QAVAD: QUALITY OF LIFE AT HOME

IP2 - Quality of Life at Home Training Programme

Annex: Principles to be found in each module

The working group identified key words for each module that illustrate the values to be found in its implementation.

In a transversal way, the training pathway puts the person at the centre of the support. The approaches aim to maintain or develop the person's autonomy and to build an individualised approach.

The conceptual framework of the training was built on pedagogical references, selected key concepts, and methodological references as follows

Educational references :

- Andragogy
- Experiential learning

Key concepts

- Quality of life WHO
- Empowerment
- Gentle care
- Care
- Person-centred approach
- Validation Therapy

Methodological references

- Augmentative Alternative Communication
- Non-Violent Communication NVC
- ETHAZI methodology
- Meaningful daily activities with people with dementia
- Montessori Method
- Reminiscence
- Reorientation therapy in reality
- Cognitive stimulation
- Sensory stimulation
- Occupational Therapy

Educational references

Andragogy

Educational reference
Andragogy
Andragogy is "the body of knowledge about adult learners that is parallel to and distinct from the pedagogical model of children's learning" (Knowles, 1996). Knowles distinguishes between the concepts of andragogy and pedagogy because he believes that it is possible to identify a series of substantial differences between children's and adults' learning. Knowles outlines these differences between pedagogy and andragogy through six key principles: **1.** The need to know: adults feel the need to know why something needs to be learned and what it can be used for. Therefore, the trainer's task is to help learners become aware of the "need to know". In addition, learning can be reinforced by real experiences. **2.** Self-image: children are seen and/or see themselves as dependent on others. Although adults see themselves as responsible for their lives, there are situations in life, work or study in which they are dependent. In this case, their self-image needs to be reworked and the adult educator's task is to facilitate the transition from dependence to autonomy in learning and in life. **3.** The role of previous experience: the learning experience of adults becomes more voluminous and qualitatively different from that of young people. New learning must somehow be integrated with previous experience. This indicates that the richest learning resources lie in the trainees themselves. For this reason, the use of experiential techniques (techniques that take into account the learners' experiences, such as group discussions, simulation exercises, etc.) in transmission techniques is fundamental in adult education. **4.** Willingness to learn: The adult shows a willingness to learn what one needs to know or be able to do, in the face of life's needs and especially in the phases of change. Adults are willing to learn what they need and know how to manage their lives effectively. **5.** Learning orientation: adult learning orientation is focused on real life. In fact, they acquire new knowledge, skills and values much more quickly and effectively when they are presented in the context of their application to real situations. The perspective is one of immediate realisation of what I have learned. **6.** Motivation: the most powerful pressures for adults are internal pressures such as increased self-esteem, job satisfaction, improved quality of life. Principles of the andragogical model: In 1984, Knowles suggested 4 principles to be applied to adult education: 1. Adults need to be involved in planning and evaluating their learning. 2. Experience and mistakes form the basis of learning activities. 3. Adults are more interested in learning things that have an immediate impact on their personal or professional life. 4. Adult education is more problem-oriented than content-oriented (Kearsley, 2010).

For more information

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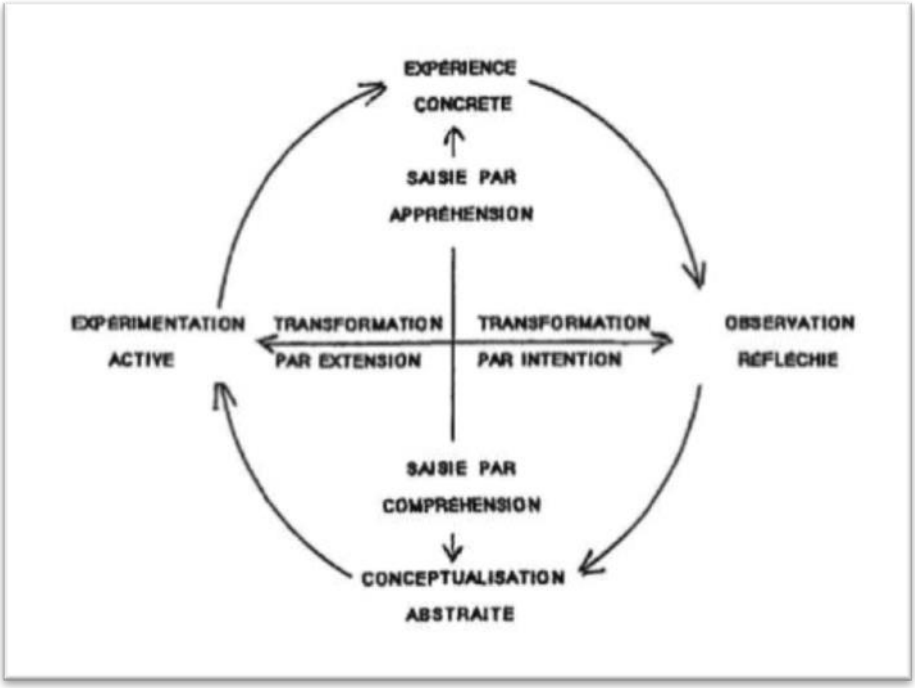
Experiential learning

Educational reference
Experiential learning
Influenced by the work of Dewey (1938), Lewin (1961), Piaget (1971) and Kolb (1984), the current concept of experiential learning refers to a process in which learners shape their knowledge and conceptions through engagement in practical tasks in real domains. Again from this holistic perspective, Kolb describes this form of learning using four action verbs: thinking, feeling, perceiving and behaving. Bell (1995) summarises this approach by describing experiential learning as a relationship between an individual and his/her environment in which the individual discovers a concrete and meaningful reality. In the first stage, the learner is actively experimenting rather than being placed on the receiving end of the experience of others as interpreted by the teacher (Herbert, 1995). In the next stage, in groups, individually or with the facilitator, the learner is given time to reflect and construct their own meanings and information from the events they have experienced. They can, for example, think about what they have learned, express their feelings or their position on what has happened, separate out the elements of the experience and relate these elements to their previous knowledge. The final step is to share the value of the experience with others or to try out what has been understood in the field. Experiential learning pedagogy is thus similar to active and affective pedagogy: during the process, learners experience emotions such as challenge, compassion, pleasure, excitement, wonder, identification, desire to share their impressions... Delay (1996) relates this type of learning to that described by constructivist theories according to which knowledge is constructed from experience. Kolb's model synthesises, in particular, the experiential learning models of Lewin, Dewey and Piaget on the basis of the following assumptions common to all three authors' approaches: - learning is a continuous process rooted in experience; - the learning process requires the resolution of conflicts between dialectically opposed modalities of adaptation to reality; - learning is a holistic process of adaptation to reality; - learning involves a continuous exchange between the individual and the context in which he or she finds him or herself; - Learning is the process of creating knowledge. According to Kolb, the experiential learning process can be described as a four-phase cycle involving four adaptive learning modalities: concrete experience, reflective observation, abstract conceptualisation and active experimentation. In this model, concrete experience/abstract conceptualisation and active experimentation/reflective observation are two distinct dimensions, each representing two opposite adaptive orientations. The structural basis for the learning process lies in the transitions between these four adaptive models, through processes of apprehension/understanding and intention/extension.



Kolb (1984)

Kolb thus identifies four stages of learning:

- Concrete Experience (CE) stage, where learning is mainly the result of perceptions and reactions to experiences;
- reflective observation (RO) stage, where learning is derived mainly from listening and observation;
- abstract conceptualisation (AC) stage, where learning takes place through the systematic analysis and organisation of information and relative flows;
- Active experimentation (AE) stage, where action, experimentation and verification of results are the basis of learning.

