Community Areas of Sustainable Care and Dementia Excellence in Europe

CASCADE

A Scoping Review of Staff Training and Education Needs

Prepared by:

Anne Martin and Carolyn Jackson

England Centre for Practice Development (ECPD),

Faculty of Health and Wellbeing,

Canterbury Christ Church University.

Acknowledgements:

Contents

Executive summary

The aim of D 3.1.4 is to review international literature to identify best practice, gaps and challenges in existing dementia training, education and continuing professional development (CPD) and make recommendations to cross border partners to complement the work that PP7 and PP9 are undertaking in Work Package 1 and 2.

The scoping review identified and synthesised literature to address the question 'what knowledge and skills do practitioners involved in caring for people living with dementia (PLWD) need to support person centred practice'? Thirty two papers were included in the review, 19 of which were training or education interventions aimed at developing healthcare staff's skills and knowledge for improved dementia care practices. The focus was mainly on person centred dementia care, managing challenging behaviour and improving communication with people living with dementia.

The findings highlight three main themes relating to the learning and development needs of staff that care for people living with dementia, which include person centred care, communication and managing dementia care. Evidence based training and education programmes for developing a skilled workforce in dementia care are still in development. The literatures cites a lack of rigour in the assessment of the effectiveness of existing programmes. However, the review provides some insight into the broad themes emerging in the literature and the methodological challenges associated with drawing any meaningful conclusions about best practice models currently for education and training. As a starting point it offers the CASCADE team potential to provide a bold new blueprint for education and training when combined with outputs from PP7 and PP9.

Our key recommendations are based on gaps identified in the literature to enable partners to develop the broadest range of training and education possible for both formal and non-formal caregivers. Recommendations in the literature (Appendix 3) identify further need for adequate dementia care skills development centring holistic person centred care, enhanced communication and understanding of dementia through facilitated practical learning opportunities, particularly in specialist dementia care facilities.

1. Introduction

1.1. Aim of the Review

The aim of D 3.1.4 is to review international literature to identify best practice, gaps and challenges in existing dementia training, education and continuing professional development (CPD) and make recommendations to cross border partners to complement the work that PP7 and PP9 are undertaking in Work Package 1 and 2.

2. Methods

The scoping review drew on the first five steps of Arksey & O'Malley (2005)'s framework to generate a summary of broad areas for dementia care learning needs identified in the literature and to identify gaps in the evidence existent. The review aimed to answer the question 'what knowledge and skills do practitioners involved in caring for people living with dementia (PLWD) need to support person centred practice'?

2.1. Identifying relevant studies

A search for scholarly literature published in English from 2006 to 2017 was conducted in three databases including Medline (OVID), British Nursing Index and CINAHL. This was accomplished with the help of a learning resources and information specialist. The search terms used to identify studies relevant for review are presented in Appendix 1.

2.2. Study selection

The criteria for inclusion focused on peer reviewed papers that explored healthcare staff learning needs relating to dementia care. Three criteria for assessing the relevancy of papers were:

- Staff learning, how they learn, or what they should learn is (or are) the main (or a major) focus of the paper
- The paper discusses staff learning or education needs from a policy or other substantive (non-empirical) viewpoint
- The paper makes recommendations s for dementia education or learning based on existing literature, or other evidence discussed

2.3. Charting data

We developed a template (Appendix 2) to facilitate charting of information significant for answering the review question. Information charted included:

- Title
- Author(s),
- year of publication,
- Country
- Setting
- Participants
- Aim(s) of the study
- Methodology including theoretical frameworks, tools used to measure outcomes
- Findings
- Recommendations

- Strength and limitations

2.4. Collating and summarising results

An electronic based template designed prior to the review set data charted into meaningful categories and provided a descriptive statistical analysis of nominal data that featured more than twice. A thematic analysis was conducted for sections on major findings and recommendations.

3. Findings

3.1. Characteristics of the studies included

Out of the 232 papers returned from the search, 164 papers were excluded during the first stage of screening on title and abstract. Full texts for 68 papers were assessed for relevance to the scoping review and a total of 32 papers were included. Two of the papers (Beer et al., 2012; Beer, 2017) reported findings from one study conducted in the UK, making 31 studies included in the review. All papers included made recommendations for dementia education or learning based on evidence that authors discussed. Sixty-nine percent (69%) of the papers discussed dementia care staff learning needs from a policy or local viewpoint.

Most of the studies included were published in 2015 (n=6) and 2009 (n=4), while others were evenly spread with 2- 3 papers published per year between 2010- 2017, except for 2014 that features only one paper in the review. Studies included in the review were mostly undertaken in the UK (n=10), USA (n=9) and Australia (n=7) respectively. Each of the countries including Canada, Germany, Norway, South Korea and Sweden feature one study included in the review.

Nineteen of the included studies were training interventions (Bauer et al., 2013; Beer et al., 2012; Bezzant, 2008; Borbasi et al., 2011); Broson & Toye, 2015; Broughton et al., 2011; Cameron et al., 2010; Dreier et al., 2016;Einang Alnes et al., 2011; Glueckauf et al., 2009; Haak, 2009; Josefsson et al., 2008; Kang et al., 2017; Kontos et al., 2010; Lathren et al., 203; Palmer et al., 2015; Robin & Cubit, 2007; Robinson et al., 2010;Surr et al., 2016; Teri et al., 2009). These studies assessed effectiveness of training in improving knowledge and management of person centred dementia care (n=7); dementia care (n= 6); managing unusual behaviour (n=3); perceptions and attitudes towards people with dementia (n= 2); and communication (n=2). Other included studies sought opinions about staff's perceived training needs (Champion, 2017; Nguyen et al., 2015; Robinson, 2015;); explored challenges and skills development in dementia care (Burns & McIlfatrick, 2015; Chang et al., 2009; Daly et al., 2015; Neville et al., 2006; Smythe et al., 2015); examined strategies of delivering training and education in acute settings (Chater & Hughes, 2013; Pulsford et al., 2007); and one study (Gandesha et al., 2012) undertook a national audit of dementia care training.

