Best practice in dementia care: A learning programme for housing staff

Introduction to the course for participants
Self-study checklist

Here is a list of the things you need to complete after your introductory ice-breaker meeting and before your first full group meeting. Tick each item as you complete it. Your facilitator will ask to see your workbooks and will check that you have completed your self-study work.

☐ read this booklet carefully from start to finish
☐ read Part 1 carefully from start to finish
☐ complete Exercise 1.6 in Part 1
☐ complete Exercise 1.7 in Part 1

I have completed the above tasks:

Name: __________________________________________
Signature: ________________________________________ Date: ________________________
Best practice in dementia care: A learning programme for housing staff

About the study course

Each booklet in this study course is designed to help you think about how you respond to the person with dementia. Underpinning each one is a person-centred approach to support and care, which focuses on the needs of the individual. During the course you will receive the support of a group facilitator who will arrange regular group meetings to discuss the topics covered in the booklets. Between the meetings you will be asked to think about the answers to exercises that relate to your practice and what you have learned.

The parts of this course are:

Part 1. The person and dementia
Part 2. Person-centred support and care and building meaningful relationships
Part 3. Communication and behaviour
Part 4. Support for the person with dementia, family and carers
Part 5. Health and wellbeing
Part 6. Legal aspects and issues in relation to dementia

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The Dementia Services Development Centre (DSDC) is based at the University of Stirling and was founded in 1989 to extend and improve services for people with dementia. It provides training and consultancy services, as well as carrying out research and producing publications.
Contents

Section A: Information for participants

1. Welcome to the course ................................................................. 3
2. The purpose of the course and the learning objectives .................... 3
3. How the course is organised ....................................................... 4
4. The six booklets ......................................................................... 4
5. Reflective practice ...................................................................... 5
6. The six group discussions .......................................................... 6
7. The group facilitator ................................................................... 6
8. A note about terminology ........................................................... 7
9. What is person-centred care? ..................................................... 7
10. Regulating housing and care ..................................................... 8
11. Providing appropriate standards of support and care ................... 9
12. Developing your skills and working towards qualifications ............ 10
13. Is there an assessment? ............................................................ 11
14. Plagiarism: what it is and the DSDC’s policy on it ....................... 12
15. Helpful hints ............................................................................ 12
16. Feedback form .......................................................................... 12
17. Further reading and references ................................................ 14

Section B: Information for the facilitator

18. Important practicalities .............................................................. 18
19. Facilitating a discussion ............................................................ 18
20. The final reflective exercise ....................................................... 19
21. Quality assurance ..................................................................... 19
22. Quality assurance checklist ...................................................... 20
Appendix 1: Format of facilitator’s training course .......................... 21
Appendix 2: Facilitator assessment checklist ................................... 23
Appendix 3: Examples of reflective exercises .................................. 24
Appendix 4: Essential standards of quality and safety ...................... 26
Section A: Information for participants

1. Welcome to the course

Domiciliary care is defined as ‘care and support provided to an individual within their own home’. This is the term local authority commissioners use when advertising or tendering for this type of service. For individuals, families and staff, the terms ‘housing support’ and ‘home care’ are probably more familiar and less intimidating, although in practice both mean the same thing. As housing support and care staff, you will be aware that the needs of the people you care for are changing. This means you will increasingly be supporting people with dementia in their own homes. As the number of people living with dementia at home grows, you will play a significant role in supporting them and their families to maintain their independence. Often you will work on your own, which can bring its own challenges in terms of safety and standards of support and care.

This course has been designed to enable you to learn more about dementia. It reflects the guidance in Common core principles for supporting people with dementia (Department of Health, 2011) and Standards of care for dementia in Scotland (Scottish Government, 2011). The course was developed following a one-day event attended by over 100 domiciliary care staff from Scotland and England. Their views, comments and ideas were used to inform how the course was designed. Following the event, it was piloted with staff groups from Scotland and England. The course has subsequently been attended by other groups of staff and new versions have been created, including this one for housing staff.

We hope you feel motivated, enthusiastic and prepared to commit time to learn. The fact that you have decided to improve your skills and knowledge through self-study means that you will be responsible for your own learning. This introductory booklet explains what the course involves. Do take time to read through the various sections. Expect to be challenged but also inspired!

2. The purpose of the course and the learning objectives

This course will help you think about how to provide the best support and care for people with dementia in their home environment. You may already feel you are doing a good job, but do you use a person-centred approach?

