Tailored to fit

Acknowledging government concerns about the effectiveness of training for improving the care of people with dementia, **Richard Fleming** describes an approach for those organisations that dare to imagine having staff and residents who understand what is going on, can manage their surroundings and find meaning in their activities

Many millions of dollars have been spent on providing workforce training to improve the care of people with dementia. However, a recently released report from the Australian Senate (Community Affairs References Committee 2017) expresses deep concern about the nature and effectiveness of the training that is being delivered. For example:

3.108: "The committee is deeply concerned that the significant issues associated with the provision of aged care workforce training are undermining the development of the aged care workforce, and will continue to do so until they are addressed."

3.109: "The committee is concerned by evidence that RTOs [registered training organisations] are providing inconsistent standards of training and that many RTOs are offering programs that are too short to ensure students gain the necessary skills and practical training to ensure they are job ready."

3.110: "The committee acknowledges that quality rather than duration of courses is paramount, but considers that the length of some courses offered is far too short to cover all the necessary skills and competencies required for aged care work."

In other words, there have been problems with the provision of training for a long time, including issues with the quality and duration of the training. The report makes it clear that these general concerns extend to the specific area of dementia care (paragraph 3.96).

Dementia Training Australia Executive Director Professor Richard Fleming (centre) with National Activities Manager Fallon Forbes (left) and Knowledge Translation Manager Associate Professor Belinda Goodenough. Photo: Kirk Gilmour

Key components

It is tempting to respond to these concerns by concluding that we simply need longer courses of higher quality. But is this in fact the case? Before reaching that conclusion, surely we must be certain that training can actually make a difference. What is the evidence base and are there key components? These questions are not as easy to answer as we might like to think.

For example, a review of the effectiveness of staff training in reducing responsive behaviours (Spector *et al* 2013) highlighted the "poor quality of the available evidence and inconsistency of the findings". However, on careful evaluation of the available evidence the authors concluded that: "Staff training is a potentially valuable method of reducing BPSD in residents with dementia living in care homes."

"Training programs which have a strong theoretical base, are of sufficient intensity and are supplemented by additional supervision and good management support may be the most beneficial."

Beyond 'off-the-shelf'

One of the issues in the delivery and evaluation of effective training to address specific issues being reported for people with dementia is that the identified issue or problem, for example depression, is potentially the wrong target for a specific intervention. Depression is likely to be the result of the interaction between a multifaceted care context and the unmet needs of the person with dementia. In other words, depression is a symptom of the problem, not the problem (Moniz-Cook E *et al* 2017).

We must look beyond a simple link between a particular problem and a specific, off-the-shelf solution. An intervention, even if 'proven' as a solution in a specific setting (eg a research study), is more likely to work if it is applied with an understanding of the person with dementia in context – understanding the role the person's psychosocial environment (and, indeed the physical environment) plays in producing the problem.

The concept of a person with dementia in context is well understood and described most notably, of course, by Kitwood in his introduction of person-centred care (Kitwood 1997). But we don't very often apply the same reasoning to training interventions for organisations. There is a tendency to jump to action; to seek large scale one-size-fits all solutions for the workforce. The concept of a person (care worker or health professional) in context is lost.

Perhaps the most common example is the automatic provision of training on 'behaviour management' (to deliberately use an outdated term to highlight a current practice) if the incidence of responsive behaviours escalates to a point that alarms staff and visitors. Perhaps this simplistic approach to training (as a reaction to a symptom confused as a problem) is one of the reasons for the ineffectiveness noted by the Senate Inquiry.

Organisation-centred

However, there is hope. What if we applied a similar approach to developing training programs for the care workforce and their organisations? We might call it 'organisation-centred'. In addition to addressing specific issues being reported for people with dementia, this approach would also take a holistic view of:

- the range of training needed by the staff,
- possible effects of the local environment in which staff are working to deliver best care, and
- readiness of the organisation to support changes in practice, plus the support available to the staff during the change process.

