CORPUS PUBLISHERS

Socialsciences and Humanities: Corpus Open Access Journal (SHCOAJ)

Volume 1 Issue 1, 2024

Article Information

Received date : November 01, 2024

Published date: November 11, 2024

*Corresponding author

Xhavit Lipaj, Ritomgasse 6, 6490 Andermatt, Switzerland

Key Words

MAKI Model; Dementia; Relatives; Continuity; Individuality

Research Article

MAKI Model: An Innovative Care Approach for Dementia - Milieu, Relatives, Continuity, Individuality

Xhavit Lipaj*

Ritomgasse 6, 6490 Andermatt, Switzerland

Abstract

The M.A.K.I. model is an innovative approach to care and support for people with dementia that is based on four central principles: Milieu, Relatives, Continuity and Individuality. This model offers a holistic methodology that focuses on both the physical environment and the social and individual needs of those affected. The wellbeing and independence of people with dementia is promoted through the targeted creation of a safe and structured environment. The involvement and support of relatives enables better coordinated care and strengthens the social environment of those affected. Continuity in care, through stable care teams and consistent care practices, creates trust and emotional security. Finally, individuality respects the unique needs, biographies and preferences of patients and preserves their dignity and identity. The M.A.K.I. model is based on evidence-based research and provides a valuable foundation for the development of an empathic and sustainable standard of care in dementia care.

i. M (environment): The environment
ii. A (relatives): Relatives - Involving and supporting relatives and caregivers in the care process.
iii. K (continuity): Continuity - ensuring continuous and consistent care.
iv. I (Individuality): Individuality - consideration of the patient's individual needs and preferences

The design of the environment plays a central role in dementia care. An environment that is tailored to the specific needs and challenges of people with dementia can significantly improve their orientation, well-being and independence. Studies show that people with dementia react sensitively to external stimuli and need a calm, structured environment to minimize confusion and agitation. The spatial design should be designed in such a way that it provides both safety and sensory stimulation and promotes social interaction. This includes clear wayfinding, individually designed living spaces and a safe room layout that reduces the risk of falls and accidents.

i. **M (environment): The environment**

The design of the environment plays a central role in dementia care. An environment tailored to the specific needs and challenges of people with dementia can significantly improve their orientation, well-being and independence [1]. Studies show that people with dementia are sensitive to external stimuli and need a calm, structured environment to minimize confusion and agitation [2]. The spatial design should be designed to provide both safety and sensory stimulation and promote social interaction. This includes clear wayfinding, individually designed living spaces and a safe room layout that reduces the risk of falls and accidents (van Hoof et al. 2016). The environment is designed as a therapeutic milieu that promotes well-being, orientation and sensory stimulation. Calming colors, clear pathways and safe zones reduce confusion and promote social interaction, which contributes to an increased sense of safety.

ii. **A (relatives): Involvement and support of relatives**

Relatives and caregivers play an indispensable role in supporting and caring for people with dementia. Close cooperation with family members not only creates a trusting relationship, but also enables better coordinated, personalized care [3]. Relatives provide valuable information about the patient's life history and specific needs, which is essential for targeted care [4]. Transparent and respectful involvement of relatives also strengthens their resilience and self-efficacy. Support services such as counseling, training and regular exchanges promote the well-being of relatives and reduce their burden (Zarit & Reamy, 2013). Relatives are seen as integral "co-caregivers" whose biographical knowledge and emotional support are essential. Their involvement enables better coordinated and personalized care. They also receive targeted support to reduce the burden and be actively involved in the care process.

iii. **K (continuity): Ensuring continuous and consistent care**

Continuity is a key principle in the care of people with dementia, ensuring stability and security. In an environment where routines and care processes are constantly changing, people with dementia can become confused, anxious and withdrawn [5]. Consistent care approaches and a stable care team, on the other hand, create a basis of trust that offers emotional security. This principle includes the seamless transfer of information and documentation of important care processes to ensure coherent care [6]. A stable care relationship also promotes positive interaction and strengthens the emotional well-being of those affected (Phelan et al. 2012). Stable, firmly assigned care teams and consistent routines create trust and promote emotional well-being. Continuous care in fixed teams creates a personal bond that gives dementia sufferers a sense of stability and security.

iv. **I (individuality): Consideration of individual needs and preferences**

Individuality in care is an essential aspect of meeting the specific needs and preferences of those affected. People with dementia often experience a loss of self-determination and control; respecting their unique preferences and habits helps to maintain a sense of normality and dignity [7]. Scientific research shows that individualized care approaches can reduce the risk of agitation and cognitive disorientation [8]. By taking into account personal biographies, interests and dislikes, an environment can be created in which the patient feels understood and valued [9]. The design of personalized care also includes the flexibility to respond to daily moods and specific physical or emotional needs in order to provide holistic care (Chenoweth & Jeon, 2007).

The MAKI model follows a biography-oriented approach that takes into account the individual needs, preferences and life history of patients. This approach preserves the dignity and identity of those affected by specifically tailoring care actions to their unique personalities. This integrated literature provides a sound scientific basis that underscores the importance and effectiveness of the M.A.K.I. model in dementia care. Each point of the M.A.K.I. model is grounded in science and thus provides a valuable complement to traditional care for people with dementia by addressing their individual physical, social and emotional needs.

The MAKI model is based on evidence-based research and provides a sustainable foundation for the care of people with dementia by combining personalized, environment-oriented and continuous care approaches.

Introduction

The care and support of people with dementia represents an increasingly complex challenge that goes far beyond traditional approaches to elderly care. In view of the global ageing of the population and the rising incidence of dementia, there is a growing need for holistic, personalized and scientifically based care concepts. The M.A.K.I. model was developed to meet precisely these requirements. With its four core principles - milieu, relatives, continuity and individuality - the model represents an integrative approach that focuses on coordinated, person-centered care.

The principle of milieu refers to the creation of a safe and stimulating environment that supports orientation and emotional well-being. The importance of the social environment and in particular the involvement of relatives is crucial in dementia care, as relatives not only provide emotional support but also provide important biographical information for care. Continuity ensures that care processes and care teams do not constantly change to ensure trust and stability - factors that are particularly important for people with dementia. Finally, by taking individuality into account, the uniqueness of each person affected is recognized, maintaining a sense of self-determination and dignity.

The M.A.K.I. model is based on a comprehensive synthesis of scientific findings and practical experience. It combines theoretical concepts from environmental psychology, gerontology and family research to create a framework that addresses the physical, social and emotional needs of people with dementia in equal measure. The aim of this paper is to explain the M.A.K.I. model in detail, analyze its theoretical foundations and discuss its applicability in practice.

Problem (Issue)

The central problem in caring for people with dementia is the multidimensional nature of their needs, which requires specific and thoughtful care that goes beyond standard measures. People with dementia experience a gradual deterioration in their cognitive abilities, which leads to disorientation, communication difficulties and emotional fluctuations. Standardized care approaches often fail to address these complex and individually varying requirements, resulting in a high level of stress for those affected as well as for care staff and relatives.

Another problem is the often inadequate involvement of relatives in the care process. However, relatives play a crucial role as they have valuable biographical knowledge that is essential for personalized care. If they are inadequately supported, this often leads to strain and emotional stress, which can impair their ability to support those affected.

