



CHCAGE005

**Provide support to people
living with dementia**

Learner Guide



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Unit of Competency

Application

This unit describes the skills and knowledge required to provide person-centred care and support to people living with dementia. It involves following and contributing to an established individual plan.

This unit applies to workers in a residential or community context, including family homes. Work performed requires some discretion and judgement and may be carried out under regular direct or indirect supervision.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian/New Zealand standards and industry codes of practice.

Unit Mapping Information

No equivalent unit

Pre-requisite Unit

None stated

Unit Sector

None stated

Performance Criteria

Element

Elements describe the essential outcomes.

Performance Criteria

Performance criteria describe the performance needed to demonstrate achievement of the element.

- | | |
|--|---|
| <p>1. Prepare to provide support to those affected by dementia</p> | <p>1.1 Apply person-centred care approaches to all interactions with the person living with dementia</p> <p>1.2 Interpret individualised plan and familiarise self with the specific needs and wants of the person living with dementia</p> <p>1.3 Identify and address person's needs for a stable and familiar environment</p> <p>1.4 Recognise signs consistent with financial, physical or emotional abuse or neglect of the person and report to an appropriate person</p> |
| <p>2. Use appropriate communication strategies</p> | <p>2.1 Use verbal and non verbal communication strategies to maximise engagement of the person with dementia</p> <p>2.2 Gain cooperation and provide reassurance as appropriate by using reality orientation</p> <p>2.3 Use a range of validation strategies to relieve distress and agitation in the person</p> |
| <p>3. Provide activities for maintenance of dignity, skills and health</p> | <p>3.1 Organise activities which aim to maintain independence, using familiar routines and existing skills</p> <p>3.2 Organise activities that are appropriate to the individual, reflecting their cultural likes and dislikes, in order to bring back pleasurable memories</p> <p>3.3 Ensure the safety and comfort of the person balanced with autonomy and risk taking</p> <p>3.4 Access information about the person's reminiscences and routines with family and carers</p> <p>3.5 Provide support and guidance to family, carers and/or significant others where appropriate</p> |
| <p>4. Implement strategies which minimise the impact of behaviours of concern</p> | <p>4.1 Identify behaviours of concern and potential triggers</p> <p>4.2 Contribute to team discussions on support planning and review</p> <p>4.3 Take action to minimise the likelihood of and reduce the impact of behaviours on the person and others</p> <p>4.4 Evaluate implemented strategies with support planning team to ensure effectiveness in minimising behaviours</p> |
| <p>5. Complete documentation</p> | <p>5.1 Comply with the organisation's reporting requirements, including reporting observations to supervisor</p> <p>5.2 Complete, maintain and store documentation according to organisation policy and protocols</p> |

Element

Elements describe the essential outcomes.

Performance Criteria

Performance criteria describe the performance needed to demonstrate achievement of the element.

6. Implement self care strategies

- 6.1** Monitor own stress level in relation to working with people with dementia
- 6.2** Use appropriate self care strategies and seek support if required.

Foundation Skills

The Foundation Skills describe those required skills (language, literacy, numeracy and employment skills) that are essential to performance.

Foundation skills essential to performance are explicit in the performance criteria of this unit of competency.

Assessment Requirements

Performance Evidence

The candidate must show evidence of the ability to complete tasks outlined in elements and performance criteria of this unit, manage tasks and manage contingencies in the context of the job role. There must be evidence that the candidate has:

- Provided support to 2 different people living with dementia:
 - using a person-centred approach to support
 - using appropriate communication strategies
 - assisting in implementing a range of suitable activities that meet the person's needs.

Knowledge Evidence

The candidate must be able to demonstrate essential knowledge required to effectively complete tasks outlined in elements and performance criteria of this unit, manage tasks and manage contingencies in the context of the work role. This includes knowledge of:

- Up to date research on dementia and the different manifestations of dementia, including:
 - Alzheimer's disease
 - vascular dementia or multi-infarct dementia
 - Lewy bodies
 - excessive alcohol intake or Korsakov Syndrome
 - fronto temporal lobar degeneration (FTLD) including Pick's disease
 - Huntington's disease
 - Parkinson's disease
 - younger onset dementia
- Dementia as a progressive neurological condition, including pathological features:
 - amyloid plaques
 - neurofibrillary tangles
 - loss of connection between cells and cell death
- Common indicators and symptoms of dementia
- Behaviours of concern, needs driven behaviour model and de-escalation procedures

- Progression of dementia and potential impact on the person with dementia, their family and significant others, including:
 - depression
 - loss and grieving
 - anger
 - despair
 - social embarrassment a family member might feel
 - isolation
 - financial burden on the family
 - social devaluation
- Principles of person-centred approach to support
- Relevant activities which enhance self-esteem and pleasure in the person's life, minimise boredom, and distract from or eliminate behavioural and psychological symptoms of dementia
- Competency and image enhancement as a means of addressing devaluation
- Verbal and non-verbal communication strategies including:
 - reality orientation
 - reminders of the day, the time, relationships, occasions
 - reassuring words, phrases and body language
 - validation
 - empathy
 - acceptance of the person's reality
 - acknowledgement
 - allowing expressions of distress
 - providing verbal and physical reassurance
 - frequent reminiscence to connect with person.

Assessment Conditions

Skills must have been demonstrated in an ageing support workplace with the addition of simulations and scenarios where the full range of contexts and situations have not been provided in the workplace. These are situations relating to emergency or unplanned procedures where assessment in these circumstances would be unsafe, impractical or threatens the dignity of the older person.

The following conditions must be met for this unit:

- Use of suitable facilities, equipment and resources, including individualised plans and any relevant equipment outlined in the plan
- Modelling of industry operating conditions, including scenarios that reflect a range of dementia support services involving a range of dementia symptoms and behaviours of concern.

Overall, assessment must involve some real interactions with people with dementia, colleagues and families/carers.

Assessors must satisfy the Standards for Registered Training Organisations (RTOs) 2015/AQTF mandatory competency requirements for assessors.

Links

Companion Volume implementation guides are found in VETNet –

<https://vetnet.education.gov.au/Pages/TrainingDocs.aspx?q=5e0c25cc-3d9d-4b43-80d3-bd22cc4f1e53>

1. Prepare to provide support to those affected by dementia

- 1.1. Apply person-centred care approaches to all interactions with the person living with dementia
- 1.2. Interpret individualised plan and familiarise self with the specific needs and wants of the person living with dementia
- 1.3. Identify and address person's needs for a stable and familiar environment
- 1.4. Recognise signs consistent with financial, physical or emotional abuse or neglect of the person and report to an appropriate person



1.1 – Apply person-centred care approaches to all interactions with the person living with dementia

By the end of this chapter, the learner should be able to:

- Describe a person-centred approach
- Take part in a role-play activity, demonstrating how to respond to a patient living with dementia whilst practising a person-centred approach.

Introduction to dementia

Before you can effectively work with people with dementia, you need a basic understanding of the condition. Dementia is a collection of symptoms, which are caused by disorders affecting the brain. The things it effects are behaviour, thinking and the ability to carry out everyday tasks.

It is a common condition associated with ageing (over 65s), but it is not necessarily something that is inevitable and can materialise earlier in life, possibly in their 40s and 50s.

The most common types of dementia are:

- Alzheimer's disease
- Huntington's disease
- Pick's disease (Fronto Temporal Lobar Degeneration (FTLD))
- Vascular dementia.

Other less common types of dementia are:

- Parkinson's disease
- Dementia with Lewy bodies
- Alcohol-related dementia (Korsakoff's syndrome)
- Creutzfeldt-Jacob disease.



Alzheimer's disease

This is the most common cause of dementia, where there is a gradual and progressive loss of brain cells. The problem is that the precise cause of this is unknown – still, there are certain things that may increase the likelihood of developing Alzheimer's.

- Getting older
- Family history of the condition
- Severe head injuries (in the past)
- Vascular disease-related conditions and lifestyle factors.

As the condition is progressive, the symptoms will increase with time. Early indicators include:

- Minor memory problems
- Difficulty saying the right words.

As the condition worsens, the following symptoms may present:

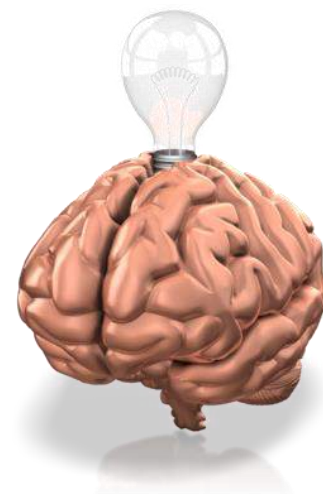
- Disorientation
- Personality changes
- Behavioural changes.

When trying to diagnose the condition, there is no single test – the GP will ask questions about the problems the person is experiencing and conduct some basic tests to rule out other conditions. If there is a suspicion of Alzheimer's, there should be a referral to a specialist.

Treatment of the condition involves medication to slow down its onset; however, there is no cure. The most suitable option is to arrange a care plan to provide support for those affected.

