Snoezelen® used as Therapeutic Recreation for In-Patient Geriatrics

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Abstract
The purpose of this article is to develop an evidence-based recreational therapy intervention using Snoezelen® products within an in-patient geriatrics unit. This is achieved through thorough pertinent literature review of scholarly journals. The protocol will be implemented, documented and evaluated. Snoezelen® is a form of multi-sensory stimulation that is experienced using visual, auditory, olfactory, and tactile stimuli (Baillon, 2004). The diagnoses targeted by this intervention include chronic pain management and behavioral and psychological symptoms of dementia (BPSD).
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Introduction

Upon World War II’s end most first world countries has since become an ageing society leaving 14% of the population in the United States older than 65 years of age (The World Bank, 2016). This is hypothesized to progressively rise until the year 2051. “One in 10 persons over 65, and nearly half of those over 85, have probable Alzheimer’s disease. Further, at least half of nursing home residents have dementia, Alzheimer’s disease or a related disorder” (Burns, 2000).

Snoezelen® was created over half a century ago in the 1960s to address people with learning disabilities (Baillon, 2004). The Snoezelen® approach is one of multi-sensory stimulation available by a designated room or mobile equipment. Snoezelen® activities provide participants with a failure-free atmosphere ideal for patients struggling with instruction conceptualization. “Recreational activities have been used as a way to introduce pleasurable experiences that provide elderly residents with the opportunity to attain happiness and purpose and to improve quality of life” (Minner, 2004). The benefits obtained from Snoezelen® therapy are listed as, relaxation, behavior modification, improved cognitive function, improved quality of life, and improved pain management (Chitsey, 2002).

Materials

**ASSESSMENTS.** Before implementing any therapeutic intervention an appropriate assessment should be performed by the trained professional to determine the treatment parameters. Below are three assessment tools available for sensory stimulation in adults with dementia.

- **The Sensory Assessment and Profiling Tool** – “This assessment identifies the sensory preference of a person. It is recommended that the Snoezelen® session should start include equipment based on the person’s identified sensory preference. This will assist
with the transition into the Snoezelen® room and can be used as a starting point for stimulating other senses as the therapy progresses” (Collier, 2014).

- **The Adult Sensory Profile** – “This assessment identifies the level of stimulation a person needs. The assessment identifies those are sensory seekers/low registration, needing high levels of stimulation; or sensory avoiders/sensory sensitive, needing lower levels of stimulation. With this information the level of stimulation required in the Snoezelen® can be adjusted” (Collier, 2014).

- **The Pool Activity Level (PAL) Instrument for Occupational Profiling** – “This assessment gives guidance on how to run a Snoezelen® session given the severity of their condition. This includes how to structure the activity. Guidance in how to facilitate the Snoezelen® session, activity characteristics and guidance on how to start and end the session” (Collier, 2014).

After conducting the PAL assessment the therapist should have the individual’s level of functioning related to leisure involvement. The four levels of functioning from highest to lowest are as follows: 1) Planned Activity Level, the individual can independently complete a task. 2) Exploratory Level, the individual is less interested in task completion but more aroused by familiar activities and effect of the process. 3) Sensory Level, the individual responds primarily to the sensory components of the task. 4) Reflex Level, the individual is unaware of the environment and movement is a reflex response to stimuli (Collier, 2008).

**EQUIPMENT.** Snoezelen® offers a variety of tools to incorporate in a multi-sensory room or environment. Not all machines are suitable to be used in unison for an extended duration. The individuals to participate in a Snoezelen® session should be assessed and machines should be selected per need.
Review of Literature

**Snoezelen® in long term care residents with dementia.** BioMed Central released a study protocol to determine whether three interventions, Snoezelen® being one of them, are effective to reduce apathy in long-term care residents with dementia. The design of the trial is a cluster randomized control trial with 20 nursing homes in Germany. The 20 nursing homes are randomly allocated into 4 study groups. A baseline assessment is completed as well as after interventions have begun one at 3, 6, and 12 months. “This trial will particularly contribute to the evidence on efficacy of non-pharmacological interventions in dementia care” (Berg, 2010).