3.2. Settings and participants

Included studies recruited participants from acute hospitals (n=11), residential care facilities or nursing homes (n=8), institutions of learning (n=4), primary/ community healthcare facilities (n=7) and specialist dementia care centres (n=1). Participants were largely qualified or specialist nurses, nurse aides and nurses in training except for three studies that included medical practitioners (Gandesha et al., 2012; Lathren et al., 2013; Robinson et al., 2010).

3.3. Methods used in included studies

Out of 31 studies included in the review, 19 reported outcomes of training interventions based on assessed learning needs using quantitative (n=7), mixed methods (n=6) and cross sectional qualitative (n=5) and quantitative (n=1) study designs. Nine out of the 19 training intervention programmes included pre and post measures with mostly three time points of outcome assessments. Only three interventions were controlled (Broughton et al., 2011; Borbasi et al., 2011; Beer et al., 2012).

Included studies that explicitly indicated theoretical frameworks guiding the research cited experiential learning (Beer, 2016, Beer et al. 2012), critical reflection in practice (Robinson, 2015), naturalistic inquiry (Smythe et al. 2015), knowledge translation (Broughton et al., 2011), principles of person centredness (Borbasi et al. 2011; Robinson et al., 2010) and story, drama, human becoming theory (Kontos et al 2010).

The majority of training intervention studies used self-report methods to measure changes in dementia care practices. Table 1 below outlines some of the measures used in studies for outcome assessments.

Table 1 Outcome measures used in some of the studies included in the review

Outcomes measures	Reference	Included study
Ageing Sexuality Knowledge and Attitudes Scale (ASKAS)	White, C. B. (1982). A scale for the assessment of attitudes and knowledge regarding sexuality in the aged. *Archives of Sexual Behavior*, *11*(6), 491-502.	Bauer & McAuliffe (2013)
Staff Attitudes about Intimacy and Dementia (SAID) (Kuhn 2002)	Kuhn, D. (2002). Intimacy, sexuality, and residents with dementia. *Alzheimer's Care Today*, *3*(2), 165-176.	
Dementia Quality of Life	Smith et al. (2007). Development of a new measure of health-related quality of life for people with dementia: DEMQOL. *Psychological medicine*, *37*(5), 737-746.	Borbasi et al. (2011)
Aspects of Caregiving (PAC) questionnaire	Tarlow, et al. (2004). Positive aspects of caregiving: Contributions of the REACH project to the development of new measures for Alzheimer's caregiving. *Research on aging*, *26*(4), 429-453.	Broughton et al. (2011)
Five case vignettes	Fick et al. (2007). Recognizing delirium superimposed on dementia: assessing nurses' knowledge using case vignettes. Journal of gerontological nursing, 33(2), 40.	Kang et al. 2017
Facts on Aging	Palmore, E. (1977). Facts on aging: A short quiz. *The Gerontologist*, *17*(4), 315-320.	Kang et al. (2017)
FCN Counselling Comfort Scale	Glueckauf, et al. (2007). Faith Community Nurse Counselling Comfort Scale. Tallahassee: Florida State University, Department of Medical Humanities & Social Sciences, College of Medicine.	Glueckauf et al. (2009)
Perceived Counselling Efficacy Scale	Glueckauf et al. (2007). *Faith Community Nurse Perceived Counseling Efficacy Scale.* Tallahassee: Florida State University, Department of Medical Humanities & Social Sciences, College of Medicine.	
The Approaches to Dementia Questionnaire (ADQ) (Lintern et al., 2000)	Lintern, T., Woods, R.T., Phair, L., 2000. Before and after training: a case study of intervention. *Journal of Dementia Care,* 15-17.	Surr et al. (2016)
The Staff Experience of Working with Demented Residents Scale (SEWDR)	Åström et al. (1991). Staff burnout in dementia care—relations to empathy and attitudes. *International journal of nursing studies*, *28*(1), 65-75.	
The Caring Efficacy Scale (CES)	Coates, C.J., 1997. The Caring Efficacy Scale: nurses' self-reports of caring in practice settings. *Advanced Practice Nursing Quart.* 3 (1), 53–59.	

The next section presents results of the thematic analysis of key findings about learning needs for dementia care staff, how they learn and barriers to their learning identified in papers included in the review.

3.4. Dementia care learning needs

The review identifies a cross section of learning needs to improve dementia care practice for staff working in all settings and the quality of life for people with dementia. We derived three broad themes from collating and summarising data, which include person centred care, communication and managing dementia care. The themes and sub themes that emerged from all analyses overlap considerably. This is not surprising in view of person centred care being the fundamental focus of quality in dementia care. The learning needs identified here could inform education and learning programmes for staff that come into contact with people with dementia. However, the depth of knowledge would depend on the level of clinical practice and the mode of interaction with people with dementia. While some of the learning needs such as palliative care and pain management would ideally be for specialist teams, the literature identifies the need to have foundation knowledge of principles of care and the skills to assess and recognise the need for relevant intervention in any context.

3.4.1. Person centred care

Person centred care constitutes values that direct the focus of care to the unique individuality of people with dementia and efforts to develop understanding of their view of physical and social environments to support their needs adequately (Surr et al., 2016). The resultant sub themes include approach to care, holistic care and privacy and dignity.

3.4.1. a. Approach to care

Education and training focusing on this aspect of dementia care aims to develop skills for eliciting positive relational outcomes. Increasing staff awareness about how to approach dementia care challenges staff to reflect on care delivery styles, perceptions and assumptions and the impact these may have on people with dementia (Beer et al., 2012; Kontos et al. 2010). Actions influenced by values, perceptions and beliefs have an effect on interaction (Einang Alnes et al., 2011). Staff are challenged to look at their own values, beliefs and practices in dementia care and in turn, they are supported to develop understanding of people with dementia, positive attitudes and meaningful interactions (Beer, 2017; Bezzant, 2008; Robinson, 2015). Some of the examples of best practice of a person centred approach to dementia care illustrated in the literature include taking time, pacing interactions, maintaining eye contact, patience, kindness and calmness (Einang Alnes et al., 2011; Kontos et al 2010; Smythe et al., 2015).