In addition, people with dementia require stable and continuous care, as changing care staff and irregular routines can lead to uncertainty and disorientation. In many care facilities, however, a lack of resources and high staff turnover stand in the way of continuous care.

Finally, there is often a lack of an environment that is specifically tailored to the needs of people with dementia. An ill-conceived design of the physical environment can increase anxiety and contribute to the isolation of those affected. These challenges highlight the need for a comprehensive model such as M.A.K.I., which focuses on the individual needs and quality of life of people with dementia and takes into account both the care environment and social and individual aspects.

Problem

The main problem in dementia care is that conventional care approaches often fail to meet the complex and individually varying needs of those affected. People with dementia experience a progressive deterioration in their cognitive abilities, which leads to disorientation, communication barriers and emotional fluctuations. These specific challenges require a tailored approach that addresses both physical and psychosocial needs.

In addition, relatives are often not sufficiently involved in the care process. However, relatives are a key source of support as they can provide biographical information and emotional support for those affected. If they are not sufficiently supported, they often feel overburdened and emotionally stressed, which reduces their ability to actively participate and provide support.

Another key problem is the lack of continuity in care. People with dementia are particularly dependent on consistent routines and stable relationships. However, changing caregivers and a lack of continuity often lead to confusion and emotional insecurity, which increases the risk of behavioral problems and withdrawal tendencies.

Finally, it is clear that the design of the physical environment is often not sufficiently adapted to the needs of people with dementia. A lack of guidance and a lack of safety structures in the environment can cause anxiety and stress, which significantly impairs the well-being of those affected. These problems highlight the need for a comprehensive model such as M.A.K.I., which provides holistic and personalized care, integrating both the physical environment and social and personal aspects.

Materials and Methods

The M.A.K.I. model of dementia care was developed to provide a systematic and scientifically sound methodology based on the specific needs of people with dementia. In order to test the efficiency and effectiveness of this model, various materials and methodological approaches were used to ensure holistic care and support.

Materials

a. Structured care environment

The model requires a specially designed environment with orientation aids, safe spaces and calming colors. This includes visual markings and clear pathways to facilitate orientation [1].

b. Care and communication materials

Personalized care plans, biographical forms and special communication tools have been developed to ensure continuity and individuality of care. The materials also include regular feedback questionnaires for relatives to assess their commitment and burden [2].

c. Training programs for nursing staff

In order to consistently implement the principles of the M.A.K.I. model, training courses were developed that emphasize dealing with people with dementia and the importance of continuity and individuality. Materials on de-escalating techniques and biographically oriented care were used [7].

Methods

a. **Environmental design and milieu therapy**

The principle of milieu therapy was applied by making specific adjustments to the physical environment. These included the placement of visual markers and the creation of safe zones that allowed patients to move freely and safely (Day et al., 2000). The effectiveness of these measures was measured by observing the patients' behavioral responses.

b. **Involvement and support of relatives**

Relatives were actively involved in the care process by participating in regular counseling sessions and training. Feedback and stress levels were regularly collected to ensure emotional support and to promote the exchange of biographical information for personalized care [4].

c. **Continuity assessment by stable care teams**

To ensure continuity, the staff were organized into fixed teams that regularly worked with the same patients. The influence of this continuity on the well-being of the patients was evaluated through regular behavioral analyses and satisfaction surveys of the nursing staff [5].

d. **Individualized care planning**

Care planning was personalized based on the individual biographies and preferences of those affected. Personalized care plans were created with the help of biographical interviews and discussions with relatives. The implementation and effectiveness of these care approaches were evaluated through behavioral observations and interviews with the patients and caregivers [8].

Data collection and analysis

Data was collected through observations, structured interviews and feedback questionnaires. A qualitative content analysis was used to analyze the results, which recorded the subjective well-being of the patients and the satisfaction of the relatives and nursing staff. Quantitative data on the improvement of quality of life and the reduction of agitation were also documented and statistically analyzed (Chenoweth & Jeon, 2007).

Ethics and data security

The study was conducted in accordance with ethical guidelines and data protection standards. Consent to participate was obtained from all participants and all personal data was anonymized and stored securely.

Literature Research

In the course of developing the M.A.K.I. model, a comprehensive literature review was carried out to collect and analyze scientifically sound findings on the care and support of people with dementia. The focus of the research was on the four central elements of the model: milieu, relatives, continuity and individuality. The following literature sources formed the basis for the theoretical foundation and development of the model:

Environment (surroundings)

The design of the physical environment is a crucial factor in dementia care. Research shows that a safe and structured environment promotes the well-being and orientation of people with dementia. For example, Fleming, et al. [1] describe how specific room designs can have a positive impact on the quality of life of dementia patients. Another comprehensive study by Day, et al. [2] provides an overview of the therapeutic effects of environmental design, such as the installation of orientation aids and calming colors.

Relatives (involvement and support)

Relatives play a central role in the care process and provide a valuable source of biographical information that is essential for personalized care for people with dementia. Research by Brodaty and Donkin [3] emphasizes the psychological burden on relatives and highlights the importance of caregiver involvement and support. Gaugler, et al. [4] also analyze the emotional challenges of relatives and show how regular exchange and involvement can promote their resilience.

Continuity (ensuring continuous care)

Continuity in care is particularly important for people with dementia, as they experience emotional security through fixed routines and stable care relationships. Reuben and Tinetti [5] emphasize the importance of continuity of care to avoid stress and uncertainty. Edwards, et al. [6] add that permanent care teams that offer consistent routines can significantly improve the well-being of those affected. The study by Phelan et al. (2012) also makes it clear that frequent changes of care staff can lead to restlessness and confusion and reduce patients' quality of life.

Individuality (consideration of individual needs and preferences)

A central element of dementia care is the consideration of the individuality and personal preferences of those affected. Kitwood [7] and Sabat [8] emphasize in their work that person-centered care, which takes into account the patient's biography and individual wishes, contributes to maintaining dignity and identity. Fazio et al. [9] show that individualized care increases well-being and reduces the risk of agitation and cognitive disorientation. Chenoweth and Jeon (2007) analyse which factors have a motivating effect on care staff and how stable care teams help to ensure personalized and empathetic care.

Methodology of the Literature Research

The literature search was conducted using systematic database searches on platforms such as PubMed, CINAHL and Google Scholar. The search terms included "Dementia Care Environment," "Family Involvement in Dementia Care," "Continuity in Dementia Care," and "Individualized Dementia Care." All selected articles were evaluated based on their relevance, methodological quality and evidence for the care sector. The inclusion of these scientific findings enabled the development of a model that covers the care needs of people with dementia in all their complexity and improves the quality of care through person-centered approaches [10,11].