Each one of the four study groups (5 nursing homes) implemented a different intervention, 1) structured reminiscence therapy, 2) 10 minute activation, 3) Snoezelen®, 4) ‘Sham Intervention’ (Berg, 2010). All interventions sessions operated on a one to one basis, once or twice a week, lasting 10-20 minutes for 12 months. The ‘Sham Intervention’ was implemented once a week for a duration of 20 minutes for 12 months. The ‘Sham Intervention’ utilizes unstructured verbal conversation as the therapeutic modality.

The aim of the Snoezelen® group is “to improve the well-being of demented people by positive stimulation of their senses with different materials in a multi-sensory stimulation room or in the resident’s room with a mobile Snoezelen® unit” (Berg, 2010). Outcomes are measured by using the Apathy Evaluation Scale, Neuropsychiatric Inventory, Staff Observation Aggression Scale-Revised, Smiley Face Rating Scale – SRS, Clinical Dementia Rating, and Care Dependency Scale (Berg, 2010). Results will be published in a peer-reviewed med-line journal.

**The effects of Snoezelen® on apathy, agitation, and ADLs in dementia patients on a short term geriatric psychiatric inpatient unit.** This study involved 24 patients with moderate to severe dementia on a geriatric psychiatric unit. “All patients receive pharmacological therapy,
occupational therapy, structured hospital environment, and were randomized to receive multi-sensory behavior therapy or a structured activity session” (Staal, 2007). Elderly patients do not tolerate pharmacological therapies as well as younger patients and arise the need for additional supportive therapies such as sensory stimulation. Staal formed an assessment method that individualizes the intervention (2010). Baseline and post-trial measures of agitation, apathy, and ADLS were recorded.

The hypothesis fueling this trial is, “participants randomized to combined psychiatric care and multi-sensory behavior therapy would have a greater reduction in agitation and apathy and improvement in ADLs compared to those who received standard psychiatric care and attention controlled structured activity group” (Staal, 2010). Outcomes were measured using the following tools, *The Global Deterioration Scale, The Pittsburgh Agitation Scale, The Scale for the Assessment of Negative Symptoms in Alzheimer’s disease, The Katz Index of Activities of Daily Living, Redefined Activities of Daily Living Scale, and The Mini Mental Status Exam*. 

The results of this trial reveal that the group attended multi-sensory stimulation interventions improved significantly in levels of agitation as compared to the control group. The multi-sensory group significantly improved in levels of apathy as compared to the control. There is no significant difference in ADL baseline between the two groups (Staal, 2010).

**Snoezelen activity: the good shepherd nursing home experience.** A nursing home in Missouri implemented Snoezelen® therapy and reported, “…the use of Snoezelen® therapy has been a successful and rewarding experience for both residents and staff members” (Minner, 2004). The nursing home chose to use a single facilitator model. One individual, a CNA or CMT, was responsible for scheduling, room up-keep, charting, and helping residents.
The registered nurse coordinator is responsible for choosing participants for Snoezelen® therapy. Residents who exhibited episodes of adverse behaviors were given priority (Minner, 2004). 19 residents used the Snoezelen® room in a one year time. Snoezelen® Therapy is implemented when residents begin to have behavior escalations, this normally occurs at time of shift changes (Minner, 2004).

Tools to analyze outcomes was The Comfort/Discomfort Scale (CDS). 324 visits were made to the Snoezelen® therapy room in the year time. The facilitator administered the CDS before, during and one hour after the intervention. Positive behaviors were recorded to show an increase from 3.7 to 5.3 following the intervention. Negative behaviors decreased from 2.1 to 0.9 following the intervention. This a significant change and proves the value of Snoezelen® therapy (Minner, 2004).