On completion of this course you should be able to:

• exhibit a greater understanding of dementia and its impact on the individual
• engage in a reflective evaluation of support and care interventions and change your practice accordingly
• implement a person-centred approach to support and care
• demonstrate evidence-based caring interventions
• demonstrate a more expansive use of communication skills when interacting with and understanding the needs of people with dementia
• recognise the role of the carer/family, their needs and possible support networks
We know from the groups of staff who tested the course that their new knowledge helped make them more confident and feel more valued as members of the support and care team.

3. How the course is organised

How will I find 60 hours of time?
Don’t panic! To help you in your study there will be group meetings and you will be given six self-study booklets. This is a six month course, and every month you will attend a three hour group meeting with colleagues and your facilitator. In between, you will be expected to spend about an hour and a half each week preparing for your monthly meeting by studying the workbooks and reflecting on your practice. However, every aspect of the course is grounded in what you do every day. We aim to get you thinking about what you do and your particular ways of working with people with dementia.

Breakdown of participant study hours to complete course (total: 60 hours)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Hours per month</th>
<th>Total hours over six months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at group meetings</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Protected study time and reflective practice</td>
<td>7</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>60</td>
</tr>
</tbody>
</table>

4. The six booklets

The course involves reading and completing a set of six self-study booklets. Each booklet contains questions, with space for you to write down your responses. The questions link to different aspects of your work. You will only be given one booklet each month, and this will form the basis of your group discussions with the facilitator. At the end of each booklet there is a reflective exercise which is designed to help you think about what you have learned and what this might mean for how you respond to the person. If you find that you do not always have examples from your own experience to draw from, please use your new learning and apply this to the exercises. In the weeks between your monthly group meetings, you should complete your self-study exercises.

Part 1. The person and dementia. This looks at the different types of cognitive impairments that are covered by the term dementia. It also explains how the impact of dementia on individuals can vary.

Part 2. Person-centred support and care and building meaningful relationships. This focuses on ways of helping the person to keep control over as many parts of their life as possible. This involves encouraging them to make maximum use of their remaining abilities.

Part 3. Communication and behaviour. This illustrates how a person with dementia can be very aware of our responses, and looks at how we can understand communication and behaviour better.
Part 4. Support for the person with dementia, family and carers. This looks at the support a family member or carer may need to help them carry on caring for their relative with dementia for as long as they feel able (providing this is in the best interests of the person).

Part 5. Health and wellbeing. This explains that providing quality support and care for a person with dementia involves promoting their health and wellbeing using a person-centred approach to enhance their quality of life.

Part 6. Legal aspects and issues in relation to dementia. This looks at the implications various legal powers have on the person. Knowing what these mean can help you understand how to respond to the person in different situations.

5. Reflective practice

The course is based on reflecting on the way you currently work. Reflection is an essential technique for improving our practice. Challenging our own practice might not be easy, but in order to develop and improve, we cannot neglect it.

Here is an example of reflective practice. When one of your clients starts talking about their grandfather, you may ‘challenge their reality’ by telling them that he died many years ago. This could cause the person to become distressed. Reflecting on this experience (in conjunction with the knowledge you will gain during the course) should help you appreciate that a person with dementia may not be able to see your view of the world, and instead you will need to enter their reality. The person’s own reality may be that they are living with their grandfather now. If so, challenging this view is likely to be distressing for them.

One writer has described reflection as ‘the path toward realising desirable . . . practice in meaningful and practical ways. It is a process of self-development, of becoming the sort of practitioner you want to be.’

In order to get the very best from this course, it is important to learn how to reflect. We use reflection in our everyday lives without really realising, for instance when we say ‘I wish I hadn’t said that to mum! I’ll apologise and do it differently next time.’ Reflection is enjoyable and rewarding because it helps you develop as a person.
Reflective practice means taking time to ask questions like ‘Why?’, ‘How?’, ‘What?’ and ‘Could I have done things differently?’ It involves looking at things from a different angle and then seeing if this might change the way you care for and support people. The aim is to help you think about different aspects of support and care and how you can develop a more person-centred approach to your work. As you read through the booklets you should reflect on how the scenarios in the exercises relate to your own experiences as a housing worker.

As you start questioning the way you practice, you will begin to change the way you interact with people with dementia. Trying out new approaches will enable you to see if they are effective. Each time you are successful – or unsuccessful – you will complete the learning cycle and can begin to refine your actions again. This is an ongoing process, and no one ever achieves perfection. However, there are always new and more effective ways of doing things that we can learn from our previous experiences and from each other.

You may find it helpful to take notes during the group sessions to remind yourself about topics to reflect on afterwards. However, it is important that your reflective practice is based on your experiences in the workplace.