During the stage of concrete experiences, the emphasis is on direct and personal involvement. This engages the emotional sphere. The interpretation of experiences tends to emphasise their uniqueness and complexity rather than any general principles. The outcome is experienced as a personal one and is promoted by an intuitive approach and the ability to adapt to the situation. During training, activities that favour this phase are workshop activities, fieldwork, examples, simulations, role-playing, "training on the job" and in general all activities that recall concreteness and application.

During the reflective observation phase, learning focuses on understanding meaning through listening, confrontation and impartial observation. The understanding, the quality of the analysis and its reliability are of great importance. During the training, the tools that best facilitate this phase are the lesson, specialised readings, theoretical references, discussion and *case histories*.

In the abstract conceptualisation stage, learning focuses on the logical organisation of content and the ability to identify rules and process dynamics that can be applied in a generalised way. Abstract theories and demonstrations are developed through analysis, identification of key concepts, cause and effect links. Training is carried out through tools such as lessons, articles, graphical representation and diagrams.

In active experimentation, the focus is on finding options for dealing with a concrete situation.

Effective and comprehensive learning involves all four stages of the process and it does not matter at what stage you start. Indeed, it is possible to start learning at any stage of the cycle. Each one requires different skills to make it work in the best possible way.

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Quality of life

Key concept sheet
Quality of life
The World Health Organisation (WHO) gave this definition of quality of life in 1993: "It is an individual's perception of his or her place in life, in the context of the culture and value system in which he or she lives in relation to his or her goals, expectations, norms and concerns. It is a very broad concept influenced in complex ways by the individual's physical health, psychological state, level of independence, social relationships and relationship to the essential elements of the environment. According to Monique Formarier, a former health executive trainer and editor of the journal Recherche en soins infirmiers, the areas that influence a person's quality of life are -the state of health and the severity of the disability, -psychological and spiritual aspects, -the family and the community, -the socio-economic level. The concept is centred on the notion of perception, of "the subject's overall satisfaction with the general meaning he or she gives to well-being". This emphasis on the individual's point of view adds to the complexity of the concept: quality of life is an assessment criterion that is supposed to be objective, yet it is subject to subjective interpretation. Quality of life varies according to each person's appreciation of their own standards and values. It changes over time, at different ages of life. According to Zribi and Poupée-Fontaine, quality of life is partly linked to people's opportunities to take part in decisions that concern them, both individually and collectively. Indeed, quality of life has a subjective dimension, i.e. each individual, depending on his or her value system, culture, expectations and concerns, has a singular perception of what he or she considers to be "good" for him or her. Thus, for people with disabilities, quality of life is correlated to the possibility to express themselves regarding their personalised project. This notion asserts the right: to free choice, to consent, to access to all information and to participation in the personalised project. It is a question of recognising people as "subjects" to be supported and not "objects" to be taken care of. Quality of life is also linked to the possibility of expressing oneself at the collective level, in the institution and in the city. It is about enabling people to exercise their role as citizens and not be confined to the role of passive beneficiaries.
For more information
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Empowerment

Key concept sheet
Empowerment
The idea of the role of the person as an actor and citizen is the basis of the support. Indeed, *empowerment* is the recognition and reinforcement of people's capacity to decide and act, both individually and collectively. According to William Ninacs (2008 p.140), *empowerment* brings together four essential components: participation, competence, self-esteem and critical awareness. Together and in their interaction, they allow the transition from a situation without power to act to one where the individual is able to act because of his or her own choices. *Empowerment* in mental health is defined by the WHO as: "empowerment refers to the levels of choice, decision, influence and control that mental health service users can exercise over events in their lives". *Empowerment* is a concept that refers to a set of skills and resources that enable the person to exercise positive power, or to have room for manoeuvre over their own life. According to the definitions of Rappaport (1981) and Zimmerman (2000), *empowerment* is a process that enables individuals to increase their capacity for active control over their own lives and includes three interrelated dimensions: an individual and psychological level, a social and organisational level and a political or collective level. Three dimensions of *empowerment* can be distinguished: - the individual dimension (concerning well-being and planning), - the socio-relational dimension (concerning the person in relation to others), - the institutional dimension (concerning the life of the person in organisations, in work or in leisure time organisations). *Empowerment* or lack of *empowerment* has implications for these three different dimensions of people's lives. A project that aims to develop the *empowerment of* the person, to make him or her autonomous and capable of exercising his or her margin of intervention and initiative in his or her life context, must act on several dimensions and areas. *Empowerment* skills can be defined in relation to the three dimensions mentioned above. As regards the individual dimension of *empowerment*, an educational process can develop the following skills: self-esteem, self-confidence, sense of self-efficacy (self-evaluation, feeling of being able to cope with the problematic situation), capacity for self-evaluation (determining one's strengths and weaknesses, taking stock of one's skills) ability to read and understand one's life (recounting and analysing the most important episodes - positive or negative - in one's life), locus of control/place of mastery (my share of free will over events, the meaning I give to what happens to me), coping strategy (way of facing a problem, defining one's strategies for success). With regard to the socio-relational dimension, a project centred on the notion of *empowerment*, through group work and cooperative learning methodologies, should enable progress to be made in the following skills communicating in the group (communicating opinions and points of view), cooperating, playing different roles in the group (proposal, opposition, mediation, guiding), managing conflicts in the group (recognising, understanding/analysing, resolving/resolving the conflict), pursuing objectives in the group (defining objectives, a plan for the work, giving oneself methods, dividing up the work to achieve the goal), steering and monitoring the work of the group (evaluating during the course the success of the work, making changes if necessary).

In terms of the institution, *empowerment* means putting in place the organisational conditions so that the person can: feel part of the group, become fully aware of their rights and duties, make their voice heard (participate in the life of the institution, take responsibility, organise activities) and take part in the decisions that concern them.

Empowerment is therefore a term that implies all the knowledge, skills and relational modalities through which an individual or group can set goals and develop strategies to achieve them effectively, using existing resources.

From an action perspective, *empowerment* means :

- being able to pursue goals,
- commit to achieving these goals,
- perceive that there is room for manoeuvre on events,
- manage change,
- building positive relationships,
- cooperate.