Snoezelen, a multisensory environmental intervention. “The purpose of this article is to review the published literature pertaining to the use of multisensory stimulation with older adults and to provide recommendations for future practice and research” (Chitsey, 2002). One study that is outlined in Chitsey’s comprehensive review is the first experimental controlled study investigating multi-sensory therapy for demented adults by Loew and Silverstone. This study involved 14 males who participated in sessions of multi-sensory activities and 14 similar males continued participation in routine activities. This study lasted for six months. “The results of the study indicated no significant change in the cognitive function of the experimental or control group, but results did suggest that the experimental group improved their memory, attention, ability to retain information, and orientation to time” (Chitsey, 2002).

A second study discussed in this comprehensive review is one by Paire and Karney that observes multi-sensory sessions on older adults with psychiatric disorders. “The experimental
group showed improved hygiene skills, demonstrated an increased interest in activities, and were more involved in group participation” (Chitsey, 2002). Maloney and Daily published a 3 year longitudinal observational study similar to Paire and Karney. “Maloney and Daily found that stimulation therapy helped older adults with dementia to relax and achieve a more peaceful state, while becoming more sociable and talkative” (Chitsey, 2002).

A study conducted by Baker et al. compared the effects of eight Snoezelen sessions to a control group who participated in eight traditional activity sessions. “Results indicated that the control group’s deviant behaviors and social and speech skills worsened…experimental group remained the same on those measures” (Chitsey, 2002). Both groups had an increase in enjoyment, contentment, happiness, attentiveness, and verbal communication. Chitsey’s comprehensive review of literature around multi-sensory stimulation as therapy concludes by stating, “although empirical research investigating multi-sensory stimulation in older adults is minimal, currently 90% of empirical research supports its use as both therapeutic and effective” (2002).

**Comparison of Snoezelen to reminiscence therapy on behavior of patients with dementia.**

This study involved 20 patients with dementia and significant agitated behaviors. Participant’s behavior, mood and heart rate were measured before during and after sessions. Each patient underwent three sessions of reminiscence therapy and Snoezelen® therapy (Baillon, 2004). The result of this study concludes that there is no significant difference in the benefit of Snoezelen® therapy and reminiscence therapy. All sessions were implemented on a one to one basis for 40 minutes unless the patient chose to leave group (Baillon, 2004).

**Snoezelen® for relaxation within chronic pain management.** This study by Pat Schofield was initiated to explore the effectiveness of teaching relaxation techniques in a multi-sensory
environment or a pain clinic (2002). The study involved a control group of a mean age of 48 years with duration of 6 years of pain and an experimental group of a mean age of 48.2 and duration of 7.5 years of pain. The variables were measured at 1 month, 3 months and post-intervention. These variables include coping, self-efficacy, anxiety, depression, pain, and disability (Schofield, 2002).

The results are as follows: The experimental group experienced significant reductions in pain and an improvement in self-efficacy and sickness impact for the following scales: physical, psychosocial, recreation and sleep. “The findings suggest that Snoezelen® environments are effective as, if not slightly better than, teaching relaxation within the traditional pain clinic environment for this group of patients” (Schofield, 2002).

Protocol Considerations

When forming a program protocol it is important to begin with evidence-based research, specific program plan and an activity analysis. An activity analysis is described as, “a process that involves the systematic application of selected sets of constructs and variables to break down and examine a given authority to determine the behavioral requirements inherent for successful participation and that may contribute to the achievement of client outcomes” (Stumbo, 2004). An activity analysis involves: interaction and social requirements, cognitive requirements, emotional (affective) factors, and administrative aspects. Variables outlined on an activity analysis are age, number of clients, facilities available, equipment and supplies, staff skills, carryover skills, and activity modification (Stumbo, 2004).

Upon completion of an activity analysis it is appropriate to make individual program protocols. Program protocols are “documents that describe the ‘best practice’ of a specific intervention as applied to a specific group of client needs that have been standardized and result
from recent research evidence, literature reviews, or professional consensus” (Stumbo, 2004). Therapeutic recreation intervention protocols include: program title, general statement of purpose, description of program, client goals/objectives, referral criteria, contraindicated criteria, intervention techniques, certification criteria, risk management considerations, outcomes expected, and program evaluation (Stumbo, 2004).