Approach to care represents increased self-awareness that enables development of empathy, understanding of the impact of one's own behaviour to care outcomes and the ability to learn from all forms of feedback (Haak, 2009; Teri et al., 2009; Robinson, 2015; Surr et al., 2016). This entails valuing people with dementia as individuals, having genuine empathy and unconditional positive regard, drawing on informal carers' knowledge, and recognising the person behind the care delivery role (Robinson et al, 2010).

3.4.1. b. Holistic care

Holism in dementia care embodies the social context with emphasis on relationships, roles and life stages combined with well-being, prevention and quality of life (Chang et al., 2009; Robinson et al, 2010). Holism recognises meaning beyond the dementia to embrace the selfhood embedded in activity and intentions of the body (Kontos et al., 2010). Training and education initiatives focused on holistic care are founded on enabling staff to develop understanding for the person inside the individual with dementia in order to identify and inspire their strengths (Beer et al., 2012; Smythe et al 2015). The approach not only stimulates staff empathy, but also facilitates access to and support for preferences, spirituality, history, memories and inner experiences/ emotions of the person with dementia, all of which are fundamental to person centred care (Beer et al., 2012; Neville et al., 2006).

Knowledge and understanding of preferences play a key role in promoting autonomy and best practice in supported nutrition, hydration and eating (Surr et al., 2016; Einang Alnes et al., 2011). The fundamentals of increased awareness of holistic care take into account the significance of involving the family in the care of the person with dementia in a setting away from home, which may also facilitate access to relevant information. Family involvement requires staff to develop skill in fostering positive relationships that enable effective sharing of information, negotiating care plans and joint decision making inclusive of the person with dementia (Chang et al, 2009; Haak, 2009; Lathren et al., 2013; Nguyen et al., 2015; Kontos et al., 2010).

Practitioners should also be able to gain skills in delivering care that focuses on all aspects of ability and impairment to facilitate development of personalised activity that creates opportunities for social interaction and engagement (Robinson, 2015). Practitioners require sufficient training and mentorship in counselling and offering guidance so that they can effectively o support people with dementia and their families, including those with visual or hearing impairments to enhance social activity, independence and dignity across the dementia trajectory (Chang et al., 2009; Dreier et al., 2016; Gandesha et al., 2012). Practitioners also need skills to fulfil the responsibility of training families and caregivers about homecare management to maintain wellbeing of people living with dementia (Dreier et al., 2016).

3.4.1. c. Respect, privacy and dignity

Taking the time to gain knowledge and understanding of the inner person of the individual with dementia derives respect and encourages optimal use of their capabilities for enhanced autonomy (Einang Alnes et al., 2011; Nguyen et al., 2015). Raising staff awareness about means of maintaining dignity, privacy and respect in dementia care minimises distress and improves quality of life (Haak, 2009). Practitioners need knowledge about sexuality in older age to enable recognition of and support for the sexuality of the person with dementia and to maintain objectivity without playing moral guardians to people in their care (Bauer et al., 2012; Teri et al., 20-09). Bauer et al. (2013) recommend that training and education initiatives focused on this element of care should facilitate learning about changes in sexual functioning in older age; issues concerning cognitive impairment and consent for sexual activity; recognising the need for privacy for sexual activity; and how to manage hypersexual behaviour. Continuous update of knowledge of ethics and dementia increases staff awareness and confidence in dealing with issues related to culture and diversity, consent, abuse, capacity and end of life (Pulsford et al., 2007).

Practitioners require the confidence to facilitate shared responsibility in developing, documenting, coordinating and regularly evaluating care plans to meet the needs of people

with dementia and their families at various stages along the dementia trajectory (Champion, 2017; Chater &Hughes, 2013; Dreier et al., 2016; Robinson et al., 2010). Advanced care plans enable effective implementation of holistic care based on preferences, strengths and the needed support identified.

3.4.2. Communication

Communication as a broad theme identifies the need to support practitioners to develop techniques for establishing and maintaining person centred interactions that facilitate improvements in the quality of life. Robinson et al (2010) posit communication is the key to achieving all other components for person centred care. Sub themes for communication encompass approaching communication and effective communication.

3.4.2. a. Approaching communication

Practitioners involved in dementia care require knowledge of support strategies for memory and communication built on a framework that links strategies to their effectiveness (Broughton et al., 2011; Einang Alnes et al 2011). Training and education programmes should provide greater understanding of how to approach talk with people with dementia and how to recognise verbal and nonverbal efforts people with dementia make to interact (Beer et al., 2012). Techniques relating to tone, attentiveness, and eye contact as well as encouraging the person with dementia to maintain rhythm in the dialogue support successful interactions (Einang Alnes et al., 2011).

Empowering staff with skills to listen and echo rhythmic or melodic vocalisations improves confidence in their caregiving role, regardless of whether or not they consider themselves musical (Beer, 2017). Vocalisations hold meaning to people with dementia and therefore, the skill to listen closely and encourage vocalisations especially for people with advanced dementia is essential (Beer et al., 2012).

3.4.2. b. Effective communication

Increased awareness of what constitutes effective communication enables meaningful contact and interaction with people with dementia and their families (Einang Alnes et al., 2011; Gandesha et al., 2012; Haak, 2009; Robinson & Cubit, 2007). Upskilling staff with communication and counselling techniques facilitates teaching and advising people living with dementia about the condition, care options including end of life care and support services available to alleviate distress (Dreier et al., 2016; Nguyen et al., 2015; Bronson & Toye, 2015). Effectiveness in communication arises from sharing all relevant information and explaining basics in a way that is understood (Smythe et al., 2015). Knowledge and skill in effective communication involves the ability to respond appropriately to verbal and nonverbal cues; present information clearly, summarize more frequently and involve the person with dementia in consultation- exploring ideas, concerns and expectations in a systematic way (Robinson et al., 2010).