For more information

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Gentle Care

Key concept sheet
Gentle Care
Gentlecare is an innovative model of care for patients with dementia, developed in Canada in the 1990s by occupational therapist Moyra Jones, who devised the approach while assisting her father with Alzheimer's disease (Jones, 1996). The main objective of this approach is to achieve and support the well-being of the ill person and to contain the stress of the carers, who play a fundamental role in the overall and individual care of the patient, the family, the social and cultural context. The carer is seen as a "mediator" with other professional figures, with the family and with institutions, so this figure must be professionally prepared and trained. The Gentle Care model (Jones, 1996) therefore addresses older people and carers with the aim of promoting the well-being of the former and reducing the risk of burnout of the latter. This approach focuses on older people and the preservation of the continuity of life. It requires an analysis of the person as a starting point: clinical and pathological status, reconstruction of biography, personal and contextual characteristics (Guaita, Jones, 2000). This broad spectrum analysis is complemented by an assessment of the impact that the disease has on the person, both physically and psychologically, in terms of experience and coping strategies. The assessment is divided into three phases: 1. knowledge of the ill person, both clinically and biographically; 2. assessment of the impact of the illness on the individual; 3. actual construction of the environment, understood as both the physical environment and all that relates to people and programmes (Jones, 1999). This evaluation is carried out with quantitative tools, typical of multidimensional evaluation, and qualitative tools, where the nursing staff (professionals and family carers) take on the role of observer of the participants and the relationship with the elderly. The elderly are the object of the assessment and self-evaluation. This assessment includes the residual abilities of the elderly, the actions and daily routines, the actions and responsibilities of the carers and the risks of stress. This complex and rich assessment process leads to the creation of a care plan, based on realistic objectives, through the analysis of the strengths and weaknesses of the patient and the given situation. In designing care, the Gentle Care model looks at the physical environment, i.e. the place and space (or spaces) of care (Guaita, Jones 2000) which should be characterised by: safety, ease of access and mobility, functionality, flexibility and change. The carer also plays an important role in the care plan, sharing it and communicating with the operators - who need to be aware of the relational dynamics within the family nucleus of the elderly person and the resources of the family - from techniques of organisation and management of daily life to strategies for dealing with critical situations. The activities form a tailor-made daily routine for each patient. It is based on the biographical and contextual elements that are known and reassuring to the person, and on the development of his/her strengths. The aim is to create a complete match between the needs and the proposed activities. Examples of activities that meet the need for safety and biological integrity are: pain control, being able to stay in comfortable positions, sufficient rest time, maintaining energy, enjoying a family routine. Examples of correspondence between needs and activities concerning the sense of belonging are: the relationship with pets, possession of and access to important personal objects, plants, the possibility of receiving sensory stimulation, listening, touching, organisation of space.

With regard to self-esteem, the needs corresponding to the activities are identified as follows: reminiscence and memories, control of money, helping others, teaching, learning, remembering and creative activities.

The meaning of empowering intervention should not be sought in the action that is carried out, but in the possible happiness of the patient and the satisfaction that the recipient has with the care they receive (Jones, 1999).

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Bientraitance (Good treatment)

Key concept sheet
Bientraitance (Good treatment)
According to the French National Authority for Health (HAS), "good treatment is a global approach to the care of patients, users and their families that aims to promote respect for the rights and freedoms of patients and users, and to listen to their needs, while preventing mistreatment. This global approach highlights the role and interactions between the various players, i.e. the professional, the institution, the family and friends, the patient and the user. It requires both individual and collective questioning on the part of the actors. According to the recommendations of good professional practice of the National Agency for the Evaluation and Quality of Social and Medico-social Establishments and Services (Anesm)[1] on good treatment, this "is a culture inspiring individual actions and collective relations within an establishment or service. It aims to promote the well-being of the user, bearing in mind the risk of abuse. It is neither the absence of abuse nor the prevention of abuse. Good treatment is characterised by a permanent search for individualisation and personalisation of the service. It can only be built within a given structure after continuous exchanges between all the players. The fundamentals of good treatment: - Good-treatment is a shared culture of respect for the individual and his or her history, dignity and uniqueness. - For the professional, it is a way of being, saying and acting, concerned about the other person, responsive to their needs and requests, respectful of their choices and refusals. Good-treatment includes the concern to maintain a stable institutional framework, with clear, known and reassuring rules for all, and an uncompromising refusal of any form of violence. - The user's expression is valued. In concrete terms, good treatment is an approach that responds to the user's rights and choices. - The good treatment approach is a permanent back and forth between thinking and acting. It requires both a collective reflection on the practices of professionals and a rigorous implementation of the measures that the collective reflection recommends to improve them. From this perspective, it requires the adoption of a culture of permanent questioning. - The search for good treatment is a continuous process of adaptation to a given situation. In essence, it is never-ending. It involves constant reflection and collaboration between all those involved in the support process, in search of the best possible response to an identified need at a given time.
For more information
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[1] Anesm joined the Haute Autorité de Santé (HAS) on 1 April 2018

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Person-centred approach

Key concept sheet
Person-centred approach
Currently, the attention given to the elderly in care services and homes is closely linked to the deficits and pathologies they suffer, which makes it difficult to perceive the person as a singular, different and valuable individual. In this sense, care has been conceived from a welfare perspective, where the professional and the institution decide for the good of the other person (to improve their health, to keep them safe...) ignoring what the person feels and thinks. It is important to continue to enjoy a meaningful life, which is essential to be happy also in old age. Person-centred care is a way of accompanying people in a personalised way to develop their own life project, with their effective participation and taking into account, in addition to their needs, their preferences and desires. The person-centred approach (PCA) is based on the recognition of the dignity of each person and their right to continue to own their own life. When a person needs support, health and personal care are essential, but so are the things they love, their habits and personal relationships. What is fundamental to this model is knowing and supporting what is really important to each person at that moment in their life. The life project of each person corresponds to the choices and strategies that each individual implements to achieve his or her goals and satisfy his or her desires in relation to work, family, leisure, etc. All people, consciously or not, have a life project. Older people also have their own life project. In the CPA model, professionals and organisations become a support for older people to pursue their life projects. In this respect, the person is an active protagonist and decides what and how he or she wants to live his or her life. The environment and the organisation become a support for developing life projects and ensuring people's well-being. CPA is a model that requires: leadership from centre managers, involvement of professionals and participation of service users and their families. In some cases, all this implies changes in organisations. To further develop the model, we highlight five important aspects: **1.** Professionals: in this model, professionals do not act as expert prescribers who indicate at all times what to do or not to do with users. In addition to providing technical guidance for the proper care and protection of people, they perform new tasks related to listening and observing, accompanying, motivating and seeking opportunities and support. Professionals are able to empower service users. **2.** Pleasant and meaningful physical environment: the physical environment is a very important dimension of people's well-being. Based on person-centred care, we aim to create a warm environment, far from the institutional character that is usually found in facilities for frail or disabled people. The aim is to ensure that these facilities resemble a normal home and, in short, that the physical environment contributes to a friendly, happy and stimulating yet calm atmosphere. **3.** Meaningful" therapeutic activities: great importance is attached to the fact that therapeutic activities are meaningful for people. Routine, boring or childish activities with little motivation are left aside. Activities that are truly meaningful are sought out and developed. The model

aims to offer proposals that people do not feel obliged to join because the professionals recommend them. This implies a great challenge within the model, because without abandoning the therapeutic objectives, some interventions must be adapted and personalised and generate new alternatives.

4. Participation of older people and their family members in the care plan and life project: In the CPA, the participation of the person in his or her care is something that cannot be renounced, even when the person suffers from severe cognitive impairment. In this case, the support of family members, close friends and professionals is necessary. To achieve this, opportunities to choose are identified and people can make decisions at any time of the day.
5. For all these considerations to be effective, the organisation needs to be flexible, so that some changes have to be made at the organisational level. To this end, possible changes are promoted, planned and carried out gradually, without losing sight of the fact that what matters is the quality of life and well-being of people. Efforts are made to move forward on the basis of consensus. To this end, the involvement of older people, their family members and especially care professionals is promoted.

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Validation Method

Key concept sheet
Validation Method

The method was developed between 1963 and 1980 by Naomi Feil, a graduate of Columbia University and member of the Academy of Social Workers. In the 1960s, Feil worked in a nursing home in Cleveland, USA, where she came into contact with the world of disoriented elderly people and began to develop the validation method.

This technique consists of promoting the mental development of elderly people with problems, interpreting their behaviour and helping them to recover their personal dignity.

