With an estimated 820,000 people with a diagnosis of dementia in the UK (Alzheimer’s Research Trust, 2010), 43,614 of whom live in Wales (Alzheimer’s Society, 2012) the likelihood is that we will have either personal or professional experience of it, whatever our chosen speciality. The odds of us developing dementia ourselves are one in three (Alzheimer’s Society, 2012).

**Dementia care training team**

The dementia care training team (DCTT) was established in 2002 to provide dementia care education and training to non-registered care home staff in the independent and
The package was developed by the team. It is iterative, changing and evolving to reflect changes in legislation and best practice guidance.

Course content is linked in with the relevant recognised awarding bodies, with consideration to key policy and drivers such as Care and Social Services Inspectorate Wales, Care Homes Wales Regulations, National Minimum Standards etc.

A variety of teaching strategies have been employed by the team, including group and case study work, buzz groups (small groups of two or three students formed impromptu to discuss a topic for a short period), games and DVD footage.

Why accreditation?
The idea of having the course accredited to a formal awarding body had been mooted for some time and was something the team was keen to pursue. There was a desire to add ‘kudos’ or some recognised legitimacy public sectors in the Bridgend, south Wales, locality. The team is jointly funded by the local authority, Bridgend County Borough Council, and Abertawe Bro Morgannwg University Health Board (ABMU HB).

The fundamental belief of the DCTT is that, irrespective of where a person with dementia is being supported and cared for, those working with them should be appropriately trained.

Since its inception, the remit of the team has developed to reflect the demand for specialist education from a wide range of staff, including domiciliary care, mental health and general hospital staff, therapists and social workers.

A dementia care training package has been delivered to these and many other staff groups, with total attendance at sessions to date being in excess of 11 500.

The traditional dementia care training package (30 hours)
The education programme comprises a modular training package covering a range of aspects of person-centred dementia care, delivered over a 30-hour period (Table 1).

<table>
<thead>
<tr>
<th>Module title</th>
<th>Aims of module</th>
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<tbody>
<tr>
<td>OVERVIEW OF DEMENTIA</td>
<td>To identify what dementia is, the main types, presentation, risk factors, signs and symptoms etc. There is an emphasis on early referral, assessment and diagnosis</td>
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<tr>
<td>COMMUNICATION IN DEMENTIA CARE</td>
<td>To identify ‘normal’ communication and to demonstrate how the ability to communicate effectively is impaired in a person with dementia</td>
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<tr>
<td>LEGAL AND ETHICAL ISSUES IN DEMENTIA CARE</td>
<td>To address some practice issues that may be faced by care staff. Content includes: Mental Capacity Act; deprivation of liberty safeguards (DOLS); adult protection issues, including administration of medication</td>
</tr>
<tr>
<td>PHYSICAL ASPECTS OF DEMENTIA CARE</td>
<td>To address some physical aspects of caring for a person with dementia. Content includes: personal care, dental care, mobility, handling, seating, pressure areas and toileting. The emphasis is around difficulties faced when caring for a person with dementia and how care staff may be able to identify and report problems early</td>
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<tr>
<td>UNDERSTANDING BEHAVIOURS IN DEMENTIA CARE</td>
<td>To identify some of the behavioural and psychological symptoms of dementia. The aim is for staff to have an increased awareness of reasons for behavioural changes and, in particular, how this may be investigated. It introduces staff to different strategies with which to manage behaviours in care settings</td>
</tr>
<tr>
<td>POSITIVE ENVIRONMENTS IN DEMENTIA CARE</td>
<td>To highlight the enabling/disabling effects the environment can have on a person with dementia. It looks at the impact on a person with dementia of moving into a care setting, along with recommendations for improving the environment</td>
</tr>
<tr>
<td>MEANINGFUL INTERACTIONS IN DEMENTIA CARE</td>
<td>To identify how the use of activities and interaction may benefit a person with dementia and to consider best practice recommendations in the provision of activity. Emphasis is placed on how daily care tasks should also be considered to be therapeutic activity and meaningful experiences for people with dementia</td>
</tr>
<tr>
<td>MENTAL HEALTH ISSUES IN DEMENTIA CARE</td>
<td>To identify some of the mental health problems that may be experienced by a person with dementia. These include psychoses, depression, anxiety, suicide awareness and substance misuse</td>
</tr>
<tr>
<td>EATING AND DRINKING IN DEMENTIA CARE</td>
<td>To identify skills needed to eat and drink successfully and the difficulties that may be experienced by people with dementia, along with the identification of useful management techniques</td>
</tr>
<tr>
<td>PAIN AND DEMENTIA (MODULE UNDER DEVELOPMENT)</td>
<td>To look at the concept of pain, the difficulties in reliably assessing and treating pain in people with dementia who are dysphasic, the resulting effect of untreated pain on behaviour and non-verbal pain-assessment tools.</td>
</tr>
</tbody>
</table>
to the course and—more importantly to the team—to allow course participants to gain some sort of credit or recognition for it. This innovative development in practice was achieved in partnership with the College of Human and Health Sciences (CHHS), Swansea University.

In 2010, a project group, comprising the DCTT, Megan Rosser, director for CPD/non-professional undergraduate programmes (CHHS) and Vivienne Aston, practice development nurse (ABMU HB), was established to consider and take forward accreditation of the Dementia Care Training Package at certificate level (Level 1), which would merit 20 credits.

Accreditation status was achieved with the university in July 2010. As a result, team members were awarded honorary lecturer status with the university. The pilot accredited course comprised the traditional package outlined in Table 1, plus 10 extra hours plus an assignment.

