2021

Interprofessional Practice and Care Partner Education for Dementia Care Excellence

Shannon Michele O'Neill
Western New England University

Recommended Citation

O'Neill, Shannon Michele, "Interprofessional Practice and Care Partner Education for Dementia Care Excellence" (2021). *OTD DEx Reports - College of Pharmacy and Health Sciences*. 60.
https://digitalcommons.law.wne.edu/otd/60

Interprofessional Practice and Care Partner Education for Dementia Care Excellence

A Doctoral Experiential Capstone Project

Presented

to the Faculty of

Western New England University

In Partial Fulfillment

of the Requirements for the

Entry-Level Doctorate

in

Occupational Therapy

---

by

Shannon Michele O’Neill

July 20, 2021

Interprofessional Practice and Care Partner Education for Dementia Care Excellence

A Doctoral Experiential Capstone Project

by

Shannon Michele O’Neill

July 2021

APPROVED BY:

Cathy Dow-Royer
Digitally signed by Cathy Dow-Royer
DN: cn=Cathy Dow-Royer, o=Western New England University,
ou=Division of Occupational, email=cathy.dow-royer@wne.edu, c=US
Date: 2021.07.14 11:42:07 -04'00'

7/14/21
Date

Cathy Dow-Royer, Ed.D., OTR
Faculty Mentor

APPROVED BY:

Ellen Rainville

July 28, 2021
Date

Ellen Berger Rainville, OT, OTD, MS, FAOTA
Doctoral Experiential Coordinator

Abstract

The Western New England University (WNE) Doctoral Experiential (DEx) is designed to assess and serve the needs of the population and setting of a community partner organization. Under the faculty mentorship of Dr. Cathy Dow-Royer, Ed. D., OTR/L, WNE OTD students teamed up with Dr. Marilyn Micka-Pickunka, Ed. D., OTR/L, owner of Still Me Dementia Care and the Interim Director of Education and Training at Rockridge Retirement Community. The doctoral experiential is divided into three phases: preparatory, proposal writing, and implementation. The preparatory and proposal phases of this project occurred simultaneously from January-March 2021. The WNE OTD students (TeamWNEU) began a literature review on dementia care excellence and wrote preliminary DEx proposals. The initial proposal provided a rudimentary outline for individual projects based on the needs of individuals with dementia identified in their literature reviews. After completing their Level II Fieldwork requirements, TeamWNEU entered the implementation phase of the DEx project, which occurred over a 14 week period, from April-July 2021. A needs assessment was conducted and identified interprofessional care partner education as an area of weakness within the organization. Students used the information gained from the needs assessment to update their literature reviews and tailor their DEx proposals into individual projects that would meet the needs of Rockridge Retirement Community. This report highlights three distinct projects created and managed by TeamWNEU which sought to address the needs of individuals with dementia and their care partners. A multidimensional approach was taken to ensure the highest quality of work possible, resulting in each project containing both collaborative work efforts and independently created materials from group members. All three projects are representations of what it means to promote dementia care excellence to interprofessional care partners.

Introduction/Background

The Center for Medicare & Medicaid Services (CMS) has identified individuals with dementia as a high priority population in need of quality improvement (Wong & Leland, 2018). The Alzheimer's Association describes dementia as a general term which covers a wide range of specific medical conditions. These conditions result in the loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life (Alzheimer Association, 2020). Disorders that fall under the term dementia are caused by abnormal brain changes and include Alzheimer's disease, which makes up 60 to 80 percent of dementia cases. Other disorders which present with dementia include Lewy Body Dementia, Vascular Dementia, and Frontotemporal Dementia, all of which make up 5 to 10 percent of dementia cases. Diagnoses such as Parkinson's and Huntington's disease make up the rest (Alzheimer Association, 2020). At a global level, around 50 million people have dementia. The total number of people with dementia is projected to reach 82 million in 2030 and 152 million in 2050 (Kristensen & Peoples, 2020). The CMS initiative emphasizes enhancing client outcomes and overall quality of life through person-centered approaches.

Dementia caregiving varies from other health issues in the duration of disease, progressive nature of disability, the fact that many caregivers are themselves old with possible disease or disability, and the lack of disease modifying treatments (WHO, n.d.). Due to the progressive nature of the disease, the level of support increases as the disease progresses, starting with support for instrumental activities of daily living (household, financial and social activities) and expanding to include personal care and eventually almost constant supervision (WHO, n.d.). The severity of cognitive impairments and challenging behavior, the presence of comorbid physical and psychological problems, the custom and habits of the individual with dementia, and their personality and significant relationships determine the extent and level of care an individual requires as they progress through the disease. Occupational therapy practitioners in particular are well suited to be part of the interprofessional dementia care team. The Occupational Therapy Practice Framework 3 (OTPF3) identifies client factors such as mental functions, problem-solving, perception, and process skills as areas specific to the OT scope of practice. Enhancing function, promoting relationships and social participation, and finding ways for those with dementia to enjoy life reflect the nature of occupational therapy practice and its emphasis on client-centered care.

Care partners of people with dementia are critical to the quality of life of the care recipients. Care partners face many obstacles as they balance caregiving with other demands, including staffing shortages resulting in overtime hours and their own relationships and responsibilities outside of the work environment (Brodaty & Donkin, 2009). Care partners are at increased risk for burden, stress, depression, and a variety of other health complications. The effects on care partners are diverse and complex, and there are many other factors that may exacerbate or ameliorate how caregivers react and feel as a result of their role. Numerous studies report that caring for a person with dementia is more stressful than caring for a person with a physical disability (Brodaty & Donkin, 2009).