Use the following questions to help think about your practice. You may find these useful when you are completing the exercises in your workbooks, or when you are discussing experiences with your colleagues or your facilitator.

- what was I aiming for when I did that?
- what exactly did I do? How would I describe it precisely?
- why did I choose that particular action?
- what did I do next?
- what were the reasons for doing that?
- how successful was it?
- what alternatives were there?
- could I have dealt with the situation any better?

- how would I do it differently next time?
- what do I feel about the experience?
- what knowledge/values/skills did I demonstrate?
- how did the person with dementia feel about it?
- what sense can I make of this in the light of my past experience?
- has this changed the way in which I will do things in the future?

Thinking about these questions will also help you complete your final reflective exercise at the end of Part 6.

6. The six group discussions

Every month, you will come to a group discussion organised by your group facilitator. These discussions will normally last for three hours and you should be given time off from your daily routine to attend. The discussions are an opportunity to share your thoughts, ideas and questions with colleagues and the group. There should never be more than eight people in the group.

7. The group facilitator

You can discuss any difficulties or concerns that you have about the course – however small – with your facilitator. Before leading the course, they will have been on a training course at the Dementia Services Development Centre (DSDC).
They are expected to follow a set of six steps in facilitating the group discussions:
1. Organise a suitable time and place for a meeting and inform your manager
2. Encourage discussion about best standards of support and care and not judge contributions from you or other group-members
3. Make constructive comments to ensure best standards of support and care
4. Maintain confidentiality
5. Help you set aside protected study time by arranging this with your manager
6. Provide the DSDC with feedback about the course, including who attended and whether any changes need to be made to the study materials for future courses

8. A note about terminology

The terminology used in supporting people with dementia continues to change. These course materials refer to ‘distressing behaviour’, rather than ‘challenging behaviour’, ‘behaviour that challenges’ or ‘behavioural and psychological symptoms of dementia’. This reflects the terminology that is currently considered to be the most appropriate.

These materials do not talk about ways of ‘managing behaviour’. This is because an approach that is based on managing behaviour suggests it is sufficient to try and minimise distress after it occurs, without seeking to understand the cause.

The DSDC believes that using the right terminology sends a clear message that behaviour which is distressing requires knowledgeable staff who understand – rather than manage or treat – behaviour. Instead of focusing on ‘managing behaviour’, the aim of this course is to help housing staff gain a greater understanding of the communication and behaviour that can be expressed by people with dementia. It places a responsibility on staff to search for the underlying meaning, emotions and beliefs which result in distressing behaviour and appropriately adjust their approach and intervention. The following terms are considered to be inappropriate when discussing patients who are cognitively impaired:

- demented
- agitated
- aggressive

- challenging
- dementia sufferer

9. What is person-centred support and care?

You will find the term ‘person-centred care’ mentioned frequently in the booklets and during the course. Being person-centred means:

- respecting and valuing uniqueness and diversity
- promoting the individual’s right to choice, privacy and confidentiality
- challenging discrimination, racism, disadvantage, inequality and injustice
- responding in non-stigmatising ways

The values that underpin a person-centred approach are:

- understanding that each person is a unique individual who deserves to be treated with dignity and respect
- being tolerant and patient of each individual’s way of being
• being willing to enhance communication and understanding
• working to maximise each individual's skills and abilities
A person-centred approach means focusing on what people can do as individuals, rather than what they can’t do. It is based on what makes each individual unique and starts from ‘where the person is at’.

**Palliative care**

The aim of palliative care is to promote the best quality of life for anyone with a life-limiting illness. It begins with the person’s diagnosis (in this case with dementia) and continues until the end of their life. You will learn more about taking a palliative care approach in Part 5.

**Equality and diversity**

Promoting equality of opportunity and valuing diversity means understanding that people with dementia have the same rights as other citizens. They should not be marginalised because of age, gender, class, ethnic group, physical or intellectual ability, religion or sexual orientation.

Our ideas and beliefs are often expressed by the language we use, including our humour. It is important to:

- avoid using words that are demeaning or depersonalising, such as referring to individuals as ‘old dears’, ‘the demented’ or ‘dementia sufferers’
- be aware that humour can be based on discrimination. This is because the ‘joke’ often involves portraying people of a particular culture or group in a negative way, which reinforces discrimination
- avoid making generalisations or stereotyping people. For instance, saying that ‘people with dementia have no insight’ lumps all individuals together. People from different ethnic groups are often at particular risk of being stereotyped or discriminated against because of cultural difference

We should recognise that we live in a diverse society and that there is a need to respond to cultural differences and affirm these.

