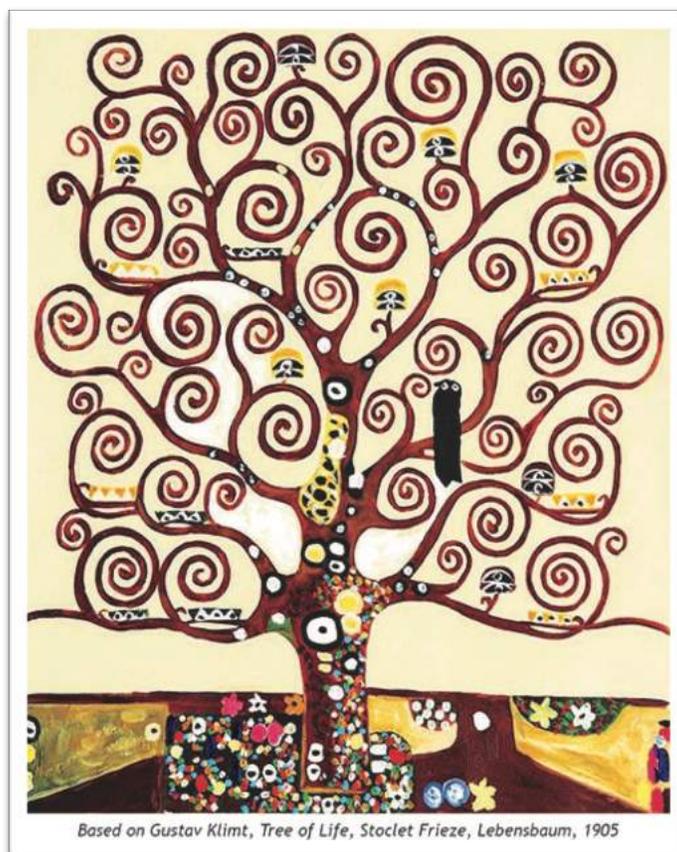




## **Norwegian Advisory Unit for Aging and Health: Methods for Success**

*Interview with Janne Rosvik*



By William Haseltine

ACCESS Health International

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**Elder and Long Term Care**

An ACCESS Health International Program Area

## **Background**

This interview is part of a larger study of elder care and dementia care in Northern Europe. In this interview, ACCESS Health interviews Janne Rosvik about her work at the National Advisory Unit for Aging and Health in Oslo, Norway. The interview focuses on caregiving methods that may improve the quality of life and reduce agitation and depression among individuals who live with dementia. Ms. Rosvik argues that it is the responsibility of family members, friends, and caregivers to do their best to interpret the signals of a person who suffers from dementia by actively assuming the perspective of the individual. In Norway, eighty percent of all persons who live in care homes suffer from dementia.

## About Janne Rosvik

The research of Janne Rosvik focuses on person centered care. Rosvik has built on the previous thinking of Tom Kitwood and of Dawn Brooker. Tom Kitwood wrote about personhood and the importance of assuming the perspective of the individual who receives care. Dawn Brooker created the VIPS (values, individuality, perspective, and social inclusion) framework, which articulates Kitwood's care philosophy. Janne Rosvik has developed the VIPS practice model.

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## Interview

**Janne Rosvik (JR):** My name is Janne Rosvik. I live in Oslo, Norway. I am a registered nurse. I also have a master's degree in political science and a PhD in person centered care and dementia care. Both of my degrees are from the University of Oslo. I developed the VIPS practice model as part of my PhD research. VIPS stands for values, individuality, perspective, and social inclusion.

The V stands for the values of person centered care. The main value is that the person with dementia and the perspective of that person are just as important as our own perspectives as caregivers. The I is for individual care, which means we observe and note each person's unique traits. What is special about this person? What are his habits? What other illnesses does he have? The P is for the perspective of the person with dementia. How does the world look from his point of view? The S is for social inclusion. Are his social needs taken care of? Is he included in social fellowship with other people? Each letter has six subindicators, which are used in the analysis that is a part of the VIPS practice model. We check all twenty four indicators and determine if any one of those is relevant to a given situation.