Among the challenges that dementia presents to both family and staff care partners, the most significant may be its impact on communication. Care partners typically have a long history of interpersonal communication habits which they relied on prior to the onset of the disease or during its early stages. When confronted with the consistent cognitive transitions of the person with dementia, there are very limited resources available to care partners that describe how they could alter their own communication behavior to accommodate the needs of their loved one, and even if they do, they may not know how to accommodate effectively. While the cognitive impairments and limitations experienced by individuals with dementia are widely studied, there are limited resources available to care partners on how an individual's cognitive level can be used as a tool to help promote meaningful engagement in activities. The resources that are available are outdated and do not appeal to the adult learner. Furthermore, staffing shortages, schedule constraints, and willingness to participate in supplemental training in addition to the high demands of their job impact care partners' ability to access education on dementia care excellence.

Doctoral Experiential Project Overview

The Western New England University (WNE) Doctoral Experiential (DEx) is designed to assess and serve the needs of the population and setting of a community partner organization. Under the faculty mentorship of Dr. Cathy Dow-Royer, Ed. D., OTR/L, WNE OTD students teamed up with Dr. Marilyn Micka-Pickunka, Ed. D., OTR/L, owner of Still Me Dementia Care and the Interim Director of Education and Training at Rockridge Retirement Community. The doctoral experiential is divided into three phases: preparatory, proposal writing, and implementation. The preparatory and proposal phases of this project occurred simultaneously from January-March 2021. During this time, the WNE OTD students began a literature review on dementia care excellence and wrote preliminary DEx proposals. The initial proposal provided a rudimentary outline for individual projects based on the needs of individuals with dementia identified in their literature reviews. After completing both Level II Fieldworks, TeamWNEU entered the implementation phase of the DEx project in April 2021.

The implementation phase occurred over a 14 week period, from April-July 2021. The first four weeks of the project took place remotely. During this initial phase, using a service learning and consultation approach, students spent their time learning about the population and setting and the organization's strengths and challenges, in addition to state regulations and guidelines. A needs assessment was conducted and identified interprofessional care partner education as an area of weakness within the organization. Students used the information gained from the needs assessment to update their literature reviews and tailor their DEx proposals into individual projects that would meet the needs of Rockridge Retirement Community. Specific group and individual projects and activities were designed and implemented over the remaining 10 week period, both in-person and remotely. The specific roles and responsibilities of the OTD students evolved during the doctoral experiential capstone to ensure the needs of the organization were being met throughout the duration of the project.

This report highlights three distinct projects created and managed by TeamWNEU which sought to address the needs of individuals with dementia and their care partners. A multidimensional approach was taken to ensure the highest quality of work possible, resulting in each project containing both collaborative work efforts and independently created materials from group members. All three projects are representations of what it means to promote dementia care excellence to interprofessional care partners. Samples of these documents may be found in the Appendices and are also linked to the associated E-Portfolio.

Successful Dining Program

The Successful Dining Program was piloted by Dr. MMP in October 2020 in collaboration with Dining Services. The intention of the program was to reduce food waste and increase resident food consumption through staff education. As part of the doctoral experiential capstone, TeamWNEU expanded on the work previously initiated by Dr. MMP and Dining Services. The student researchers completed baseline screening assessments on the Garden's residents using a modified version of the Dementia Mealtime Assessment Tool (DMAT), which can be seen in Figure 1. Of the residents who were screened, TeamWNEU identified four individuals as candidates for participation in the program. The Successful Dining Program revitalization was founded on the "3 P's Approach: Positioning, Plating, and Positivity". The first step to promoting more self-feeding for increased food consumption was to ensure the residents were sitting in the most optimal position possible. TeamWNEU aimed to ensure that residents were sitting upright with supports added to promote 90 degree flexion at the hips and knees. The second step was to take a person-centered approach to determine the best "Plating" situation for each resident. Plating included the setup of their table for dining, how the food was presented to the resident, and with what utensils. This person-centered approach was essential to the success of the individual during mealtime as it provided them with a personalized set-up to their physical and cognitive needs. The final "P", Positivity, was a broader term which referred to both the physical environment but also the occupation of eating. Physically, TeamWNEU educated staff on reducing as many external stress factors as possible, starting with noise. Keeping the volume of staff conversations low was important, as the dining area could get very loud. Overall, "Positivity" referred to creating a positive social environment around the occupation of eating food. TeamWNEU educated staff on the importance of maintaining a positive attitude with residents throughout the meal, since some residents exhibited anxiety around eating, which would prevent them from participating in meals.

Staff education was an essential component to the carry-over and future success of the Successful Dining Program. In order to ensure an interprofessional collaborative approach was taken, Dr. MMP re-implemented the “10:45 Team Huddle” after breakfast was served. During these meetings, TeamWNEU had the opportunity to collaborate with the Wellness staff to educate them on their intervention approaches and discuss the failures and successes. These meetings provided insight into the Wellness staffs’ perspective on the residents and allowed the Team to educate staff. The first Team Huddle that was conducted identified opposing priorities between Dining Services and Wellness, which were easily addressed. Dining Services felt their priority was to ensure all residents receive enough food, and they did this by plating our large portions for each individual. This frustrated the Wellness staff, whose experience taught them that most residents become overwhelmed when they are presented with large portions of food. Through facilitating a conversation between the two departments explaining their different perspectives, both sides determined that having the Wellness staff plate the food would be the most person-centered approach to dining, since they know the residents best.

After working with the residents for a number of weeks, TeamWNEU was able to come up with a personalized meal-setup for each participant. In ensuring that each resident was receiving food in a way that was accessible for them to actually eat. Examples of this include presenting the individual with finger food, served alone on a plate when a utensil was no longer an accessible dining option due to motor and cognitive deficits.

Alzheimer’s Association Training Modules

Person-Centered Care (PCC) is the foundation for Dementia Care Excellence. The Alzheimer’s Association Person-Centered Dementia Care Training Program was developed with evidence from the Dementia Care Practice Recommendations. The program educates professional care workers on current evidence-based, person-centered practices to care for individuals living with dementia.