There are several steps you can take which may help delay the onset of dementia, such as:

- Quitting smoking and cutting down on alcohol
- Eating a healthy balanced diet
- Having regular health tests as you get older
- Staying physically fit and mentally active.



Pathological features of Alzheimer's

The typical neuropathological signs of Alzheimer's are amyloid plaques and neurofibrillary tangles – these are brain abnormalities that define the disease. These two signs are required to be present in the brain tissue for a definitive diagnosis of Alzheimer's, regardless of the other symptoms. The appearance of these can precede any behavioural symptoms by years. However, their main effect is the loss of connection between cells and cell death.

Amyloid plaques

These are dense, insoluble clumps of protein that deposit a damaging substance around the nerve cells of the brain. In Alzheimer's these plaques are common in the hippocampus, which is responsible for memory (including spatial awareness). This explains why people with Alzheimer's have trouble recalling short-term memories and get lost when they wander.

Neurofibrillary tangles

These are insoluble twisted fibres that clog the brain from the inside. Brain nerve cells (neurons) transfer information, nutrients and molecules through microtubules – a protein called tau is responsible for stabilising the microtubules. In Alzheimer's, the tau becomes tangled, and the microtubules consequently disintegrate. Therefore, information can't be transmitted, causing memory loss.

Loss of connection between cells and cell death

The loss of connection between cells and eventual death of cells responsible for memory, learning and communication affect the respective functions. When these neurons' communication paths are damaged, they cannot function efficiently and can eventually die altogether. This causes brain atrophy, as the affected regions of the brain shrink when cells waste away – a progressive process that results in significant shrinkage of brain tissue in the final stage of Alzheimer's disease.

Huntington's disease

This is a genetic condition that damages specific nerve cells in the brain, causing a progressive loss of function for the affected areas of the brain.

The things it can affect are:

- Movement
- Cognition
- Behaviour.

The early symptoms are things such as:

- Personality changes
- Mood swings
- Unusual behaviour.



It can sometimes be recognised by involuntary movements; while it is inherited, there is no family history in about three percent of cases.

Again, there is no cure for Huntington's; however, the process cannot be slowed down or reversed either. The only provisions that can be made are to improve or maintain the daily life skills that may be affected by the condition.

The types of things that can help are:

- Medication to help with excessive movement/irritability
- Speech/language therapy
- Occupational therapy
- Family support for choosing care plan.

Once the condition has developed, it will progress and worsen until the person dies after 10-20 years. In the latter stages, the person will become completely dependent on care and require full-time care. The actual death will come from another cause usually, such as pneumonia, heart failure or infection.

The symptoms will usually present in adulthood and can affect men and women – with 90 per cent of cases presenting at this stage in life.

Pick's disease (Fronto Temporal Lobar Degeneration (FTLD))

This is quite a rare form of dementia (accounting for only five percent of progressive dementia cases) – excess protein build-up causes shrinkage of brain cells. It affects the frontal and temporal lobes of the brain – these areas control speech and personality; as such, the noticeable effects are personality and behavioural changes, as well as a decline in the ability to speak coherently.

The accumulation of these abnormal brain cells known as Pick's bodies are the cause of character changes, poor decision making, intellectual, memory and speech impairment, and socially unacceptable behaviour. The most common onset is between 40 and 60 years of age – it is also occurs more commonly in women. The cause is unknown, but a few studies suggest it may have a genetic component.

Symptoms are behavioural, emotional, language and physical.

Behavioural symptoms:

- Losing their inhibitions
- Losing interest in people and things
- Losing sympathy or empathy
- Showing compulsive behaviours
- Craving sweet or fatty foods/alcohol and cigarettes.

Emotional symptoms:

- Abrupt mood changes
- Coldness in character (lack of empathy)
- Apathy
- Impatience and rudeness
- Poor attention span
- Unaware of behavioural changes.



Language symptoms:

- Slow, hesitant speech/stutters
- Grammar errors
- Understanding of complex sentences diminishes (but not single words)
- Asking the meaning of familiar words
- Trouble finding the right word, leading to less precise descriptions instead or using generalised words such as 'person' instead of 'husband'
- Difficulty recognising familiar people or objects.

Physical symptoms:

- Lack of coordination
- Movement difficulties
- Increased muscle stiffness and rigidity
- Memory loss
- Incontinence
- Weakness (in general).

Treatment options

While there is no cause, there can be lifestyle adaptations to help cope with the symptoms:

- **Sensory function aids** – hearing aids, eye glasses
- **Behaviour modifications** – have positive behaviour reward systems to reinforce desired behaviours
- **Therapy** – speech/occupational therapy to improve communication and movement
- **Medication** – selective serotonin reuptake inhibitors (SSRIs) are antidepressants that offer temporary relief to apathy and depression symptoms; other things they can reduce are food cravings, compulsive behaviour and cause an increase in impulse control.

**Vascular dementia**

This is a common form of dementia and is caused by the gradual death of brain cells – this causes a loss of mental ability. Vascular dementia is caused by an inhibited blood flow to the brain due to problems with the blood cells that supply it.

If this type of dementia is caught early, the brain deterioration can be stopped – this stage is referred to as 'vascular cognitive impairment'.

The symptoms include:

- Slowness of thought
- Difficulty with planning
- Memory loss
- Trouble with language
- Mood or behavioural changes.

Any of these symptoms indicate brain damage and require urgent medical assessment by a GP.

The causes of vascular dementia are blockage and narrowing of blood vessels inside the brain. It is also caused by the inheriting of genes from parents and can run in parents. High blood pressure can also cause it and worsen the effects. Therefore, managing blood pressure, losing excess weight and quitting smoking are methods of reducing the risk of development or slow its progression.

It usually starts before the age of 75 and is more common in men, especially Asian and Black Caribbean people.

Identifying dementia

Dementia is easily mistaken, due the similarity of some its symptoms with other conditions. Some of these symptoms include:

- Vitamin and hormone deficiencies
- Depression
- Medication clashes/overmedication
- Infections and brain tumours.

An early medical diagnosis can result in better treatment options for treatable conditions; if dementia is diagnosed, it can mean better support, information and medication for the person affected.

General signs of dementia

Early dementia signs are not overly obvious. Common symptoms may include:

- Gradual and frequent memory loss
- Confusion
- Changes in personality
- Apathy/withdrawal
- Loss of ability to perform everyday tasks.

Dementia support

As well as medication, there are other support systems in place for dementia systems:

- Families
- Friends
- Carers.



Advances/current research

There have been many advances in Alzheimer's research since the G8 decided to combine global efforts to combat the disease.

Below is a summary of the major findings from 2013:

- Changes in the brain due to Alzheimer's can begin a decade or more before symptoms appear – therefore, treatments may need to begin in the very early stages of dementia to be effective. This is what clinical trials are now focusing on – patients with mild to moderate dementia symptoms, with a variety of drugs
- Tracers such as Amyvid and Vizamyl can be injected that binds to beta-amyloid, to reveal the presence of amyloid plaques on a standard PET scan. This is an improvement on the previous method, which only allowed an estimate of amyloid in the brain. There are also tracers for Tau, another protein that accumulates in the brains of people with Alzheimer's. The amount of tracer in the brain correlates with the severity of the dementia symptoms
- Eleven new genes were discovered in October 2013 that increase the risk of developing Alzheimer's, which means the total number of genes related to Alzheimer's development is now 20. The newly identified genes have a small effect on the risk of Alzheimer's by themselves, making them ineffective for identifying people at risk. The main use of their discovery lies in identifying new processes linked to the disease and directing future research and drug development
- Providing training courses for carers can reduce depression and improve their quality of life, as they better understand the behaviour of patients with dementia and are taught coping and relaxation strategies. For this to become more commonplace, more attention needs to be given to psychological intervention, as opposed to the current major focus on drugs
- Future investment will be focused on prevention research and intervening with people showing signs of the disease on brain scans but no symptoms. There will also be \$21.7 million funding by the government for research into the causes and prevention of the condition, and an improvement in the processes of caring for people with dementia. There are presently 321,000 Australians with dementia – this will increase to 900,000 by 2050.



Progression of dementia

All types and variations of dementia are progressive, with the brain's structure and chemistry becoming ever more damaged over time. This results in a decreased ability to remember, understand and communicate with others.

It is worth noting that, while most dementia cases are progressive, some are reversible – this can happen if there is a nutritional deficiency, an infection, a side effect from medication or brain bleeding. If the underlying cause is treated in these cases, then the symptoms of dementia can be stopped.

The speed of the progression can vary greatly between individuals, and the experience will also differ according to things such as physical condition, emotional resilience and support networks available.

Professionals use the Clinical Dementia Rating (CDR) to evaluate the progression of symptoms in people with dementia – it has five stages that describe the patient's ability to perform in orientation, memory, judgement, home and hobbies, personal care and community.