Collier who is a noted researcher on the effects of multi-sensory interventions stated, “Multi-sensory environment activity most commonly fails when little or no consideration is given to an individual’s abilities or of how the session should be facilitated” (2008). She described the guidelines for multi-sensory activity to be 1) simple, short tasks presented one-step at a time with a limited chance for failure 2) receptive, routine and familiar 3) multi-sensory, sight, sound, taste, tactile, smell, movement 4) safe, with little environmental risk 5) adaptable, spontaneous vs. planned, individual vs. group 6) respectful, offering compatibility with age, using reminiscing skills, and incorporating old interest (Collier, 2008).

Utilizing relevant and recent research, professional considerations, facility considerations, and standardized diagnostic outcomes, goals and objectives three Snoezelen® intervention protocols have been formed for the use in the Veterans Affair Hospital, West Haven, Connecticut for the recreation therapy professional. These intervention protocols will include an activity analysis and evaluation. These intervention protocols are adaptable for use in various settings when utilizing the pertinent research available in the literature review and protocol considerations portion of this paper. Certain areas of protocol should not be adapted including, certification criteria, referral criteria, client goals and objectives, and outcomes expected.
Multi-Sensory Stimulation Protocol

Program Protocol

Program: multi-sensory stimulation
Participants: 1
Population: in-patient geriatric with a major neuro-cognitive impairment [Alzheimer’s Disease, Vascular Dementia, Parkinson’s Disease, Lewy Body Disease, Fronto-Temporal Dementia]
Facility: multi-sensory environment (MSE) room/area
Facilitator: 1
Equipment: multi-sensory devices (touch, taste, smell, audio, visual, movement)

I. Treatment Modality
Multi-sensory stimulation therapy for dementia and end-of-life care

II. Rationale
Multi-sensory therapy interventions can be implemented in various ways. People who are institutionalized often experience sensory deprivation. Multi-sensory stimulation includes arousing all senses (touch, taste, hearing, vision, movement). The optimal environment for multi-sensory therapy for people who have dementia is on a one-to-one, failure-free basis (Minner, 2004).

“Although empirical research investigating multi-sensory stimulation in older adults is minimal, currently 90% of empirical research supports its use as both therapeutic and effective” (Chitsey, 2002). “Maloney and Daily found that stimulation therapy helped older adults with dementia to relax and achieve a more peaceful state, while becoming more sociable and talkative” (Chitsey, 2002). Baillon et al found that sessions of 40 minutes are appropriate for adults with dementia, if the participant wishes to leave at any time during the session they should not be stopped (2004). Berg’s study protocol suggest a one to one basis for 10-20 minutes (2010). Baillon and Minner’s research both concur that multi-sensory stimulation should be implemented on a one to one basis (2004, 2004).

III. Referrals
Participants will be referred to this program by physicians or recreation therapy professionals based off of assessment. Participants must have a diagnosis of a neuro-cognitive impairment meeting the criteria outlined in the DSM V. Participants should be institutionalized, experiencing sensory deprivation, isolative tendencies, and/or behavior issues.

IV. Risk Management
Participants who are not appropriate for this program include: people with medical precautions that inhibit their ability to leave their room such as, MRSA, and participants who are not conscious and unarousable. Other participants might require special considerations for approval and admittance to program.
V. Criteria

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<tr>
<th>Structure Criteria</th>
<th>Process Criteria</th>
<th>Outcome Criteria</th>
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<tbody>
<tr>
<td>Multi-sensory stimulation therapy will be implemented on a one-to-one basis. Each session will last 30 minutes but can end before or last longer. This intervention will be available 5 times a week.</td>
<td>Therapist will:</td>
<td>Participant will:</td>
</tr>
<tr>
<td>Depending on tolerance Patient will be introduced to the equipment one sense at a time</td>
<td>Therapist will provide materials and equipment as tolerated</td>
<td>Patient will interact with the materials and equipment as tolerated and desired</td>
</tr>
<tr>
<td>All senses will be engaged for complete sensory emersion</td>
<td>Therapist will assure a safe environment that engages all senses</td>
<td>Patient will be comfortable and engaging with materials and equipment as desired and tolerated</td>
</tr>
<tr>
<td>Session will naturally end or depending on facility requirements end at a set time</td>
<td>Therapist will slowly transition senses. One sensory stimulating device or material will be terminated at a time.</td>
<td>Patient shows signs of disinterest/lack of comfort/over-stimulating the session should be ended. Patient will be aware of session slowly ending.</td>
</tr>
</tbody>
</table>

VI. Conclusion

The therapist implementing multi-sensory stimulation should be a supervisor and PRN facilitator. The participant is in control of the stimulation of his senses. Various materials and equipment (lights, aromas, food, etc) are integrated as tolerated. All sessions should be documented. Effectiveness and therapist performance should be assessed for success routinely.
Activity: Multi-Sensory Stimulation

PHYSICAL ASPECTS:

1. What is the primary body position required?
   - x_lying down
   - x_sitting
   - _other: ________________
   - x_kneeling
   - x_standing

2. What body parts are required?
   - x_arms
   - x_feet
   - x_upper torso
   - x_hands
   - x_neck
   - x_lower torso
   - x_legs
   - x_head
   - _other: ________________

3. What types of movement does the activity require?
   - _punching
   - _bending
   - x_reaching
   - x_stretching
   - _catching
   - x_grasping
   - _standing
   - _throwing
   - _skipping/hopping
   - x_walking
   - _hitting
   - _running
   - _other: ________________

4. What are the primary senses required for the activity?
   - x_touch
   - x_sight
   - x_smell
   - x_taste
   - x_hearing
   - x_movement

5. What is the amount of coordination and movement between body parts required by the activity?
   - Much 1 2 3 4 5 Little

6. What is the amount of hand-eye coordination needed for the activity?
   - Much 1 2 3 4 5 Little

7. What is the degree of strength needed for the activity?
   - Much 1 2 3 4 5 Little

8. What is the degree of speed needed for the activity?
   - Much 1 2 3 4 5 Little

9. What is the degree of endurance needed for the activity?
   - Much 1 2 3 4 5 Little

10. What is the degree of energy needed for activity?
    - Much 1 2 3 4 5 Little

11. What is the degree of flexibility needed for the activity?
    - Much 1 2 3 4 5 Little

SOCIAL ASPECTS:

1. What is the primary social interaction pattern required in the activity?
   - x_Intraindividual (action taking place within the mind or action involving the mind and a part of the body; requires no contact with another person or external object)
   - x_Extraindividual (action directed by a person toward an object; requires no contact with another person)
   - _Aggregate (action directed by a person toward an object while in the company of other persons who also are directing actions toward objects; action is not directed toward each other; no interaction required among participants)
Interindividual (action of a competitive nature directed by one person toward another)

Unilateral (action of a competitive nature among three or more persons, one of whom is an antagonist; interaction is in simultaneous competitive relationship)

Multilateral (action of a competitive nature among three or more persons with no one person as an antagonist)

Intragroup (action of a cooperative nature by two or more persons intent upon reaching a mutual goal; action requires positive verbal or nonverbal interaction)

Intergroup (action of a competitive nature between two or more intragroups)