Practitioners in all care settings would benefit from learning how to communicate effectively with people with dementia and their families to augment respect, autonomy and choice (Teri et al., 2009; Bronson & Toye, 2015). Care experiences for both staff and people with dementia would become more pleasant.

3.4.3. Managing dementia care

Managing dementia care represents a skillset required to increase practitioners' confidence in drawing on care guidelines and using assessment tools to identify and manage care needs effectively. Three sub themes emanated from summarizing and collating data under this category namely; knowledge of dementia, managing challenging behaviour and working in partnership.

3.4.3. a. Knowledge of dementia

The dementia care workforce requires better understanding of dementia as a condition, its trajectory and implementing dementia care guidelines to minimise challenges encountered in all aspects of caregiving, (Bezant, 2008; Cameron et al., 2010; Chang et al 2009). Greater understanding of dementia and its progression enables increased awareness for early diagnoses and tailored care provision and support for people living with dementia (Cameron et al., 2010; Gandesha et al., 2012). However, it is essential that training initiatives are adapted to care settings and roles and responsibilities of staff (Smythe et al., 2015).

Understanding of the dementia condition empowers staff to differentiate not only between dementia and delirium but also the different dementias and appropriate treatments (Daly et al. 2015; Kang et al., 2017; Lathren et al., 2013). Practitioners require skill in assessment and management of various aspects of care embracing pain, discharge from hospital care needs; administering medication including the various analgesic options and their effects; as well as behavioural disorders and the confidence in using non-drug management strategies (Burns & Malfatrick, 2015; Dreier et al 2016; Daly et al., 2015; Josefsson et al., 200; Palmer et al., 2014; Robinson, 2015).

In addition, practitioners caring for people with advanced dementia require a set of skills to facilitate recognising the need for and applying principles of palliative care (Champion, 2017), symptom management, pain assessment; sharing information openly and negotiating care with families (Chang et al. 2009).

A comparative study of competence development between primary care nurses and dementia care nurses cites the need for nurses involved in dementia care to gain knowledge and skill in mentoring students undertaking placements (Josefsson et al., 2008). Student mentorship necessitates techniques in facilitating sustainable motivation to learn; enabling self-reflection and critical inquiry; and creating opportunities for exposure to various clinical situations to improve confidence in their capabilities (Beer et al., 2012).

3.4.3. b. Managing challenging behaviour

Challenging behaviours that people with dementia exhibit impacts negatively on the capacity of practitioners to provide effective care and yet, the lack of skill in managing such behaviours aggravates anxieties for both staff and the people with dementia (Bezzant, 2008; Borbasi et al., 2011; Glueckauf et al., 2009; Lathren et al 2013; Robinson & Cubit, 2007; Teri et al., 2009). Behavioural challenges, often not asymptomatic of dementia are reflected in an array of indicators some of which include agitation, undressing, persistent and cyclical questioning, aggression, use of coarse language and wandering (Borbasi et al., 2011; Daly et al, Kontos et al., 2010). Staff involved in the dementia care giving role need to continuously update their knowledge of policies and guidelines concerned with dealing with challenging behaviour in dementia care, specifically 'inhumane' use of restraints and sedation and associated risks (Gangesha et al., 2012; Kontos et al., 2010).

Principles of person centred dementia care require managing challenging behaviour without pharmacologic intervention (Daly et al. 2015; Kontos et al 2010). Training or education content focusing on developing skills in deescalating challenging behaviour should enable practitioners to redefine behaviour to meaningful expressions of unmet needs and understanding of the importance of involving families to achieve this objective (Kontos et al., 2010; Surr et al., 2016). Redefining behavioural difficulties in dementia care requires drawing on reasoning, observation and problem solving capabilities to apply de-escalation techniques to different situations in a person centred way (Smythe et al., 2015; Teri et al 2009).

3.4.3. c. Working in partnership
Active partnerships in dementia care optimise the use of community resources available to support people with dementia to live in their homes for as long as possible (Lathren et al., 2013). Raising staff awareness about community resources and the role of other care providers reduces unnecessary hospital admissions of people with dementia and promotes social engagement and activity (Cameron et al 2010; Gandesha et al., 2012; Lathren et al 2013). This also facilitates timely triage to appropriate healthcare services (Borbasi et al., 2011; Chang & Johnson, 2009). Knowledge and skill of utilising technical support systems such as telehealth enhances access to specialist services and community resources (Dreier et al., 2016).

Similarly, collaborative working entails sharing person specific information effectively during handovers within departments and across care settings to enable continuity of care and person centred relationships (Chater & Hughes, 2013). Practitioners require training support about mechanisms for complete handovers to improve information flow and personalised dementia care and support. Partnerships in dementia care recognise the role of families in getting to know the individual with dementia, tailoring support and developing therapeutic relationships to enable conflict management and holding difficult conversations (Josefsson et al., 2008; Latheren et al., 2013; Pulsford et al., 2007).

In addition to practitioners' learning needs identified from studies included in the review, a few studies highlighted how practitioners can best learn, based on evaluation feedback from practitioners that participated in the studies. The findings relating to effective learning and barriers to learning are now presented.

3.5. How dementia care staff learn
Intervention studies included in the review that aimed to bridge dementia care skills gaps identified varied significantly in terms of programme duration, mode of delivery and content. A few studies highlighted how people involved in dementia care can best learn, based on evaluation feedback from participants in the studies. Effectiveness of the mode of learning may be contingent on whether the purpose of training is skills (*abilities staff need to perform a task*) or competence (*how staff apply skills in practice*) development.

The literature identifies that training emphasising competence development is more effective when content incorporates elements of experiential learning to create opportunities for practice-based learning alongside skilled mentors and mutual peer support (Neville et al., 2006; Smythe et al., 2015). Pulsford et al. (20017) suggested linking nursing care homes with higher education institutions to enhance work-based learning opportunities. Where there is no immediate opportunity for work based learning, role play exposes learners to care experiences

related to dementia (Beer et al., 2012; Kontos et al., 2010). Robinson (2015) endorsed the power of reflection combined with critical thinking in enabling learning from colleagues' and care recipients' feedback and from all situations in the process of care delivery, whether good or bad.