The stages are as follows:

- CDR-0 – this represents no impairment in the abilities of a person, regarding orientation, memory, judgement, home and hobbies, personal care and community
- CDR-0.5 – this represents slight impairments. They may have memory inconsistencies, struggle with challenging problems and have trouble with time. They may slip easily but can manage personal care without any help
- CDR-1 – this means the person is mildly impaired in every area. Short-term memory suffers and disrupts their day slightly; they may be geographically disorientated and have trouble with directions. They may have trouble functioning independently outside of the home and chores, and personal hygiene may become neglected
- CDR-2 – this means moderate impairment. The person needs help with personal hygiene and must be accompanied for social activities and chores. Time and space disorientation has become more noticeable, and short-term memory is seriously impaired
- CDR-3 – the last stage represents severe dementia. The affected person cannot function in any area without help, have extreme memory loss and have lost all orientation of time and geography. They cannot engage in everyday activities, even with assistance and need help to function in their home as well.



Person-centred approach

As there is no known cure for dementia, often the best way of managing the condition is through support systems and offering a stable and familiar environment for the person affected.

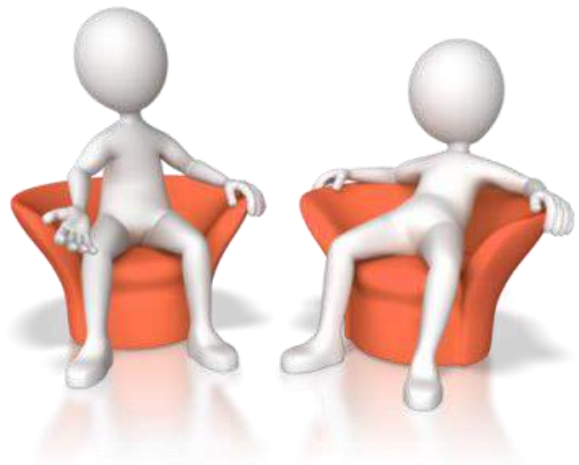
This type of approach to care focuses on viewing each patient with dementia as an individual, as opposed to the abilities they have lost/the effects of their condition. Good care personnel follow this approach with all patients – viewing them as individuals with defining characteristics and uniqueness. You should not view the person as a combination of symptoms and behaviours, i.e. something to be controlled. If you can hone in on the individual interests, needs, preferences, qualities and abilities, you can deliver a much more personal and tailored service. Other considerations include treating people suffering from dementia with respect and dignity.

Care homes that practise person-centred care are aiming to make the experience of each person with dementia who lives there. The mission statement of the home should reflect this concept – therefore, this philosophy will be ingrained in the staff and standards will be measured against compliance with it.

For example, if a resident with dementia makes repeated requests to see a specific relative or to go home, a person-centred approach would attempt to respond to these needs and accommodate them, as well as acknowledging emotional needs of insecurity.

Brooker (2007) uses the acronym VIPS to summarise the meaning of person-centred care:

- **Valued** – the person with dementia and their carers must feel valued
- **Individuals** – they must be treated as individuals
- **Perspective** – use the perspective of the person with dementia to understand their needs
- **Social** – the person's social environment must be positive and relationships maintained.



Activity 1A



1.2 – Interpret individualised plan and familiarise self with the specific needs and wants of the person living with dementia

By the end of this chapter, the learner should be able to:

- Provide examples of information which can be found in an individualised plan
- Give examples of how to help someone with dementia maintain a good quality of life
- Interpret a care plan and highlight specified information
- Summarise the specific needs of a person from a care plan provided.

Interpreting care plans

Individual care plans for people with dementia living in care homes are essential. They should contain information about the individual care needs of the person and how staff can meet these; it should identify the unique strengths and qualities of the client and how to encourage these. Regular reviews of this plan should be conducted, as care needs can change at a rapid rate.

Staff dealing with people with dementia should have received adequate training – this will enable them to understand the difficulties in communication that dementia sufferers have and how best to deal with them.

Part of maintaining the dignity and respect of the client is referring to them by their preferred name, whether this is informal or formal – treating them as an adult and the appropriate respect that entails is essential in maintaining dignity. Chat to them while you are performing care tasks for them – getting to know them will make them feel much more comfortable with your presence in their life. It is also necessary to assign a certain member of staff to each care patient, so they are responsible for their well-being; it is their duty to develop knowledge of the client's interests, routines and history.

Choice of care

People with dementia should be included in decisions about their care, with support provided to help them make these choices. Examples of things they can choose are:

- Food
- Clothes
- Activities
- Likes/dislikes.

Also, just because someone has dementia does not mean they have lost the ability to do things for themselves - they should be encouraged to do whatever they can for themselves. Physical and mental activity will all help slow down the process of dementia.



Quality of life

In order for care to be effective and dementia sufferers to have the best quality of life, the following practices should be adhered to:

- Ensuring they have enough to eat and drink
- Maintaining personal care (washing, personal grooming, etc.)
- Participating in group activities
- Participating preferred activities
- Social opportunities
- Maintain relationships with family and friends outside of care.

Care home environment

In order to make the person suffering from dementia's life as comfortable as possible, the care home (if they live in them) should be made as homely as possible – it needn't be overly tidy like a hotel but should be well kept – as similar as possible to someone's own home.

There should be things that stimulate the interests of the residents (pictures, puzzles, etc.), as well as the opportunity to get involved in household tasks, if desired.

Clear labelling of areas will help confused dementia sufferers, and there should be an outdoor area with easy access so residents can spend time outdoors and get regular exercise.

A member of staff should always be on hand to talk to the residents, if need be, and the manager should be available for staff to talk to, should they have any concerns or issues to bring up.

Palliative care

If dementia is terminal, a palliative approach should be made available from the time of diagnosis. This includes:

- Encouraging the person to live life as normally as possible, while accepting the inevitability of death (not seeking to quicken or slow down the process)
- Treating distressing symptoms
- Maintaining quality of life
- Holistic care – family and friends should be included, and grief and bereavement support offered after death
- Combining spiritual, biological, spiritual and social care.



Activity 1B



1.3 – Identify and address person’s needs for a stable and familiar environment

By the end of this chapter, the learner should be able to:

- Explain why it is important to establish a stable environment for people with dementia
- Outline how to identify a person’s needs for a stable and familiar environment
- Address the needs for a stable and familiar environment for one specified person in a written report.

Stable and familiar environments

Unfamiliar environments can act as behavioural triggers, for people with dementia, for concerning behaviour such as aggression, psychosis and withdrawal. If this is the case, or the client or family are worried about unfamiliarity, you should think about how you can address this need.

As well as being able to interpret a person’s need for stable and familiar environments through their behavioural responses, the individualised plan may also contain information about the person’s needs in this respect. Through conversation and getting to know the person, you may also be able to learn about the places and objects that are most familiar and comforting to them.

Clients often prefer to stay in familiar surroundings, and this allows them more privacy and to engage in their daily living activities without feeling that carers are being over-intrusive; this may be their own home, or a relative or friend’s home. However, sometimes it is not possible to do this without posing serious risk to the client and alternatives might need to be arranged.

Creating a stable and familiar environment in residential care:

- Taking familiar items from home, such as:
 - ornaments
 - furniture
 - photographs
- Ensuring a routine is kept familiar, e.g. times to wake, sleep, eat, etc.
- Serve familiar food – find out client’s favourites
- Restricting the number of different carers involved in client’s personal care
- Encouraging visits from family at regular/similar times.



Activity 1C



1.4 – Recognise signs consistent with financial, physical or emotional abuse or neglect of the person and report to an appropriate person

By the end of this chapter, the learner should be able to:

- Outline how to appropriately respond to an older person being violated
- Define elderly abuse
- Identify two signs that may indicate abuse in a range of areas
- Follow proper reporting procedures in response to a suspected financial exploitation.

Defining elderly abuse

Elderly people may be abused in their own homes, in care facilities or in relatives' homes. Elderly abuse is any instance where someone takes advantage of an elderly person.

It can include:

- **Financial exploitation** – this is the unauthorised use of an older person's money or their property by either a caregiver or an external party

The types of practices include:

- stealing money
- forging cheques/credit cards/accounts
- forging the older person's signature
- identity theft
- requesting them to pay money to claim a 'prize'
- charity scams
- investment fraud



- **Physical abuse** – this is the deliberate use of force on an older person, causing them pain, injury or disability. It includes violent assaults, using drugs (inappropriately), restraining them or keeping them captive
- **Emotional abuse** – also known as psychological abuse, this involves treating elderly people in any way that causes them distress or emotional pain

This can include:

- verbal abuse – threats, intimidation, yelling, humiliation, placing blame
- non-verbal abuse – ignoring, social isolation, terrorising behaviour

- **Sexual abuse** – this includes contact with an older person without their consent; this can mean physical sex acts but also includes making them watch sex acts, pornography, or forcing them to undress
- **Neglect/abandonment** – this includes failure to fulfil carer duties and is responsible for over half of elderly abuse cases. It can be intentional or unintentional, based on ignorance or denial of the care requirements for the elderly person
- **Healthcare fraud** – this can be committed by care providers or medical personnel; it includes:
 - charging for healthcare they don't provide
 - overcharging for services
 - taking 'kickbacks' (bonuses) for referring patients to providers of certain drugs
 - over/under-medicating
 - recommending incorrect/fraudulent remedies for medical conditions/illnesses
 - Medicare fraud.