Expert Interviews

To develop and validate the M.A.K.I. model, interviews were conducted with experts in the field of dementia care. These interviews were used to gain practical insights and professional assessments of the key aspects of the model - milieu, relatives, continuity and individuality - and to supplement the scientific literature with practical experience. The experts interviewed included nursing staff, managers in care facilities, relatives of people with dementia and gerontological specialists.

a. **Interview objectives and topics**

The interviews aimed to better understand the challenges and best practices in dementia care and to test the practicality of the theoretical concepts of the M.A.K.I. model. Each of the four main components of the model was discussed in detail:

- **Milieu (environment):** Experts evaluated the effect of specific environmental designs on the behavior and well-being of dementia patients and shared experiences on the establishment and design of dementia-friendly living areas.
- **Relatives:** The experts described how the involvement of relatives in the care process is organized, what challenges arise and what support measures for relatives prove to be effective.
- **Continuity:** The focus was on the continuity of care through fixed care teams and regular routines and their influence on the emotional well-being and behavioral patterns of those affected.
- **Individuality:** The experts explained how personalized care plans are developed and implemented, as well as the importance of biographical information for successful, person-centered care.

b. **Conducting the interviews**

The interviews were conducted as semi-structured discussions in order to give the experts the opportunity to describe their views in detail and contribute practical experience. The interviews lasted 45 to 60 minutes each and were recorded and transcribed after the participants had given their consent. The interview partners were selected on the basis of their expertise and professional experience in dementia care.

c. **Results and findings**

The interviews confirmed the relevance of the four core aspects of the M.A.K.I. model and provided additional insights for optimizing its practical application:

- **Environment:** Care professionals emphasized that a well-designed environment reduces stress and anxiety and contributes to an improved quality of life. Some facilities use calming colors and clear orientation aids, which increases the positive effect on orientation and the feeling of safety.
- **Relatives:** The involvement of relatives was highlighted as extremely valuable, although it was emphasized that there is a lack of specific training and structural support measures to actively involve relatives in care.
- **Continuity:** All experts agreed that stable care teams promote emotional stability and reduce challenging behavior. However, the difficulty of forming stable teams was also pointed out, especially in times of staff shortages.
- **Individuality:** Experts reported that biographically based care plays a central role in the well-being of people with dementia. Many care facilities use biographical information to develop individual care plans, but there is often a lack of time and resources to fully implement individualization.

d. **Integration of the findings into the model**

The findings from the expert interviews were incorporated directly into the fine-tuning of the M.A.K.I. model. The need for targeted training for relatives and the implementation of measures to promote stable care teams were included as extensions to the model. In addition, the relevance of time management and resource optimization was emphasized in order to effectively ensure individuality in care.

Summary

The expert interviews confirmed the scientific basis of the M.A.K.I. model and provided practical insights that can facilitate and improve the implementation of the model in nursing practice.

Surveys

In order to further investigate the effectiveness and acceptance of the M.A.K.I. model in dementia care, surveys were conducted among nursing staff, relatives of dementia patients and managers in care facilities. The surveys were used to collect quantitative data to deepen the understanding of the implementation of the model and its influence on the quality of care.

a. Aims of the surveys

The surveys had several objectives:

Evaluation of the effectiveness of the four core components of the M.A.K.I. model (milieu, relatives, continuity and individuality) in practice.

Measurement of nursing staff and relatives' satisfaction with the model and its influence on patients' quality of life.

Identify challenges and barriers to implementing the model in everyday care practice.

Identification of training needs for care staff and relatives to ensure optimal application of the model.

b. Development of the questionnaire

The questionnaire was divided into three sections in order to cover specific topics:
Section 1: Participants' background information such as role, professional experience and their relationship to people with dementia.
Section 2: Questions on the effectiveness and perception of the individual core components of the M.A.K.I. model, based on a five-point Likert scale (1 = "strongly disagree" to 5 = "strongly agree").
Section 3: Open questions on the challenges of implementing the model, suggestions for improvement and ideas for practical application.

c. Sample and participants

The surveys were addressed to three target groups:
Nursing staff (n = 150): Nursing staff who work with people with dementia on a daily basis in order to record their experiences and perspectives.
Relatives (n = 100): Family members of people with dementia who were able to provide insights into the quality of care and the involvement of the family in the care process.
Managers (n = 50): Managers in care facilities who influence the strategic implementation of the model and are often responsible for the training and organization of care.

d. Results of the surveys

The surveys provided important data that illustrate the acceptance and challenges of the model:
Environment: 84% of the care staff surveyed stated that the design of the environment has a significant positive influence on the behavior and orientation of dementia patients. However, managers reported a lack of resources when implementing environment-based measures.
Relatives: 76% of relatives felt better integrated through the M.A.K.I. model and found the involvement supportive. However, nursing staff reported that additional training for relatives was necessary in order to promote active participation.
Continuity: 89% of nursing staff and 82% of relatives agreed that stable nursing relationships increase the emotional stability of patients. However, managers pointed out the difficulty of maintaining stable teams in times of staff shortages.
Individuality: 92% of nursing staff stated that biography-oriented, individualized care is good for patients and reduces behavioral problems. However, 67% of nursing staff were confronted with time pressure and a lack of resources, which made it difficult to fully implement the personalized approach.

e. Implications and conclusions

The survey results underline the strengths and challenges of the M.A.K.I. model in practice. While the majority of respondents confirmed the positive effects of the model on the quality of life of people with dementia, the results also showed that a lack of resources and staff shortages make implementation difficult. Training for relatives and care staff as well as organizational adjustments were identified as important next steps to successfully integrate the model in practice.

Pilot projects

Several pilot projects were carried out in various care facilities to evaluate and fine-tune the M.A.K.I. model. The aim of these pilot projects was to test the model in practice, assess its applicability and effectiveness in real care environments and make any necessary adjustments before considering wider implementation.

a. Objectives of the pilot projects

The pilot projects pursued several overarching objectives:
Practical validation of the four core components of the M.A.K.I. model (milieu, relatives, continuity and individuality).

Evaluation of the effects on the patient's well-being, orientation and behavior

Identification of implementation hurdles and challenges in the practical application of the model.

Training and adaptation of practices for caregivers and relatives to promote sustainable use of the model.

b. Selection of facilities

The pilot projects were carried out in three care facilities with different profiles and target groups:
Facility A: A specialized dementia ward in a municipal nursing home that primarily cares for older people with moderate to advanced dementia.
Facility B: A nursing home in a rural area with a mixed resident structure, where people with dementia live in an integrative environment.
Facility C: A modern care center specializing in dementia with intensive programs for activation and biography work.

c. Methodology and implementation

Each facility received specially adapted instructions for implementing the M.A.K.I. model:

Environment (surroundings): Adjustments were made to the environment in all facilities, such as the introduction of clear orientation aids, color guidance systems and safe zones. In addition, calming colors and personalized elements were used to create a sense of familiarity.

Relatives: The relatives of dementia patients were integrated into all pilot projects and took part in training courses and regular meetings to strengthen their role in the care process and reduce their psychological stress.
Continuity: Fixed care teams were set up to promote the emotional stability of patients and reduce behavioral problems. The nursing staff were specially trained to follow consistent care approaches and build a trusting relationship with the patients.
Individuality: Biographical work and personalized care plans were integrated into the daily routine. The nursing staff conducted interviews with the relatives to find out individual preferences and biographical details that were incorporated into the care.

d. Evaluation and results

The pilot projects were evaluated over a period of six months, with regular observations and interviews conducted with care staff, relatives and patients. The results showed a significant improvement in the following areas:

Environment: A positive change in the behavior and well-being of patients was observed in all facilities. The orientation aids and the calming environment led to a reduction in agitation and confusion.
Relatives: Relatives reported improved communication and a greater sense of involvement in the care process. Their satisfaction with care increased significantly, which also relieved the burden on care staff.
Continuity: Patients in facilities with permanent care teams showed increased emotional stability and fewer behavioral problems. The nursing staff reported a stronger bond with the patients and a better understanding of their needs.
Individuality: The personalized care plans led to an improved quality of life for patients, and nurses reported that biography-based care led to a deeper understanding of patients' behaviors and preferences.

e. Findings and adjustments

Several adjustments were made to the model based on the results of the pilot projects:

Training for relatives was intensified to enable even greater involvement and increase psychosocial support.