While the content in the training program is rich, the presentation itself does not appeal to its target audience, the adult learner. Under the direction of Dr. MMP, TeamWNEU applied the five principles of adult learning theory to redesign the presentation format. This process included the addition of multimedia in format of short videos, or “TikToks”, GIFs, audio clips, and more. To begin the process, TeamWNEU assigned each group member 2-3 modules to independently be responsible for editing, as seen in Table 2. The modules associated with the author of this report can be viewed in Figures 2 and 4. Each group member was also responsible for adapting the quiz at the end of their module to follow a multiple choice format, with 4 answer options. Once this was complete, each team member created a curricular matrix, as shown in Figures 3 and 5, to ensure that all of the content from the original presentation was included and that all of the original learning objectives were covered. Additionally, the curricular matrices ensured that all quiz questions were covered in the content presented in the module. Each module went through multiple rounds of edits with the entire group to ensure the highest quality work.

In addition to redesigning the Alzheimer’s Association PCC Training modules, TeamWNEU used the practice test questions from the original modules to create a pre/posttest designed to measure knowledge gained from the training program. This test was separate from the certification exam that participants were required to take in order to become certified in person-centered care. Participants from building services, life enrichment programming, and the Wellness department volunteered to participate in the training, which took place during paid working hours. The full educational intervention occurred over a six week span. The first week, participants took the pretest and were oriented to the program. Over the next four weeks, participants attended weekly sessions where they were taught up to 3 modules at a time. 20 members of Rockridge Retirement Community staff participated in the completed educational intervention. An additional intervention opportunity was offered as a condensed, accelerated version of the nine training modules. The condensed educational intervention occurred over two days, in which six members of staff participated. A posttest was administered after the completion of the nine training modules. Quantitative data were collected to assess the percentage of questions participants scored correctly in both the pre- and posttest. The assessment was stored using Google Forms on a protected Google Drive account to summarize participant pretest and posttest scores regarding educational intervention retention. In addition to utilizing the functions available on Google Forms, Google Sheets was utilized for the comparison of pre-and post- test scores by department. The data collected were analyzed to compare pre-and posttest scores by department.

There were significant changes to the participants' pre-post scores after completing the Alzheimer's Association training. The scores of the pre-test are shown in Figure 6, with Figure 7 representing the departments that participated. The pre-test scores were an average score of 76% with the correct answers ranging from 11-19 out of 20. The posttest scores can be seen in Figure 8, the average score was 97% with correct answers ranging from 17-20 out of 20. Each participant that completed the test had scored higher on the post-test. Indicating a positive correlation of using adult learning theory when testing dementia care educational training retention in staff.

Reminiscence Therapy Group

The Reminiscence Therapy Baking Group was designed as an interprofessional program involving the Wellness department, Life Enrichment Programming, and TeamWNEU, led by Dr. MMP and Shannon O’Neill. Reminiscence Therapy (RT) involves the discussion of past activities, events and experiences with another person or group of people, usually with the aid of tangible prompts such as photographs, household and other familiar items from the past, music and archive sound recordings (Woods, Spector, Jones, Orrell, & Davies, 2005). Reminiscence therapy is one of the most popular psychosocial interventions in dementia care, and is highly rated by staff and participants. Reminiscence groups typically involve group meetings in which participants are encouraged to talk about past events at least once a week. Family care-givers and other care partners are increasingly encouraged to be involved in reminiscence therapy. TeamWNEU determined that the RT model would pair well with a baking group, which would appeal too many if not all of the five senses, as recommended by the Alzheimer's Association PCC training. It would also provide an additional opportunity to increase caloric intake for residents, as weight loss is a major concern for individuals with dementia.

The Rockridge Reminiscence Therapy Baking Group occurred during two sessions over two consecutive weeks. The first session took place in the "Owner's Cottage" on the Garden's Unit. Five participants were randomly chosen to be invited down for a "baking group". All five of the participants were able to participate in some or all aspects of the group. Participants were given a choice between chocolate or vanilla pudding, and were paired with a student researcher. Each student researcher graded the activity according to the just-right challenge for the participant. Student researcher Shannon O'Neill then facilitated a conversation around baking, where participants shared stories about their favorite foods to bake. The conversation developed organically, with student researchers asking questions to residents that provoked memories of past experiences. Once the residents divided the pudding into individual portions, they were brought to lunch. After lunch, TeamWNEU teamed up with Life Enrichment Programming to facilitate a "Snack and Chat". It was during this time that all of the residents were invited to join in eating and sharing stories about the past. Life Enrichment Programming reported that this particular event had the highest attendance rate that they had yet seen on the Gardens Unit.

The second RT baking group occurred the following week. All residents were invited to join in making chocolate chip cookies, with six residents agreeing to participate. Residents were provided raw cookie dough with directions to roll the dough into smaller balls for cookies. The group followed the same format as the previous one, with student researchers available to grade the activity as-needed and facilitate thought-provoking conversations on past experiences. Once all the cookies were rolled out, they were baked in the dining room where residents were eating lunch. This provided a sensory experience for the residents and staff members alike, as the cookies could be smelled from outside the Gardens Unit. Following lunch, residents were invited to return to the dining room to eat the cookies.

Discussion and Recommendations

One recommendation for the program moving forward is to encourage students to use the objectives from the Learning and Evaluation Plan, as seen in Figure 10 to help them determine and define the roles and responsibilities they will take on when designing their project. It would be beneficial for students' understanding of what the DEx actually is to emphasize that while this is “their project”, their job is to meet the needs of an organization using the skill set they have as an occupational therapist. This is a hard mental shift because leading up to the DEx, everything is about the *student’s* development and growth as an occupational therapist. The DEx, however, is about the student’s ability to use their skillset as an OT to determine the needs of an organization and help them meet those needs using an OT lens. The project is “theirs' ' in that they need to be accountable and responsible for themselves, their scholarship, and their integrity.