Signs of abuse

It can be easy for people to explain away the signs and many people may dismiss them as a minor issue. However, you should not believe a caregiver at face value and investigate if you are at all concerned.

The following are things you should be on the lookout for:

General abuse

- Arguments (frequent) between elderly person and caregiver
- Changes in personality of the elderly person
- Odd behaviour.

Physical abuse

- Unexplained injuries
- Broken bones/sprains/dislocations
- Medication irregularities
- Broken glasses
- Signs of restraint
- Caregiver refuses to let elder be seen alone.



Emotional abuse

- Experience of threatening, bullying or controlling behaviour from caregiver
- Dementia-like behaviour from elder – rocking, mumbling, sucking thumb.

Sexual abuse

- Bruises around genitals
- Unexplained genital infections or STDs
- Unexplained vaginal/anal bleeding
- Torn/stained clothing.

Neglect

- Weight loss, malnutrition, dehydration
- Being left unclean
- Untreated physical problems
- Unsuitable clothing for the conditions
- Unsanitary living conditions
- Unsafe living conditions
- Desertion in a public place.

Financial exploitation

- Unexplained withdrawals from elder's accounts
- Sudden changes in financial situation
- Missing items/cash from the elder's house
- Suspicious will/policy/power of attorney changes
- Addition of names of documents
- Unpaid bills/lack of medical care (despite a healthy financial situation)
- Financial activity taking place when the older person is incapacitated
- Unnecessary services being provided.

Healthcare fraud

- Duplicate medical bills
- Evidence of over/under-medication
- Evidence of inadequate care pertaining to the amount paid
- Problems in the care facility.



Acting on elder abuse

There are three things you must do to prevent elder abuse:

- Listen to elders and caregivers
- Intervene when you suspect abuse
- Educate others on how to identify and report elder abuse.

As a caregiver, you can do the following if you are overwhelmed by the demands:

- Request help from colleagues, friends and family (of the elder)
- Maintain your own health
- Practice stress reduction exercises
- Seek counselling if you are depressed
- Finds support groups (if necessary)
- Seek help for any substance abuse
- Contact elder abuse help-lines.



If you suspect any kind of elder abuse, the main thing you need to do is report it to the appropriate person – this can include any of the following:

- Supervisor
- Member of senior management
- Colleagues
- Carers
- Health professionals
- External agencies (complaints and advocacy services and professional registering authorities)
- Law enforcement officer.

Activity 1D



2. Use appropriate communication strategies

- 2.1. Use verbal and non verbal communication strategies to maximise engagement of the person with dementia
- 2.2. Gain cooperation and provide reassurance as appropriate by using reality orientation
- 2.3. Use a range of validation strategies to relieve distress and agitation in the person



2.1 – Use verbal and non verbal communication strategies to maximise engagement of the person with dementia

By the end of this chapter, the learner should be able to:

- Explain what active/empathic listening is and how it can be used to help care for people with dementia
- Demonstrate their ability to use verbal and non-verbal communication during two interactions and reflect on these interactions in a report.

Engage people with dementia

Engaging people with dementia in communication is important for mentally stimulating them – again, you should treat them like normal and engage them with respect and dignity.

Encouraging communication

- Make eye contact whenever you are communicating with them
- Short, simple statements
- Speak slowly and clearly
- Be patient with them for responses
- Don't interrupt them or try to finish their sentences
- Encourage them to join in conversations with others
- Don't speak on behalf of the person – especially during conversations about decision-making. This is demeaning
- Don't patronise/ridicule them
- Don't dismiss what they say, even if it is irrelevant to the current conversation
- Keep choices and decisions as simple as possible
- If they don't appear to understand you, rephrase what you say or utilise different communication strategies, e.g. visual communication.



Body language/contact

- Gentle touch
- Using a friendly and positive tone
- Not standing too close/invading their personal space when talking to them.

Empathic/active listening

Empathic/active listening is a form of communicating that requires the listener to feedback what they hear to the speaker, by way of restating or paraphrasing what they have heard in their own words. This helps both the counsellor and client clarify and confirm what is being communicated. Empathic/active listening is the most effective form of communication between counsellor and client – it is functional, mechanical and leaves little room for assumptions/interpretation. Feedback shows understanding and involves both verbal and non-verbal communication.

When a counsellor is listening to the words being spoken by the client, they are also taking note of the way the words are being spoken. Often, clients can find it difficult to express their feelings in words and non-verbal cues can express a client's feelings more effectively. When a counsellor communicates through active listening, it shows respect for the client and validates their worth. This enhances the client's self-esteem which, in turn, enables the client to relax and means they are less likely to put up defensive barriers.

OARS skills (open-ended questions, affirmations, reflections, summaries) are one example of empathic listening skills because they are all about listening in a heartfelt manner without trying to change or push the individual. These OARS skills come from a therapy called Motivational Interviewing, developed by Professor William R Miller.



Activity 2A



2.2 – Gain cooperation and provide reassurance as appropriate by using reality orientation

By the end of this chapter, the learner should be able to:

- Create a plan for a reality orientation session, detailing what skills it aims to develop and who needs to be involved, as well as materials required
- Take part in a role-play activity, demonstrating the implementation of reality orientation behaviour through speech and activities.

Reality orientation therapy

As well as knowing the way you should communicate, the context and context of what you communicate is equally important. These sort of things help orientate themselves in reality and remain connected with the rest of the world.

Things you should regularly communicate include:

- Reminders of the day, the time, relationships, occasions
- Reassuring words, phrases and body language.

Reality orientation is a type of therapy that improves self-esteem, by reducing mental disorientation, memory loss and confusion. It can involve group work and session where information such as: the current date and day; the location of the room they are in; the names of everyone in the room are displayed on a whiteboard. In addition to this, the group then complete tasks aimed at providing mental stimulation. They will also reinforce the information displayed on the board.

The activities include things like:

- Discussions/debates
- Word games
- Memory games.

Reassuring words, phrases and body language

Using positive words, phrases and body language can encourage the person with dementia to communicate more openly and feel safer and comfortable in their environment.

Examples of reassuring words, phrases and body language include:

- Praise
- Jokes (not at their expense)
- Facing them when you talk to them
- Smiling
- Maintaining eye contact.



Activity 2B



2.3 – Use a range of validation strategies to relieve distress and agitation in the person

By the end of this chapter, the learner should be able to:

- Write a script between a person living with dementia and their carer that continues from the given prompt, demonstrating an example of a carer using a range of validation strategies to relieve distress and agitation in the person.

Validation therapy

This works by accepting the values, beliefs and reality that the person with dementia believes. Rather than disagree or tell them that they are wrong, you should agree with what they suggest but then get them to agree to something else without them realising they have been redirected from their original line of thought.

The techniques and methods it includes are:

- Empathy
- Acceptance of the person's reality
- Acknowledgement
- Allowing expressions of distress
- Providing verbal and/or physical reassurance
- Use reminiscences frequently to connect with clients.

Benefits of validation therapy:

- Not confrontational
- No-one is told off
- No-one is shouted at
- No-one is told they are wrong.

Disadvantages of validation therapy:

- It promotes lies
- Can be difficult for caregivers and family to lie.



Case study – Validation therapy

Chloe is an 85-year-old woman with severe dementia, living in a residential care home. Her husband, Andrew, died five years ago; however, she has the following panicked conversation with her carer:

Chloe: "I need to call Andrew!"

Carer: "Ok. You need to call Andrew?"

Chloe: "Yes, I need to remind him to get milk!"

Carer: "You're out of milk?"

Chloe: "Yes, I need it for cereal and tea tomorrow when my friends come round."

Carer: "You drink a lot of tea, don't you?"

Chloe: "Yes, I have about three cups a day. I also like coffee – it helps me stay awake during the day."

Carer: "I could go for a coffee right now actually, and was just about to make one. Do you want a cup?"

Chloe: "Oh, yes... I am, feeling a bit drowsy."

Notice here how the carer never mentions that Andrew is dead and redirects Chloe subtly away from the phone, to milk and then to coffee. By this time, Chloe has forgotten about calling Andrew at all.



Reminiscence therapy

This is where people suffering from dementia are encouraged to recall memories from their distant past – it can prove therapeutic and enjoyable for them. In therapy, they meet with a group and share their stories – as well as being helpful to their emotional health, it provides social stimulation and boosts their self-esteem. It can also help them resolve thoughts from their past and connect them to the present.

Note that sufferers of dementia usually only have problems with their short-term memory, which can lead to confusion, lack of confidence and feelings of vulnerability.

In a session, the therapist will encourage everyone to share their stories and use memorable items such as photos, music and postcards to trigger people's memories. Individual sessions can also happen, if there is enough evidence to compile a 'life book'. Sessions usually last between 30 and 60 minutes.