Funding was secured via the National Leadership and Innovation Agency for Healthcare (NLIAH) for 15 healthcare support workers (HCSWs) working within ABMU HB to pilot the accredited course. Course participants worked within either hospital or community settings. The pilot module was delivered in 2011.

In order to meet university requirements, material from the traditional package was delivered over a 40-hour period, which ran for a day a week, over 7 weeks. The additional 10 teaching hours allowed greater exploration of salient points—we were able to spend a day delivering the legal and ethical issues, for example.

The DCTT believes this debate added value to the package and benefited course participants. University staff provided a session on reflection.

In addition to the taught days, there was an assignment component to the course: a 2500-word care study and a 1500-word reflective account.

**Participants’ evaluation**

The pilot was evaluated by course participants, with a written evaluation form after each day of training. A verbal evaluation was completed on the final day.

Each day evaluated well, with all participants agreeing it was pitched at the correct level, and that content and delivery was ‘excellent’ or ‘very good’.

Participants reported that they had improved their knowledge base and, perhaps more importantly, had considered how this acquired knowledge could be applied in practice.

‘I think, as always, most elements can be practised, and fresh impetus can be used, and hopefully practice and implementation put to use.’

‘Think about approach to patients when seeing to personal needs.’

‘Try and get signs put up, especially in bedrooms and bathrooms.’

‘Look at why they are behaving the way they are. Is there something physical going on?’

‘I would like to think I could now spot signs that previously I may not have had in-depth insight into.’

The teaching methods used were felt to be useful, with particular mention of the DVD footage.

‘The films were very poignant and, although I care in abundance, complacency does set in and it makes you re-evaluate.’

‘The videos made us feel very upset, and tissues should be supplied.’

The team recognises the powerful nature of the DVD footage and uses it to highlight important messages. For example, one DVD used during training depicts the story of a husband caring for his wife with dementia at home, and the breakdown of that care. One course participant was particularly moved by this DVD.

The footage is chosen for its practice relevance and our research tells us that participants remember the DVDs and that they impact upon person-centred care (Jenkins et al, 2010). The DCTT ensures there is a thorough debrief of all DVD footage.

‘DVD can be a powerful teaching aid.’ (Curzon, 2004)

Interestingly, several participants felt the course could also benefit registered staff.

‘Should be mandatory for all staff, even bank staff.’

‘Qualified staff should attend.’

This opinion is shared in many key drivers:

‘Health and social care managers should ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia care training. (NICE/SCIE, 2006).

‘Dementia care training should be made a core and substantial part of the training curriculum for nurses and social care staff.’ (Alzheimer’s Society, 2007)

**Final results of the 2011 pilot**

- 1st submission
  - 6 (out of 15) passed both elements
  - A further 5 passed one of the two.
  - 4 people failed to submit
- Resubmission
  - 3 additional candidates passed both
It may have benefited some participants to have had a more structured approach to completing the assignments, perhaps setting goals each week towards its completion. Additional support from the university for both participants and the team would be beneficial.

Where are we now?
A course planned for 2012 was unable to run, due to lack of suitable nominations. Initial enquiries led us to believe that this was due not to the content and delivery of the package, but to the perception that the assignment component was too difficult.

The DCTT recognises that both the course participants and the team were challenged by the demands of the assignment component during the pilot course.

Our challenge now is to revisit the assignment process. We need to research alternative methods of assessment that will demonstrate learning and application of acquired knowledge within the workplace. We need to alter the perception, finding an ‘easier’ method of assessment, while meeting the standards set by the university.

Conclusion
HCSWs are a much-valued member of the mental health care setting and play a critical part in the care of people with dementia.

The DCTT is passionate about its role and continually strives to improve and develop HCSW training. It is our desire to bring these elements together and for staff to get the recognition they deserve for their continued professional development. That motivates us to ensure the success of ‘An introduction to Dementia Care for Mental healthcare Support Workers’.

Another course is scheduled for early 2013.

Lessons learnt
The pilot course was well received by all course participants and in that respect the course was deemed to be a success. However, Chin and Totterdell (2009) maintain that the effectiveness of practice development outcomes needs to be evaluated by clinical teams. With this in mind, the DCTT was keen to reflect on the process and consider solutions.

Interviewing candidates prior to course
Some candidates were unaware that there was an expectation they would complete 2 assignments. While this was made clear to managers, it does not appear to have been cascaded to all participants. A certain level of anxiety was created that we feel could have been avoided if we had met and interviewed potential candidates prior to commencing the course.

Mix of participants
Both hospital- and community-based staff attended the course. This allowed for breadth of discussion; however, some was more relevant to one group of staff than the other. A more distinct group would allow greater exploration of some issues, but would need to be tempered with what would be lost.

More time allocated for taught sessions and for supportive work
The team feels it totally underestimated the demands placed upon it in terms of supporting participants through the assignment process. Many acknowledged they had not produced any written assignments for years and basic computer skills were limited.

Identifying named mentors in workplace
A formal system of mentoring within the workplace may alleviate some of the responsibility for this support role.

The team would propose a short session with the mentors to outline course content, key messages and expectations.

Goals set to assist participants in the assignment process
Additional time needs to be allocated during the training to offer more advice about:
- Structuring a care study
- Reflection
- Referencing
- Computer skills e.g. emailing; and using the ‘track change’ facility in word processing
- Blackboard

‘Both course participants and team were challenged by the demands of the assignment component during the pilot.’