In this approach, we might also consider the overall purpose of the training. Is it

simply to take away problems or is it to make a positive contribution to the well-being of the residents or clients; to help a care organisation and staff go beyond the old pathogenic model of care, focused on ill health and problem reduction, to the recognition that the care of the elderly is about making the most of life?; to dare to imagine an organisation where staff and residents understand what is going on, can manage their surroundings and find meaning in their activities?

Customised training

Dementia Training Australia (DTA) has been funded by the Australian Government to deliver a wide range of training opportunities to the aged and health care sectors. The scale and breadth of these training opportunities is, in part, recognition of the need for customised training solutions in dementia care. They include guest lectures, workshops, a three-day Dementia Essentials course leading to a VET accredited qualification, and a web portal that provides easy access to a huge amount of resources and e-learning courses.

These are benefiting many thousands of individual learners. But what about the organisation that recognises it needs to provide training as a team response to identified issues and has the desire to improve the care being delivered?

The organisation could access any of the courses and resources available to the public on the DTA website (www.dta.com.au) and use them to develop courses for their staff. Or, they could opt for a DTA Tailored Training Package (TTP).

Tailored Training Packages

TTPs are the equivalent, at an organisational level, of person-centred care. They are 'organisation-centred'. DTA will work with the organisation to put together a customised combination of recommended courses, services and resources to meet specific needs.

The TTP service begins by defining the unmet needs – gathering key information to enable DTA to understand the organisation's dementia care training requirements. To do this a sample of staff and managers is asked a short series of questions to identify the areas of dementia care that they see have room for improvement.

A built environment assessment is also conducted to identify how it may be contributing to problems experienced by staff and residents and how changes may make a positive contribution to care.

The training needs assessment involves a brief, online survey and the assessment of the environment is conducted using a smart phone app (BEAT-D). The organisation is then given a menu of courses and resources relevant to its training needs. While many of these will be directly from the DTA stable, DTA will also recommend courses and resources from third party suppliers where these best match the identified need.

The organisation can then select the courses and resources relevant to its current circumstances. It may, for example, decide that many of the staff need the three-day Dementia Essentials course, but it can't commit to the training right now. However, the organisation can begin raising awareness of better practice by introducing a series of DTA's online courses and making a set of its resources available to staff.

Translating knowledge

The beauty of the TTP is that DTA will put that package of resources and online courses together for the organisation and assist with delivery. DTA will also be there when circumstances change and the three-day course becomes a possibility. This is because DTA recognises that training is not only about improving the knowledge base of the staff, it is about translating knowledge into better practice, and we have to accept that improving practice takes time.

A TTP is expected to take between six and 18 months to develop and deliver, giving the organisation and DTA time to go through the knowledge translation processes of raising awareness in, and gaining agreement from staff before entering the difficult stage of having the new knowledge adopted into practice.

So TTPs are provided in the knowledge that successful training interventions are "of sufficient intensity and are supplemented by additional supervision and good management support" and need to have a "strong theoretical base" (Spector *et al* 2013).

They are also provided with the financial support of the Department of Health. There is no charge for the development of a TTP and any charges that are made for the delivery of the training and resources is subject to negotiation and very substantial discount. The goal is to improve the care of people with dementia, not to make a profit.

Evaluation

The need for careful evaluation is also recognised. If the research base is not sufficiently strong for DTA to be sure that a training intervention will work, we have a responsibility to carefully evaluate its effects.

However, DTA is not a research organisation. Its job is to provide training to improve the lives of people with dementia. There is no funding for complex randomised control trials. Instead TTPs will be evaluated against the specific goals of each TTP. These will be specified during the process of choosing the training to be offered and will form part of a Memorandum of Understanding with the organisation. These goals will be defined in such a way that they can be assessed by the application of robust and practical measures. For example, the Dementia Knowledge Assessment Scale (DKAS) (Annear *et al* 2017) would be used to measure changes in staff knowledge.

Changes in the quality and quantity of communication, along with improvement in access to the outdoors, for example, will be evaluated by, whenever possible, asking the residents. When this is not possible, their families and the staff will be asked, using objective tools when practical, to describe what changes have taken place and their impact.