Learning Outcomes

The following learning objectives were met throughout the course of the doctoral experiential capstone:

1. Recognize and be able to describe the diverse systems of service delivery that are most cost-effective and considerate for health, social, and educational settings, both traditional and nontraditional. Through both clinical and reflective writing, be able to articulate a sensitivity to cultural, linguistic, and other diversities and describe solutions for care disparities.
2. Documentation of a needs assessment for a particular population and using assessment as the foundation for planning a successful Doctoral Experiential Project. Additional evidence will include feedback from consumers that indicates the impact of the project on the population they represent.
3. Demonstrated proficiency with the use of personal computers, learning platforms, electronic health records and assistive technology sufficient to fully document the Doctoral Experiential Project for WNE as well as for members of the population served by the project.
4. Recognize and be able to describe the diverse systems of service delivery that are most cost-effective and considerate for health, social, and educational settings, both traditional and nontraditional. Through both clinical and reflective writing, be able to articulate a sensitivity to cultural, linguistic, and other diversities and describe solutions for care disparities.
5. Document the ability to work with others to identify meaningful objectives, organize, and motivate people and resources, communicate effectively, and oversee action to accomplish stated program or service goals.
6. Through both clinical and reflective writing, be able to articulate the therapeutic / clinical reasoning (procedural, interactive, narrative, ethical, scientific, pragmatic) process that I use during planning, delivery, and evaluation of population-based and evidence driven occupational therapy services. Demonstrate the ability to implement, in existing programs, and plan for in developing programs, an occupational therapy process that is occupation-based, client-centered, culturally sensitive, and ethically appropriate.
7. Document an experiential and scholarly project that reflects the literature in the field and uses responsive, ethical methods. The scholarly process and results should be made accessible to the college and the community, especially to the population served by the project. A report of the project, presented in a professional format that others can replicate or build upon, will be evidence of accomplishment.
8. Through both clinical and reflective writing, be able to articulate a clear awareness of my own personal and professional strengths and boundaries and identify supports and strategies for goal achievement.

9. Understand how person-centered care, the PEO model and ACL framework can be used to create innovative occupational therapy services, in this case, a care partner education curriculum.
10. Learn about caregiving, especially dementia caregiving, in order to determine the barriers experienced by care partners in their interactions with residents with dementia
11. Learn more about educational program development and evaluation and explore how to provide care partner education through a variety of formats including online and in-person platforms that align with state regulations

Comments/Additional Information

Occupational therapy practitioners, through their academic curricula, expertise in activity analysis, and work with older people in various settings, approach dementia as a condition that affects occupational performance (AOTA, 2017). Practitioners work with care partners, including family members, concerned others, and those in the early stages of the disease to address the functional implications of dementia. Occupational therapists evaluate persons with dementia to determine their strengths, impairments, and performance areas needing intervention (Schaber & Lieberman, 2010). Remediation of cognitive performance is unlikely and therefore not a productive approach to dementia care excellence. Practitioners instead focus on habilitation rather than *re*habilitation, where the emphasis is placed on abilities that remain with the individual rather than what has been lost. This model may result in their demonstrated improved function through compensation or adaptation and aligns well with the philosophy of person-centered care.

References

Alzheimer’s Association (2020). *Retrieved from* https://www.alz.org/alzheimers-dementia/what-is-dementia

American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*, 68(Suppl.1), S1-S48.

Assisted Living Federation of America. (n.d.). What is assisted living? Retrieved from http://www.alfa.org/alfa/Assisted_Living_Information. Asp

Atkinson, R. (1998). The life story interview (qualitative research methods). Thousand Oaks, CA: Sage

Bennett, P. N., Wang, W., Moore, M., & Nagle, C. (2017). Care partner: A concept analysis. Nursing outlook, 65(2), 184–194. https://doi.org/10.1016/j.outlook.2016.11.005

Brodaty, H., & Donkin, M. (2009). Family caregivers of people with dementia. *Dialogues in clinical neuroscience*, *11*(2), 217–228. https://doi.org/10.31887/DCNS.2009.11.2/hbrodaty

Bryan, R., Krueter, M., Brownson, R. (2009). Integrating adult learning principles into training for public health practice. *Health Promotion Practice*. October 2009 Vol 10, No. 4, 557-56

Burke, J. P., & Gitlin, L. N. (2012). How do we change practice when we have the evidence? American Journal of Occupational Therapy, 66, e85–e88. https://doi.org/10.5014/ajot.2012.004432

Cole, M. B., & Tufano, R. (2008). *Applied theories in occupational therapy: A practical approach.* Thorofare, NJ: Slack, Inc.

Dudgeon, B., & Greenberg, S. (1998). Preparing students for consultation roles and systems. *American Journal of Occupational Therapy*, November/December 1998, Vol. 52, 801-809. https://doi.org/10.5014/ajot.52.10.801

Fazio,S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The Fundamentals of Person-Centered Care for Individuals With Dementia, *The Gerontologist*, Volume 58, Issue suppl_1, February 2018, Pages S10–S19, ttps://doi.org/10.1093/geront/gnx122

Fitzler, S., Raia, P., Buckley, F. O., Jr, & Wang, M. (2016). Does Nursing Facility Use of Habilitation Therapy Improve Performance on Quality Measures?. *American journal of Alzheimer's disease and other dementias, 31*(8), 687–692. https://doi-org.wne.idm.oclc.org/10.1177/1533317516662335

Francis, T., Tomita, M., Binkewicz, K., Dinatale, K., Anderson, V., Grandolph, L., Tse, D., Vasisko, S., & Grandoloph, L. (2020). Effects of OT-Based Interventions to Reduce Perceived Burden and Depression of Caregivers of Older Adults With Dementia. *The American Journal of Occupational Therapy*, August 2020, Vol. 74, Supplement 1. DIO https://doi.org/10.5014/ajot.2020.74S1-PO3405

Green, B. N., & Johnson, C. D. (2015). Interprofessional collaboration in research, education, and clinical practice: working together for a better future. *The Journal of chiropractic education*, *29*(1), 1–10. https://doi.org/10.7899/JCE-14-36

Kelsey, S., Laditka, S., & Laditka, J. (2009, July 24). Dementia and transitioning from assisted living to memory care units: perspectives of administrators in three facility types. *The Gerontologist*, *50*(2), 192 – 203. https://doi.org/10.1093/geront/gnp115

Lieb, S. (1991). Principles of adult learning. Retrieved May 19, 2006, from http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/adults-2.ht

Maitra, K. K. & Erway, F. (2006). Perception of client-centered practice in occupational therapists and their clients. American Journal of Occupational Therapy, 60, 298–310.