We look for several indicators. Is the external environment here good for the person? Is there something in the environment that is disturbing him? Do we care about his perspective? Are his human rights taken care of? The I, P, and S indicators are used most because they are more concrete, but we do not skip any of the four elements. This is how we make sure that person centered care is the focus here.

I have worked here in Oslo at the National Advisory Unit for Aging and Health for six years. Before that I was a lecturer in the bachelor's degree program for registered nurses. I used to work as a registered nurse and as a manager in homecare services.

When I was teaching students and preparing them for their first training period with old people in care homes, I became interested in research. About eighty percent of people living in care homes here have dementia, so most of the students' residents by far would require special care. I insisted that the program not just focus on basic nursing, but also on dementia training. The focus before was on basic nursing, personal hygiene, and nutrition. The students weren't prepared. They had to learn something about dementia care.

In my time as a practicing nurse, I found that I had a special heart for people with dementia. I like being with them. I visited those people when I was a nurse. If there were people with dementia, I volunteered to be responsible for them. It provoked a lot of thought when I talked with them. Having dementia goes to the heart of who you are as a human being. They have to battle with big existential questions. Who am I when my brain is not working well?

Another institution asked the nursing college to send some teachers to teach elder care in China. My employer sent me and another lecturer. In China, as in most of the third world, there is no tradition of care homes because they care for their elderly at home. In the big cities they have the same problem as we do in the western world: there are no people at home to give care. Both the husband and the wife are working, so there is no one at home to care for their elderly. They now recognize a need for care homes in China, but they need to teach their healthcare professionals how to care for people who are old.

When I went back to teach again, I noticed that there were no people with dementia in the care homes. When I asked them about this, they said, “We cannot admit people with dementia. They are too hard for us to handle. They do things that we cannot deal with. We do not have the skills to care for persons who are dying or for persons who are too ill.”

I said, “But those two groups are the most important groups. If you cannot take in the terminally ill and people with dementia because you lack skills, then I will provide those skills.” I changed the program to include those two areas. Then I developed a new program to teach those two areas specifically. As I returned year after year and visited the same places, I saw that they had started to admit people with dementia. They now know better how to care for them.

I taught all over China. I went there for nine years in a row and visited places all over the country. Back in Oslo, I started focusing more and more on dementia to prepare for my teaching in China. I started looking for literature. I found Tom Kitwood’s writings. I was fascinated by person centered care and made that the main topic of my doctoral research.

**SW:** What is at the core of person centered care?

**JR:** The core of person centered care is to think of a person with dementia as a person who has the same needs as everybody else. The thing that is happening in his brain does not change his value as a person. It makes him a person with

problems in the brain. His feelings and his emotions are still there, maybe even a bit stronger. When the person becomes agitated, which we often see, it may be because he is unable to express himself. We need to learn how to use all the knowledge we have about the symptoms of dementia to try to understand the person's perspective on the world around him. What is happening in his brain often makes it difficult for him to explain with words, so he may have to use other means of communication. It is our responsibility to learn his way of communicating. We don't just try to make this person nonaggressive; we try to understand him.

Tom Kitwood has given us a way of thinking that can help our understanding. We focus on the need for inclusion, the need for comfort, and other basic psychological needs. We look for physical needs and for pain. We cannot change the person with dementia—we have to change the focus of our care. This person is saying something sensible, like he always has. He is just struggling to say it. We have to learn how to understand each person, do the research, talk to the person, and figure out what he is trying to communicate.

Kitwood developed dementia care mapping as a way of observing how a person with dementia is doing during the day. An example of feedback from dementia care mapping might be: "This person was sitting alone for three hours, sometimes crying. When someone sat down with her, she responded very well to communication." That kind of thing. Dementia care mapping has continued to develop, but we need more methods we can use to teach healthcare personnel person centered care.

**SW:** Please describe dementia care mapping in more detail.

**JR:** You must take some courses to become a certified mapper. It is a structured way of observing a person's mood and engagement. There are fifteen categories, which you rate within a range of minus five to plus five. You watch two or three individuals for three to six hours and you record what is happening. You do not go into private rooms. You sit in a common area like the living room or the lounge. If the person is just sitting there, there is a code for that. Is he engaging in something or not? How is his mood? You use the categories to record what happens. You might see that a caregiver comes and sits down and talks to the person, and you can record that his mood goes up, his engagement rises. You record how long this activity goes on. You record what happens to the person's mood and engagement when the caregiver leaves, and so on.