This approach supports DTA's goal of using training to bring about real changes in practice. If the residents, families and carers can't describe any change then it is unlikely that any significant change has taken place.

Finding a better way

It is clear that TTPs are labour intensive. They are only suitable for organisations (or

DTA's Fallon Forbes (left) and Associate Professor Belinda Goodenough (centre) discuss the Tailored Training Package service with Alex Reed from care provider IRT Group. Photo: Kirk Gilmour

individual sites) that are ready for a systematic approach to improving practice. TTPs are also in limited supply, with only 140 per year for delivery across Australia. So the decision to take up a TTP is a serious commitment for the organisation and DTA.

But, as the Senate Inquiry found "the significant issues associated with the provision of aged care workforce training are undermining the development of the aged care workforce" (Community Affairs References Committee 2017), so a serious and innovative attempt at finding a better way to deliver training is needed.

The systematic approach used in developing Tailored Training Packages for organisations and carefully evaluating their impact is contributing to finding that better way.

For more details about TTPs visit the DTA website www.dta.com.au ■

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The Butterfly effect

This year Barunga Village became Australia's first accredited provider of The Butterfly Household Model of Care – a model requiring organisations to undergo a major culture change in dementia care. **Louise DeWolf** reports on the home's 12-month transformation

Barunga Village is a residential aged care facility in Port Broughton, north-west of Adelaide, South Australia, and has been operating for more than 20 years. Over the past 12 months, the village has made major changes to the way it cares for people living with dementia.

In early July, Barunga Village underwent a rigorous grading process and received the Butterfly National Accreditation Kitemark Quality of Life Award, at Level 1, the highest rating possible, to become Australia's first 'Butterfly Home'.

The Butterfly Household Model of Care was founded by Dr David Sheard of Dementia Care Matters (DCM) in 1995 in the UK, and has since expanded to become a global dementia care culture change movement with more than 50 Butterfly Homes around the world.

According to DCM a Level 1 rating is an outstanding, and rare, achievement. Homes need to achieve Level 3 or above to receive the Butterfly Award and only 14 homes in the UK hold the Level 1 award.

Barunga Village's grading process was conducted by DCM Consultant Trainer Sally Knocker at the end of a 12-month pilot of the program, which started in July 2016. It included observing interactions and activities of people with dementia and staff members for more than five hours.

"The core reason why Barunga Village achieved Level 1 is because over 80% of the day showcased 'positive social experiences', whereas this time last year 70% of the day was spent with very little interaction," Sally said.

Barunga Village house member Betty Gray (left) with the author, Clinical Nurse Louise DeWolf (centre) and DCM Consultant Trainer Sally Knocker. All photos courtesy Barunga Village

"This means that people living with dementia now have a high quality of life. They are taking part in an array of activities that you and I do every day – such as washing up after breakfast, making scones, feeding the chickens and chatting with friends and family.

"Their engagements with staff demonstrated there was no sense of 'us and them'. The interactions were similar to how you are with your friends and family – this is a key of the model."

Underpinning this model of care is the belief that 'Feelings Matter Most'. This approach is about using the primary competency of emotional intelligence to connect with people and understand their vulnerability. Only when staff value the importance of being 'loved' as the essence of what is needed to truly reach others can they help people feel that they matter. One of the fundamental beliefs of this model is that it is possible to enable people living with dementia to feel alive again by restoring their positive emotions.

While dementia care has a history of being task-oriented and institutional, the model sees a total transformation in the way people with dementia are cared for, with a focus on their emotions and replicating home-like environments and the everyday activities they enjoyed earlier in life.

The need for change

Barunga Village is a multi-award winning facility, with an extensive range of activities for residents. It even won an Alzheimer's Australia SA Dementia Care Excellence Award in the 2014 South Australian Community Achievement Awards, so many would question the need to change the model of care. However, after discovering the Butterfly Household Model of Care the management team knew they had no choice but to adopt it.

An observational audit of the lived experience of people with dementia in the home indicated