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Feelings Matters Most

Consultancy • Training • Service Development • Research

Butterfly Household Model of Care™

dementia care matters®

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Culture Change Matters in Dementia Care

The Butterfly Household Model of Care ®

Action Checklist

(Revised Version 2.)

" In the Butterfly Approach transforming cultures of care, creating households and focusing on quality of life matters "

Dr David Sheard
CEO / Founder, Dementia Care Matters

The Butterfly Household Model of Care®

This checklist has been devised to share with a wide global audience. It is a blueprint of very practical ideas in achieving quality of life in care homes. Many of these will be easy to understand and action but all the elements are based on a model which has been devised by Dementia Care Matters over many years.
If you would like more information or clarity on any parts of the checklist and how to implement these, please contact a member of the Dementia Care Matters team at.

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The Model's points are listed in priority order i.e No1 is the highest priority

The purpose of this Model Checklist is not to be definitive or comprehensive, nor to create another version of institutionalised approaches.

All of the points on the Model Checklist need to be considered in terms of their relevance to each individual care home and each person.

The purpose of the Model Checklist is to focus on inspiring and improving culture change in dementia care

Whilst this Model Checklist focuses on achieving excellence in Dementia Care we also believe that *"good dementia care = good care for everyone "* and therefore the Butterfly Household Model of Care has been found to be relevant in supporting a wide range of people and for all forms of care and support.

The Butterfly Household Model of Care®

Care Home:

Name of person completing the Model Checklist:

Date of completion:

Work through the Model Checklist on the basis of:

"If I came to the Home today would I see evidence of ……

being offered / provided to people living with a dementia?"

Thank you for being committed to improving people's quality of life and the culture of care

	(Tick one box per element listed below)	YES	NO	PARTLY
	"Feelings Matter Most" Approaches			
1.	**Feeling Based Recruitment & Training:** All staff are recruited and appraised on their values, attitudes and emotional intelligence.			
2.	**One Key Belief:** Staff are able to express the care setting's one key belief - its one purpose about the household model of dementia care.			
3.	**Feeling Based Home:** On arrival people would see, hear and feel immediately it is a feeling based Home within 5 minutes of walking in.			
4.	**Manager Modelling:** Staff feel the manager models a "Feelings Matter Most" approach - the manager is seen modelling person centred care during the day in the households, and feels truly a team member by all household staff.			
5.	**Nurse Leadership:** Individual nurses are appraised on being a new culture nurse - their emotional intelligence and their capacity to lead on this.			
6.	**Being With:** Lots of feelings based communication by staff can be seen occurring with love and comfort visibly happening, when needed - with staff at times sitting and just 'being with' people.			
7.	**Two-way Giving:** People living with a dementia are enabled to be in positive relationships 'giving' to people as well as 'receiving' support from people – their contributions are extremely valued and nurtured.			
8.	**Qualitative Observation:** Staff are trained in observing quality interactions and on at least an annual basis each person undertakes a qualitative observation, feeding back their findings to the team to improve care.			
9.	**Language of Dementia:** Staff demonstrate they know the language of dementia is about feelings and that when people living with a dementia talk about Mum, Dad, Kids, School, Home and Work, it is often not literal but about how people are feeling now and their needs now.			
10.	**Staff Well-Being:** Staff express positive comments about why they work there, the feelings and well-being working there creates for them, and that their emotional labour is recognised and supported.			
	TOTAL :			

	(Tick one box per element listed below)	YES	NO	PARTLY
	Removal of 'Them' and 'Us' Barriers			
11.	**Uniform Removal:** Uniforms have been removed and staff look like friends, not like nurses in charge, using their 'Look' to help connect with people, looking like colourful butterflies, creating fun and at times wearing their activity aprons.			
12.	**Sharing Lives:** People living and working together share their lives, use family-like terms to refer to people living and working in the home, eating together, with no separate staff areas in people's households i.e. no separate staff toilets etc.			