Activity 2C



3. Provide activities for maintenance of dignity, skills and health

- 3.1.** Organise activities which aim to maintain independence, using familiar routines and existing skills
- 3.2.** Organise activities that are appropriate to the individual, reflecting their cultural likes and dislikes, in order to bring back pleasurable memories
- 3.3.** Ensure the safety and comfort of the person balanced with autonomy and risk taking
- 3.4.** Access information about the person's reminiscences and routines with family and carers
- 3.5.** Provide support and guidance to family, carers and/or significant others where appropriate



3.1 – Organise activities which aim to maintain independence, using familiar routines and existing skills

3.2 – Organise activities that are appropriate to the individual, reflecting their cultural likes and dislikes, in order to bring back pleasurable memories

By the end of this chapter, the learner should be able to:

- Create a plan to organise an activity which aims to maintain independence using familiar routines and existing skills
- Create a plan to organise an activity that is appropriate to an individual, reflecting their cultural likes and dislikes, in order to bring back pleasurable memories.

Organise activities to maintain independence

It is important for people with dementia to maintain their independence, if this is possible. These can be simple, routine things such as:

- Maintaining personal safety
- Communication (speech, writing, non-verbal communication)
- Eating and drinking
- Mobilising and transferring (moving from place to place and position to position)
- Attending to personal hygiene (bathing, laundering personal linen)
- Dressing and undressing
- Attending own spiritual needs
- Grooming
- Expressing sexuality
- Accessing financial resources and allowances
- Paying bills and regular outgoings
- Shopping
- Preparing meals
- Climbing stairs
- Maintaining household (cleaning, laundry, décor, repairs)
- Travelling by private and public transport
- Interacting with others and socialising
- Accessing leisure, recreational and sporting activities



- Recreational and sporting activities
- Craft and creative activities
- Reminiscing activities.

The extent to which they will need assistance with these activities can vary between individuals – you will need to research and find out their preferences. This can be done by asking them directly or finding out through family, friends, advocates and health professionals.

You need to determine their current skill levels and their physical and mental ability. The types of skills/abilities you are looking out for include:

- General mobility
- Memory
- Ability to use stairs
- Coordination
- Senses (sight, hearing, etc.)
- Strength.



Needs and preferences can be determined by:

- Aged Care service provider assessments
- Aged Care Assessment Team (ACAT) assessments.

Activities for pleasure and reminiscence

Modified from: Alzheimer's Society

(https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=115) Access date: 28/10/16.

We have discussed a range of activities that a person may engage in to increase their independence. However, it is also important to engage the client in activities which bring them pleasure.

These may include:

- Creative activities
- Games
- Music
- Outdoors activities.

The choice of activity will depend upon the client and their personal preferences, likes and dislikes. You will need to work collaboratively with them to determine which activities are most enjoyable for them.

Reminiscence

People with dementia can often find the distant past easier to remember than recent events. For this reason, it can bring them pleasure to engage in activities which incorporate the memory of past times.

These types of activities may include:

- Talking about the past and fond memories
- Looking at photo albums, home movies, etc.
- Visits to familiar places
- Looking at books, photos or online to reminisce about major events in the lifetime of the individual, e.g. the moon landing.

You should be prepared for clients to become emotional when reminiscing about the past. To try and ensure that these activities are as enjoyable as possible, avoid pressing your clients for facts and precise details that they might not remember; rather, allow them to enjoy the feelings the memories bring.

Activity 3A



3.3 – Ensure the safety and comfort of the person balanced with autonomy and risk taking

By the end of this chapter, the learner should be able to:

- Identify common risks associated with people living with dementia
- Write an essay which discusses how the safety and comfort of an individual can be ensured in way that is balanced with autonomy and risk-taking.

Common risks

Whatever activities you organise and carry out, the safety and comfort of clients should be at the forefront of your mind.

There are a number of common risks associated with people with dementia, including:

- Ability to find their own way
- Ability to negotiate traffic
- Wandering or other behaviours relating to agitation
- Behaviours relating to psychotic experiences or mood disorders
- Ability to safely prepare, cook and store food and drink
- Ability to control temperature of water
- Ability to use home appliances
- Ability to maintain personal and home security
- Ability to manage own finances
- Ability to recognise dangers in their environment
- Ability to recognise the safety of others.



Activities must be planned with consideration of these factors – where they cannot perform certain tasks unassisted, the appropriate help will need to be provided. Think also about hazard assessment – sharp objects, uneven terrain, chemicals, electrical outlets and fire risks. If there are any safety issues, think about what measures can be put in place to prevent/minimise the risk of harm.

Dignity of risk

‘Dignity of risk’ is a term used to describe a person’s right to make their own decisions, even if this presents a level of risk.

People with dementia are vulnerable to risk, but it is also important to preserve their independence and autonomy. This can present a dilemma for a carer trying to balance their duty of care – a professional responsibility to keep a person safe – with the principle of dignity of risk.

A middle ground is to accept a person's decisions, but to take responsibility for supporting the person to carry out those decisions as safely as possible. For example, Elizabeth Lodge in Kings Cross, Sydney, has taken to providing residents with GPS watches, so that they can go for walks alone, but the staff can know where they are at all times.

Source: *Journal of Dementia Care*, March 25, 2017, <http://journalofdementiacare.com/taking-the-risk-dementia/> (14/06/17)

With creativity and clever-thinking, it can be possible to increase the independence of people living with dementia by managing the risks that their choices may present.

Adaptive technology, assistive equipment and careful monitoring are all things that can be employed to help a person remain independent and autonomous by reducing risk of injury or harm.

Activity 3B



3.4 – Access information about the person’s reminiscences and routines with family and carers

By the end of this chapter, the learner should be able to:

- Take part in a role-play activity, demonstrating the ability to access information about an individual living with dementia from their relatives.

Learning their life story

When trying to design activities around someone's cultural likes and dislikes, it helps to have an idea about their life history. This is because the activities people carry out are often linked to their social identity and roles – as dementia can cause people to forget these, activities that remind them of their roles are useful and enjoyable. Their experiences from the past shaped who they are today – keeping a hold of these is important in keeping a person 'who they are'.

The types of information you need to find out are:

- Previous jobs
- Domestic interests
- Recreational pastimes
- Religious views
- Family members
- Family history
- Homes and neighbourhoods
- Nationality and countries of residence.



This information can come from friends, family or past neighbours – treat it as confidential within the workplace. It will need to be shared with staff to help them plan activities and understand how to interact with individuals. The idea is to find out how the person lived before they were in residential care/diagnosed with dementia – you want to try and recreate this environment for familiarity purposes.

Using their life story to plan activities

As we've already discussed, activities should be, wherever possible, based upon the life experiences and interests of the patients.

So, for example, if you find out that they used to work in a food preparation, you can base activities on this – have them prepare and cook basic meals in an activity kitchen; involve them in baking; involve them in a local cookery class.

Also, consider their routine – if you can keep them in the same routines they were used to before dementia, it will increase the likelihood of them remembering those days. The structure will also keep their mind engaged. Knowing their routine will also allow easier identification of abnormal behaviour patterns and routines.

Activity 3C



3.5 – Provide support and guidance to family, carers and/or significant others where appropriate

By the end of this chapter, the learner should be able to:

- Identify different problems which can affect carers, family or significant others
- Give examples of support and guidance which can be provided to the daughter of a person living with dementia.

Providing support and guidance

All of those working with people with dementia and those closely related to the person affected should have an understanding of the disease, its effects and the basic methods of effective care provision.

While caring can be a rewarding role, it inevitably comes with a burden of responsibility for the wellbeing of others. The types of problems associated with caring include:

- Depression
- Physical exhaustion
- Emotional exhaustion
- Social isolation
- Financial hardship
- Resentment.

An education on the condition and how to effectively can help in reducing the onset of some of the above effects – simply understanding something can often make it easier to accept the negative aspects of it.

To provide support and guidance to family, carers and/or significant others, you may:

- Direct them to local support groups
- Provide information and advice on caring
- Recommend adaptations that can be made to the environment and equipment
- Provide information on local authority support, such as respite care, day centres and counselling for carers
- Give self-care advice and information.



Caring for someone with dementia

While all care needs will be individual to a degree – there are some general standards that you can base things off. For example, the average care needs of someone with dementia living at home are around 35 hours of informal care a week.

The types of things people may need help with/ include:

- Bathing
- Dressing
- Sleep disturbances
- Emotional support
- Paying bills
- Cooking meals
- Household chores.

The stress of the demands of caring for someone with dementia is often greater than in other types of care. Carers should have access to psychological therapies, such as cognitive behavioural therapy – 52 per cent of carers for dementia are not getting adequate support.

Financial implications

For family carers, the financial burdens of looking after someone with dementia can be huge – they often have to use private savings and assets. Thirty-five per cent of carers for people with dementia say they have trouble meeting monetary demands of care, according to a survey by Alzheimer's Australia SA.

The demands can include the following:

- Transport costs
- Utility costs
- Care costs
- Giving up/reducing work to care for someone
- Inadequate benefits.

**Support and guidance available**

There are many support networks that can provide information and guidance for family carers and significant others, such as Alzheimer's Australia.

For more information, see www.fightdementia.org.au.

