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HOW TO DESIGN AN INCLUSIVE CARE, BASED ON INDIVIDUALS' SOCIAL COGNITION CAPACITIES TO IMPROVE QUALITY OF LIFE FOR PEOPLE WITH DEMENTIA?

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BACKGROUND:

Social isolation is one of the consequences of dementia. By progression of dementia the ability to talk, remember, and orient oneself in space gradually reduces and the need for assistance with daily tasks increases. These physical and mental abatement causes decline in social, behavioural, and emotional capabilities.

OBJECTIVES:

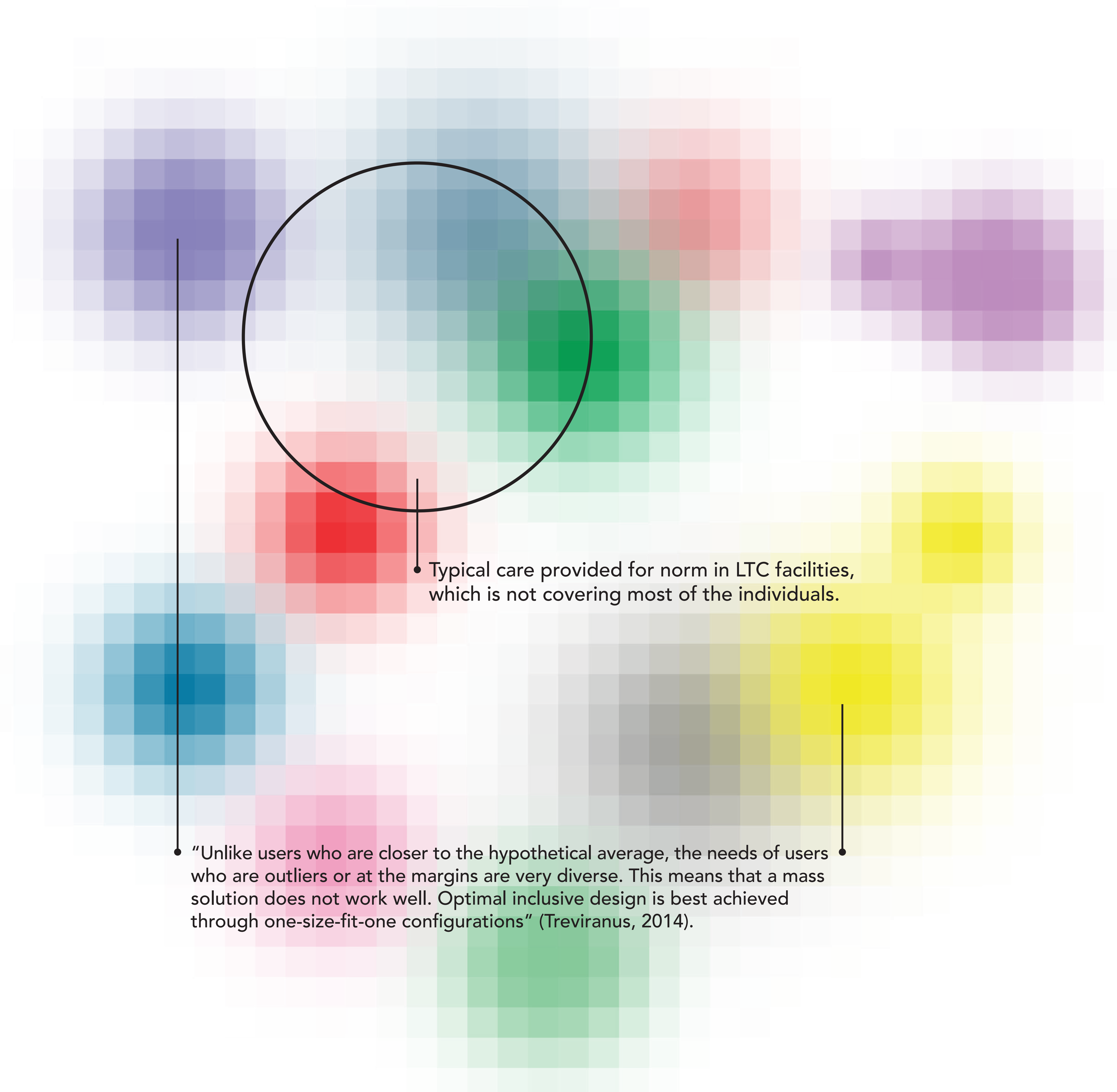
Aim of this study is to focus on individuals, who are dealing with dementia, their passion and physical and cognitive abilities to motivate and encourage them to participate in social activities based on their own interests and background.

METHODS/OVERVIEW:

World Health Organization (WHO) estimated the number of people living with dementia at 47 million in 2015 and predicted to increase to 75 million by 2030. Dementia is known to be more common in older adults. As a result, people with dementia either live in long-term care (LTC) facilities, or have to relocate to LTC to reduce the responsibility of care from their families and loved ones. Social cognition decline is one of the challenges of this population. Based on Susan Fiske and Shelley Taylor “Social cognition is the study of how people make sense of other people and themselves” (Social Cognition: From Brains to Culture, 2017). Once this sense declines, isolation and loneliness substitute sociable life of people with dementia.

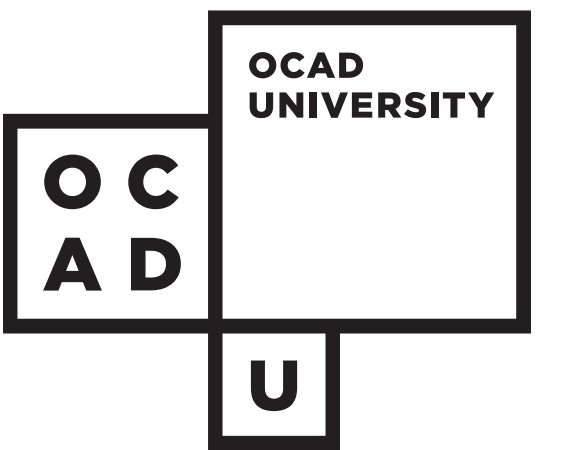
Jutta Treviranus, director of the Inclusive Design Research Centre, (2014) describes older adults as the most diverse population while they all have different skills, experiences, and different physical capability and health incidents. Typical care systems are normally based on one solution for all patients, considered as an average patient.

As Deborah Estrin suggests we might “begin to leverage our small data to bring more vigilance and insight to everyday care. We can think of this as new kind of medical evidence, evidence where $n=me$ ” (Estrin, 2014).



• Typical care provided for norm in LTC facilities, which is not covering most of the individuals.

• “Unlike users who are closer to the hypothetical average, the needs of users who are outliers or at the margins are very diverse. This means that a mass solution does not work well. Optimal inclusive design is best achieved through one-size-fit-one configurations” (Treviranus, 2014).



RESULTS:

The above overview shows that finding/designing an activity for all members of any LTC facility, is not the right answer for keeping older adults socially active. Instead of focusing on a system of care that tries to provide a universal care approach for average patients, we need to define variety of solutions based on individuals to reflect patients' needs and preferences. Instead of looking at big data to focus on average population and “norm” we may use small data.

CONCLUSIONS:

By focusing on small data, we will bring more careful approach into healthcare especially for this specific population with diverse needs, and increase the social inclusion of people with dementia rather than socially isolating them.

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