**10. Regulating housing and care**

In England, domiciliary care providers are regulated by the Care Quality Commission (CQC) under the Health and Social Care Act 2008.

Domiciliary care organisations in Scotland are regulated by Social Care and Social Work Improvement Scotland (SCSWIS) and Healthcare Improvement Scotland (HIS). These were created by the Public Services Reform (Scotland) Act 2010 to coordinate and deliver efficient and effective scrutiny of health and social care, social work and child protection.

In Wales, domiciliary care providers are regulated by the Care and Social Services Inspectorate Wales.

In Northern Ireland, the Regulation and Quality Improvement Authority (RQIA) and Northern Ireland Social Care Council are the statutory regulators for domiciliary care providers.
11. Providing appropriate standards of support and care

Across the UK, a range of standards documents have been produced to ensure that people with dementia receive support and care that is appropriate to them.

Common core principles for supporting people with dementia
This guidance document was produced by the Department of Health in 2011 as part of the implementation of the national dementia strategy, *Living well with dementia*. It embodies the principle that everyone with dementia should have the support of people who are able to respond to them appropriately, reducing the stress and anxiety that dementia can bring. The principles stress the importance of tailoring support to the person and their specific interests and needs. The aim is to encourage independence and choice in the decisions they make.

The eight principles are:

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle 1</td>
<td>Know the early signs of dementia</td>
</tr>
<tr>
<td>Principle 2</td>
<td>Early diagnosis of dementia helps people receive information, support and treatment at the earliest possible stage</td>
</tr>
<tr>
<td>Principle 3</td>
<td>Communicate sensitively to support meaningful interaction</td>
</tr>
<tr>
<td>Principle 4</td>
<td>Promote independence and encourage activity</td>
</tr>
<tr>
<td>Principle 5</td>
<td>Recognise the signs of distress resulting from confusion and respond by diffusing a person’s anxiety and supporting their understanding of the events they experience</td>
</tr>
<tr>
<td>Principle 6</td>
<td>Family members and other carers are valued, respected and supported just like those they care for and are helped to gain access to dementia care advice</td>
</tr>
<tr>
<td>Principle 7</td>
<td>Managers need to take responsibility to ensure members of their team are trained and well supported to meet the needs of people with dementia</td>
</tr>
<tr>
<td>Principle 8</td>
<td>Work as part of a multi-agency team to support the person with dementia</td>
</tr>
</tbody>
</table>

Essential standards of quality and safety
The Care Quality Commission has developed a document called *Essential standards of quality and safety* which details 28 outcomes that health and social care providers are measured against. For further information on the essential standards see Appendix 4.

Standards of care for dementia in Scotland
These standards were published by the Scottish Government in 2011. They are designed to help people with dementia and their unpaid carers understand their rights and make sure that they receive the support they need. The six standards are:
I have the right to a diagnosis.

I have the right to be regarded as a unique individual and to be treated with dignity and respect.

I have the right to access a range of treatment, care and support.

I have the right to be as independent as possible and be included in my community.

I have the right to have carers who are well supported and educated about dementia.

I have the right to end of life care that respects my wishes.

### 12. Developing your skills and working towards qualifications

Training in support and care for people with dementia is developing rapidly throughout the UK. This is because of the heightened profile and importance of dementia that the various national dementia strategies have emphasised. As a result, a range of qualifications and frameworks have come into operation across the UK.

The Scottish Government’s document, *Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers*, is particularly relevant to staff working in Scotland. It details the knowledge and skills all health and social care staff should aspire to in order to provide the best care for people with dementia. It defines four levels of knowledge and skills, and staff should aspire to move through these levels as their career progresses:

- **informed practice**: the baseline knowledge and skills required by all staff working in health and social care settings
- **skilled practice**: the knowledge and skills required by all staff that have direct and/or substantial contact with people with dementia and their families and carers
- **enhanced practice**: the knowledge and skills required by staff that have more regular and intense contact with people with dementia
- **expert practice**: the knowledge and skills required for health and social care staff who by virtue of their role and practice setting play an expert specialist role in the care, treatment and support of people with dementia

The content of this course relates to the informed practice and skilled practice levels. Some parts are also relevant to the enhanced practice level.

**Accreditation from City & Guilds**

City & Guilds have accredited the programme with 6 Scottish Credit and Qualifications Framework (SCQF) credits at level 6. This references the Qualifications and Credit Framework in England at level 3.

**The Qualifications and Credit Framework**

In January 2011 the Qualifications and Credit Framework (QCF) was launched in England. This includes both a Certificate and Diploma in Health and Social Care. Both feature dementia-specific units. The booklets that make up this course provide a knowledge base for the 16 specialist dementia units in the
QCF at levels 2 and 3. Person-centred values, approaches and practices are firmly embedded into all the booklets, as well as the reflective exercises and facilitated group discussions.