Validation theory is based on the principles of analytical and humanistic behavioural psychology. Each of the following sentences illustrates a facet of the theory:

- Accept your patient without judging them (Carl Rogers)
- The therapist cannot really understand or change the behaviour if the patient is not willing to change or does not have the intellectual capacity for introspection. (Sigmund Freud)
- Think of your patient as a unique individual (Abraham Maslow)
- Feelings that are expressed and then acknowledged and legitimised by a listener who enjoys the patient's trust will become less intense. When they are ignored or denied, feelings gain strength "The ignored cat becomes a tiger" (Carl Jung).
- Each phase of life has a central task that we must face within the short space of human life. We must make the effort to do this task well and then move on to the next task (Erik Erikson).
- A neglected task needs to be completed at the next stage (Erik Erikson)
- Human beings make an effort to maintain balance (homeostasis). (S. Zuckerman)
- When recent memory (short-term memory) is weakened, very old people restore balance by recalling old memories. When visual capacity decreases, they use the mind's eye to see. When hearing fades, they listen to the sounds of the past (Wilder Penfield)
- Well-preserved distant memories persist in the very old. (F. G. Schettler and G.S. Boyd)
- The brain is not the only regulator of behaviour in the very old. Behaviour is a combination of physical, social and intrapsychic changes that occur during the short period of life (Adrian Verwoerdt)
- Autopsy examinations have shown that many very old people survive with severe brain damage, remaining relatively oriented. (Charles Wells)

  There is a cause behind the behaviour of very old and disoriented people. (Naomi Feil)
- Every human being is valuable regardless of their degree of dependency. (Naomi Feil)

As can be seen, these sentences, chosen by Naomi Feil, set out a theory which places at the centre of the older person's deep respect for him or her as important, despite the losses due to psycho-physical decline.

The Validation method is based on Erik Erikson's life stage theory, which emphasises the strict dependence between the biological, mental and social aspects of the human being and his or her actions. In practice, he argues that we will only succeed in a given task, which we have to perform at a certain stage of our life, if we have successfully completed the previous tasks of the early

years of life.
There is another stage of life, reached by those who live to an advanced age. During this period, unresolved emotions from the past must be unblocked: anyone in this condition feels the need to be listened to, otherwise they will slip irreparably into a vegetative state.
Thus a fundamental task of the Validation operator emerges: listening, even if we will probably not arrive at a real resolution, given the advanced stage of life.

Below are some basic points of the technique:

1. Gather information about the older person.

In particular, it is essential to know: the person's stage of disorientation; unfinished tasks and emotions; past human and emotional relationships; occupation, hobbies; relationship with religion; how the person deals with difficulties and losses; clinical history. This information can be collected through questions to the person, asked at different times of the day and for at least two weeks. The questions have been indicated by Feil, as they should be precise enough to guide the operator.

2. Assess the stage of disorientation. Stages can be:
   - First stage: orientation disorders.
   - Second stage: temporal confusion.
   - Third stage: repetitive movements.
   - Fourth stage: vegetative life.
3. Meet the person regularly and use validation techniques.

The length of each interview depends on the stage of disorientation in which the person finds himself: from a minimum of one to a maximum of fifteen minutes (the shortest time is dedicated to those with the major problems). In all cases, it is not the quantity but the quality of the time that counts. The ideal frequency also depends on the individual situation: from several times a day to a few meetings a week, or even less frequently. It is important to be able to recognise in good time the feeling of reduced discomfort in the older person, which indicates the end of the interview (here too, Feil gives very precise indications).

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Enabling approach

Methodological reference sheet
Enabling approach
The Capacitive Approach (CA) is a modality of interpersonal relationship based on speech that aims at a positive cohabitation between frail and/or dementia-affected elderly people, professionals and relatives. The method used is the recognition of basic skills and can be used in all areas, and is also applicable to the training of operators. Born in 2000 in the Anchise group following Giampaolo Lai's conversation analysis, the approach has been enriched by the contribution of other authors: Naomi Feil and the *Validation* approach, Tom Kitwood and the psychosocial approach, Moyra Jones and the *Gentlecare approach*, Amarthia Sen and the *Capability approach*. KT goes beyond the traditional approach to care, which starts from the analysis of the needs of the users and, in the case of people with dementia, tries to meet them without their involvement. Five *core competences* are addressed in the CA: **1.** *Competence to speak*, i.e. to produce words independently of their meaning. The word is valued, especially the word of the person with dementia, whatever it may be, even if it is truncated, repeated or meaningless, because the person speaking is not isolated, but immediately slips into a context. We seek, through appropriate verbal techniques, to keep the use of speech alive, convinced that the words of the person with dementia have meaning (from their point of view), even if we do not understand them. **2.** *Communication skills* (different from speaking) expressed through verbal, paraverbal and non-verbal language. **3.** *Emotional competence*, i.e. feeling emotions, recognising the other person's emotions and sharing them. **4.** *Negotiation skills* regarding everyday matters (an expression of this skill can be seen in the choice of the topic of conversation in verbal exchanges). **5.** *Competence to decide*, even in the presence of cognitive deficits and in contexts of reduced decision-making freedom. The extreme expressions of this competence are represented by oppositional behaviour, relational closure and isolation from the world. In an enabling environment the older person can carry out the activities they are capable of, as they are capable of, without feeling at fault, with the sole aim of being satisfied (as far as possible) with doing what they do, as they do it, in the context in which they find themselves. The second characteristic of t h e enabling approach is that it can be used both in specific contexts (e.g. intake interviews, individual interviews, discussion groups for people with dementia, self-help groups for relatives, training courses) and in non-specific activities, in occasional meetings in everyday life and during the professional activities of each operator.
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Alternative Augmentative Communication (AAC)

Methodological reference sheet
Augmentative Alternative Communication
Augmentative Alternative Communication (normally abbreviated to AAC) is the term used to describe all modes of communication that can help communicate with people who have difficulties with the most commonly used communication channels, particularly language and writing. It is defined as "augmentative" because it does not simply replace or propose new modes of communication but, by analysing the subject's skills, indicates strategies to amplify them (e.g. vocalisations, verbal language, gestures and signs). It is called "alternative" because it uses strategies and techniques other than spoken language. This "approach" aims to create opportunities for real communication and effective involvement of the person. Therefore, it must be flexible and tailored to the person him/herself. This type of communication may include the use of new technologies for cognitive stimulation. Some studies have shown that the use of new technologies (tablets, touch screens, C.A.A. programmes) leads to improved attention span, manual eye coordination and better management of mood swings, the acquisition of new skills and increased self-esteem. C.A.A. is not a "method" but a set of techniques, strategies and technologies that are accessible to the person who does not speak, to those with whom he or she interacts and to the environment in which he or she lives. The priority is to facilitate the expression of people who do not speak, or do not speak in a comprehensible way, to help them be active and communicate. Within C.A.A. there are many different technical approaches derived from clinical, scientific and cultural experience. The C.A.A. expert has the technical responsibility to choose and apply the most effective and appropriate approach to the needs and individual characteristics of the non-speaking person (age, basic pathology, residual communication skills, visual abilities, etc.). In accordance with these needs, solutions are adopted or suggested that the person adopts in their daily life. There is no single protocol, as the action depends on the person's basic pathology, age and communication needs. There is generally no divide between learning and functional use, as solutions must be learned in real communication situations directly through their use. However, C.A.A. should potentially be used by all people who come into contact with people who have difficulties with speech. It is usual for a more experienced or competent person to play a particular role as facilitator.
For more information
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Non-violent communication (NVC)