	(Tick one box per element listed below)	YES	NO	PARTLY
13.	**Personalised Medication:** Administration of medication is personalised, with all staff trained and peer reviewed regularly on their practice, giving this out individually, from locked cupboards in peoples own rooms.			
14.	**Going with the Flow:** 'Going with the flow' is how the day feels - with no sense of the routines that occur in hospitals, and where task orientation is not the model that 'runs the day' but where tasks are more subtly completed in a model based on people first.			
15.	**Night Clothes for Staff:** At night time, when appropriate, staff wear their own night clothes to match their 'look' to the help people need - in terms of helping people distinguish between day and night and giving the correct cues to people living with a dementia.			
16.	**Respect:** Staff do not talk about people living in the home whilst in the households and instead remove themselves to staff areas for any necessary discussion.			
17.	**Homely Desks:** Nursing stations and other hospital-like features are removed, replaced if necessary by domestic looking desk areas giving a more 'homely' feel.			
	TOTAL :			

	(Tick one box per element listed below)	YES	NO	PARTLY
	Creating Households			
18.	**Home Like:** Positive attempts have been made to reduce the impact of a hotel like environment whilst retaining a quality environment – it looks more like a home than a hotel.			
19.	**Households:** The Home is ideally divided into a number of separate households or at least separate house-like living areas.			
20.	**Domestic Size:** Real small-scale domestic living exists i.e. maximum lounge sizes of 8 – 12 people.			
21.	**Own Front Doors:** Where possible care homes are divided into households which exist with their 'own front door', through which staff and visitors come and go as 'Guests' in a person's home.			
22.	**Matching People:** People are matched i.e. grouped together at a similar point of experience of living with a dementia in order to reduce stress, to not mix up people fearful of one another and to increase individual well-being.			
23.	**House Leaders:** House Leaders are appointed on the basis of their values, attitudes, emotional intelligence and emotional competency.			
24.	**Housekeepers:** Housekeepers are appointed as the heart of each household ensuring that domesticity, cleaning and food preparation are a core part of the day involving everyone living and working together.			

	(Tick one box per element listed below)	YES	NO	PARTLY
25.	**Lounge Diners:** Lounge diners are created where visibility, sensory cues and meal time preparation become central to the day rather than "herding" people unnecessarily backwards and forwards to dining rooms.			
26.	**The Household 'Story':** The whole household environment is created 'to tell the story' in the lounge diner, hallways and personal rooms of people's past and present lives and the new moments they have shared living together.			
27.	**Personal Rooms:** Bedrooms are turned more into personal rooms with a living function i.e. not just a place to sleep where the bed and ensuite over dominate.			
28.	**Later Stage Household:** A 'Later stage' dementia care household (or living area) is created and the specialist skills needed to support people at this stage of their life has been developed.			
29.	**Care Partners**: Families are seen to be 'at home' and are significantly visibly involved in the daily life of the household as "care partners". As care partners, emphasis is placed on quality of relationships really mattering between families, staff and people living in the household.			
30.	**Sense of Community:** People living in households visit each other in different households, maintain friendships across households and the wider local community is actively involved within the home.			
	TOTAL :			

	(Tick one box per element listed below)	YES	NO	PARTLY
	Evidence of Freedom			
31.	**Emotional Memory:** Staff clearly recognise the importance of people's emotional memory and their treasured emotional possessions and understand the interplay between these, demonstrating this in their daily contact with people.			
32.	**Free Outside:** People are freely able to go outside into safe enclosed private areas, without needing doors to be unlocked or having to be accompanied.			
33.	**Acceptance of Reality:** Clear evidence exists that families have been educated in the philosophy of the household model of care. Families are visibly accepting of people living with a dementia's different realities and appear not to try to force their own reality when they visit. Families also understand the need for different households for each 'stage' of experience of a dementia.			
34.	**Promoting Rights**: Staff are not obsessed with risk prevention and excessive health and safety beliefs – they meet legal requirements but evidence during the day that their approach is in the context of promoting rights and measured risks.			