Chater & Hughes (2013) described four broad categories of holistic learning about dementia, some of which are also recommended in other studies included in the review:

- interacting directly with individuals in early stages of dementia may provide insights into the condition when people are not in stages of acute infirmity;

- learning about the person and their uniqueness to accelerate the development of therapeutic relationships for a person centred approach to care;

- promoting a team approach to learning to support mutual and interdisciplinary learning from the diversity of experiences within teams and partners (Dreier et al., 2016); and

- observing practice in dementia specialist care facilities to acquire evidence-based knowledge from experts (Neville et al., 2006; Robinson et al., 2010).

While lectures, distance education (Burns & McIfatrick, 2015), research evidence (Robinson, 2015), pocket guides, online resources (Daly et al., 2015) and obtaining resources from dementia care charities (Chater & Hughes, 2013) may render effectiveness for skills development, competence development is subject to mastery of the skills through work based learning opportunities.

3.6. Barriers to learning

Barriers to learning in this respect represent factors that affect willingness to learn, induced by individual staff's preconceptions about learning. Learning reflects a complete process of knowledge accumulation and translation through meaningful application of skills in the workplace.

- Practitioners in healthcare predominantly manage several demands, and their learning may be affected by presumption of lack of time, even when accorded the time for developing skills to make their work easier (Smythe et al., 2015; Teri et al., 2009). For example, participants in a study by Smythe et al. (2015) viewed person centred care as a task separate from usual care responsibilities.

- A general perception that staff in frontline practice know much more from their work with people with dementia than trainers who may not directly be involved in practice, especially those from higher institutions of learning that may be more familiar with classroom-based approaches to teaching (Smythe et al., 2015).

- Acquiring competence above normal roles and responsibilities could be met with resistance because of reference to new skills as out of the remit of a job description (Teri et al., 2009). In the same vein, temporary change of roles prior to and or post completion of training may affect applying newly acquired skills in practice (Bronson & Toye, 2015).

- Workplace cultures entrenched in everyday practice brew reluctance to change practice (Borbasi et al., 2011). Experiences of prior dementia care training initiatives

with varying programme content and purpose of training may preoccupy trainees with opinions against useful values and new ways of doing things (Teri et al., 2009).

- False perceived competence that may stand in the way of effective self-reflection and self-awareness that links individual practice to required improvement (Teri et al., 2009).

4. Discussion

The scoping review presents a summary of learning needs identified in the literature for healthcare practitioners in formal dementia care. Increased awareness of dementia in clinical settings particularly to improve early detection has recently featured in different fora including international appeals and national policy statements, but regulated enactment is yet to trickle down to institutions of learning (Pulsford et al., 2007; Thornhill & Conant, 2018). The call for education initiatives to support practitioners and caregivers in counteracting the challenges of dementia care has witnessed an exponential increase in training programmes but evidence of their effectiveness is problematic due to limited rigour in their evaluation (Whitlatch & Orsulic-Jeras, 2018).

Whilst nineteen intervention studies were included in the current scoping review, the majority of studies evaluated the effectiveness of interventions using self-report measures with the majority employing a maximum of delayed time points of three months. Borbasi et al. (2011)'s measurement of the extent to which training of residential care staff impacted on residents' quality of life registered inconclusive results at six months follow up. The greater need to develop evidence based education and training programmes for improved practices in dementia care remains a task yet to be fulfilled.

Beer (2017) and Kontos et al. (2010) endorse the significant role of art, drama and music in behaviour and interaction and the contribution to illuminating care experiences and valuing the practitioner's role in dementia care. Arts are largely not part of curriculum in healthcare training, despite existing evidence on the synergy between visual arts and enhanced scientific learning (Tyler & Likova, 2012). Work based learning offers opportunities for fostering competence (Manley et al., 2009), but creativity integrates learners in the process of skills development (Tyler & Likova, 2012). While training and education facilitate the skills development, practice opportunities for developing confidence in dementia care complete the learning process.

Knowledge of dementia care is broad but many training and education interventions target specific elements of care such as diagnosing dementia, managing challenging behaviour, supporting care givers or person centred care, all of which aim to improve practice (Dreier et al., 2016). This approach offers limited support for holistic learning to enable practitioners to weave knowledge accumulation into practice and interdisciplinary partnerships. A dementia care manager curriculum developed in Germany (Dreier et al., 2016) was an attempt to increase the scope of dementia care training, but the curriculum development process focused on nursing care and validation of content was not concluded due to lack of a comparator.

Although proficiency in certain dementia care skills may apply to specific levels of clinical practice, the nonlinear nature of dementia care cuts across all healthcare professions, urging practitioners to look beyond medical treatment and incorporate selfhood (Fazio et al., 2018). The discourse about person centredness being innate and that it cannot be taught is intriguing, even though the literature widely suggests that the attribute can be learnt (Smythe et al., 2015). The concerted effort to increase awareness of person centred dementia care is aimed

at sustaining the individual's identity threatened by progressive cognitive decline (Kitwood, 1997). Implementation of learning in the workplace requires a shift in culture that can be supported through organisational policy, leadership support and shared responsibility within teams (Borbasi et al., 2011).

Limitations

Findings of the scoping review are based on small scale studies in localised contexts most of which recruited convenient samples, predominantly nurses. While the majority of studies recommend need for training practitioners to promote more person centred approaches to care, it is not possible to make conclusions about best education and training models for best practices in dementia care based current findings due to methodological challenges established in the studies included in the review.