Methodological reference sheet
Non-violent communication (NVC)

Non-Violent Communication (NVC) is a practice (and a communication process) conceived and developed by Marshall Rosenberg, an American psychologist and student of Carl Rogers.
Rosenberg grew up in Detroit during the era of racial and class conflict, a city in which he encountered violence almost every day.
He studied clinical psychology and comparative religions; he delved into the lives of 'peacemakers' and was interested in all the disciplines that he felt helped him to understand the drivers of violence and what helps to reduce it.
Trained in humanistic psychology (A. Maslow, C. Rogers, E. Gendlin etc.) he integrated his skills in the process he called "Non Violent Communication".
Rosenberg founded the Center for NonViolent Communication in 1984, an international non-profit organisation with more than 100 trainers who disseminate NVC in 30 countries - in North and South America, Europe, Asia, the Middle East and Africa - and hold seminars for teachers, psychologists, parents, mediators, managers, prisoners and prison guards, police, military personnel, clergy and public administration staff

NVC suggests an easy-to-understand and effective method for getting to the root of violence, suffering and conflict.
Fundamentally, it is about knowing what frustrated needs underlie what we do or say, and what is likely to help us reduce hostility, relieve pain, and build more satisfying personal, emotional or professional relationships.
The method is based on the development of awareness, empathy and communication practices.
The novelty lies in the integrative character, clarity and simplicity of the model which invites us to turn our attention away from thoughts (right/wrong, you must/cannot, deserve/guilt), in order to focus our awareness on four fundamental points or information that facilitate expression:

- facts
- feelings
- needs
- possible ways of meeting these needs (strategies/demands)

The method supports us and offers us a safe path to the two components of communication: how we express ourselves and how we receive messages from others.
With regard to oral communication, NVC invites us to differentiate between the observations of
It suggests that we observe carefully what is going on, avoiding interpretations and giving priority to observing the facts rather than making moralistic judgements. It invites us to express our needs simply and honestly without criticising or insulting others, concluding with an expression of what we would like.
The practice thus allows us to gain a great deal of insight into what we feel and where our feelings come from, it helps us to recognise and express our needs and values, and to be able to express precise and concrete requests in the present.

By the term needs, NVC means a wide variety of requirements shared by all human beings: from

survival needs such as food, air, rest, to more complex needs such as respect, autonomy, esteem etc.
With regard to listening, NVC allows us to understand the needs of others beyond the criticism, judgement or aggression felt.
No matter how people address us, NVC allows us to be aware that we have the power to choose between conflict or deciphering - empathically - in others the four pieces of information (facts, feelings, needs, strategies) even when they are hidden under a blanket of egocentric thinking and expressed in tragic ways, through self-righteous judgements, demands or obligations.
This language is simple and at the same time requires training because the dominant culture in which we have been trained has probably most often taught us to communicate in a way that is disconnected from what is naturally alive in us and in others.
NVC is based on the assumption that all conflict is based on the mismatch of proposed strategies, and that many alternative strategies can be devised to satisfy the same needs.
Needs are shared by all, while the means of satisfying them may be very different from one person to another and from one culture to another.
In other words: needs are universal, therefore shared and understandable by all, and on the basis of these we can all understand each other, whereas strategies are multiple and highly subjective. If we remain focused only on the latter, it is easy to end up in conflicts and to fuel violence.
In the presence of two contradictory points of view, the emergence of each other's needs allows a connection between the parties and the identification of relevant strategies to satisfy all needs.

The facilitator's action in mediation therefore aims to:

- support the identification of each party's needs (however they are expressed),
- ensure that these needs have been correctly perceived by the other party,
- stimulate the empathy that everyone needs to welcome and understand the needs of the other, check that everyone understands their own needs and those of the other,
- help the parties to translate possible solutions into specific actions.

By proposing NVC, Rosenberg has given rise to peace-building programmes in conflict-torn countries such as Rwanda, Burundi, Nigeria, Malaysia, Indonesia, Sri Lanka, Sierra Leone, the Middle East, Colombia, Serbia, Croatia and Northern Ireland.

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ETHAZI methodology

Methodological reference sheet
ETHAZI methodology
The ETHAZI (High Performance Cycles) methodology is a new way of learning through teamwork and self-learning based on collaborative learning through challenges. The methodology tries to bring the professional reality closer through "challenges". A challenge is an approach to a problematic situation with several possible solutions that the participants try to solve as a team. By solving these challenges, students acquire technical skills, as well as other skills necessary for their future career, such as teamwork, conflict resolution, flexibility to adapt to new situations, communication, creativity, etc. Companies and organisations are a key factor in creating these challenges. It is very interesting to collaborate with them, as they can provide the teams with real situations to solve and give very valuable feedback when presented with the teams' results. The challenge learning mechanism consists of 6 steps: 1. Define the challenge, identify it and address it. 2. Define parameters, obtain and organise information 3. Generate alternatives, submit proposals and select the most appropriate. 4. Plan and implement actions 5. Present the results 6. Reflecting and evaluating for learning In other words, the teams are confronted with realistic problematic situations that should allow the students to work with the perspective of multiple alternatives. The working process should allow them to experience the situation as a challenge and, from there, they have the opportunity to generate the necessary knowledge that allows them to provide the best solutions. Secondly, the students, individually and as a team, act on the requirements needed in professional life and produce a result. The challenge model approach understands learning as an evolutionary process, where students are responsible for their own learning and teachers facilitate this. Therefore, at the end of each challenge, the teams interpret the results, analyse what worked and what didn't, and decide what will be done differently in the next challenge in order to achieve higher goals.
For more information
Websites
https://tknika.eus/cont/proyectos/ethazi/

Meaningful daily activities with people with dementia

Methodological reference sheet
Meaningful daily activities with people with dementia

Throughout our lives, our days are filled with daily activities that we carry out, most of the time, without even realising it. Yet many of these activities give meaning and content to our lives and reflect our individual personalities. The same is true for people with dementia, although research into the importance of meaningful daily activities is a relatively new and underdeveloped area, some studies have found that for the psychological well-being of people with dementia, participation in activities may be even more important than the overall physical and social environment (Marshall & Hutchinson, 2001).

We need to keep in mind that when we talk about 'occupation', the term 'being busy' goes beyond leisure activities and can also imply work, free time and play, but also, and very importantly, time to get up, eat and drink, receive physical care, receive sexual stimulation, take an interest in objects, help others or hold a conversation (Elliot, 2011).
Attempting to identify what constitutes a meaningful activity from the perspective of the person with dementia shows that they find meaning in 'doing', and that they consider occupation to be very important to their quality of life (Phinney et al., 2007; Train et al., 2005; Droes et al., 2006).
People with dementia face losses in their cognitive abilities on a daily basis. Seeking daily activity then becomes a way of maintaining that sense of identity through what have been habits in their lives, their daily routines. Perhaps with daily routines, part of the pleasure comes from the fact that they don't need to think about how to do things, but only to do them (thanks to procedural memory). Daily activities mean that the task ceases to be hard work and can become a let-go, requiring much less effort and demands to complete (Phinney et al., 2007).
It is important to be aware that these daily tasks may be one of the few opportunities for people with dementia to participate in familiar activities, activities that they can still do and that can improve their quality of life (Edvardsson et al., 2013).

What do we mean by "meaningful daily therapeutic activities"?