Murphy, J. L., Holmes, J., & Brooks, C. (2017). Nutrition and dementia care: developing an evidence-based model for nutritional care in nursing homes. *BMC geriatrics*, *17*(1), 55. https://doi.org/10.1186/s12877-017-0443-2

Rafeedie, S., Metzler, C., & Lamb, A. J. (2018). Health Policy Perspectives—Opportunities for occupational therapy to serve as a catalyst for culture change in nursing facilities. American Journal of Occupational Therapy, 72, 7204090010. https://doi.org/10.5014/ajot.2018.7240003

Ray, C. A., Ingram, V., & Cohen-Mansfield, J. (2015). Systematic review of planned care transitions for persons with dementia. Neurodegenerative Disease Management, 5(4), 317+. Retrieved from ttps://linkgale.com.wne.idm.oclc.org/apps/doc/A428761620/HRCA?u=mlin_w_westnew &sid=HRCA&xid=6fa0b17d

Reia , P. (1999). Habilitation therapy: a new starscape. In *Enhancing the Quality of Life in Advanced Dementia* (pp. 21–37). essay, Brunner/Mazel Publishing Co.

Rockridge (2020). RockridgeMA.org. Retrieved January 21, 2021, from https://www.rockridgema.org

Sallim, A. B., Sayampanathan, A. A., Cuttilan, A., & Ho, R. (2015). Prevalence of Mental Health Disorders Among Caregivers of Patients With Alzheimer Disease. *Journal of the American Medical Directors Association*, *16*(12), 1034–1041. https://doi.org/10.1016/j.jamda.2015.09.007

Schaber, P., & Lieberman, D. (2010). Occupational therapy practice guidelines for adults with Alzheimer's disease and related disorders. Bethesda, MD: AOTA Press.

Small, J. & Perry, J. (2013). Training family care partners to communicate effectively with persons with Alzhimers disease: The TRACED Program. *Canadian Journal of Speech-Language Pathology and Audiology*. Winter 2012/2013. Vol. 36, No 4.

Swiech, P., Sullivan, A., Helfrich, C., (2020). Self-feeding with the adult population: back to the basics. American Occupational Therapy Association Continuing Education. Retrieved on May 13, 2021 from https://www.aota.org/~/media/Corporate/Files/Publications/CE-Articles/CEA_August_2020.pdf

Tough, A. (1971). The adult's learning projects. Toronto, Canada: Ontario Institute for Studies in Education.

Weiss, J., Tumosa, N., Perweiler, E., Bailey, D., Blackwell, E., Forceia, M. A., … Worstell, M. (2017). Workforce gaps in dementia education and training. Retrieved from https://aspe.hhs.gov/pdf-report/workforce-gaps-dementia-education-and-training

Wicks, A. & Whiteford, G. (2003). Value of lifestories in occupation-based research. *Australian Occupational Therapy Journal* (2003) 50, 86–91

Wong, C. & Leland, N.E. (2018). Applying the Person-Environment-Occupation Model to Improve Dementia Care. *American Journal of Occupational Therapy*

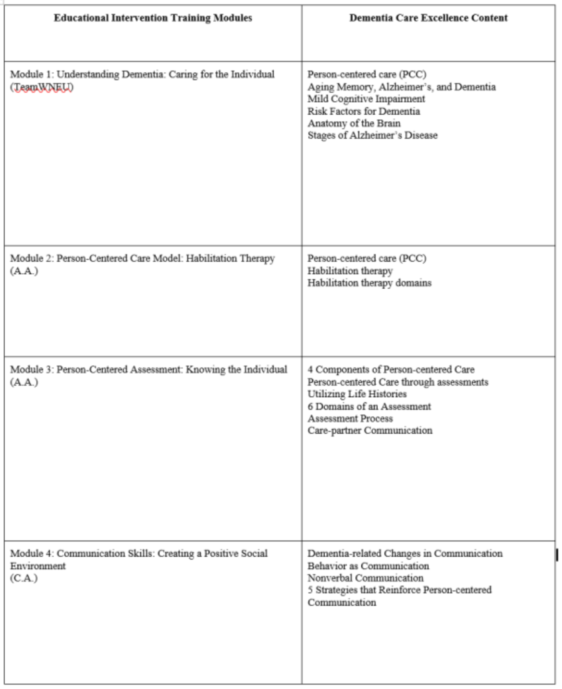
Woods B, Spector AE, Jones CA, Orrell M, Davies SP. Reminiscence therapy for dementia. Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD001120. DOI: 10.1002/14651858.CD001120.pub2.