The search terms used (Appendix 1) to identify papers to include in the review omitted broad search terms such as "best practice", "gaps" and "challenges" in existing dementia training, education and continuing professional development (CPD). This may have yielded more detailed examples in order to make recommendations to cross border partners to complement the work that PP7 and PP9 are undertaking in Work Package 1 and 2. However as this is a deliverable report 3.5.1 with a limited time span, we consider this to provide a useful foundation for further development work over the lifespan of the project

5. Conclusions

The scoping review provides some insight into the broad themes emerging in the literature and the methodological challenges associated with drawing any meaningful conclusions about best practice models currently for education and training. As a starting point it offers the CASCADE team potential to provide a bold new blueprint for education and training when combined with outputs from PP7 and PP9. Here follows a summary of our key recommendations based on the gaps identified in the literature. Given that CASCADE is a European project, it is important to draw upon the knowledge and skills of the partners in this collaboration to develop the broadest range of training and education possible for both formal and non-formal caregivers and for people living with dementia. The project provides an excellent opportunity to create a shared EU platform for learning.

6. Key recommendations

An EU platform for education and training should:

1. Be co designed with people living with dementia, their care givers, practitioners from a variety of care sectors, charities and voluntary sectors engaged in offering holistic mechanisms of support.

2. Be designed with the whole system in mind across health and social care and offer pathways for career progression and knowledge development from foundational knowledge to highly specialised expert knowledge for:

    - The public (PLWD and their families, communities and neighbourhood hubs)

- Formal and informal caregivers

- Practitioners

- Private and voluntary sector workers

- Leaders of services, policy makers and commercial sector directors

3. Draw on existing best practice models that are not widely published in the literature .e.g. national curriculum frameworks, online platforms, web based resources drawn together in a repository.

4. Offer more extensive guidance to Universities engaged in undergraduate and postgraduate programmes so that dementia awareness moving through to specialist roles are catered for in a spiral of learning supported by active and experiential learning models, longer placements focused on the community rather than hospital, and a spiral of specialist qualifications at post qualifying level e.g. pain management, managing challenging behaviours, advanced care planning.

5. Provide an EU career competence framework for all practitioners (nurses, midwives, allied health professionals, social care, medicine) engaged in supporting people to live well with dementia.

6. Develop a research evaluation strategy to measure the impact of education and training on the target groups of stakeholders identified in 2 to determine benefits and strategies that provide the most effective outcomes in terms of client care, quality of life, staff wellbeing and quality of services.

7. References

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International journal of social research methodology*, *8*(1), 19-32.

Bauer, M., McAuliffe, L., Nay, R., & Chenco, C. (2013). Sexuality in older adults: Effect of an education intervention on attitudes and beliefs of residential aged care staff. *Educational Gerontology, 39*(2), 82-91.

Beer, L. E. (2017). The role of the music therapist in training caregivers of people who have advanced dementia. *Nordic Journal of Music Therapy, 26*(2), 185-199.

Beer, L. E., Hutchinson, S. R., & Skala-Cordes, K. K. (2012). Communicating with patients who have advanced dementia: training nurse aide students. *Gerontology & geriatrics education, 33*(4), 402-420.

Bezzant, K. (2008). Practice development: providing benefits for both managers and older patients with delerium and dementia. *Journal of Nursing Management, 16*(2), 141-146.

Borbasi, S., Emmanuel, E., Farrelly, B., & Ashcroft, J. (2011). Report of an evaluation of a nurse-led dementia outreach service for people with the behavioural and psychological symptoms of dementia living in residential aged care facilities. *Perspectives in public health, 131*(3), 124-130.

Bronson, M., & Toye, C. (2015). Providing information for family carers of hospital patients experiencing dementia. *Dementia, 14*(2), 267-272.

Broughton, M., Smith, E. R., Baker, R., Angwin, A. J., Pachana, N. A., Copland, D. A., . . . Chenery, H. J. (2011). Evaluation of a caregiver education program to support memory and communication in dementia: A controlled pretest–posttest study with nursing home staff. *International Journal of Nursing Studies, 48*(11), 1436-1444.

Burns, M., & McIlfatrick, S. (2015). Nurses' knowledge and attitudes towards pain assessment for people with dementia in a nursing home setting. *International journal of palliative nursing, 21*(10), 479-487.

Cameron, M. J., Horst, M., Lawhorne, L. W., & Lichtenberg, P. A. (2010). Evaluation of academic detailing for primary care physician dementia education. *American Journal of Alzheimer's Disease & Other Dementias®, 25*(4), 333-339.

Champion, E. (2017). What support do nurses need to provide palliative care for people with dementia? *Nursing older people, 29*(7). doi:10.7748/nop.2017.e934

Chang, E., Daly, J., Johnson, A., Harrison, K., Easterbrook, S., Bidewell, J., . . . Hancock, K. (2009). Challenges for professional care of advanced dementia. *International Journal of Nursing Practice, 15*(1), 41-47.

Chater, K., & Hughes, N. (2013). Strategies to deliver dementia training and education in the acute hospital setting. *Journal of Research in Nursing, 18*(6), 578-593.

Colquhoun, H. L., Levac, D., O'Brien, K. K., Straus, S., Tricco, A. C., Perrier, L., ... & Moher, D. (2014). Scoping reviews: time for clarity in definition, methods, and reporting. *Journal of clinical epidemiology*, *67*(12), 1291-1294.

Daly, J. M., Bay, C. P., Levy, B. T., & Carnahan, R. M. (2015). Caring for people with dementia and challenging behaviors in nursing homes: A needs assessment geriatric nursing. *Geriatric Nursing, 36*(3), 182-191.

Dreier, A., Thyrian, J. R., Eichler, T., & Hoffmann, W. (2016). Qualifications for nurses for the care of patients with dementia and support to their caregivers: a pilot evaluation of the dementia care management curriculum. *Nurse education today, 36*, 310-317.

Einang Alnes, R., Kirkevold, M., & Skovdahl, K. (2011). Insights gained through Marte Meo counselling: experiences of nurses in dementia specific care units. *International journal of older people nursing, 6*(2), 123-132.

Fazio, S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The fundamentals of person-centered care for individuals with dementia. *The Gerontologist*, *58*(suppl_1), S10-S19.

Gandesha, A. e. a. (2012). Adequacy of training in dementia care for acute hospital staff. *Nursing Older People, 24*(4).

Glueckauf, R. L., Davis, W. S., Allen, K., Chipi, P., Schettini, G., Tegen, L., . . . Mosser, B. (2009). Integrative cognitive–behavioral and spiritual counseling for rural dementia caregivers with depression. *Rehabilitation psychology, 54*(4), 449.