The Scottish Credit and Qualifications Framework
Best practice in dementia care has been accredited with 6 SCQF credits at level 6. If you successfully complete the course you will be able to use the six credits towards further qualifications.

Republic of Ireland and Europe
In the Republic of Ireland and Europe, SCQF Level 6 can be referenced to EVQ Level 4.

Meeting the knowledge requirements for S/NVQ health and social care units
If you are undertaking your S/NVQ qualification or are engaged in continuing professional development, these booklets will provide a knowledge base for the S/NVQ Level 3 qualification for staff working with people with dementia.

To have your work assessed for this qualification you need to be registered with an S/NVQ assessment centre which will assign you an assessor. Completion of this programme should contribute towards the evidence you require for the Level 3 qualification. However, your assessor will also need to directly observe your practice (or arrange for another competent person to do this). He or she will probably ask you additional questions to satisfy themselves that you do indeed meet the knowledge and skill requirements for this S/NVQ.

To complete the S/NVQ Level 3 for staff working in health and social care, candidates must complete eight units in total. Four of these must be core units, with another four units taken from the optional list. The units taken must be appropriate to the candidate’s work role and setting.

The four core units:
HSC 31 Promote effective communication for and about individuals
HSC 32 Promote, monitor and maintain health and security in the working environment
HSC 33 Reflect on and develop your practice
HSC 35 Promote choice, wellbeing, and the protection of all individuals

13. Is there an assessment?

There is no exam at the end of the course. However, we are eager for you to show how your practice has changed and so we have set two questions at the end of Part 6 that require 300 word answers. You will need to write 600 words in total – 300 for each question.

At the end of the course, a certificate will be awarded to participants who:

- have attended all of the group discussions and completed all of the self-study booklets
- have met the learning objectives detailed on page 3
- show an understanding of best practice
- demonstrate greater awareness and understanding
- identify further learning needs
14. **Plagiarism: what it is and the DSDC’s policy on it**

Plagiarism means pretending that someone else’s work is your own. It includes copying someone else’s words or ideas without making it clear that the information has come from them. Copying information from the internet, even when the original source isn’t clear, is also plagiarism. When you work through the self-study exercises in this course you must write down answers that you have thought of yourself. Sometimes you may need to quote information from another person or a text book. Providing you use quotation marks and make it clear what the source of the information is, you will not be plagiarising. If either your facilitator or the DSDC thinks that you have plagiarised any of your answers, you may not be awarded your certificate of completion.

15. **Helpful hints**

- plan your study time in advance
- use resources that are available at your work, e.g. computers or library resources
- share your experiences and knowledge with your colleagues
- support each other
- reflect on your own caring practice and the routines of where you work
- recognise that each individual has their own learning style
- pay attention to key points throughout the workbooks
- use the self study checklists
- enjoy the study course
- remember, the booklets are your property

16. **Feedback form**

If you would like to provide us with feedback on this course, you can photocopy the form opposite, fill it in and post it to us, or email your comments to dementia@stir.ac.uk.

We rely on feedback from participants to help us improve the courses we provide, and your comments will be used to ensure future versions continue to be as relevant as possible. If you would like us to respond to your feedback, please include your name and contact details. If you prefer, you can provide feedback anonymously.

All participants have the opportunity to resubmit their final exercises if their written submission has not met the required criteria as set out on page 11. We ask that a resubmission is made within a two week period. Following an insufficient resubmission, additional evidence of learning may be required.

**Appeals and complaints**

If you wish to appeal about any aspect of this course please contact us by post or email us at the address opposite.
Feedback form (please photocopy)

Best practice in dementia care: A learning programme for housing staff

Name:  
Email address:  
Place of work:  

Your comments

General feedback

How could we improve the course?

What were the best aspects of the course?

Were there any areas we didn’t cover that would be relevant to you?

Please send your completed form to the Dementia Services Development Centre, Iris Murdoch Building, University of Stirling, Stirling, FK9 4LA

As a department within the University of Stirling we adhere to the University Appeals and Complaints Procedure. The University of Stirling is committed to providing all its users with high quality services and we aim to do so fairly and efficiently. However there may be times where a student, member of staff or member of the public feels that their expectations have not been met. Where this happens, our procedures aim to make it as easy as possible for users to submit a complaint. The procedures and guides have been drawn up in compliance with the Model Complaints Handling Procedure published by the Scottish Public Services Ombudsman (SPSO) in December 2012.