Although activities with people with dementia have been around for several decades, it is still not clear what meaningful activities are. "Meaningful activity" could be defined as the things a person does in their daily life that are perceived as meaningful to them.

However, engaging people with dementia in activities is a very difficult task for a number of reasons:

- Stimulating activity in people with dementia is more complex than it seems, especially in people with more advanced dementia.
- Staff are often not fully aware of the benefits of involving people with dementia in daily activities.
- The involvement of people with dementia in daily activities often seems less important to us than basic physical care, cleanliness of the environment or comfort.

What are the benefits of performing meaningful daily activities?

- They encourage the maintenance of personal identity.
- They facilitate decision-making and choice for people with dementia.
- They promote and facilitate people's participation, as they perceive the activities as something that is their own, in accordance with their culture and customs.
- The environment can be adapted to the needs, tastes and preferences of each person.
- It takes place in real environments, using everyday objects, which gives a particular meaning to the task, as opposed to 'traditional' stimulation activities which are carried out with people with dementia, with simulated materials and environments, or with pen and paper tasks.
- It allows different tasks to be carried out with very different levels of difficulty and therefore adaptable to the abilities, needs and interests of each person.
- The activities can be broken down into many small steps, which can be practised and completed together or independently.
- It is not always necessary to use verbal communication, since the activities are known to the people and they can easily act by imitation or in a very automatic way.
- Even if people are not directly involved in the activities, they benefit from an active and meaningful environment, with a rhythm and routines of daily life as close as possible to the reality of a home.

A guide to facilitating meaningful daily activities with people with dementia

The person-centred approach (PCA) is based on the premise that older people, as human beings, deserve to be treated with the same consideration and respect as any other person, on the basis that we all have the same dignity. The dignified treatment of older people in situations of dependency means seeking the maximum possible therapeutic benefits and the maximum possible independence and control of daily life, within the framework of comprehensive care and quality of life for the individual. From this model of care, we emphasise what is specific, daily and meaningful for each person as the main characteristics of interventions and quality of care' (Martínez, 2011).

How to work with meaningful daily activities

- Examples of significant daily activities: setting the table, sweeping, choosing clothes, preparing meals, shopping, doing the laundry, looking after plants.....
- The activities consist of many steps that can be carried out independently. The steps do not necessarily have to be carried out in a specific order, although it is true that some steps inevitably come before others (e.g. putting the tablecloth on before putting the dishes on).
- The activity and its steps should be personalised and adapted to each person who will participate.
- Some tasks can be done individually, in groups or with help.
- Each person may be able to do one or more parts of the whole task, or there may be people who cannot do any part of the activity, but who like to be there at the time. Remember that watching others do the activity can be stimulating and create a sense of belonging for the person watching.
- It is very important to respect the time that each person takes to do the activities.
- In addition, it is also important to understand that the concept of "well done" is relative, and that any intention to participate and any outcome of the task are successes, and should therefore be taken as such.

- It is also useful to sort the steps: you can keep a list, if it will help the people who are going to do the task, as a checklist.

For more information

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The Montessori Method

Methodological reference sheet
The Montessori Method
Maria Montessori created the method that bears her name by observing children. She relied on the sensory, physical and intellectual capacities of the child to enable the development of his or her potential. For her, the conditions for successful development are: - Respect for people's rhythm, - Awakening the link to others. The Montessori approach to senior care was first tested by Dr. Cameron Camp, author of Montessori-Based Dementia Programming (MBDP) at the Myers Research Institute in Beachwood, Ohio, where he is director. In this clinical and rehabilitation setting, Dr. Camp experimented with the principles and materials of Montessori education. By studying the role of the brain amygdala, a group of neurons preserved until very late in Alzheimer's type dementia, we find that : - if the rational brain is impaired, the emotional brain works. - if declarative memory is impaired, procedural memory works. The environment is redesigned to support behaviour and independence. Thus, by circumventing deficits and relying on preserved skills, people with cognitive disorders can relearn everyday gestures. It is then our view that changes. We borrow Maria Montessori's motto: "Help me to do it alone". In order to make the patient's pathway effective, it should be personalised and built with the active collaboration of the patient and his/her family. More generally, it is necessary to ensure that the Montessori method and the associated materials are appropriate to the needs of the person. Some important points to observe are Starting from observation. The Montessori specialist builds his or her own educational proposal from the careful observation of the patient, providing him or her with materials suitable for maintaining and strengthening his or her residual abilities. This serves to look at the subject in a new way, focusing attention not on the disease, but on the person's abilities. Need for order. Putting materials in order and using them in a certain way helps to maintain inner order. The material is organised so that the person perceives one characteristic of the object at a time: work on sound or colour, roughness or length, size or taste, etc. This allows the attention to be focused on one aspect of the material. A characteristic of Montessori materials is to focus on one characteristic. Sensory competence. The senses are the tools that everyone has to know and recognise the living environment. The specialised operator who prepares the material will adapt it (depending on the subject and the time) to cope with any sensory disabilities. Use of appropriate material. The material presented should be adapted to the skill level of the subject: it should not be too easy (risk of getting bored) and not too complex (can lead to frustration). Need for regularity and routine. Disorientation is one of the first symptoms of the disease and is a great difficulty to face with the patient. Each activity seeks order by having its own place, a precise and ritualised mode of execution. The material is always clean and tidy. Work on memory, in particular procedural memory. The exploration of the field of memory is done through the exploration of the senses, from the concrete to the abstract, through simple, linear paths, characterised by a clear and defined procedure. The specialised operator proposes each activity through a precise presentation, based on a careful analysis and selection of the necessary movements.

Attention to interpersonal relations. The individual relationship between the patient and the specialist operator during the presentation of the activity allows the creation of a relationship of trust and mutual knowledge useful for the construction of an optimal rehabilitation pathway. Group activities, on the other hand, allow the maintenance of social relations, cooperation and mutual aid.
Work on language. Maria Montessori studied an effective system for promoting reading and writing, using concrete actions to move from the hand to the mind and to abstraction.
Taking care of oneself and the environment. The activities proposed are based on the needs expressed explicitly or implicitly by the patient and are consistent with daily activities, useful for maintaining autonomy as long as possible. In addition to personal care, the activities aim to take care of the living environment: watering plants and flowers, cleaning leaves, dusting ...
Freedom of action and choice. The patient is free to choose the activity to be performed and the duration of its execution. The (open) activity ends when the subject is satisfied with the work done. There is no predefined programme by the operator. What counts is to stimulate his interest by presenting materials that are "attractive" to him, i.e. useful to stimulate his well-being and skills. This approach will allow to work on the self-esteem that the patient often has to rebuild, as well as on his autonomy of thought. The self-correction of the material allows the subject not to be corrected from outside in case of error, but to find the solution to the problem independently.
Effects and consequences :

- Reactivation of the capacity for social connection
- Desire to belong to a community of people
- Participation in activities of daily living
- Revaluation and appeasement of families
- Reappropriation and rehumanisation of the environment
- Changing the way we look at disease and people