Haak, N. (2009). Maintaining privacy and dignity of patients admitted to a District General Hospital NHS Trust. *Dev Pract Improv Care, 5*(2), 1-4.

Josefsson, K., Sonde, L., & Wahlin, T.-B. R. (2008). Competence development of registered nurses in municipal elderly care in Sweden: a questionnaire survey. *International Journal of Nursing Studies, 45*(3), 428-441.

Kang, Y., Moyle, W., Cooke, M., & O'dwyer, S. T. (2017). An educational programme to improve acute care nurses' knowledge, attitudes and family caregiver involvement in care of people with cognitive impairment. *Scandinavian journal of caring sciences, 31*(3), 631-640.

Kitwood, T. M., & Kitwood, T. M. (1997). *Dementia reconsidered: The person comes first* (Vol. 20, pp. 7-8). Buckingham: Open University press.

Kontos, P. C., Mitchell, G. J., Mistry, B., & Ballon, B. (2010). Using drama to improve person-centred dementia care. *International Journal of Older People Nursing, 5*(2), 159-168.

Lathren, C. R., Sloane, P. D., Hoyle, J. D., Zimmerman, S., & Kaufer, D. I. (2013). Improving dementia diagnosis and management in primary care: a cohort study of the impact of a training and support program on physician competency, practice patterns, and community linkages. *BMC geriatrics, 13*(1), 134.

Manley, K., Titchen, A., & Hardy, S. (2009). Work-based learning in the context of contemporary health care education and practice: A concept analysis. *Practice Development in Health Care*, *8*(2), 87-127.

Neville, C., McCarthy, A., Laurent, K., Creedy, D. K., & Walker, R. (2006). Pain management skills of regional nurses caring for older people with dementia: a needs analysis. *Collegian, 13*(2), 31-36.

Nguyen, C. M., Jansen, B. D. W., Hughes, C. M., Rasmussen, W., & Weckmann, M. T. (2015). A qualitative exploration of perceived key knowledge and skills in end-of-life care in dementia

patients among medical, nursing, and pharmacy students. *Journal of palliative medicine, 18*(1), 56-61.

Palmer, J. L., Lach, H. W., McGillick, J., Murphy-White, M., Carroll, M. B., & Armstrong, J. L. (2014). The dementia friendly hospital initiative education program for acute care nurses and staff. *The Journal of Continuing Education in Nursing, 45*(9), 416-424.

Pulsford, D., Hope, K., & Thompson, R. (2007). Higher education provision for professionals working with people with dementia: a scoping exercise. *Nurse Education Today, 27*(1), 5-13.

Robinson, A., & Cubit, K. (2007). Caring for older people with dementia in residential care: Nursing students' experiences. *Journal of Advanced Nursing, 59*(3), 255-263.

Robinson, J. (2015). Reflection, return to practice and revalidation. *Nursing Older People (2014+), 27*(6), 31.

Robinson, L., Bamford, C., Briel, R., Spencer, J., & Whitty, P. (2010). Improving patient-centered care for people with dementia in medical encounters: an educational intervention for old age psychiatrists. *International psychogeriatrics, 22*(1), 129-138.

Smythe, A., Bentham, P., Jenkins, C., & Oyebode, J. R. (2015). The experiences of staff in a specialist mental health service in relation to development of skills for the provision of person centred care for people with dementia. *Dementia, 14*(2), 184-198.

Surr, C. A., Smith, S. J., Crossland, J., & Robins, J. (2016). Impact of a person-centred dementia care training programme on hospital staff attitudes, role efficacy and perceptions of caring for people with dementia: A repeated measures study. *International journal of nursing studies, 53*, 144-151.

Teri, L., McKenzie, G. L., LaFazia, D., Farran, C. J., Beck, C., Huda, P., . . . Pike, K. C. (2009). Improving dementia care in assisted living residences: addressing staff reactions to training. *Geriatric Nursing, 30*(3), 153-163.

Thornhill, L., & Conant, R. (2018). Improving care through public policy. The Gerontologist, 58, S141–S147. doi:10.1093/geront/gnx181.

Tyler, C. W., & Likova, L. T. (2012). The role of the visual arts in enhancing the learning process. *Frontiers in human neuroscience*, *6*, 8.

Whitlatch, C. J., & Orsulic-Jeras, S. (2018). Meeting the informational, educational, and psychosocial support needs of persons living with dementia and their family caregivers. *The Gerontologist*, *58*(suppl_1), S58-S73.

Appendix 1. Search terms

Medline (OVID)
Exp dementia/ AND
((Doctor* OR physician* OR nurse* OR health care professional* OR occupational therapist* OR physiotherapist* OR Chiropodist* OR Optometrist* OR Audiologist* OR Speech therapist* OR Music therapist* OR Dentist* OR Dietitian*) adj1 (train* OR learn* OR education OR continuing professional development OR CPD OR skills OR competen*)).tw.

British Nursing Index
((Dementia OR Alzheimer* OR Lewy OR (Dementia AND Vascular) OR Frontotemporal OR (Dementia AND HIV) OR (Dementia AND AIDS) Memory Loss OR Huntington Disease OR Kluver-Bucy Syndrome)) AND ((Doctor* OR physician* OR nurse* OR health care professional* OR occupational therapist* OR physiotherapist* OR Chiropodist* OR Optometrist* OR Audiologist* OR Speech therapist* OR Music therapist* OR Dentist* OR Dietitian*) NEAR/1 (train* OR learn* OR education OR continuing professional development OR CPD OR skills OR competen*))

CINAHL
((Dementia OR Alzheimer* OR Lewy OR (Dementia AND Vascular) OR Frontotemporal OR (Dementia AND HIV) OR (Dementia AND AIDS) Memory Loss OR Huntington Disease OR Kluver-Bucy Syndrome)) AND ((Doctor* OR physician* OR nurse* OR health care professional* OR occupational therapist* OR physiotherapist* OR Chiropodist* OR Optometrist* OR Audiologist* OR Speech therapist* OR Music therapist* OR Dentist* OR Dietitian*) N1 (train* OR learn* OR education OR continuing professional development OR CPD OR skills OR competen*))