To make a complaint please visit http://www.stir.ac.uk/complaints/
17. Further reading and references

Useful websites [accessed 2 December 2015]

Alzheimer Scotland http://www.alzscot.org/
Alzheimer’s Society http://www.alzheimers.org.uk/
British Dietetic Association http://www.bda.uk.com/
Care Inspectorate http://www.scswis.com/
Care Quality Commission http://www.cqc.org.uk/
Chartered Society of Physiotherapy http://www.csp.org.uk/
College of Occupational Therapists http://www.cot.co.uk/
Dementia Services Development Centre http://www.dementia.stir.ac.uk/
Businessballs.com http://www.businessballs.com/
Healthcare Improvement Scotland http://www.healthcareimprovementscotland.org/home.aspx
NHS Education for Scotland http://www.nes.scot.nhs.uk/
National Institute for Health and Clinical Excellence (NICE) http://www.nice.org.uk/
Office of Public Sector Information http://www.opsi.gov.uk/
Royal College of Nursing http://www.rcn.org.uk
Regulation Quality Improvement Authority http://www.rqia.org.uk/home/index.cfm
Royal College of Speech & Language Therapists http://www.rcslt.org/
Scottish Intercollegiate Guidelines Network (SIGN) http://www.sign.ac.uk/
Unionlearn with the TUC http://www.unionlearn.org.uk/

Books and articles


Section B: Information for the facilitator

This part of the introductory booklet contains information that relates to the group facilitator. We have included it here so that you can gain a better understanding of what their role is.

18. Important practicalities

Preparation prior to leading the group discussions:

- make sure you know in advance the staff who will be attending and ensure that they have been informed of the meeting time
- if possible, avoid early morning meetings or Friday afternoons
- ensure a suitable meeting room is booked in advance for all seven sessions (including the initial icebreaker session)
- ensure you have organised a flipchart (and DVD player where required)
- make sure you have read and understood the content of the booklets (including the facilitator’s guide) in advance
- be prepared to answer questions

19. Facilitating a discussion

The facilitator’s handbook provides a suggested timetable for each group meeting. The timings can vary to some degree, and common sense should prevail! However, if no questions are forthcoming then do not assume that everyone has fully understood everything.

| Reflect, summarise, and provide examples. Link knowledge to practice and encourage participants to share experiences. Where staff do not have direct practice examples to draw on please support them to apply their new learning to the exercises. |

| Make sure all breaks take place, even when learners want to miss out on a break and ‘finish early’. |

| The average person’s attention span is about 20 minutes, so try and limit the sections to bite-sized chunks, as outlined in the guidance notes. |

| Remember that different participants will have different styles of learning. However, learning is unlikely to be effective if participants simply read booklets or have sections read to them. |

| Use the flipchart to write down answers to any questions that are included in the session. It can be useful to write the question clearly on the flipchart beforehand. Writing up answers can help visual memory. |

| Make it a safe and comfortable environment, where learners are not afraid to ask questions or discuss their thoughts, worries or concerns. |
20. The final reflective exercise

- the final reflective exercise is completed at the end of Part 6
- before a certificate is awarded, a copy of each participant’s exercise must be sent to the project leader at the DSDC, along with a completed copy of the checklist on page 20
- a comments form will be returned to the facilitator for sharing with each participant
- once the exercise has been completed successfully it may be shared with the participant’s line manager

21. Quality assurance

Facilitators are expected to meet the following criteria. Your manager will have signed an agreement saying that they are aware of the implications and demands of the course. To be registered as a facilitator you must:

- attend the two-day training course and study the six booklets and facilitator’s guide
- be in a supervisory role and have a minimum of two years experience of working with people with dementia
- understand the challenges that dementia creates for the person with dementia, their families, and the staff who support and care for them
- have a positive attitude towards supporting people with dementia
- be committed to ensuring best practice at all times
- accept supervision and support from the DSDC’s staff
- maintain and update personal knowledge and skills through further reading and study

Personal qualities that you will need as a facilitator include:

- self-motivation
- the ability to motivate others
- good communication skills
- a flexible approach
- problem-solving skills
- trustworthiness
- self-confidence
22. Quality assurance checklist

A key part of your role as course facilitator involves assessing the learning that your participants have undertaken. At each meeting, you should ask to see their workbooks to ensure that they have completed all the self-study exercises relevant for each stage. You must also stress the importance of attending all the group meetings. When the course is finished, please photocopy this checklist, complete it and return it to the DSDC. Certificates of completion cannot be issued until the DSDC has received both a completed checklist for your group and a final reflective exercise of a suitable standard from each participant.