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Reminiscence

Methodological reference sheet
Reminiscence
Reminiscence is a psychosocial intervention that aims to increase well-being, self-confidence and integrity of the self. It has been shown to be effective in reducing behavioural problems in people with dementia. It is based on the predisposition of older people to recall the past, as well as on the preservation of long-term memory in the person with dementia. Technological tools such as the computer, through the use of photographs, music and videos, can be used as facilitators in the process of memory retrieval. Reminiscence can also provide a supportive tool for personal history taking by preserving it in the later stages of the disease. Reminiscence can be used for different purposes: to increase life satisfaction and well-being in the elderly, to intervene with elderly people suffering from mild and major depression, to stimulate cognitive functions in dementia. One of the cognitive abilities mainly affected by dementia is short-term memory, while long-term memory remains intact until severe stages of the disease. Cognitive deterioration involves a loss of identity, supported by autobiographical memory, and social relationships (Addis and Tippet, 2004). Indeed, our memories are fundamental to sharing our experiences, to our relationships and to maintaining our identity and sense of self (Addis, 2004, Cohene and colleagues, 2006). Reminiscence therapy is based precisely on the importance of memory in supporting a person's identity and well-being. It involves 'discussion of past activities and experiences with another person or in a group, usually with the use of aids such as photographs and other items from the past such as music' (Woods and colleagues, 2008). Reminiscence is not only an intervention but is useful for "the achievement of many goals, including communication, socialisation and providing a sense of pleasure and involvement" (Woods, 1999). The main goals that reminiscence achieves are memory stimulation, improved mood and well-being, effective care through personalisation of the intervention, and reduction of the burden on the carer. Research shows that there are predictive factors for the success of reminiscence therapy. Studies by Watt and Wong (1991) show a link between the use of integrative and instrumental reminiscence and significant improvements in positive coping and psychological well-being, with a significant reduction in depressive symptoms (Karimi et al., 2010; Bohlmeijer et al., 2003). There is a better outcome for people with a positive attitude towards reminiscence than for those who are disinterested in it (Bohlmeijer et al., 2003). In order to design a satisfactory intervention, it is necessary to define specific factors: the environment, the objectives of the intervention, the characteristics of the reference group and the competence of the intervention leader. Two types of therapy can be identified: - Simple reminiscence: unstructured and spontaneous narration of personal life. The central objective is to recall positive memories, facilitate communication and social contact to improve immediate well-being (Webster and colleagues, 2010). The role of the conductor is to facilitate the process of spontaneous reminiscence and to promote social interaction. Life review: this is more structured, focusing on the integration of positive and negative events. It is primarily aimed at people who need support and coping strategies to overcome life's adversities. It helps the person to see the bigger picture of how these events came about and how they became what they are. It helps to focus on the coping resources used in the past and the values that enabled the person to successfully adapt to change and overcome life's

difficulties. It thus has a problem-solving and identity-forming function. The main objective is self-acceptance: people are encouraged to reformulate their experiences in a more appropriate way, integrating positive and negative experiences. The facilitator must have more specific skills, and must try to restructure the meaning of past events.
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Website
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ROT (Reality Orientation Therapy)

Methodological reference sheet
ROT Reality Orientation Therapy Orientation in Reality
The Reality Orientation Therapy (ROT) methodology was conceived by Folsom (1974) and later developed as a specific rehabilitation technique for patients with cognitive impairment or cognitive deterioration (Onder et al. 2005). Reality orientation therapy is based on the principle that people feel better when they are not in a state of confusion and are therefore oriented towards reality and the present space. It is a technique that focuses on the cognitive stimulation of the subject. The patient is presented with information about his or her personal history and spatio-temporal environment in order to improve behaviour, orientation, autonomy and quality of life. It aims to reorient the patient in relation to himself, his own history and his environment. This is a very simple technique that can be applied by any operator. It can be done individually or collectively and consists of gently eliciting the right answers to questions such as: what day is it today? what time is it? where are we? and so on, using tools such as calendars, clocks and all those things that help to affirm reality. ROT has proven to be very effective for patients with moderate to mild dementia. Through multiple stimuli, different cognitive abilities are promoted: praxis, attention, memory. Two different modes of ROT can be identified: - Formal ROT: also known as class ROT, consists of daily sessions of about 45 minutes and can be conducted individually or in groups. Participants should have the same level of cognitive impairment. The aim of ROT programming is to enable the patient to move around and orientate themselves in their daily life; therefore, the group ROT session leader will encourage the patient to use memory strategies, which are repeated frequently over time. - Informal ROT, also known as 24-hour ROT, is a reinforcement of patient orientation throughout the day, and can be performed by both caregivers and carers of the elderly. The aim is always to re-orientate the subject so that he/she remembers his/her personal history and can re-orientate him/herself in reality by remembering the day, date, time and place. Informal ROT aims to reinforce what has been done in the formal ROT sessions. The ROT session cannot last too long and, in general, each session is divided into two phases: - The first part is based on a daily time orientation. - The second part focuses on narrative and orientation in time and space. When ROT is done in a group, the participants should be on the same level and the group should not exceed 4-5 people. The setting should be reminiscent of a house and should essentially contain: a large wall clock with clearly visible numbers, a calendar showing the current day, comfortable chairs and a notepad. Rooms can also be decorated with some plants and paintings, but care should always be taken not to make the room too heavy. The start time of the session should always be the same during the cycle of meetings, and the same attention should be paid to the end, so that the patient knows that about an hour has passed since the session started. The therapeutic group allows for interaction between participants and therefore increases and supports the social skills (through timeliness and listening skills) of individual members.

During the session, it is very important to maintain a sufficiently high tone of voice, to explain words and, if necessary, syllables, as some older people may have hearing problems and will find it difficult to hear the questions asked. It is also advisable to call people by their own names, possibly adding the word "Mrs" or "Mr" as a sign of respect.

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Cognitive stimulation

Methodological reference sheet
Cognitive stimulation
Cognitive stimulation is an intervention strategically oriented towards the general well-being of the person in order to increase his/her involvement in tasks. It aims to reactivate residual skills and slow down the functional loss due to the pathology. The initial mistrust of the scientific world towards non-pharmacological treatments of dementia has given way, in recent years, to a growing interest due to two types of motivation. Firstly, the limits of pharmacological efficacy impose a diversified clinical approach whose keystone is not the (impossible) cure of the patient, but the care (understood as taking care) of the overall quality of life. Secondly, the evolution of neuroscience has only enriched the data supporting the plastic and adaptable nature of the nervous system in the face of internal and external changes, including those due to traumatic or pathological events. Indeed, neuroplasticity implies the ability of the brain to modify its structural organisation and functioning to adapt to new demands. The complex functions that the brain handles are determined by the number of connections between the nerve cells. To clarify, we will use the famous car metaphor. The nervous system could be compared to a very rich road system on which huge amounts of information travel. Normally, to go from Lyon to Paris, I enter the motorway, the journey is generally quite fast and easy. If, however, due to an accident, the motorway is blocked, I will still be able t o reach Paris through a rich network of national roads. It will take me longer, the traffic might be less easy, I might also get lost, but in the end I will reach my goal. Mental activity, environmental experiences, the quality of cultural training and life work are powerful factors that determine the number and quality of active neuronal connections. The more connections a network has, the richer it is in alternative routes that can replace and compensate for circuits damaged by disease or minor trauma. In the adult and elderly brain, remodelling phenomena mainly concern two neurological processes: the formation of new synapses (connections between neurons) in response to damage to consolidated nerve pathways, and the reactivation of latent, little-used pathways. Cognitive stimulation therefore acts by promoting the progressive functional reactivation of secondary nerve pathways, which are widely distributed in adult nervous systems. In response to a lesion or physiological loss of neuronal material, it would therefore be possible to recover certain inhibited connections through systematic stimulation experiments (Cesa-Bianchi M., 1999). Our brains seem to have a kind of cognitive reserve made up of the large number of nerve cells we have and the number of pathways that connect them. One could imagine a large army engaged in warfare: the soldiers of certain elite corps (like our neurons), used in the most delicate operations, can be subject to dramatic losses but also be replaced, training new soldiers to replace their missing companions. This is how our brain, if sufficiently stimulated, repairs its small damages autonomously. It is not only the number of connections that is crucial, but also their strength, i.e. the frequency with which they are used. Each time a pathway is traversed by new information, it stabilises and consolidates, so that the more we 'dust off' a memory or skill, the more we promote its maintenance. It is a very familiar experience for those who decide to take up a sport that has not

been practised for many years: noticing how uncertain the first movements are, a little clumsy, rigid perhaps, but, after a little practice, the pleasant feeling of easily recovering hyper-learned gestures (practised many times in the past) and of quickly recovering that fluidity of gesture that we had in the past.