Understanding behavioural changes

Some notable changes in behaviour of people with dementia include:

- Aggression
- Agitation
- Anxiety
- Depression
- Disinhibited behaviour
- Hallucinations/falsifications
- Wandering
- 'Sundowning' (restless in afternoon and evening).

First, you need to try and understand the cause of the behaviour if before you can understand it – look for any triggers or external factors. Once this is identified, it can be a lot easier to prevent or control the behaviour. If it is caused by an external trigger, you can prevent exposure to this situation; if it is down to chemical processes in the brain, medication may help inhibit this.

If you keep a record of any problems, noting the situational factors, it can make it easier to figure out the cause. The four possible causes you should be including are:

- **Health** – medication, impaired senses, illness (acute and chronic), dehydration, constipation, depression, fatigue, discomfort
- **The environment** – overwhelming, cluttered, overly stimulating, confusing (if too contrasting), changing routines, unfamiliar environment
- **The activity** – too difficult, unfamiliar, poor communication.



Activity 3D



4. Implement strategies which minimise the impact of behaviours of concern

- 4.1. Identify behaviours of concern and potential triggers
- 4.2. Contribute to team discussions on support planning and review
- 4.3. Take action to minimise the likelihood of and reduce the impact of behaviours on the person and others
- 4.4. Evaluate implemented strategies with support planning team to ensure effectiveness in minimising behaviours



4.1 – Identify behaviours of concern and potential triggers

By the end of the chapter, the learner should be able to:

- List a range of behaviours of concern for those with dementia
- Identify situations or triggers which can be responsible for behaviours of concern
- Explain how *not* to react to behaviours of concern.

Behavioural and psychological symptoms of dementia

With dementia comes behavioural changes – these are inevitable, and most can be managed and accepted. However, it is important to be able to identify particular concerning behaviours.

They may include:

- Physical aggression
- Psychosis (hallucinations/delusions)
- Social withdrawal
- Verbal disruption
- Repetitive actions or questions
- Resistance to personal care
- Sexually inappropriate behaviour
- Refusal to accept services
- Problems associated with eating
- Socially inappropriate behaviour
- Wandering or intrusiveness
- Sleep disturbances.



All of these symptoms can be signs of dementia and, if you note any of these in patients, they should be assessed by a medical professional and diagnosed appropriately.

Behavioural triggers

Now you have identified the symptoms of dementia, the next stage is to try and identify the potential triggers for these behaviours.

It may be that they only react in a concerning way in certain situations – if this is the case, it may be possible to remove this trigger from their life, therefore eliminating the problem. This is where person-centred care becomes essential – it will help identify the individual causes for each patient.

Possible causes of concerning behaviour may include the following:

- Unfamiliar environments
- Changes in routines
- Difficulty understanding what's happening to them
- Feeling humiliated/frightened
- Frustration about communication difficulties
- Physical effects of dementia (making them less independent)
- Loss of inhibitions and awareness of rules
- Trying to communicate unmet needs.



You should refrain from becoming angry or upset about their changes in behaviour – their behaviour is often not deliberately aggressive or upsetting, or even aimed specifically at you. It can sometimes just be down to you being the person present when the trigger sets off their behavioural/psychological change.

Try and establish what is wrong in order to prevent future occurrences of the behaviour – it can often be a way of them trying to communicate a problem to you. Don't attempt to argue and remain calm in the face of the behaviour – allow it to pass naturally and give them plenty of space.

If possible, try and identify early warning signs of the concerning behaviour and assess the environment for any possible causes – if you can remove it at this early stage, you can prevent the behaviour developing into anything more concerning/aggressive.

You should communicate with colleagues and carers to discuss any behavioural triggers for all patients – they can often be simple things such as changing batteries in hearing aids, so they can understand you. There is also the simple matter of talking to the person with dementia and ask what is upsetting them – reassure them that you will resolve the problem and be patient with them.

Activity 4A



4.2 – Contribute to team discussions on support planning and review

By the end of this chapter, the learner should be able to:

- Identify matters which might be discussed at a team discussion for someone with dementia
- Create a draft agenda for such a meeting.

Team discussions

Once triggers and behaviours are identified, the next stage is to create a care plan that addresses and resolves the triggers. This should involve discussion between carers, care home managers, family carers and the person with dementia themselves.

Everyone involved should have a role in decision-making; remember that the person with dementia has a choice in their care plan – they cannot be forced to do anything they don't want.

The aim should be to minimise the concerning behaviours – the aims of the discussions should be to:

- Identify any medical causes
- Identify any physical discomforts
- Discuss medication and side effects
- Identify the warning signs of behaviours
- Reduce the demands on the person with dementia
- Eliminate stressful situations
- Create a consistent and planned routine
- Keep the environment stable
- Explain the plan to the patient in short, simple sentences and a calm, reassuring tone
- Avoid confrontation
- Ensure regular exercise is part of the plan
- Ensure the person is comfortable.



The existing care plan should be reviewed to make sure that it is meeting all of the client's current needs – if they have changed since the last assessment, the care plan needs to be adapted accordingly.

Some of the successful tactics for minimising concerning behaviours may include:

- Distraction
- Current events
- Reminiscences
- Music, dancing
- Walking
- Talking reassuringly about familiar and favourite topics
- Behaviour modification (if appropriate)
- Addressing physical triggers to behaviour including pain
- Alternative therapies.

Activity 4B



4.3 – Take action to minimise the likelihood of and reduce the impact of behaviours on the person and others

By the end of this chapter, the learner should be able to:

- Outline five psychosocial strategies and their methodology for minimising the likelihood and reducing the impact of behaviours on the person and others
- Demonstrate the application of two psychological strategies previously identified in response to a given person.

Taking action

Once the appropriate strategies for behavioural minimisation have been identified, they now need to be implemented and monitored – these include:

- Distraction
- Current events
- Reminiscences
- Music, dancing
- Walking
- Talking reassuringly about familiar and favourite topics
- Behaviour modification (if appropriate)
- Addressing physical triggers to behaviour including pain
- Alternative therapies.



The idea of these strategies is that they reduce the impact of the undesired behaviours on the carer and other people. The types of management are strategies psychosocial and pharmacological.

Psychosocial strategies

These can be used to manage a wide variety of behaviours exhibited by people with dementia. They include the following:

- **Validation therapy:**
 - accepts 'reality' of the person with dementia (no matter how absurd it is)
 - reduces stress and frustration reactions
 - relies on verbal and non-verbal communication cues

- **Exercise therapy:**
 - improves health and wellbeing
 - adds social elements and increased movement quality, equalling a better quality of life
 - make sure the participants are safe to exercise (consult doctors and physios)
- **Multi-sensory stimulation:**
 - involves stimulating sight, hearing, touch, taste and smell
 - uses music, lighting, scented objects
 - improves concentration, alertness and wellbeing
 - be careful not to over-stimulate (this can have the opposite effect)
- **Scheduled reassurance therapy (SRT):**
 - positive social interactions for one minute every 30 minutes
 - repeated throughout the day
 - reduces agitation, anxiety and provides companionship
 - consistency is key – if the cycle is broken it can lead to the symptoms you are trying to prevent
- **Aromatherapy:**
 - uses essential oils to calm the patient, e.g. lemon balm and lavender
 - ensure it doesn't conflict with current medications
- **Spirituality:**
 - includes alternative and traditional beliefs
 - can reduce anxiety and provide comfort
- **Pet therapy:**
 - animals/pets used to improve quality of life, reducing anxiety and stress
 - should be done under supervision (as animals may react unpredictably)



- **Music therapy:**
 - can involve humming, singing, listening, laying or swaying/tapping feet
 - using favourite music is most beneficial
 - avoid triggering unpleasant memories
- **Bright light therapy:**
 - exposure to natural sunlight (or equivalent) for 30 minute periods in the morning and evening
 - can reduce sleep disturbance
 - intensity and time needs to be closely monitored
- **Reality orientation therapy:**
 - using verbal and visual prompts to re-orientate a person to the present
 - reduces agitation and assists with independence
 - distress can alert you whether they need to be re-orientated
- **Spaced retrieval:**
 - used for information retention
 - uses prompt questions and answers to help recall information
 - time between tests is gradually increased
 - improves memory and independence
 - use a trained specialist for best results
- **Doll therapy:**
 - interaction with a lifelike baby doll
 - reduces agitation, improves quality of life and provides social interaction
- **Simulated presence therapy:**
 - pre-recorded audio or video loops used to stimulate conversation with the person in the recording
 - controls boredom and reduces agitation
 - ensure that they have a positive reaction to the recording
 - don't use it as a replacement for actual social interaction



- **Dementia-friendly environments:**
 - environments purpose-built to be inhabited by people with dementia
 - features include:
 - disability enabling
 - self-orienting
 - allowing independence
 - reinforcing identity
 - minimal staff involvement required.

Pharmacological strategies

Sometimes, medication will be required to control behaviours. However, there are a number of behaviours it is poor at solving:

- Shouting
- Wandering or pacing
- Repetition
- Cognitive deficiencies
- Incontinence
- Insomnia
- Withdrawal.