WHO., (2010). *Framework for Action on Interprofessional Education and Collaborative Practice. Retrieved June 6, 2021 from http://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf?sequence=1*

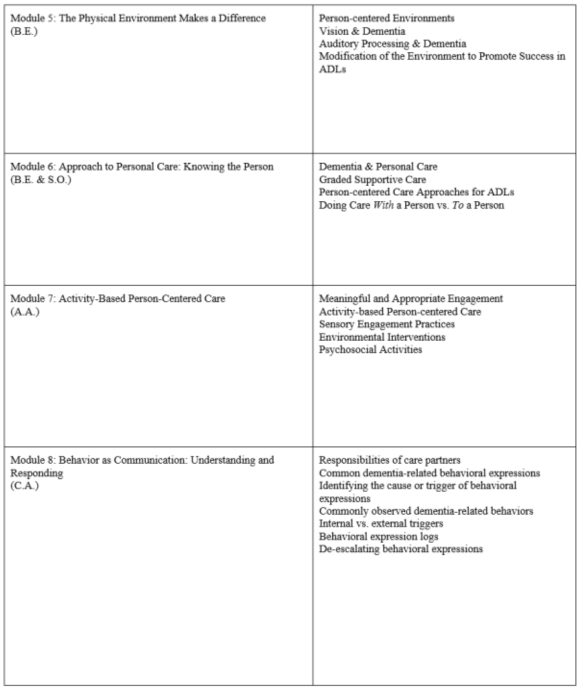
WHO (n.d.) re*trieved from https://www.who.int/mental_health/neurology/dementia/dementia_thematicbrief_informal_care.pdf*

Appendices

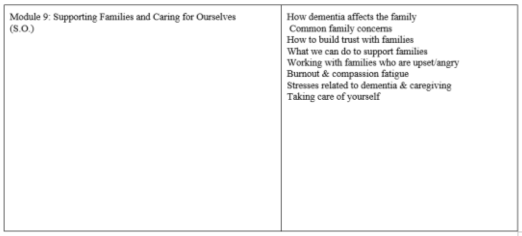
Table 1



Educational Intervention Training Modules	Dementia Care Excellence Content
Module 1: Understanding Dementia: Caring for the Individual (TeamWNEU)	Person-centered care (PCC) Aging Memory, Alzheimer's, and Dementia Mild Cognitive Impairment Risk Factors for Dementia Anatomy of the Brain Stages of Alzheimer's Disease
Module 2: Person-Centered Care Model: Habilitation Therapy (A.A.)	Person-centered care (PCC) Habilitation therapy Habilitation therapy domains
Module 3: Person-Centered Assessment: Knowing the Individual (A.A.)	4 Components of Person-centered Care Person-centered Care through assessments Utilizing Life Histories 6 Domains of an Assessment Assessment Process Care-partner Communication
Module 4: Communication Skills: Creating a Positive Social Environment (C.A.)	Dementia-related Changes in Communication Behavior as Communication Nonverbal Communication 5 Strategies that Reinforce Person-centered Communication