After the observation (the mapping), you give feedback to the staff about your observations. Then you discuss with them what can be done. If the person responds well to something, they may decide to do more of that activity. You use mapping to discover how to help a person have a good day by noting how he fares in a variety of situations. There should be a natural flow of moods throughout the day. You can do a new mapping later to see if the intervention the staff implemented after the previous mapping session worked as intended.

**SW:** Do many care homes use this in Norway?

**JR:** Norway is one of the countries where mapping is most used.

**SW:** Are there disadvantages of dementia care mapping?

**JR:** You need to keep the knowledge present in your head. All fifteen categories. It is a lot of information. It is also very intense to sit for three to six hours and mark what is going on every five minutes. It takes time to prepare to do it, to analyze it, and then to present it. I would not say it takes too much time, but it is demanding. You need to do it frequently to be good at it.

**SW:** Where can you receive training in dementia care mapping?

**JR:** Designated persons are certified to train. It is an international network. There is a headquarters in the United Kingdom, at Bradford University.

**SW:** Was the VIPS practice model developed here in Norway?

**JR:** Yes, I developed VIPS in my PhD thesis. I think dementia care mapping is a very good tool, but I wanted something additional. It was very important that it be easy to learn. The VIPS practice model is easy to learn, but once you learn it the real training begins. With the VIPS practice model, you can send a few caregivers from each unit for a course, but then the rest of the staff in the unit needs an introduction, and all of the staff needs to work together from then on. It is not like dementia care mapping, where one or two receive the training and do it independently. The whole staff uses the VIPS practice model.

We hold a weekly meeting in which everyone has a role. There is one staff member who represents the majority of the staff. This person is the chair of the meeting. If registered nurses are the majority, the chair will be a registered nurse. If assistant nurses are the majority, one of them will chair the meeting. The leader of each unit has to be present, as well as the primary contact for the

resident whose care is discussed at the meeting. We also have a VIPS practice model coach in each institution who helps the staff while the VIPS practice model is new to them to help them get a good start. Those are the main roles. The primary contact for each person is supposed to speak on behalf of the person who receives care and present the situation from his perspective.

The hub of the VIPS practice model is this weekly consensus meeting. At the meeting, each primary contact addresses the chair and says, for instance, “I would like to discuss the morning care situation for my patient.” They need to discuss just one situation—not the whole person, just the morning care procedure, for example.

There is obviously something this person is trying to communicate that the caregiver does not understand. We need to discuss that. In the meeting, the caregiver is asked by the chair to tell the others what she thinks happens in this situation. How does the individual experience it, based on his facial expression and what he is saying? We encourage caregivers to interpret signals. Does he look angry? Does he look scared? Does he look frustrated? Is there some word that he is repeating? Is there something disturbing him? What does his body language say? Does he try to grab you or does he push you away? What is his perspective on the situation? This is very difficult, so we spend a lot of time training and focusing on that. We use films to teach staff how to look for signs. We have some very good films produced in England that help us take that perspective.

When the primary contact has presented the situation from the perspective of the individual, the other nurses describe how they perceive the situation. You receive as much information as you can. Then you use the VIPS framework with all the indicators and determine which indicators are relevant.

**SW:** How often do you recommend meetings about one person? Is it only when issues arise, or are they scheduled regularly?

**JR:** If we focus on two indicators and make some interventions to improve the situation, then we typically evaluate these after a week. Did it improve the situation? If it did not, then we have to reassess the situation.

**SW:** Is it challenging to make time for these meetings?

**JR:** Homes have to find time, and they do. They do not all find time every week, but maybe every other. The staff love the meetings because they want to do a better job. The V, values, goes for the staff as well. They are valued too.

It is very difficult if one person says, “We need to change our routine,” but the rest of the staff says, “Why should we?” But if you sit in a meeting and you conclude together that you need to change the routine to meet a person’s needs, then everybody is on board. It is very difficult to change routines without the consensus of the whole group.