2. What is the minimum number or maximum number of people required for this activity?

   _1_ minimum _1_ maximum

3. What clothing is needed to be social appropriate?

4. How much physical proximity is required by this activity?

   Close 1 2 3 4 5 Distant

5. How much physical contact is required by this activity?

   Much 1 2 3 4 5 Little

6. What degree of communication is required by the activity?

   High 1 2 3 4 5 Low

7. What degree of noise is generated by the activity?

   Much 1 2 3 4 5 Little

COGNITIVE ASPECTS

1. How many rules are required in the activity?

   Many 1 2 3 4 5 Few

2. How complex are the rules to understand?

   Complex 1 2 3 4 5 Simple

3. What degree of strategy is required in the activity?

   Many 1 2 3 4 5 Little

4. What degree of complexity is involved in scoring?

   Much 1 2 3 4 5 Little

5. What degree of long-term memory is required in the activity?

   Much 1 2 3 4 5 Little

6. What degree of short-term memory or immediate recall is required in the activity?

   Much 1 2 3 4 5 Little

7. What degree of verbalization of thought process is required in the activity?

   Much 1 2 3 4 5 Little

8. What degree of concentration is required in the activity?

   Much 1 2 3 4 5 Little

9. What degree of concrete thinking is required by the activity?

   Much 1 2 3 4 5 Little

10. What degree of abstract thinking is required by the activity?
11. To what degree are each of the following skills used in the activity?

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<tr>
<th>Skill</th>
<th>Much</th>
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</table>

12. To what degree does the participant need to identify or use the following?

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<tr>
<th>Skill</th>
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AFFECTIVE ASPECTS

1. To what degree does the participant have the opportunity or outlet to express the following?

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<tr>
<th>Emotion</th>
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2. To what degree does the participant need to inhibit or control the expression of the following?

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<th>Emotion</th>
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ADMINISTRATIVE ASPECTS

1. What type of leadership style is required by the activity/

   _specific activity-skill expertise_ x _supervisory style_

   x _general activity-skill expertise_ _no specific leadership style needed_

2. What type of equipment is needed for this activity?

   x _specific commercial product (specify: _sensory stimulation (i.e. Snoezelen)___)
   
   x _can be made (specify: _food_________)
   
   _no equipment required_

3. What type of facility is required by the activity?

   _specific natural environment (specify: __________)___
   
   x _specific created environment (specify: _MSE_______)
no specific environment required

4. What is the duration of the activity?
   x set time (specify:__________)
   x natural end
   x continuous

5. What is the number of participants required for the activity?
   __any number can participate
   x fixed number or multiple (specify:__1__)

Printed Name: Rebekah J Plavnick
Signature: __________________________
Date: __April 15, 2016_______________
Protocol Evaluation

Multi-Sensory Stimulation was implemented by this writer, Rebekah Plavnick a senior recreational therapy intern. The program was implemented at the Veteran’s Affair hospital in West Haven, Connecticut. The participant at the time was an in-patient geriatric. His primary medical provider was spoken to about limitations and appropriateness. Without assessment the patient is believed to be at an exploratory functioning level. He is appropriate for multi-sensory stimulation because of a diagnosis of vascular dementia and being admitted for an extended hospitalization.

The Snoezelen® equipment was set up in an empty hospital room because of its dark environment. The equipment used in the room included: mobile bubble machine, two projectors, fibro-optic strands, two tactile balls, nature sounds CD.

The participant was approached by me. I described the MSE to the patient as a room that promotes relaxation and self-exploring. He was receptive to the information and expressed that he understood. I asked if he would like to go into the room. He agreed to go in and was assisted to room. He transferred from a manual wheelchair to a large recliner that contained the two tactile balls and a soft blanket that he brought himself. He was asked about his comfort level to assure successful transition. He responded well to all equipment being on. Veteran independently observed the fiber-optic strands while seated. Veteran independently observed all equipment. He only physically engaged with the fiber-optic strands. Veteran brought a magazine with him into the room and he read and observed it. This session lasted for 20 minutes. He reported that he was indifferent about the room and that he would come back again if available.

Considerations for future implementation include: change locations due to unmovable hospital equipment in room and noise in the hallway. Incorporate a taste stimuli when implementing
multi-sensory stimulation. Implement during shift change as suggested by Minner’s research (2004). Purchase appropriate assessments to form better individual treatment plans. There was no adverse effects recorded by this writer or participant, however the absence of negative outcomes does not equate to a positive outcome. Further intervention should be implemented and recorded for multi-sensory stimulation analysis on in-patients with a neuro-cognitive impairment.
References