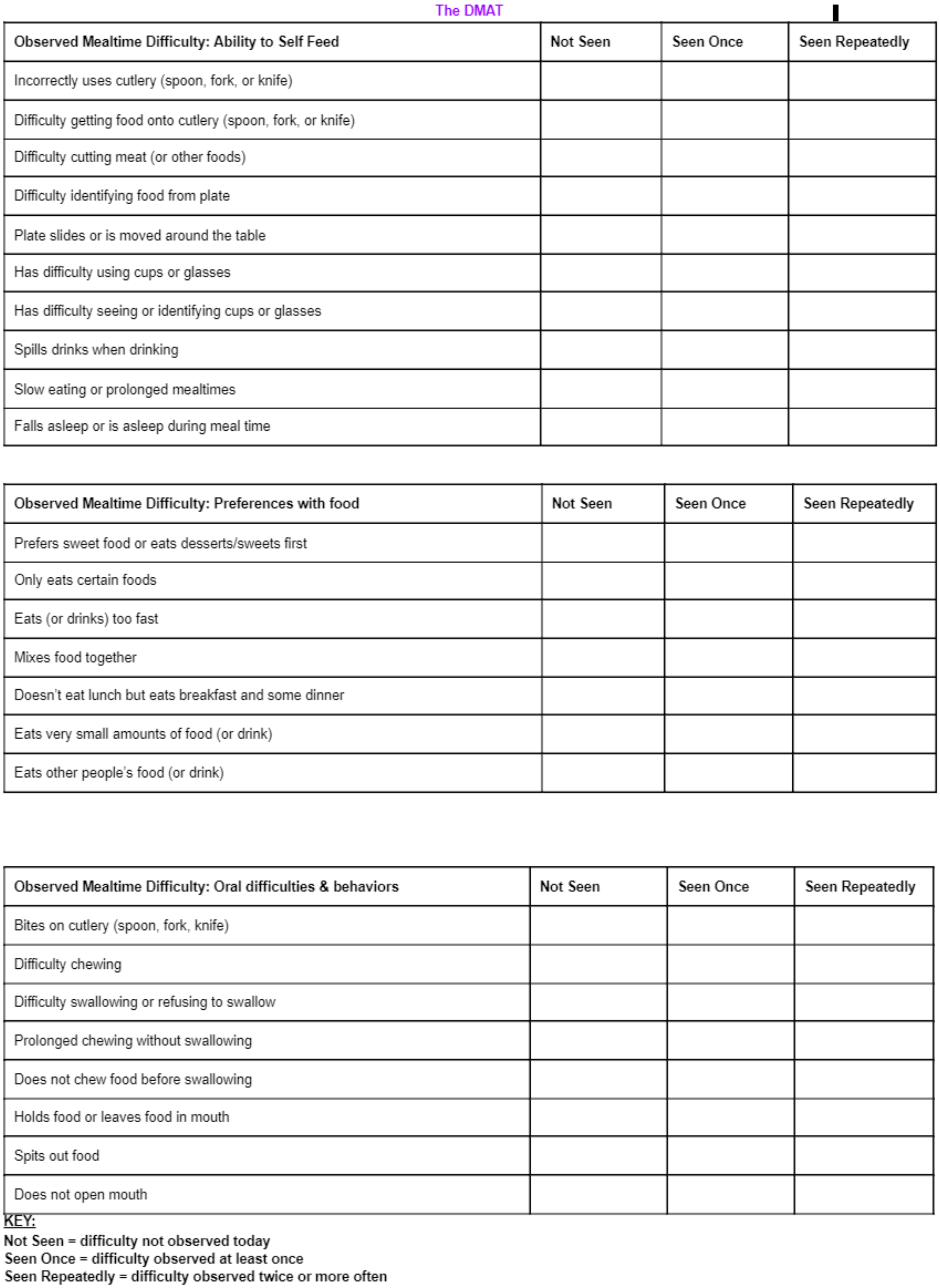


Module 5: The Physical Environment Makes a Difference (B.E.)	Person-centered Environments Vision & Dementia Auditory Processing & Dementia Modification of the Environment to Promote Success in ADLs
Module 6: Approach to Personal Care: Knowing the Person (B.E. & S.O.)	Dementia & Personal Care Graded Supportive Care Person-centered Care Approaches for ADLs Doing Care *With* a Person vs. *To* a Person
Module 7: Activity-Based Person-Centered Care (A.A.)	Meaningful and Appropriate Engagement Activity-based Person-centered Care Sensory Engagement Practices Environmental Interventions Psychosocial Activities
Module 8: Behavior as Communication: Understanding and Responding (C.A.)	Responsibilities of care partners Common dementia-related behavioral expressions Identifying the cause or trigger of behavioral expressions Commonly observed dementia-related behaviors Internal vs. external triggers Behavioral expression logs De-escalating behavioral expressions



Module 9: Supporting Families and Caring for Ourselves (S.O.)	How dementia affects the family Common family concerns How to build trust with families What we can do to support families Working with families who are upset/angry Burnout & compassion fatigue Stresses related to dementia & caregiving Taking care of yourself

Figure 1



The DMAT

Observed Mealtime Difficulty: Ability to Self Feed	Not Seen	Seen Once	Seen Repeatedly
Incorrectly uses cutlery (spoon, fork, or knife)			
Difficulty getting food onto cutlery (spoon, fork, or knife)			
Difficulty cutting meat (or other foods)			
Difficulty identifying food from plate			
Plate slides or is moved around the table			
Has difficulty using cups or glasses			
Has difficulty seeing or identifying cups or glasses			
Spills drinks when drinking			
Slow eating or prolonged mealtimes			
Falls asleep or is asleep during meal time			

Observed Mealtime Difficulty: Preferences with food	Not Seen	Seen Once	Seen Repeatedly
Prefers sweet food or eats desserts/sweets first			
Only eats certain foods			
Eats (or drinks) too fast			
Mixes food together			
Doesn't eat lunch but eats breakfast and some dinner			
Eats very small amounts of food (or drink)			
Eats other people's food (or drink)			

Observed Mealtime Difficulty: Oral difficulties & behaviors	Not Seen	Seen Once	Seen Repeatedly
Bites on cutlery (spoon, fork, knife)			
Difficulty chewing			
Difficulty swallowing or refusing to swallow			
Prolonged chewing without swallowing			
Does not chew food before swallowing			
Holds food or leaves food in mouth			
Spits out food			
Does not open mouth			

KEY:
Not Seen = difficulty not observed today
Seen Once = difficulty observed at least once
Seen Repeatedly = difficulty observed twice or more often

Figure 2.1


Approach to Personal Care: Knowing the Person

Module 6


How does this sound and visual make you feel?


What are some bathing rituals and routines that you have?

- Do you listen to music?
- Do you light a candle?
- Do you prefer a bath over a shower?
- How long do you spend in the bath?
- What time of day do you prefer to bathe?


Person-Centered Care
Self Discovery

I prefer to bathe •••


Today's Topics

- Dementia and personal care
- Graded supportive care
- Person-centered care approaches to assist individuals with ADLs
- Doing care *with* a person vs. *to* a person


Learning Objectives

01 Describe two challenges individuals with dementia face with personal care
02 Identify 3 ways to support a person-centered care approach to ADL's
03 Understand the meaning of the "Spend 5 to Save 20" rule
04 Define graded supportive care
05 Identify two benefits of doing care WITH a person


Dementia and Personal Care

Dementia often makes personal care tasks challenging due to:

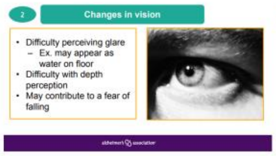
1 Decreased judgement and insight
2 Changes in vision
3 Difficulty with multi-step tasks


1 **Decreased judgement and insight**

Individuals with dementia:

- may not realize they need help
- might not realize they even *need* to complete tasks

This confusion can lead to conflicts between residents and care partners


2 **Changes in vision**

- Difficulty perceiving glare
  - Ex. may appear as water on floor
- Difficulty with depth perception
- May contribute to a fear of falling


3 **Difficulty with multi-step tasks**

Seemingly simple tasks can become complex

Activity:

- List 5 steps in order to brushing your teeth in your workbook
- Let's share - how are your steps different from those of others?


Think back to our opening activity...


How might your bathing routine change if…?

...you had dementia?

...you lived in a care facility?

Figure 2.2

Person-Centered Care for ADL Support

1. Preferences & History
2. Meaningful Connections
3. Maintaining Dignity
4. Graded Supportive Care


ADL Support
1. Preferences & History

- **Personal Preferences**
  - *What type of food does the individual like?*
  - *How do they prefer to dress?*
- **Life History**
  - *Meaningful people, pets, and places to the individual*
  - *Know traumatic events to avoid triggers*


What preferences does Carol Rogers have?

What about her life history do you know?


ADL Support
2. Meaningful Connections

When completing personal care tasks:

- Put the person at ease
- Start with a non-threatening task
- Provide positive validation

This may help avoid agitation, confusion, and fear


Spend 5 to Save 20

The idea that we must first connect with the person with a **positive** emotion

How can we do this?