	(Tick one box per element listed below)	YES	NO	PARTLY
35.	**Later Stage Freedom:** People experiencing the later stages of life are given greater access to light, air, the natural world and 'live' experiences e.g. music, children and animals.			
36.	**Outdoor Occupation:** Regular use by people living in the home of the outdoors is ensured, the outdoors is more than a garden and has become an area to occupy people e.g. an old car on blocks, a washing line, 'activity' based sheds etc. and where the outdoors is brought closer to the inside.			
37.	**Neuroleptic Reduction:** Limited use exists of 'anti-behaviour' medication – i.e. anti-psychotic medication/neuroleptics, where this is used only as a last resort to relieve acute distress when other ideas and strategies which have been tried first have not worked.			
	TOTAL:			

	(Tick one box per element listed below)	YES	NO	PARTLY
	Being Occupied			
38.	**Being a Butterfly:** Masses of short one minute connections between people living and working together occur – staff look like they know how to be butterflies creating lots of positive moments of social interaction.			
39.	**'Theatre Stage' Setting:** Staff set up the houses each morning with props and 'stuff' to encourage engagement and connections and develop a loose but flexible plan for the day on how to occupy people.			
40.	**Domesticity:** People living with a dementia are encouraged and when they choose are seen regularly doing domestic activities and maintaining their own life skills during the day.			
41.	**Work Like Encouragement:** Some people living with a dementia, when it is helpful, are supported in their reality to 'do' a part of a work-like job they did in the past.			
42.	**Physical Activity:** There are regular opportunities for people to enjoy physical activity and independence ranging from pouring your own milk to going out for a walk.			
43.	**Matching Activities:** Knowledge exists of how to 'match' the right level of activity and occupation, appropriate to where an individual is, in relation to their point of experience of living with a dementia.			
44.	**Sensory Approaches:** Sensory calming periods alongside sensory stimulating items are alternated, when appropriate at different times of the day, for people living with a dementia who have repetitive expressions.			
45.	**Comfort Objects:** Comfort objects, i.e. dolls, prams, soft toys, sensory items and sensory fabrics e.g. velvet, are all available and visible within the service.			

	(Tick one box per element listed below)	YES	NO	PARTLY
46.	**Attachment & Touch:** The concept of attachment, approaches to supportive touch and the use of massage and other physical therapies are evidenced as central to the home's model of care.			
47.	**Individual Music:** Choices of music and a variety of music geared to an individual's experience including other natural sounds, e.g. bird song are introduced at relevant moments of the day.			
48.	**Media Use:** Music, TV, radio and tablet computers are provided and regularly reviewed i.e. appropriate usage to ensure enjoyment, variety and interest.			
	TOTAL:			

	(Tick one box per element listed below)	YES	NO	PARTLY
	The Mealtime Experience			
49.	**Mealtime Orientation:** Orientation towards the meal (approximately 45 minutes prior to a meal) is actively encouraged through the use of cooking smells, food discussions, talking about recipes, using pictures of food, laying tables, being involved in food preparation with the aim of encouraging engagement, increasing appetite and achieving potential increase in weight gain.			
50.	**Meal Quality:** The quality of the dining experience, standard of food and setting up of dining tables indicates people are valued in terms of the meal experience being offered.			
51.	**Sociability:** The mealtime experience is turned into a social occasion and not a task. Staff are clearly trained in how to keep mealtime conversations going to improve appetite using objects, items in their pockets, and for example, perspex boxes on tables which are full of things to talk about, including photos.			
52.	**Visual Choice:** At each meal the meal choice and drinks are visually shown at the time of the meal and people are encouraged to serve themselves and each other at the dining table.			
53.	**Food Availability:** In the lounge diner food availability is always visible over a 24-hour period, and whilst meeting Food Hygiene Regulations, this is with the key aim of encouraging people to eat when they feel like it.			
	TOTAL :			

	(Tick one box per element listed below)	YES	NO	PARTLY
	Person Centred Care Planning			
54.	**Positive Language:** Controlling care and labelling language in care plans has been removed i.e. words such as: wanderer, challenging, aggressive - staff replace this negative language with words that first describe the person's feelings that are leading to the person's expressions.			
55.	**Focus on Strengths:** Care plans whilst evidencing people's needs in terms of eligibility for support also do focus on people's strengths and are not lists of losses and dependency. Care Plans are not solely based on problem sheets, but on supporting people's remaining abilities with daily records of what people have enjoyed doing.			