In Kitwood’s 1997 book, *Dementia Reconsidered*, there is a chapter called “The Caring Organization.” three of the main elements from this chapter are teamwork, supportive leadership, and coaching or guidance. You can recognize these elements in our model. Teamwork is in the meeting. Supportive leadership is in the presence of a leader. That is important because she is there to support, not to lead and coach. The VIPS framework is Dawn Brooker’s. She is the coauthor of two or three of my papers.

**SW:** Please describe the effect of person centered dementia care on quality of life measurements.

**JR:** In *The Effects of Person Centered Dementia Care*, we tested the effect of dementia care mapping and the VIPS method using the Brief Agitation Rating Scale, the Neuropsychiatric Inventory (NPI), the Cornell Scale for Depression and Dementia, and the Quality of Life in Late Stage Dementia Scale (QUALID).

We did not find a significant effect on the Brief Agitation Rating Scale with either method. We saw significant effects on neuropsychiatric symptoms with both methods. When we looked at the twelve items on the NPI (depression, agitation, irritation, sleeping disturbances, psychosis, hallucinations, delusions, and so on) we found significant reductions in all of those compared to the control group. When we looked at the subscales—one agitation subscale, one subscale for psychiatric symptoms such as hallucinations and delusions, plus another one for mood—we also found significant reductions compared to the control group.

There was a reduction in depression for both methods, but the reduction was only significant for the VIPS practice model, not for dementia care mapping. Usually depression and quality of life are parallel. If one goes up the other goes up; if one goes down the other goes down. It was very unexpected that both methods did not have a significant effect on both.

Dementia care mapping had a significant effect on quality of life and the VIPS practice model had a significant effect on depression. I think it has to do with the point of contact. In dementia care mapping, the observations were done in the eating lounge, so it focused on what was happening at the meal. The feedback was centered on things that had to do with the meal, which corresponded with some of the items on the QUALID scale.

In the VIPS practice model, the points of contact were in the individuals' rooms, not in the common areas. The focus was often on situations that corresponded with some of the items on the depression scale.

**SW:** What are your recommendations for the future based on these results?

**JR:** We think this indicates that person centered care can decrease agitation. We always thought this was the case, but it is difficult to prove. The fact that we were able to observe significant results is exceptional because this is a psychosocial intervention and very difficult to measure with a randomized control study. That is the reason why it is so difficult to say that person centered care works. So many factors can be compounded. Dementia care mapping is the method that has been researched most because it was developed two decades ago. The VIPS practice model is new.

**SW:** In terms of these models and your results, what would you recommend to caregivers today?

**JR:** We have just published a booklet called *Implementing Person Centered Care*. We recommend using four methods at the same time. Two of these methods are dementia care mapping and the VIPS practice model.

**SW:** Can you describe the other two methods?

**JR:** They do not spring from Kitwood's work, but the theory they use is very compatible with Kitwood's. Marte Meo focuses on micro communication, the communication between the individual and the nurse. They use video cameras. They take three to five minutes of film of a difficult situation, then they analyze it. They determine what is happening and how the nurse can change her way of communicating. When you see it on film, things that you are not able to see when you are in the middle of it become very clear. They coach staff based on these films. It is very revealing.

**SW:** What is the fourth method?

**JR:** It is a planning tool. When we decide something in the consensus meeting in the VIPS practice model, then we have plans for the day shift regarding who does what when and the same for the night shift. How does the week look? What kind of group activities have we got during the week? These kinds of things. The plans are a way of making sure that everything is fit into the routine. That way people know what to do and when to do it.

All the methods work very well together. They do not overlap, but they reinforce each other. We tested this in two care homes. They used all the methods for nine months. They found it possible to use them all, even within our limited resources. It is not too expensive, but you have to prioritize it.

**SW:** Do you now train nurses in these four methods?

**JR:** We have courses to train them in three of these methods. We train people in conducting courses in the VIPS practice model so they can go to other institutions and train the staff there. We train the trainer.

**SW:** What are the key research questions that still need to be answered?

**JR:** They are many. How can you be a person centered leader? What should the leader do to implement person centered care and maintain focus on it? The use of these methods in homecare is also very important. These are methods that can be used outside an institution as well.

**SW:** Thank you for your time.

END