Name (please print): ________________________________

☐ Attended all meetings* ☐ Completed all self-study exercises, plus final reflective exercise

Name (please print): ________________________________

☐ Attended all meetings* ☐ Completed all self-study exercises, plus final reflective exercise

I confirm that the information supplied here is correct.

Name of facilitator (please print): ________________________________

Signature: ________________________________ Date: ________________________________

* If a participant misses any group meetings because of illness, holidays or other commitments, you may still tick this box, as long as you are satisfied that they have completed the learning they have missed, including providing written answers to the group exercises for these meetings. If participants miss more than one group meeting please inform the DSDC as soon as possible.

Send your completed form to The Dementia Services Development Centre, Iris Murdoch Building, University of Stirling, Stirling, FK9 4LA
Appendix 1: Format of facilitator’s training course

The following timetable is for guidance only, and the content of the training course may be changed to reflect current best practice.

Aims of training course:

- to become familiar with the format of the course
- to be aware of the demands of the role of facilitator
- to maintain DSDC standards for the course
- the changing policy scene
- dementia, delirium and depression
- what’s expected of the housing support worker on the course
- the role of the facilitator
- understanding reflective practice

Day 1

9.30 Coffee/tea and registration
9.45 Welcome and introductions
- about the Centre’s work
- the DSDC philosophy
- the changing policy scene
- dementia, delirium and depression
10.00 An overview of the course
- the emerging role of the housing support worker and links to the Knowledge and Skills Framework
- what’s expected of the housing support worker on the course
- the role of the facilitator
- understanding reflective practice
11.15 Coffee/teabreak
11.30 The study course (group exercise)
- reviewing the course booklets
- becoming familiar with the format of the course
- facilitation skills
1.00 Lunch
1.45 The study course (group exercise continued)
3.00 Coffee
3.20 Feedback from exercise
- question time
- preparation for Day 2 (identifying learning needs as a facilitator)
4.00 Close of Day 1
Day 2

9.30 Welcome back
- recap of issues from Day 1
- helping adults learn
- recognising barriers
- what facilitating means in practice

11.15 Coffee/tea break

11.30 The experience of being a facilitator (invited facilitators share experiences)

12.45 Lunch

1.30 Setting a quality standard
- support from the DSDC
- registration with the DSDC
- promoting change
- accessing additional resources
- maintaining personal learning

3.00 Coffee

3.15 Question time
- summarising issues from Day 1 and Day 2
- maintaining contact
- questions

4.00 Close of training session
Appendix 2: Facilitator assessment checklist

Best practice in dementia care: facilitator assessment checklist

I, _____________________________________________, Dementia Services Development Centre, University of Stirling, verify that ______________________________________________ has met the following criteria to become a registered facilitator for the above named programme.

Date of facilitator training: __________________________________________________________

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possesses organisational skills</td>
<td></td>
</tr>
<tr>
<td>Communicates effectively with staff, people with dementia and family/informal carers</td>
<td></td>
</tr>
<tr>
<td>Understands the challenges for staff, people with dementia and family/informal carers</td>
<td></td>
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<tr>
<td>Understands the course format</td>
<td></td>
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<tr>
<td>Demonstrates good facilitation skills</td>
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<tr>
<td>• understands group dynamics</td>
<td></td>
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<tr>
<td>• includes and engages all group members</td>
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<tr>
<td>• allows free speech and is non-judgemental</td>
<td></td>
</tr>
<tr>
<td>Understands the concepts regarding adult learning and reflective practice</td>
<td></td>
</tr>
<tr>
<td>Has read/understood and signed the facilitator profile</td>
<td></td>
</tr>
<tr>
<td>Has attended and participated in the two-day facilitator training</td>
<td></td>
</tr>
<tr>
<td>Has attended and participated in the course activities over the two days</td>
<td></td>
</tr>
</tbody>
</table>

Assessors comments:

Date: ___________________________   Signature: ___________________________
Appendix 3: Examples of reflective exercises

These examples have been reproduced with the permission of the worker concerned, with minor amendments. They provide examples of the type of response expected. Participants are expected to write 600 words in total – 300 for each answer.