	(Tick one box per element listed below)	YES	NO	PARTLY
56.	**Life Story:** Detailed life stories – books, memory boxes etc. are being used daily by people working there with people living there and staff's life stories are also produced and visible to everyone in the home as a way, on a daily basis, for people living and working in the home to reach and connect with one another.			
57.	**Quality Personal Care:** Each person is involved in, assessed and receives a personal care plan that supports their holistic personal care.			
58.	**Wellbeing:** Individual assessments of people's well-being and ill-being are regularly completed and acted upon - with the aim of increasing an individual's well-being and creating in a household a sense of mutual regard between people.			
59.	**Pain Assessment:** A validated dementia care pain assessment tool is used to monitor and respond to people's individual experience of pain.			
60.	**Closeness & Intimacy:** Each person in terms of their rights, well-being, capacity and consent is assessed and appropriately supported to experience the individual closeness they need to still feel in life, which may include expression of intimacy needs.			
61.	**Rescuing Approach:** Staff see all 'behaviours' as an expression first of feelings and through training understand when needed how to support and rescue people experiencing 'stuck' feelings.			
62.	**Quantitative Measures:** The home collates, through individual care planning, group statistics and evidence of culture change measures i.e. reduction in falls, decrease in safeguarding concerns, decrease in hospital admissions etc.			
63.	**Holistic Handovers:** During staff handovers a positive feeling-based approach to reporting back and sharing people's daily life is used rather than a medicalised model focused inappropriately only on people's bodies and physical functioning.			
	TOTAL :			

	(Tick one box per element listed below)	YES	NO	PARTLY
	Adapting Dementia Specific Environments			
64.	**Orientation:** Orientation aids i.e. colour, objects and appropriate domestic like signage throughout the household exists to enable people to find their way through a range of cues, including pictorial signage where appropriate on bathrooms and toilets.			
65.	**Engaging Hallways:** Hallways exist which are divided into coloured sections, with objects and / or seating to prevent a sense of sterile, clinical areas. Activity and sensory items are on the walls to occupy people consistent with fire regulations, reasonable infection control procedures, and Dementia Care Matters Fire Safety guidance.			

	(Tick one box per element listed below)	YES	NO	PARTLY
66	**Filling the Place Up:** Untidiness exists with clutter and rummage items all being out in lounges, offering opportunity for people to be busy on an individual or small group basis and where staff encourage spontaneity by involving people in the house with all the "stuff".			
67.	**Personal Room Identification:** Doors to personal rooms i.e. bedrooms look easily identifiable – with either coloured front doors or surround frames, notice boards like stories in a journal, or memory boxes by the door are created - whatever works for each person.			
68.	**Shared Seating:** Lounges have sofas to encourage people living there, working there, or visiting and supporting people to sit and share time together.			
69.	**Cues in Artwork:** Lounges have artwork and pictures that denote the function of the room as a cue i.e. not placing confusing pictures up on the walls unrelated to the room's function.			
70.	**Inviting Bathrooms:** Bathrooms are not clinical but warm, inviting places to want to relax in and give a sense of well-being, therefore reduction of reflective tiling, and glare has been actioned.			
	TOTAL :			

Now you have completed all the sections please collate the total number of 'YES' 'NO' and 'PARTLY'	YES	NO	PARTLY
OVERALL TOTALS :			

	Please list below any areas that this checklist has not identified that you feel the service is achieving or has not considered but needs to action in developing a more person centred response.	YES	NO	PARTLY
71.				
72.				
73.				
74.				
75.				

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- This model checklist is only one practice development approach within the whole Butterfly Household Model of Care.

  This Checklist should be considered alongside Dementia Care Matters other approaches:

  - 'The 30 Point LOOK Checklist ' available from Dementia Care Matters.
  - The Quality of Interactions Schedule (QUIS) in a care home – 'Enabling: quality of life an evaluation approach' published by Dementia Care Matters.

Future Action Planning – our Commitment

Date of next review: …….

6 elements in this Checklist which we commit to turning into a **'Yes'** are :

ITEM **DESCRIPTION**

Please select 6 elements from the Checklist listing the Element number, its heading and its description in the 6 boxes below

"Dementia Care Matters believes that a specialist model of dementia care is required to build on the care sector's current level of expertise.

However, in the future the real success of a household model of care will be in the creation of true inclusion. Eventually specialist dementia care may no longer be required because each person will be accepted as an individual by everyone living together. The long term goal should be to create staff teams emotionally intelligent enough to know how to match their skills to each individual person." **– Dr David Sheard**