The objectives of cognitive stimulation:

- Promote the use and maintenance of residual functions over time. Cognitive deterioration does not occur in all subjects with the same characteristics and with the same level of severity. Subjects differ in the degree and quality of their remaining abilities.
- Stimulation means, above all, knowing the global and specific level of functioning and modulating the activity proposal in order to promote the use of skills that are still sufficiently retained. Cognitive stimulation is therefore a highly structured activity, not to be confused with any other type of recreational or playful proposal. The difference between a naive intervention and a correct stimulation does not consist mainly in the individual activities proposed, but in the targeted, individualised and specific nature of the exercises.

Promote rewarding experiences that support self-esteem and self-image. For any type of proposal to be accepted and implemented by the older person with dementia, it must be adapted to the person's interests and social skills. In particular, it is important that the activities allow for a healthy self-esteem and promote the maintenance of a good personal image. For this reason, activities carried out using childish materials may, for example, be experienced as humiliating and therefore rejected.

For more information

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Sensory stimulation

Methodological reference sheet
Sensory stimulation

Ageing is normally accompanied by a progressive deterioration of the five senses. However, knowledge about how the senses change due to dementia is limited (Strøm, Ytrehus, Grov, 2016; Wittmann-Price 2012). What we do know is that the way a person with dementia interprets what they see, hear, taste and smell appears to change as a result of the disease (National Institutes of Health, 2002) and depending on the stage of dementia (Alves et al. 2014).

Sensory stimulation is based on the activation of one or more senses (taste, smell, sight, hearing, touch) through various tools and materials, which helps to stimulate the senses. Sensory activities provide a level of stimulation that works on awareness and attention due to the simplicity of the task.

Various psychosocial interventions based on the stimulation of the senses, sometimes called "activities, methods, therapy or stimulation", have been developed (Fossey et al. 2006, Kolanowski et al. 2010).

Types of sensory stimulation and their benefits :

1. Auditory stimulation :

Very useful for improving mood, cognition and relaxation. This includes a wide range of sounds: natural sounds, symphonies, songs, etc. Listening to sounds is an essential part of connecting with our senses. Many dementia patients have hearing problems, so it is essential to stimulate this sense, remembering that adjustments may be necessary.

2. Tactile stimulation :

This type of stimulation is about awareness of texture and touch. The brain pathways are used and stimulated every time we use our hands to hold something.

3. Visual stimulation :

Sight is one of the most important senses that helps us deal with a huge amount of information. Tragically, Alzheimer's disease and various dementias can affect the visual processing system.

- Light therapy is a visual therapy that has been successfully tested in patients with Alzheimer's disease and dementia. It can improve sleep cycles, reduce wandering and wandering and improve cognition and behavioural functioning.

Films and videos offer auditory and visual stimulation. When choosing a film, it is best to opt for a film with a story that the individual can easily follow or for the recipient's favourite film to stimulate memory. Films with beautiful images, for example those set in nature, or with soft music, are suitable.

- The decoration of the living space is very important. Creating a visually stimulating environment, even with pictures, can be profoundly helpful for a person with dementia.

4. Olfactory stimulation

Some of our oldest and strongest memories are activated by the sense of smell. Well-known basic aromas such as mint, lavender or rosemary are used for olfactory stimulation. These are also essences used in aromatherapy, which is much more than sensory stimulation. Spices and flavours can also stimulate the memory or the sense of taste.

5. Snoezelen

This is called controlled sensory stimulation. It is used with people with severe intellectual disabilities. They are exposed to a 'calming' and 'stimulating' environment called a Snoezelen Room (or more precisely a multi-sensory stimulation room) which uses light effects, sounds, music, scents, surfaces, tactile shapes and taste stimuli.

To date, several studies are available in the literature on the use of the Snoezelen methodology as a therapeutic tool. The results show that following multisensory stimulation sessions, there is a reduction in non-adaptive behaviours, with an encouragement to positive behaviours (Baker 2001, van Diepen 2002, Hope 1998, Long 1992). In short, the Snoezelen approach allows behavioural disorders to be managed, promotes relaxation, contact, interpersonal relations and well-being; the person becomes active again. The operator adapts to the person's forms and methods of communication. He is a partner fully involved in the action because he is the one who interacts and helps the person to interact with the objects present, he is his conscientious guide. It is also open to the signals sent and encourages the person's free choice.

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Occupational therapy

Methodological reference sheet
Occupational therapy
Occupational therapy (OT) is a rehabilitation activity that promotes health and well-being through occupation. It is a rehabilitation process that uses as a privileged means the "doing" and the numerous activities of daily life. Through individual or group intervention, it involves the whole person to help him/her adapt to a certain context or life condition from a physical, psychological or social point of view, in order to improve the overall quality of life, even in a situation of disability. It is supported by the "occupational science", born for scientific research, based on the importance of occupation in human nature. Occupations are the set of activities that are meaningful to their cultural context, appropriate to age, choices, organised and carried out by each individual to support themselves, experience the joy of living and contribute to the economic and social life of the community (Canadian Association of Occupational Therapy, 1997). Occupation is the goal of OT but also the means by which one tries to modify the person's bodily functions (sensory-motor, perceptual-cognitive, emotional-relational abilities). In general, there are three areas in which we can find occupational activities: self-care, work (school) and leisure. Occupational therapy is practised in many places, including hospitals, health centres, the home, workplaces, schools and nursing homes. Patients are actively involved in the therapeutic process and the outcomes of occupational therapy are varied, patient-driven and measured in terms of participation or satisfaction derived from participation (World Federation of Occupational Therapy). Occupational therapists (OTs) play an important role in helping people of all ages. Occupational therapy is necessary to overcome the effects of dysfunction caused by illness, ageing, accidents, temporary and permanent disabilities. Occupational therapists intervene professionally so that the person can carry out daily or professional activities with the highest possible degree of independence. They are qualified professionals who find solutions to everyday problems. Occupational therapists address all physical, psychological, social and environmental needs, providing support that makes a difference in the patient's life, opening up new horizons. Occupational therapists serve users by giving them the opportunity to make decisions: they bring their medical expertise, They help the person to choose the objectives and the form of treatment he/she prefers, by giving him/her a voice. Occupational therapists have extensive training that gives them the skills and knowledge to work with individuals or groups of individuals who have structural or functional deficits due to a health problem and who face barriers to participation. Occupational therapists believe that participation can be supported or limited by the physical, social, attitudinal and legislative environment. Therefore, OT practice can aim to change aspects of the environment to increase participation.
For more information
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Website

Canadian Association of Occupational Therapy https://www.caot.ca/