Appendix 2. Data chart template

Authors *(Just list first name and date of publication unless there are >1 publications from the same author or team)*				
Year of publication		**Country of origin**		
Inclusion/exclusion criteria *(stop review here if there is clear indication that the following are not met and record ↓)*				
Staff learning, how they learn, or what they should learn regarding dementia care is (or are) the main (or a major) focus of the paper	*The paper discusses staff learning/education needs re dementia care from a policy or other substantive (non-empirical) viewpoint*	*The paper makes recommendations for dementia education or training on the basis of literature, data or other evidence discussed*	**Recommendation** *Please record for each paper seen even if not fully reviewed.*	
Yes / No	Yes / No	Yes / No	Include(d)	Exclude(d)
Manuscript Title				
Journal where published				
Keywords				
Discipline of the main authors if stated				
Funding source if identified				
Stated aim of the research				
Locations where/from whom data collected				
Nature of the sample, population or evidence reviewed				
Methodology/methods *(please note all tools, scales, measures used)*				
Theoretical frameworks underpinning the study if stated				
Main findings or recommendations				
Main strengths of the paper/methods used				
Main limitations or criticisms of the paper				

Appendix 3. Recommendations from the literature

The literature reviewed identified some key recommendations for further development as part of training and education programmes for health practitioners and formal and informal care givers. These tended to be determined by the focal nature of the publication and many were vague and lacked detail of how recommendations could be implemented. These recommendations are presented here from macro- to micro- perspectives focusing on systems needed to sustain new approaches to training and education through to recommendations for specific content focus.

Whole system approach to training and education

One paper identified the need to take a whole system approach to improving education and training, drawing on the expertise of relevant specialists to ensure that practitioner and PLWD needs are met. Champion et al (2017) suggest that such a whole system perspective will enable new networks to be developed to provide the support systems required for practitioners and their patients while Borbasi et al. (2011) underscore the need for a cultural change moving away from task oriented care focusing on physical needs to person centered care focusing on the whole person.

In the UK Gandesha et al (2012) called for a national competence framework to be developed that would adopt the common core principles to ensure that guidance on staff training is implemented across all primary and secondary care settings. Focus on a national curriculum would enable baseline, enhanced and specialist skills in dementia care to be mapped across all undergraduate and postgraduate medical, nursing and allied health professional curricula. This is important given that this study identified that on the whole in-patient hospital wards do not specialise in the care of older people or mental health (Gandesha et al., 2012) and hence this is largely missing from undergraduate curricula currently.

Training and Education Content

Enhancing Communication

The literature identified core themes that emphasized the need to focus on practical communication techniques and strategies to increase quality of life for people living with dementia. Burns and McIfatrick (2015) recommended improvements in communication would result in better coordination of patient treatment for nursing home residents but did not provide any detail of how this could be implemented. Broughton et al (2011) recommended the use of more creative training materials for the workplace that promote use of web based resources and rely more on self-directed learning. They identified the importance of embedding these in staff orientation programmes making a tenuous link to the introduction of such initiatives in influencing staff wellbeing, retention and quality of care. Further recommendations for enhancing communication in the hospice setting included use of handouts for staff (Beer, 2017) and drawing on the expertise of ward based champions to embed effective communication both with staff and support carers (Bronson & Toye, 2015).

Extended practical placements and specialist input

Some papers focused on making key recommendations for curriculum delivery and content at undergraduate and postgraduate level. Beer et al (2012) recommended a three part

curriculum that focuses on understanding and knowledge, practical application and targeted foundational understanding about dementia and the care required for different phases of progression.   Robinson and Cubit (2015) identified the need to provide undergraduate students with longer practice placements specifically focused on care contexts that provide support for people living with dementia. In addition they suggest not only increasing curricula content but also employing strategies to improve collaboration between University schools of nursing and settings for care of older people.

For post qualifying education, Dreier et al (2016) recommended a longer practical phase of specialist training and increasing the number of lessons in their dementia care management programme across two modules that focused on gerontopsychiatry and interdisciplinary case reviews. The development of critical thinking skills and reflection were identified as being important for staff wellbeing and improvements in quality of care (Robinson, 2015). The literature identified that training is more likely to be successful if it includes emphasis on experiential learning, and provide opportunities for learning through modelling alongside credible trainers using a problem based approach, and 'learning through doing' (Smythe et al., 2015).

Improving Awareness and Management of Sexuality and Sexual Health Needs

One paper reviewed emphasized the need to raise practitioner awareness and attitudes towards sexuality, sexual health and upskilling how to recognise sexual needs underpinned by improvements in policy and guidelines in the workplace (Bauer et al., 2013).

Enhancing Understanding of Dementia

Several papers specifically identified the need to enhance aspects of understanding how to manage challenging behaviours (Daly et al., 2015), pain management (Neville et al., 2006) and end of life care including advanced care planning (Nguyen et al., 2015).

Future Research

A key recommendation from several papers was the need to invest in research which explores new models of care for people with advancing dementia. The emphasis was on cost effectiveness and suitability for practice but acknowledges the importance of providing key evidence for governments and health care services to improve the lives of PLWD and those that care for them. (Chang et al, 2009). Daly et al (2015) recommended investing in research that considers the perceptions and opinions of staff providing direct care to people living with dementia particularly, understanding the challenges this brings and using this evidence to inform education and training curricula. Kang et al (2017) called for research that focuses on evaluating the impact of educational programmes on practice change and patient health-related outcomes including incidence of delirium, length of hospital stay and hospital-acquired complications (Kang et al., 2017). Lathren et al (2017) recommended the need for future work to include the expansion and dissemination of interventions to reach a larger primary care audience in a cost- and time-effective manner, while integrating protocols that measure the intervention's direct impact on physician behaviour and family outcomes (Lathren et al., 2013).