They can, however, be used to treat conditions like depression and psychosis. The types of medicines that may be used include:

- Psychotropic medicines
- Antipsychotics
- Benzodiazepines
- Anticholinesterases
- N-methyl-D-aspartate (NMDA) antagonist
- Anticonvulsants
- Antidepressants.

The medication should be monitored closely and regular reassessments conducted. It should be started at the lowest possible dose, and one medication started at a time – otherwise, it is hard to monitor the effects. Also, side effects should be noted and reviewed – all of the previous should only be done by a medical professional.

Activity 4C



4.4 – Evaluate implemented strategies with support planning team to ensure effectiveness in minimising behaviours

By the end of this chapter, the learner should be able to:

- Identify the information which should be recorded in a sample observation
- Outline the ABC method for analysing behaviour
- Write an evaluation of strategies implemented in a previous activity.

Evaluating strategies

Evaluating the implemented strategies is about assessing whether they are working to minimise behaviours of concern or not. In order to evaluate, you will need to observe the client for a nominated amount of time and make a record of what you find. It is important to share your findings with your team so they can be prepared to handle the behaviour either differently, (if behaviour strategies did not work) or the same (if they did work).

Observing clients

Event samples are good for assessing concerns about behaviour. They focus on one type of behaviour, tracking it over a period of time (such as a day or a week) to see how often this behaviour is displayed and the possible reasons behind it.

You may have to record:

- The event number
- The date/time
- The context of the situation, e.g. family visited, going to bed
- Who was involved? e.g. family members, carers
- Dialogue/incident.



Needs-driven behaviour model

The needs-driven behavioural model recognises that people with conditions such as dementia become increasingly unable to meet their own needs. This helps convey an understanding of the fact that the person is driven by their needs but cannot fulfil these; their behaviour becomes their only means to communicate this to others.

Needs-driven behaviour is influenced by:

- Proximal factors – the person's needs and the environment they live in
- Background factors – the person's state of health, their characteristics and the situation

- Needs-driven, dementia compromised behaviours – the person’s behaviours in response to not being able to meet their own needs.

You can use the following approach to understand need-driven behaviour or, if your strategy did not work, you could try the ABC method to find out why.

ABC method

You can use the ABC method for analysing behaviour in dementia clients. This looks at three different elements to try to assess what caused the reaction.

ABC method:

- A = Antecedent: the event that happened directly before the client became upset
- B = Behaviour: the upsetting behaviour
- C = Consequence: the events happening as a response to the behaviour.

You will also need to look at the many environmental factors – for example, the task being completed, the communication and interactions between people. Try to consider things from the patient’s view, thinking about their likes and dislikes.

De-escalation procedures

When a person responds with behaviours of concern due to their dementia, you can use de-escalation procedures to help calm the situation. Procedures relevant to dementia care should be developed by your organisation.

These should follow a few simple rules:

- Always speak in a calm, low voice, without heightened emotion or aggression
- Try to identify and resolve the issue and feelings they may have (e.g., use the ABC method)
- Use clear and simple language to communicate with them
- Allow them to calm down without restraining them or being too close to them
- Use any predetermined strategies for de-escalation (as documented in the person’s care plan) to distract the person (for example, take them for a walk or play music).



Each person may require a different approach, depending on what works with them; for example, some people may respond well to eye contact and a gentle touch, while others may need time to calm down before you try to address the problem at hand.

It is always better to pre-empt behaviour from occurring when possible; you should look for the triggers that may cause these and try to prevent their occurrence. For example, triggers may include changes in the person’s behaviour, a situation known to cause the person stress or a change in the environment.

Activity 4D



5. Complete documentation

- 5.1. Comply with the organisation's reporting requirements, including reporting observations to supervisor
- 5.2. Complete, maintain and store documentation according to organisation policy and protocols



5.1 – Comply with the organisation’s reporting requirements, including reporting observations to supervisor

By the end of this chapter, the learner should be able to:

- Outline organisation’s reporting requirements for written and verbal reports
- Create a mock report for a fictional observation.

Organisation’s reporting requirements

When creating reports and workplace documents, you need to comply with organisational reporting requirements at all times.

As well as being aware of the client's beliefs and values, you should observe them and document what you see – documentation should be objective and used to make any adjustments to the care plan in the future.

In order to keep track of quality of service, it is important to have good documentation practices in place. Each person receiving aged care services must have a care plan in place to monitor their ongoing needs. This care plan should contain progress notes, as these will be used to review care needs in the future. Besides being useful, this documentation is a legal requirement and will directly affect how much government funding the person in care receives.

The following general tips are useful in all cases:

- Documentation should be completed as soon as possible after any event/incident
- Progress notes are legal documents. They must be filled out the following way:
 - using black ink and printed
 - no correction fluids (tip-ex, whiteout) to be used
 - corrections must be indicated by a line drawn over the mistake. initial the correction and re-write the information
 - draw a line to the end of the page where documenting information does not fill all the allocated lines (as per a personal cheque)
 - date all notes and include the time of the incident
 - sign all notes a print documenter's name and position/status.



Written documents

Ensure progress notes are written in the active voice rather than the passive, as this gets the message across more directly and helps with concise writing. Written documents can include progress reports, case notes and incident reports.

Documents should be:

- Concise
- Objective
- By exception
- Appropriate in language (no slang, unless recording direct speech)
- Include only necessary information.



Concise documentation

This means including the right amount of information – not too little or too much. You need to get to the point in as few words as possible; use appropriate words, sentence structures and avoid frivolous information that is not relevant.

Objective documentation

This involves only including the facts in documentation and no opinions or bias affecting what is recording. Subjective information is based on assumptions and feelings and will not accurately portray the incident.

Documentation by exception

This means to only include events and information that affect the care plan. Such examples could be changes in client behaviour, emotions and physical ability, as well as incidents involving the client.

You need to think in terms of things that:

- Will affect the direction of care plan
- Relate to the health of the client
- Involve client care refusals, care omissions, client complaints
- Involve client behaviour affecting their health and wellbeing.

Verbal reports

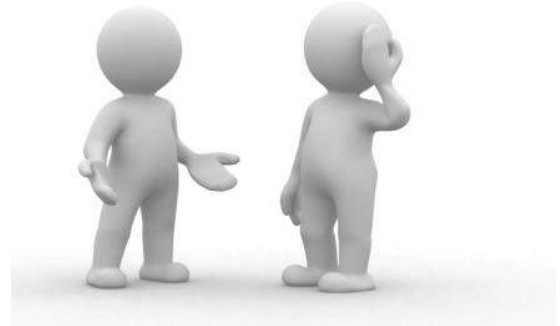
These can be done face-to-face or over the telephone. You should use this method of reporting when communication is required urgently, or in an emergency situation, i.e. those involving the immediate safety of carers or the people in care.

The same principles apply to verbal reporting as to written reporting – keep it concise, objective and include only relevant information.

Structuring notes

When thinking of what information to include in notes, use the following as a guide:

- Who is it about?
- Where did it happen?
- When did it happen?
- What happened?
- Why did it happen?
- How did it happen (if factual evidence exists)?
- What did you do (if applicable)?



Incident reports

Incident reports are an important aspect of documenting process. If you notice an inconsistency, it could be related to an incident. The essential elements to an incident report involve answering the following questions about the incident.

- Who?
- What?
- When?
- Where?
- How and why?

The following table demonstrates the essential components of an incident report and how they might be used to guide you to giving details on incidents.

| Component | Question | Answer |
|--------------|--|--------|
| Who? | Who is reporting the incident? | |
| | Who is affected by it? | |
| What? | What happened? | |
| | What action did you take? | |
| | How severe is the incident? (you may use an incident severity scale) | |
| When? | When did the incident take place? | |
| Where? | Where did the incident take place? | |
| How and why? | What were the elements that contributed to the incident? | |

A good incident report should be:

- Complete – it should cover all components in relevant detail
- Concise – it should include everything that is needed but exclude flowery descriptions, abbreviations can be used put sparingly as they can also cause confusion and detract from the writing
- Specific – It should make reference to exact times, dates and other facts
- Objective – It should not give opinions or inferences
- Confidential – the identities of who was involved and where it took place should not be revealed in the ‘what happened’ box as this has to be sent to the Department of Health.

Activity 5A



5.2 – Complete, maintain and store documentation according to organisation policy and protocols

By the end of this chapter, the learner should be able to:

- Outline how to complete and maintain documentation
- Suggest how records can be made identifiable
- Complete one piece of workplace documentation according to organisation policy and protocols.

Completing and maintaining documentation

Documentation must be maintained in line with reporting requirements – this means ensuring that it is kept in a safe place, backed up and easily accessible for future use. It can also mean updating and amending existing documentation.

The very documentation system you use must be kept up-to-date – this can mean digitalising existing records (if your organisation hasn't already done so). It can also mean shifting records onto a new server, as cloud storage becomes more popular in the modern age.

If the reporting format changes, you may have to update older formatted documentation to comply with the new system – keeping things consistent makes documents easier to interpret; while the initial time spent doing this can appear costly, it saves more time in the long run.