- **Spend 5**: Take extra time to connect with a person
- **Save 20**: Helps complete the task more quickly overall


ADL Support
3. Maintaining Dignity

- **Avoid arguing**
  - This will put the person on defense
- **Honor their choices**
  - Examine your approach and the environment

ADL Support
3. Maintaining Dignity, continued...

Keep ADLs private

- Avoid talking publicly about "going to the bathroom" or "are you constipated?"
- Do so in a private, quiet manner


ADL Support
4. Graded Supportive Care

Allows an individual to remain **as active and independent** as possible in their **own care**.

What does this look like?


Focus on doing care *with* the individual not *to* the individual


Helping Your Child Bake
How would they feel if…

- You decided ***when*** to bake?
- You chose the ***type*** of cake?
- You ***did the measuring..***
- They couldn't use the mixer because ***they make a mess..***
- You finished the cake because ***they're slow*** and you're in a hurry..


When We Do Care *TO* a Person They May Feel:

- ashamed
- embarrassed
- hopeless
- resentful
- angry or frustrated

When we do Personal Care *WITH* the person it:

- fosters positive emotion
- utilizes remaining skills
- maintains independence
- creates social connections
- **promotes dignity, respect and choice**

Figure 2.3

Let's Practice!

Graded Support with Dressing

Early
- Simplify closet
- Evaluate clothing

Middle
- Environmental Cues
- Simplify clothing
- Simplify process
- Verbal/nonverbal cues
- Privacy & safety
- Validation

Late
- Gentle tone
- Music
- Props
- Privacy
- Comfortable clothing

Dressing Scenario

Graded Supportive Care for ADLs

Why Might Bathing be Frightening or Stressful?

- Person is **naked**; they feel **exposed**
- Person feels **embarrassed** or **uncomfortable**
- Person doesn't like **feel** or **sound** of water
- Water is too **cold** or too **hot**
- Bathroom is **cold**
- Person is **afraid** they will **fall**

Graded Support with Toileting

Early
- Monitor clothing
- Reminders
- Limit evening fluids

Middle
- Clear path
- Well lit
- Remove items
- Bright colors
- Verbal instructions
- Verbal/nonverbal cues
- Simple steps
- Schedule
- Safety

Late
- Use of incontinence products
- Monitor skin
- Infection prevention
- Validation & reassurance
- Constipation Prevention

Toileting Scenario

Graded Support with Bathing

Early
- Prepare bathing area
- Offer reminder

Middle
- Simplify
- Coach
- Communicate
- Use props
- Demonstrate
- Hand-under-hand
- Safety
- Dry shampoo

Late
- Sponge bath
- Warm towel
- Rinse free soap
- Props
- Music
- Singing

Support with Bathing

Graded Support with Feeding

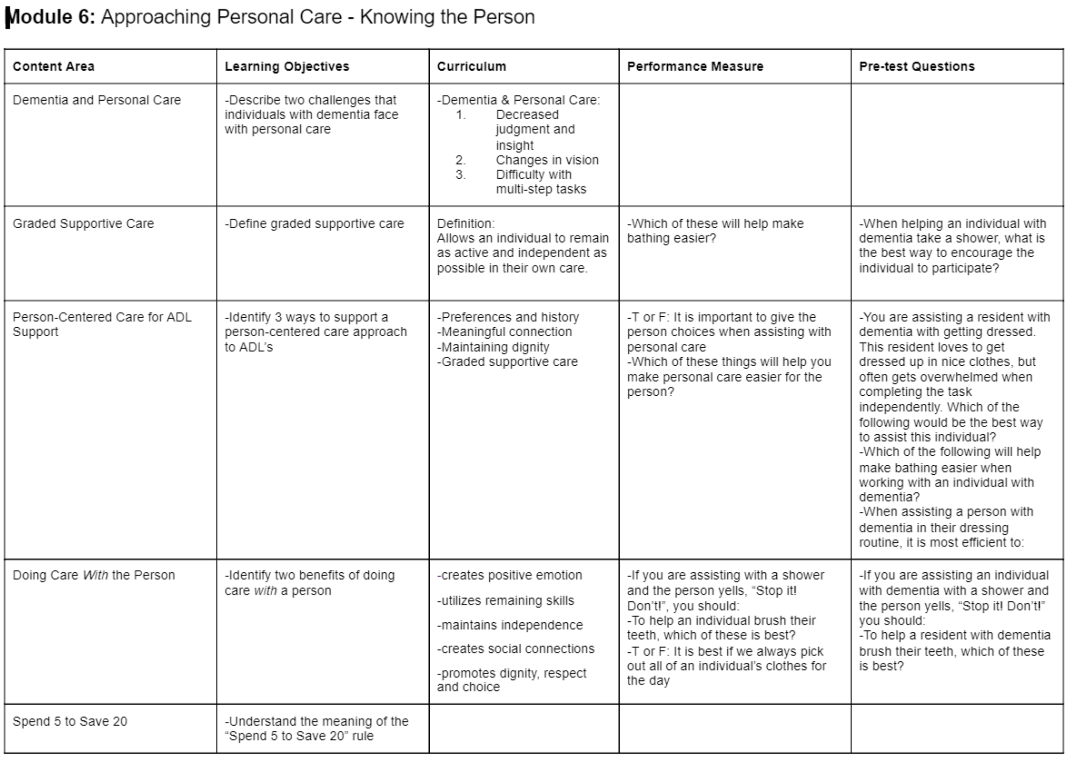
Early
- Routine access to prepared foods
- Monitor intake

Middle
- Advanced preparation
- 1 food at a time
- Colored/lipped plates
- Adapted foods
- Verbal prompts
- Nonverbal techniques
- Soft music

Late
- Difficulty swallowing
- Hydration
- Adapt food
- