically at this point. You are being shifted to a routine and stabilization pattern that you can maintain for a long period of time as the healing is nearly completed. It could actually impede your healing if you were to NOT have an increase in life activities with people who matter to you and activities that you enjoy.
4. **Long Term Care:** Once you have graduated to long term care – a need for some medical support, but not an intensive need – your need for life is the greatest need that you have. For this reason, it only makes sense that you be surrounded by people who know how to provide quality of life activities and support for you to do things that you enjoy and are good at. The need for medical care is very small in comparison.

Unfortunately, the premise of this model shows that by placing people in environments such as nursing homes, with primarily staff who monitor medical needs as employees, we are depriving people who live there of a certain level of quality of life. For people with dementia, this can lead to difficult behavior, depression, fast declines in ability and premature death. It is vital that we begin to recognize the need for life that exists and begin to shift the focus of care from measuring a person's medical declines and deficits to restoring a quality of life that a person can thrive on. Currently there is very little focus on social and emotional needs and no measures, as medical needs have.

This is the cultural shift from medical model dementia care to a person centered care culture of life.

	1. ICU	2. MED FL	3. REHAB	4. Long Term Care/ HOME/ADC	
A	DOCTORS	DOCTORS	THERAPY OT/PT/ST	MEDICATIONS	C
	MEDICATIONS	MEDICATIONS	TRIAL VISITS @ HOME	NURSES-MDS	
	MEDICAL TX	MEDICAL TX	MEDICATIONS	MONTHLY BI-ANNUAL VISITS	
	NURSES	NURSING	DOCTORS		
	BED REST	GET OUT OF BED	NURSES		
C	IV'S	HOURLY MONITOR			H
	MONITOR EVERY 5 MINUTES				
U					R
T					
E					O
					N
					I
					C

Example:

Under the current medical model we have highly trained nurses, nursing assistants, doctors and other medical professionals who keep track of things like vital signs, medications, behavioral displays, amounts of food eaten, voiding and the like. All of these things are carefully charted and measured.

In this environment a person with dementia is not as capable of asking clearly for what s/he needs due to disability of some parts of the brain, so it is very common for the basic needs a person has to be overlooked. The four universal needs not usually met for people with dementia are:

- The need to be useful
- The need to care (for others/self)
- The need to give and receive love
- The need to have self-esteem boosted

Imagine on one hand a person with dementia. She is crying out over and over “Help me, help me”.

Imagine on the other hand the nursing staff and aides responding to this behavior. They might check:

- Is she wet?
- Is she hungry?
- Is she sick?
- Is she constipated? (etc.)

Let us imagine that all of her physical needs have been met. After investigation the nursing staff and aides conclude that this is something that they have to label and report on, so they call it “attention seeking behavior”. How do you suppose this influences their behavior? It would be natural for them all to stay away from the person with dementia and not “reinforce” the behavior.

Imagine that you are the person with dementia – what need might you be trying and reaching out in the only way you know how to have recognized? The need to give and receive love? Let’s say that is it. What might you do? Well, as the staff avoid you, your cries get louder and louder, you may throw yourself on the floor or hit or spit.....and your need is for life.

There is a vital need to have people who are trained on providing life – not just medical care.

Model developed by Christa Monkhouse, a Swiss nurse who works on culture change with organizations in Switzerland, Austria and Germany. Presented in a lecture given by Jane Verity, Founder and President of Dementia Care Australia 8/05.