It is a good idea to have a checklist of things to remember for documentation, so that the maintenance process is minimal.

You should appoint a registrar, who is responsible for updating the documentation system – they are the point of authority, and nothing can be moved or updated without their consent. This ensures that documentation is well tracked and the system is consistent across the board.

Creating a procedural manual is a good idea to outline the documentation processes in full and ensure that there is no doubt over how to do things, and that nothing is omitted.

Documentation must be filed in accordance with organisation policy and protocols – this ensures it can easily be located at a later time. For instance, there may be a dispute about the quality and level of care, which can easily be resolved to accessing and consulting the documents relevant to the time.

Filing is something many people have problem with; organisation cannot only make you more productive, it can also simplify your workload and make it less stressful to file or look for a specific document in the future.



Documenting information

Making records identifiable

It is highly important to make records easily identifiable so that mistakes do not occur when treating clients.

You might need to include the following information:

- Unique identifier, e.g. medical record number
- Client's full name
- Date of birth/age
- Sex.

Some organisations use a printed sticky label that includes all the above identifying information.

Documentation standards

When completing documentation, there are a set of standards that you should comply with.

Standards that you should uphold include:

- Be clear and accurate
- Ensure writing is legible and in English
- Only use approved abbreviations and symbols
- Use dark ink that you cannot erase
- Include date and time of entry using 24-hour clock method
- Include name of author and signature (or electronic alternative)
- Students or support workers should sign and then have their signature co-signed by supervisor
- Structure writing and give relevant details so as to be clear
- Be objective in your writing
- Distinguish between what was observed or performed, what was reported by others as happening and/ or professional opinion
- Make records as soon as possible after an event
- Any bare lines at the end of your writing should be crossed with a line to show they are not left for later entries
- Do not use personal information of other people unless necessary

- Additional details should be integrated and documented next to the heading 'addendum' with the date and time of the omitted information and date and time of the subsequent addendum
- If an error has occurred, you should leave it so that it is readable with one line drawn through to show that it is a mistake (or in electronic write 'written in error'). Errors should include the author's name, signature, time and date of correction. Electronic errors should be linked to a note saying 'written in error'.

Frequency of documentation

There are also regulations for when records should be updated. These should reflect the care that the client has received.

For example:

- By each carer to give care to client/each session
- Significant changes to the client's condition
- Significant changes to treatment/activities/preferences
- Reviews.



Other relevant standards

Other standards regarding documentation include:

- Documentation of telephone conversations between client and health worker – identification of the caller must be documented
- Any leave taken by clients
- Leave taken against medical advice – should obtain a client signature.

The above standards refer to the New South Wales area; they may differ slightly between areas so you must check with your state

(https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_069.pdf).

Note on confidentiality: Health care workers should only access documents about clients when it is directly related to their duties.

Managing computer directories

A computer directory is a computer-based filing system that is organised into files and folders on a computer. You will be given specific procedures in order to manage this system correctly and according to your organisational requirements.

To manage this filing system, you may need to:

- Create new folders
- Copy folders or files within folders and move to other locations
- Change the name of a file or folder
- Delete files and folders.



Sorting and storing information

How information is stored depends upon the purpose of the task; long-term storage should be in a secure location, either in the office or on the computer, whereas short-term storage tasks will vary from task to task. An example of this would be putting some papers into a folder for a co-worker to collect on their way to a meeting this afternoon; the papers would be stored in a folder, which, in turn, would be placed in the worker's pigeonhole or tray.

- **Established procedure:** this may be implemented by organisational stipulation or through how your workplace works
- **Organisational stipulation** will likely be company-wide and is in place to ensure that legal obligations are met and that a uniform system is used across the company
- **Workplaces** may have their own system that revolves around the space, layout and staffing of the office, for example:
 - the use of filing cabinets
 - whether all staff have access to the same files on the computer
 - whether staff have pigeonholes or trays
 - whether there is a member of staff employed to manage the information system or whether everyone does their own work
 - security restrictions:
 - who has access to the computer?
 - who has access to the filing cabinet?
 - who has access to the office area?



If you do not have access to records, you may need to ask a supervisor for assistance. If there is a member of staff appointed to manage information systems, you may need to leave the task with them. Your level of authority in this area and workplace procedures will affect how you carry out a task, so always remember to factor this into your work.

After sorting the documents, you will be ready to file them into their respective folders. A system will also be in place to make sure that more files are complete in the same manner. For example; alphabetical order, e.g. according to clients' names, or chronological order, e.g. the oldest to the most current date, etc.

Activity 5B



6. Implement self care strategies

- 6.1. Monitor own stress level in relation to working with people with dementia
- 6.2. Use appropriate self care strategies and seek support if required



6.1 – Monitor own stress level in relation to working with people with dementia

By the end of the chapter, the learner should be able to:

- Monitor their own stress level by documenting it while working with people with dementia.

Monitoring own stress levels

As well as caring for patients, you also need to monitor your own health – one of the main factors related to working with people with dementia is stress – this is because of the high demands, in terms of time, the burden of caring for someone and the financial (if informal care) and social impacts of caring for someone with dementia.

Signs of stress

There are ten signs of stress in caregivers:

1. **Denial** – refusing to accept the reality of the disease and inevitable effects on the person with dementia
2. **Anger** – at the person diagnosed, that no cure exists or the reactions of other people
3. **Depression** – giving in to the inevitability of the situation and seeing no point in doing anything
4. **Anxiety** – worrying about what will happen in the future
5. **Social withdrawal** – becoming reclusive from activities and friends you used to do/see
6. **Sleeplessness** – due to worrying and inability to relax, e.g. going over possibilities in your head while lying in bed
7. **Exhaustion** – leading to a lack of desire to complete everyday tasks – they tend to stop taking care of themselves
8. **Irritability** – triggering negative responses and moodiness
9. **Health problems** – susceptibility to illnesses due to the mental and physical burden
10. **Trouble concentrating** – making it difficult to function and perform tasks that were once second nature.



If you feel yourself getting stressed, you should utilise the help and resources available. These can be things like:

- Additional carers
- Counselling
- Assistive services (meal delivery, visiting nurses, adult day programs)
- Use carer support programs
- Contact the National Dementia Helpline.

Managing stress

In order to minimise the amount of stress you experience from working with people with dementia, you should try and implement the following concepts into your life:

- Develop a consistent schedule
- Remember not to blame the person with dementia for their behaviour
- Educate yourself on the effects of dementia and strategies for managing it
- Talk to family, friends, or other people in a similar situation
- Take care of yourself – manage your diet, take regular exercise and maintain a social life
- Be realistic about your ability to carry out required tasks – if you take care of yourself, the quality of your care increases.



Activity 6A



6.2 – Use appropriate self care strategies and seek support if required

By the end of this chapter, the learner should be able to:

- Identify self-care strategies which could be employed to minimise the development of stress and manage any that surface.

Self-care strategies

As well as stress, there are a myriad of other feelings a carer may experience, such as guilt, anger, grief and loss. Whatever the feelings, it is important to have systems of dealing with them, so as not to be overcome by them.

These could include:

- Allowing expression of the feelings (rather than bottling them up)
- Crying
- Talking (sharing feelings can be cathartic)
- Keep a journal – writing feelings down can help you understand them and process them more easily
- Don't become consumed by the feelings
- Perform comforting rituals/behaviours
- Think carefully before you make any decisions on your feelings
- Find a balance between the negative feelings and positive ones in life
- Rediscover your sense of humour.

Sharing the workload

If you feel you need help with your workload, it is important that you ask – this can be from friends, family and neighbours of the person with dementia. External help can also be sought from doctors, psychologists, social workers and counsellors.

The types of things that relatives can help with are things like meals, shopping, and housework. External help can offer up services such as day centres, where the person with dementia can be left while the carer has a brief break from their responsibilities.



Resources/support systems

There are a number of support systems for those working with people suffering from dementia.

They include:

- Aged Care Assessment Teams (ACATs) – they assess older people and help them, and carers work out effective care plans (residential or home care)
- Aged Care Information Line – general information line for matters about care access, respite fees, bonds and charges
- Commonwealth Respite and Carelink Centres (1800 052 222 during business hours, or 1800 059 059 outside of business hours) – information on community care programs and services to allow dementia sufferers to live at home
- Carer Advisory and Counselling Service – information and advice for carers on entitlements and relevant services
- Doctors
- Local councils
- Local community health centre
- Dementia Australia (1800 100 500)
- My Aged Care provider and assessor helpline (1800 836 799)
- My Aged care (1800 200 422)
- Cognitive Dementia and Memory Service clinics Victoria (1300 135 090)
- Carers Victoria (1800 242 636)
- Dementia Behaviour Management Advisory Service (1800 699 799).



Activity 6B



Summative Assessments

At the end of your Learner Workbook, you will find the Summative Assessments.

This includes:

- Skills assessment
- Knowledge assessment
- Performance assessment.

This holistically assesses your understanding and application of the skills, knowledge and performance requirements for this unit. Once this is completed, you will have finished this unit and be ready to move onto the next one – well done!