Part 6: Reflective exercise - question 1

We have a resident within independent living who has been diagnosed with vascular dementia. When he moved in I didn’t know what this was and he deteriorated considerably over a period of twelve months or so. This was a concern for everyone involved in his care and support, as it became more and more difficult to reason with him. It appeared that he was not taking the medication he had been prescribed. He had a spell in hospital which was followed by a care package when he came home. He was doing very well until the care stopped after six weeks. The carers had been giving him his medication on a regular basis, and although he was capable of taking it himself, he was forgetting to do so. His symptoms became worse the more medication he missed. He got very aggressive and blamed everyone else for the way he was feeling. This was around ten months ago. I called his family, who live abroad, and they phoned him and tried to reason with him. His behaviour included using bad language and threatening to punch people. This was not something I had experienced in the past. I only really knew about dementia affecting people with memory loss. I had to get advice about what to do and how to work with him so I didn’t cause him any more stress. I have done several courses over the last three years but was not aware of how diverse dementia could be, and I needed help with supporting this gentleman. He continued to get worse, even though we had the doctor in to see him. The doctor changed the medication he was receiving for a heart condition, but he still didn’t take it regularly. We were told the medication could have helped his symptoms considerably. In the end, he went back into hospital for a further two weeks, and this was followed by another six weeks of care. When this gentleman takes his medication regularly he is a different person.

Part 6: Reflective exercise - question 2

The way I respond to people who have been diagnosed with dementia, and people who may have dementia, has completely changed since the best practice in dementia care course. I will use the gentleman described in part 1 as an example. Since completing the course there has been a further incident with this gentleman, but this time he didn’t need to go to hospital. I responded to him completely differently this time, as I had a much clearer understanding of how his dementia was affecting him. When similar symptoms with his health and mood started to occur, I went and sat down with him to listen to him and try and understand why he felt how he did. He kept saying he didn’t want to be there anymore and wanted to die. I asked him if I could do anything to help relieve the way he felt. I said that I understood that he was frustrated and that I really wanted to help him. I asked him if he had been taking his medication, but soon learnt that he did not understand what all of
his medication was, or when he should take it. I then realised this was one of the main reasons for his mood swings. I explained that I couldn’t assist him with his medication but could ask someone else to help him with it. After that he started to open up to me, rather than just getting angry about people he didn’t like or didn’t want to see. He eventually said that he didn’t think anyone could help him. I assured him that there was help that we could get him if he was willing to let me try.

I explained that he may have to speak with other people, and he objected to this. I assured him that I would be present at any meeting between him and anyone else. I then spoke with his family to make sure they were happy for me to go forward with possible assistance, and they agreed. Then I spoke with his doctor and asked her to visit him. I also got the safeguarding team from social services involved. This was to assist with the help and care we needed to put into place to support him. I had a series of meetings with him, one of which was with his doctor and several with a person from the safeguarding team. During one of the meetings we had a long chat with him and then asked him how he felt about having a regular carer just to come in to give him his medication. He agreed to this. Helping this gentleman take his medication regularly has been the key to him becoming happier and more stable. He has now got a routine and I know he is coping much better with both his heart condition and his dementia these days. I feel this has been assisted by my growing knowledge of dementia, resulting from the very informative method of the course. The fantastic discussions during the course, as well as my own interest and growing confidence to find out as much as I can about dementia, has meant my whole attitude has changed. I’m certain that I can help people now and in the future using this new knowledge.
Appendix 4: Essential standards of quality and safety

Involvement and information
Outcome 1: Respecting and involving people who use services
Outcome 2: Consent to care and treatment
Outcome 3: Fees

Personalised care, treatment and support
Outcome 4: Care and welfare of people who use services
Outcome 5: Meeting nutritional needs
Outcome 6: Cooperating with other providers

Safeguarding and safety
Outcome 7: Safeguarding people who use services from abuse
Outcome 8: Cleanliness and infection control
Outcome 9: Management of medicines
Outcome 10: Safety and suitability of premises
Outcome 11: Safety, availability and suitability of equipment

Suitability of staffing
Outcome 12: Requirements relating to workers
Outcome 13: Staffing
Outcome 14: Supporting workers

Quality and management
Outcome 15: Statement of purpose
Outcome 16: Assessing and monitoring the quality of service provision
Outcome 17: Complaints
Outcome 18: Notification of death of a person who uses services
Outcome 19: Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983
Outcome 20: Notification of other incidents
Outcome 21: Records
Suitability of management

Outcome 22: Requirements where the service provider is an individual or partnership
Outcome 23: Requirement where the service provider is a body other than a partnership
Outcome 24: Requirements relating to registered managers
Outcome 25: Registered person: training
Outcome 26: Financial position
Outcome 27: Notifications – notice of absence
Outcome 28: Notifications – notice of changes
The Dementia Services Development Trust exists to extend and improve services for people with dementia and their carers. It funds projects undertaken by the Dementia Services Development Centre. For further information visit: www.justgiving.com/dementiaservices

The University of Stirling is a charity registered in Scotland, number SC 011159