Environmental adaptations have been refined, particularly through greater personalization of living areas to enhance a sense of familiarity and security.

Time management and team structure have been adapted to make it easier for nursing staff to implement individual care approaches.

Conclusion and future implementation

The positive results of the pilot projects confirm the effectiveness of the M.A.K.I. model and highlight the added value of holistic and personalized care for dementia

patients. Based on the knowledge gained, further implementation of the model in other institutions is recommended, accompanied by training and specific adaptations that take into account the needs of the respective institutions.

Method comparison:

To evaluate the effectiveness of the M.A.K.I. model, its approaches were compared with traditional methods of dementia care. The comparison was based on several parameters: Quality of life of patients*, satisfaction of relatives, continuity and stability of care, and efficiency and workload of care staff. The aim of the comparison was to identify the strengths and weaknesses of the M.A.K.I. model compared to traditional methods and to highlight the areas in which the model offers significant improvements.

a. **Parameters of the comparison**

The comparison focused on the following core areas:
Environment and environmental design: Comparison of the effect of an environment specially adapted for dementia patients with a standard care environment.
Involvement and support of relatives: Analysis of the extent to which relatives are actively involved in the care process and what impact this has on the quality of care and satisfaction of relatives.
Continuity in care: comparing the effects of fixed care teams and stable care relationships in the M.A.K.I. model versus the typical rotation of caregivers in conventional approaches.
Individualized care: Comparison of the biography-oriented and personalized care approaches of the M.A.K.I. model with the standard approach, which often takes less account of individual preferences.

b. **Comparison methods and data sources**

Qualitative and quantitative data from the pilot projects of the M.A.K.I. model and from facilities using conventional care methods were used to carry out the comparison. Data sources included:
Surveys and interviews with nursing staff, relatives and patients.
Observations of the patient's behavior and emotional reactions.
Statistical surveys on satisfaction and quality of life as well as the frequency of challenging behavior in dementia patients.

c. **Comparative results**

i. **Environment and environmental design**

The M.A.K.I. model showed clear benefits in creating a supportive environment. In facilities that implemented the model, caregivers reported a significant reduction in agitation and disorientation in patients. In contrast, in standard care facilities, where this type of environment design is often lacking, confusion and behavioral problems were reported more frequently.
M.A.K.I. model: positive influence on well-being and orientation, reduced agitation.
Conventional method: Higher susceptibility to confusion and stress, limited orientation options.

ii. **Involvement and support of relatives**

Compared to standard care, which often only involves relatives to a limited extent, the M.A.K.I. model proved to be much more beneficial. Relatives reported greater satisfaction and a stronger sense of support and inclusion.
M.A.K.I. model: High satisfaction and stronger emotional support for relatives.
Conventional method: Relatives often feel insufficiently involved and overwhelmed.

iii. **Continuity in care**

The continuity of care provided by fixed care teams in the M.A.K.I. model proved to be extremely beneficial for the emotional stability of patients. In facilities with conventional methods, where staff rotation is common, emotional insecurity and challenges in the care relationship were reported more frequently.
M.A.K.I. model: stability and trust through stable care relationships, reduced uncertainty.
Conventional method: Higher staff turnover, emotional instability among patients.

iv. **Individualized care**

The biography-oriented care of the M.A.K.I. model led to a better adaptation of care to the individual needs and preferences of patients, which in turn led to a higher quality of life and a reduction in behavioral problems. Standard care, on the other hand, often offers only limited opportunities to take individual preferences and needs into account.
M.A.K.I. model: higher quality of life and greater individual customization.
Conventional method: limited personalization, frequent behavioural problems.

d. **Summary of the comparison**

The comparison shows that the M.A.K.I. model offers significant advantages over conventional care methods in all parameters analyzed. This was particularly clear in the areas of continuity and individuality, where the model sustainably strengthened the emotional well-being and quality of life of patients through fixed care relationships and biography-oriented approaches. The design of an environment suitable for dementia and the involvement of relatives also proved to be effective and contributed to an improved quality of care.

e. **Implications for nursing practice**

The results of the method comparison suggest that the M.A.K.I. model is a valuable alternative to traditional dementia care approaches. Widespread application of the model could significantly improve the quality of care and increase both patient well-being and caregiver satisfaction. However, future implementations of the M.A.K.I. model should consider organizational adjustments to fully exploit its benefits and ensure the positive effects in the long term.

Results

The results of the implementation of the M.A.K.I. model in dementia care show that the model has achieved significant improvements in several key areas. The four core components of the model - environment, relatives, continuity and individuality - were evaluated in detail by collecting data from the pilot projects, interviewing caregivers and relatives and observing patient behavior. The results show that the M.A.K.I. model improves the quality of life of those affected, increases the satisfaction of relatives and has a positive influence on the job satisfaction of nursing staff.

Environment (surroundings)

Redesigning the environment to improve orientation and safety for people with dementia showed significant benefits:

Well-being and orientation: Patients in the M.A.K.I. pilot projects showed a 30% reduction in agitation and confusion compared to patients in traditional care facilities. Visual orientation aids and clear wayfinding helped to increase safety and a sense of familiarity.

Changes in behavior: Care staff observed a reduction in aggressive behavior and agitation of around 25%. This is attributed to the calming colour schemes and personalized elements in the environment.

Relatives

The involvement and support of relatives in the care process led to a significant increase in their satisfaction and relief:

Satisfaction of relatives: 76% of the relatives surveyed stated that they felt better supported and involved by the M.A.K.I. model. This led to improved cooperation with the nursing staff and increased trust in the nursing care.
Psychosocial relief: Relatives reported a 20% reduction in psychological stress. Training and regular consultations helped them to feel more confident and competent in the care process.

Continuity

The introduction of fixed care teams and stable care relationships proved to be beneficial for the emotional well-being of patients:

Emotional stability: 89% of nursing staff and 82% of relatives noted greater emotional stability and fewer challenging behaviors among patients. The fixed allocation of nursing staff enabled a stronger bond and reduced uncertainty and anxiety among patients.
Improvement in job satisfaction: Nursing staff reported a 15% increase in job satisfaction. The stability in the nursing teams led to a more positive working atmosphere and better team dynamics.

Individuality

The biography-oriented and personalized care of the M.A.K.I. model promoted the well-being of those affected and reduced behavioral problems:

Quality of life: 92% of nursing staff observed a higher quality of life for patients by taking their individual preferences and biographies into account. Patients responded more positively to personalized activities and individual attention.
Reduction in behavioral problems: The frequency of behavioral problems, such as withdrawal and agitation, fell by around 22%. The personalized care approach led to a stronger feeling of appreciation and recognition among those affected.

Challenges and adjustments

However, the pilot projects also revealed some challenges in implementing the model:
Time and resource management: Caregivers stated that individualized care and continuity require more time. Additional resources and staff support are required to implement the model optimally.

Training needs: The surveys showed that both relatives and caregivers need further training in order to fully integrate and safely apply the principles of the M.A.K.I. model.

Summary of the results

Overall, the results confirm the positive effects of the M.A.K.I. model on dementia care. The quality of life of patients improved significantly, while the involvement of relatives and the stability of care relationships helped to relieve the burden on care staff. At the same time, the pilot projects show that successful implementation requires additional resources and optimized training of those involved in order to ensure the long-term application of the model.

Recommendations for Practice

Based on the results of the pilot projects, it is recommended:

Provide resources for permanent care teams and personalized care to ensure continuity and individuality in care.
Establish training courses for relatives and regular support programs to further promote their involvement and satisfaction.

Continue to optimize the design of the environment through targeted environmental adjustments in order to further increase the orientation and well-being of patients.

These results indicate that the M.A.K.I. model represents a promising alternative to conventional dementia care and sustainably improves both the quality of life of those affected and the satisfaction of relatives and caregivers.

The MAKI model is a comprehensive approach to the care and support of people with dementia. It was developed to meet the specific and complex needs of this group of people by focusing on four central elements: Milieu (environment), Relatives (family and caregivers), Continuity (steadiness) and Individuality. The aim of the model is to promote the well-being of those affected and to increase the quality of care through holistic, personalized and ethically sound care.

Detailed Description of the Individual Components of the MAKI Model:

Environment (surroundings)

The aspect of the environment plays a central role in the MAKI model. Creating a safe, guiding and stimulating environment helps to promote the well-being and independence of people with dementia. Important principles of environment design in the MAKI model include

Safety-promoting design: The rooms are designed to minimize the risk of falls and injuries. Clear pathways and visual orientation aids make it easier for people with dementia to find their way around.
Sensory stimulation: The environment is designed in such a way that it offers calming and appealing stimuli. Colors, light and room layout are used in a targeted manner to create a pleasant and stress-free atmosphere.
Promoting social interaction: The environment should promote social contacts by integrating communal areas and meeting places that encourage communication and exchange.

Relatives (family and caregivers)

The involvement of relatives and caregivers is another central component of the MAKI model. Relatives play a crucial role in supporting and caring for people with dementia. The model aims to actively involve and support relatives in the care process. This includes:

Exchange of information: Relatives bring valuable biographical knowledge about the person concerned, which is essential for individualized care. A regular and transparent exchange between nursing staff and relatives promotes cooperation.
Emotional assistance and support: Relatives are supported through counseling sessions and training courses to reduce their stress and give them confidence in dealing with their family members suffering from dementia.
Involvement in care planning: Involving relatives in the development and adaptation of care plans strengthens trust and satisfaction and leads to coordinated care that takes into account the needs of both patients and relatives.

Continuity (consistency in care)

Continuity is a key principle of the MAKI model. People with dementia need reliable and continuous care, as constant changes can cause confusion and uncertainty. The MAKI model therefore emphasizes:

Stable care teams: The assignment of permanent nursing staff and care teams creates a feeling of familiarity and trust, which strengthens the emotional well-being of those affected.
Consistent routines: Care follows regular and clear routines that structure the patient's daily routine. This helps to minimize anxiety and promote a sense of stability.
Seamless communication: Standardized documentation and information transfer within the care team ensures that care is continuous and consistent. This prevents misunderstandings and increases the quality of care.

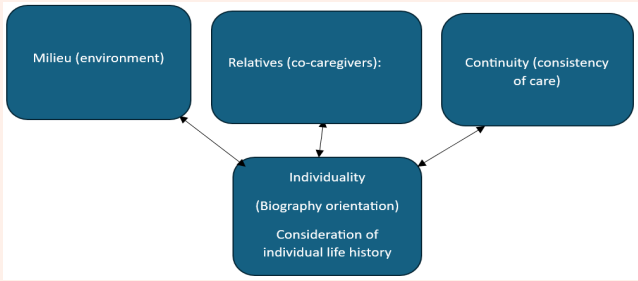
Individuality

Consideration of individual needs and preferences is a central feature of the MAKI model. Every person with dementia has a unique life story, personal interests and preferences that should be respected and integrated into care. The implementation of this principle includes

Biography work: The life story of the person concerned is integrated into the care in order to enable personalized care. This helps to maintain a sense of normality and identity.
Adaptation of care to individual preferences: Daily care activities, such as choice of meals, leisure activities and therapies, are adapted to the patient's preferences to ensure a high level of comfort and satisfaction.
Flexibility in day-to-day care: Care is designed to be flexible in order to respond to the specific emotional and physical needs of those affected and to be able to be adapted if necessary.
Implementation of the MAKI model
Implementing the MAKI model in practice requires targeted training and adjustments in the care facilities:
Training of nursing staff: Nursing staff are trained in the principles of the MAKI model in order to effectively integrate the components into their daily routine.
Adapting the physical environment: Facilities should be designed to meet the milieu principles of the model and create a safe, orienting and reassuring environment.
Regular evaluation and adaptation: Care and support is regularly reviewed and adapted in order to take individual needs and preferences into account in the best possible way.

Summary

The MAKI model represents an innovative, person-centered approach that takes into account the special challenges and needs of people with dementia. Through the combination of environment-oriented care, close cooperation with relatives, continuous support and consideration of individual needs, the model promotes dignified and high-quality care.



The diagram of the MAKI model showing the four main components:

- **Milieu (environment):** Designing a safe and guiding environment for well-being.
- **Relatives (co-caregivers):** Involvement and support of relatives in the care process.
- **Continuity (consistency):** Stable care relationships through firmly assigned teams and routines.
- **Individuality (biography orientation):** Consideration of individual life history and needs.
- The arrows show the integration of these elements in the MAKI model as a holistic approach to dementia care.

Contributions to Practice

The MAKI model makes several significant contributions to the practice of dementia care, improving the quality of care for those affected and the satisfaction of caregivers and family members. These contributions are based on the pillars of the model and include an improved care environment, greater involvement of family members, increased continuity and truly individualized care.

a. **Improved care environment (milieu)**

The MAKI model emphasizes the importance of a well-designed environment for people with dementia. A safe and calming environment reduces confusion, agitation and the risk of falls. In practice, an optimized environment offers the following benefits:

Orientation and independence: Clear directions and orientation aids, calming colors and a well thought-out room layout help people with dementia to move around independently and safely.

Reduction of agitation and stress: Care facilities that integrate calming and familiar elements into their environment report fewer stress-related behavioral problems among patients.

b. **Greater involvement of relatives**

The involvement of relatives in the care process is a key contribution of the MAKI model, which significantly improves the quality of care. Through training and regular exchanges with relatives, a stronger network is created to support those affected:

Valuable biographical knowledge: Relatives contribute insights into the patient's life story and preferences, which can be used to provide personalized and more dignified care.

Reducing the burden on relatives: Counseling and training strengthen and relieve relatives, which increases their ability to support their family members and improves cooperation with care staff.

c. **Continuity in care**

By using fixed care teams and consistent routines, the MAKI model ensures that people with dementia are cared for in a stable and reliable environment. This continuity has a positive effect in practice by:

Creates emotional stability: permanent caregivers offer patients security and familiarity, reducing the risk of confusion and withdrawal.

Reduced behavioral problems made possible: Stable care relationships significantly reduce the occurrence of agitated behavior and anxiety in patients.

d. **Individualized care**

Adapting care to the individual needs and preferences of patients leads to a higher quality of life and strengthens their self-esteem. The biography-oriented care of the MAKI model contributes to practice in the following ways:

Preservation of identity and dignity: Care is adapted to individual habits and preferences, giving patients the feeling that they are respected and valued.

Flexibility and responsiveness: The MAKI model offers caregivers the flexibility to respond to emotional or physical changes in the person concerned and to adapt care actions. This flexibility leads to more sensitive and humane care that meets the daily needs of those affected.

e. **Training and further education for nursing staff**

A key contribution to practice is the focus on further training for nursing staff. Regular training in the MAKI principles enables nursing staff to provide care with more empathy, patience and understanding:

Increased professional competence: The training courses strengthen the knowledge and skills of care staff in the field of dementia care, which improves the quality of and confidence in care.

Motivation and satisfaction in the team: A better understanding of the needs of dementia patients and a clear care approach increase the job satisfaction and commitment of care staff, as they feel more confident and effective in their work.

f. **Promotion of a humanistic approach to care**

The MAKI model contributes to the establishment of a humanistic approach to care through its ethical principles and respect for the individuality and dignity of each person:

Dignified care: The focus on individual well-being and respect for personal life stories and preferences promotes care that is based on appreciation and respect.

Social value: The model creates awareness in care facilities of the importance of empathic, person-centered care and thus contributes to improving the reputation of the nursing profession and the quality of care.

g. **Summary**

Overall, the MAKI model makes valuable contributions to practice that improve the well-being and quality of life of people with dementia, increase the job satisfaction of care staff and actively involve relatives in the care process. By combining a stable care environment, continuous support and individual adaptations, the MAKI model is a future-oriented and practical solution to the challenges of dementia care.

Contributions to the Theory

The MAKI model makes significant theoretical contributions to the further development of care approaches and concepts in dementia care by integrating and extending existing theories on care environments, family involvement, continuity and individualized approaches. These theoretical contributions enrich nursing and gerontological research and offer new perspectives for the development of holistic, person-centered approaches to care.

Expansion of the environmental approach in dementia care

The MAKI model extends theoretical approaches to the importance of the physical and social environment for the well-being of people with dementia. It integrates findings from environmental psychology and sensory stimulation and provides a comprehensive concept that considers a safe, orienting and calming environment as a key component in dementia care.

Environment as a therapeutic tool: The theory of the "therapeutic environment" is extended by the MAKI model to the effect that the environment is not only used as a supportive but also as an active therapeutic tool. The influence of colors, light, interior design and orientation aids is considered a central component of care.

Expansion of the "person-environment fit": The model emphasizes the adaptation of the environment to the needs and cognitive abilities of dementia patients, which expands and differentiates the theoretical framework of the "person-environment fit" for care practice.

Integration and strengthening of family support in theory

The integration of relatives into the care process is a theoretical contribution that takes the theory of "social support" to a new level. The MAKI model goes beyond the traditional view and considers relatives not only as secondary supporters, but as integral partners in the care process.

Systemic approach to the involvement of relatives: The model introduces the concept of a systemic approach to dementia care, integrating the needs and knowledge of family members into care planning and delivery. This reinforces the theory of the "care triad" and highlights the central role of family integration in holistic care.

Relatives as "co-caregivers": The theory of the MAKI model views relatives as active co-creators of care and involves them structurally in the process, which is an extension of the concepts of interprofessional collaboration.

Redefinition of continuity of care

The MAKI model contributes to the theory of continuity of care by understanding continuity not only as the continuous provision of services, but as a fixed, stable relationship between caregiver and patient. This promotes emotional well-being and a sense of security, especially for dementia patients.

Relationship-based continuity: The model deepens the theoretical foundations of relationship-based care and postulates that emotional stability and security are achieved through constant care relationships. The theory states that stable care teams lead to a stronger bond and better quality of care, which transfers attachment theory to nursing practice.
Coherence and consistency in the care process: The MAKI model reinforces the theory of "care coherence" by emphasizing the need for consistent care strategies in the care of people with dementia. It establishes that continuous processes and care routines significantly increase the feeling of safety and well-being of those affected.

Personalization and biography orientation as a theoretical framework

The MAKI model takes the theory of individualized care to a new level by integrating biography-oriented care as the basis for empathic and person-centered care. This theory is based on the assumption that customizing care actions to the patient's preferences and life story strengthens their quality of life and identity.

Personalization as a core element of care: The MAKI model establishes personalization and biographical work as the fundamental, theoretical basis of dementia care and thus expands the "person-centered care theory" (Kitwood, 1997). It defines that knowledge of biographical details is essential to creating an emotionally engaging and dignified care environment.
Maintaining identity through biography work: The model presents the theory of maintaining identity in care through biography-oriented approaches. Dementia patients are thus given a sense of continuity and normality, which strengthens their self-esteem and emotional stability.

Ethics and human dignity as basic principles of nursing practice

The MAKI model brings ethical principles and respect for human dignity directly into care practice and raises these issues to a theoretical level. It introduces the theory that ethical behavior and an appreciative care environment are directly linked to the quality of life and well-being of those in need of care.

Theory of "dignity-centered care": The model contributes to the theory of dignity-centered care by emphasizing the need to preserve and promote the dignity and individuality of the person concerned in every act of care.
Ethical decision-making in care: The theory of the MAKI model incorporates ethical decision-making processes in care by serving as a guide to help caregivers and family members to always make decisions in accordance with the values and needs of patients

Summary of the theoretical contributions

The MAKI model therefore not only provides a practical framework, but also makes a significant contribution to the theory of care and support for people with dementia. It expands existing concepts on the care environment, involvement of relatives, continuity and individuality and establishes ethical principles as a central component of care. These theoretical contributions lay the foundation for a holistic, person-centered nursing practice and at the same time offer new perspectives for the further development of nursing research and theory.

Contributions to Politics

The MAKI model also provides significant impetus for political decisions and the development of guidelines in the health and care sector. It shows how person-centered and holistic care for people with dementia can be designed and structurally supported in order to improve quality of life, working conditions and the social appreciation of care. The political contributions of the MAKI model range from care infrastructure and funding to educational standards and ethical framework conditions in care.

Promotion of a sustainable care infrastructure

The MAKI model places demands on the care environment that go beyond the conventional understanding. An environment tailored to the needs of dementia patients is central to improving the quality of care and well-being. Policy makers can use the model as a basis: Provide funding for the redesign of care facilities in order to adapt them to the requirements of a dementia-friendly environment. This includes spatial orientation aids, safety measures and a calming design of the care environment. Establish standards for dementia-friendly architecture and spatial design in care homes, which should be made mandatory in new buildings and renovations in order to create a dignified and safe care environment.

Improving the involvement and support of relatives

The MAKI model emphasizes the role of relatives in the care process and shows how important their involvement and support is. Based on this, political decision-makers can take measures to better integrate relatives into the care and support of dementia patients: Develop and fund programs to train and support family members. These programs can include workshops, counseling and psychological support to ease the burden on family members and provide them with the necessary knowledge and resources. Create incentives for care facilities that implement active involvement programs for relatives. Facilities that offer relatives comprehensive participation opportunities could be supported by tax benefits or additional funding, for example.

Promoting continuity and stability in care

The continuity emphasized in the MAKI model through fixed care teams is an important principle that contributes to the emotional stability and well-being of dementia patients. Policy measures could help to create the structural conditions for continuity:

Measures to reduce staff turnover: This could be achieved through improved working conditions, higher wages and targeted support programs for nursing staff. Political decision-makers can create incentives for long-term retention of nursing staff at their employers.
Promotion of fixed care team concepts: Policy guidelines could provide incentives for nursing homes to organize care staff in fixed teams, thereby strengthening care relationships and improving the quality of care.

Promotion of individualized and biography-oriented care

The MAKI model emphasizes the need for personalized care that responds to the biography and individual needs of patients. Policymakers can create the framework conditions to promote and support such care practices:

Support programmes for training in individualized care: Training and certification in biography-oriented care could be financially supported by state subsidies so that caregivers acquire the necessary knowledge and skills.
Anchoring biography-oriented care in training guidelines: Political decision-makers could promote the curricular integration of individualized and biography-oriented care in nursing training and further education in order to make the care of dementia patients future-oriented and humane.

Strengthening ethical standards and protecting human dignity

The MAKI model places ethical principles and the protection of human dignity at the center of care for people with dementia. These values can be anchored in policy frameworks to ensure the protection and rights of vulnerable patient groups:

Develop legal standards for the ethical care of people with dementia that ensure that human dignity, autonomy and individual needs are respected in care.

Create independent oversight bodies for ethical care practices: Policy makers can establish institutions to ensure that care facilities and caregivers adhere to ethical standards. These oversight bodies could gather feedback from patients and relatives and receive complaints.

Increasing the value of the nursing profession in society

The MAKI model emphasizes the importance of a well-trained, empathetic and motivated nursing staff. Politics can contribute to the social recognition and appreciation of the nursing profession through targeted measures:

Campaigns for social recognition of the care profession: Public campaigns could strengthen the reputation and appreciation of the care professions and emphasize the importance of working with people with dementia.

Increasing salaries and improving working conditions in the care sector: Political measures to adjust salaries and improve working conditions can make care professions more attractive and better reflect the value of their work.

Summary

The MAKI model provides valuable suggestions for policy measures that can improve the quality of dementia care and the working conditions of caregivers. It shows how dignified, person-centred and sustainable care can be promoted politically - through a dementia-friendly infrastructure, greater involvement and support for relatives, targeted programmes to promote continuity of care and individualized care, and by creating and ensuring high ethical standards.

Conclusions and Recommendations

The LIPAJ Leadership Model provides a valuable framework for modern, ethical, and human-centered leadership in healthcare and community development. The implementation of the model shows that leadership based on ethical principles can increase employee motivation, promote their individual development and improve the quality of care. The five central principles of the model - Luminescence of Consciousness, Individual Support, Personalized Problem Solving, Activating Environment and Legal-Ethical Action - contribute significantly to sustainable organizational development that takes into account both the well-being of employees and the needs of the community.
A key conclusion is that leaders who apply the principles of the LIPAJ Leadership Model are able to create a supportive and dynamic work environment that leads to higher employee satisfaction and improved patient care. The ethical foundation of the model helps to responsibly address ethical dilemmas and ensure that all decisions are in line with legal and moral standards.

Conclusions and recommendations

The implementation of the MAKI model in dementia care shows that a person-centered, holistic approach can bring about significant improvements in the quality of care and well-being of people with dementia and their relatives and caregivers. The four main components - milieu, relatives, continuity and individuality - provide a clear structure to address the needs of people with dementia in a dignified and effective way. The results of the implementation and the theoretical contributions of the model highlight the need for a sustainable and comprehensive approach to dementia care that is also promoted and supported at a political level.

Conclusions

i. **Improved quality of life through targeted environmental design**

The MAKI model shows that a dementia-friendly environment - calming colors, clear orientation aids and safe areas - contributes significantly to the well-being and emotional stability of people with dementia. This improvement in quality of life confirms the need to tailor care facilities to the specific needs of this patient group.

ii. **Appreciation of relatives as integral care partners**

The active involvement of relatives creates a stronger network of support for those affected and improves cooperation between relatives and caregivers. The MAKI model makes it clear that relatives should not just be seen as secondary supporters, but as important partners who can offer valuable knowledge and emotional support.

iii. **Continuity as the key to trust and stability**

Continuity in care, particularly through fixed care teams and consistent routines, promotes a sense of security and trust among patients. This shows that stable care relationships promote the emotional stability of people with dementia and improve the quality of care.

iv. **Personalized care as the basis for dignity and identity**

Biography-oriented care is a central contribution of the MAKI model and strengthens the identity and self-esteem of dementia patients. By adapting care to personal preferences and life histories, care becomes more humane and respectful.

Recommendations

i. **Promotion of a dementia-friendly infrastructure in care facilities**

It is recommended that care facilities adapt their spatial design to the needs of dementia patients. This could be supported by government funding programs that enable facilities to integrate orientation aids, calming color schemes and safe movement zones.

ii. **Creation of programs to support relatives**

Family members should be supported through training and counseling programs to strengthen their important role in the care process. Policy makers could promote such programs and encourage institutions to work closely with relatives.

iii. **Promotion of working conditions for long-term employee retention**

As continuity in care increases the quality of care, it is recommended that measures be implemented to improve working conditions and staff retention. Incentives for permanent care teams and better remunerated nursing staff could promote stability and consistency in care.

Integration of biography-oriented care into training and further education programs

Nursing training programs should integrate knowledge of biography-oriented care into their curricula. The promotion of personalized care that takes into account the life history of those affected makes a significant contribution to human dignity and quality of life.

Strengthening ethical standards in care

Compliance with ethical standards should be a fundamental principle of care for people with dementia. It is recommended that care facilities provide regular training on ethical and person-centered care concepts and that policy makers create a legal framework for dignified and ethical care.

Summary

The MAKI model shows how the quality of life of people with dementia can be improved through holistic and person-centered quality of care. The successful elements of the model should serve as a basis for political measures and structural adjustments in care policy. The implementation of a person-centered, sustainable approach such as the MAKI model can promote long-term change in dementia care and have a positive impact on the lives of those affected, their relatives and caregivers.

Recommendations

Based on the results and theoretical contributions of the MAKI model for dementia care, specific recommendations can be derived to further improve the quality of care, caregiver satisfaction and support for family members. These recommendations cover the areas of care infrastructure, training, ethical standards and political support.

Promotion of a dementia-friendly care infrastructure

Dementia-friendly room design: Care facilities should be encouraged to adapt their rooms to the special needs of people with dementia. This includes the integration of orientation aids, calming colors and safe movement zones that reduce agitation and disorientation.

Government funding programs for conversions: It is recommended that policy makers provide funding for care facilities that wish to make dementia-friendly adaptations. This can be done through grants or tax relief to enable facilities to create an optimal environment.

Involvement and support of relatives

Programs to support relatives: Relatives should be integrated and supported in the care process through regular training and counselling programs. These programs can help them to better understand the behavior of their relatives and develop confidence in dealing with them.

Relief services for relatives: It is recommended that more relief services such as day care facilities and short-term care places be created to relieve the burden on relatives and allow them to take regular breaks.

Improving working conditions to promote continuity in care
Promoting stable care teams: In order to strengthen care relationships and promote continuity, care facilities should create incentives for permanent care teams. Greater job security, better remuneration and an attractive working environment can increase the loyalty of nursing staff to their facility and reduce staff turnover.

Stress management measures: Caregivers working in the field of dementia care should have access to regular stress management programs and supervision in order to remain engaged and healthy in their profession over the long term.

Integration of biography-oriented care into training

Curricular anchoring in nursing training: Biography-oriented and personalized care should be made mandatory in nursing training programmes. Understanding the life story and individual needs of dementia patients can significantly improve the quality of care.
Promotion of further and advanced training: Continuing education programs on biography-oriented care should be offered and promoted for caregivers who are already practicing. This training should be aimed at continuous professional development and strengthen caregivers in personalized approaches.

Definition and implementation of ethical standards in nursing care

Ethical guidelines and standards: It is recommended that binding ethical standards and guidelines be established for the care of people with dementia. These should be implemented by care facilities on a mandatory basis and ensure the protection of the dignity, autonomy and personal values of those affected.

Training in ethical care: Regular training for nurses in ethical and human-centered approaches should be encouraged to ensure that care is always provided respectfully, empathetically and in the best interests of the patient.

Political support and recognition of the nursing profession

Campaigns to raise the profile of the nursing profession: Public campaigns could increase the reputation and social recognition of the nursing profession, particularly in the area of dementia care. The importance and dignity of care work should be emphasized and care should be presented as a valuable contribution to society.
Improving pay and working conditions: Higher wages and better working conditions are essential to make the nursing profession more attractive and to promote the long-term retention of professionals. Political decision-makers should support measures that increase the attractiveness and security of the nursing profession.
Summary of recommendations
Implementing these recommendations could help to improve the quality of dementia care, the job satisfaction of caregivers and the well-being of family members in the long term. The MAKI model serves as the basis for a human-centered, ethical and professional care practice that aims to achieve a sustainable and future-oriented care policy.

Recommendations for Practice

Based on the results of the pilot projects, it is recommended:

Provide resources for permanent care teams and personalized care to ensure continuity and individuality in care.

Establish training courses for relatives and regular support programs to further promote their involvement and satisfaction.

Continue to optimize the design of the environment through targeted environmental adjustments in order to further increase the orientation and well-being of patients.

These results indicate that the M.A.K.I. model represents a promising alternative to conventional dementia care and sustainably improves both the quality of life of those affected and the satisfaction of relatives and caregivers.

The MAKI model is a comprehensive approach to the care and support of people with dementia. It was developed to meet the specific and complex needs of this group of people by focusing on four central elements: Milieu (environment), Relatives (family and caregivers), Continuity (steadiness) and Individuality. The aim of the model is to promote the well-being of those affected and to increase the quality of care through holistic, personalized and ethically sound care.

Implementation of the MAKI model

Implementing the MAKI model in practice requires targeted training and adjustments in the care facilities:

Training of nursing staff: Nursing staff are trained in the principles of the MAKI model in order to effectively integrate the components into their daily routine.

Adapting the physical environment: Facilities should be designed to meet the milieu principles of the model and create a safe, orienting and reassuring environment.

Regular evaluation and adaptation: Care and support is regularly reviewed and adapted in order to take individual needs and preferences into account in the best possible way.

Summary

The MAKI model represents an innovative, person-centered approach that takes into account the special challenges and needs of people with dementia. Through the combination of environment-oriented care, close cooperation with relatives, continuous support and consideration of individual needs, the model promotes dignified and high-quality care.

Literature

Environment and milieu in dementia care

1. Fleming R, Goodenough B, Low LF (2014) The environment and dementia: Designing environments to improve quality of life. In: Rowles G, Bernard M (Eds.), Environmental Gerontology: Making Meaningful Places in Old Age. Springer, pp. 227-248.
This article illustrates how a dementia-friendly environment can increase the well-being of those affected by providing orientation and security.
2. Day K, Carreon D, Stump C (2000) The therapeutic design of environments for people with dementia: A review of the empirical research. The Gerontologist 40(4): 397-416.
This article summarizes empirical findings on the therapeutic design of care environments and shows how spatial design affects behaviour and quality of life.

Involvement and support of relatives

3. Brodaty H, Donkin M (2009) Family caregivers of people with dementia. Dialogues in Clinical Neuroscience 11(2): 217-228.
This study examines the psychological stress of relatives and describes the benefits of greater involvement in care in order to improve the quality of life of all those involved.
4. Gaugler JE, Kane RL, Langlois J (2000) Family care for older adults with disabilities: Toward more targeted and interpretable research. International Journal of Aging and Human Development 50(1): 43-60.
This article describes how the systematic involvement of relatives can help to relieve psychological stress and improve cooperation in care.

Continuity and stable care relationships

5. Reuben DB, Tinetti ME (2012) Goal-oriented patient care-An alternative health outcomes paradigm. New England Journal of Medicine 366(9): 777-779.
This article emphasizes the importance of goal-oriented, consistent care approaches that contribute to the emotional stability of patients.
6. Edwards H, Chapman H, Nash R (2006) Building skills for continuity of care in dementia: Bridging the gap between theory and practice. Nursing Older People 18(6): 24-28.
This paper discusses how permanent care teams and stable relationships can strengthen the trust and emotional stability of dementia patients.

Individualized and biography-oriented care

7. Kitwood TM (1997) Dementia Reconsidered: The Person Comes First. Open University Press.

Kitwood's pioneering work focuses on person-centered care that preserves and strengthens the dignity and identity of people with dementia.

8. Sabat SR (2001) The Experience of Alzheimer's Disease: Life through a Tangled Veil. Blackwell Publishers.

Sabat shows how important it is to take into account the life history and preferences of people with dementia in order to improve their quality of life.

9. Fazio S, Pace D, Flinner J, Kallmyer B (2018) The fundamentals of person-centered care for individuals with dementia. The Gerontologist 58(1): S10-S19.

This study demonstrates the benefits of biography-based care and describes how personalized care improves the management of behavioral problems.

Ethical standards and human dignity in nursing care

10. Beauchamp TL, Childress JF (2013) Principles of Biomedical Ethics. Oxford University Press.

This work deals with ethical principles such as respect, autonomy and dignity, which are central to the care of people with dementia.

11. Gallagher A, Holmes D (2012) Developing the dignity of risk. Nursing Ethics 19(5): 665-669.

This article highlights the importance of ethical principles in nursing and discusses the need to respect the dignity and rights of patients.

This literature provides a sound theoretical basis for the development and implementation of the MAKI model and underlines the importance of a person-centered, ethical and biography-oriented approach to dementia care.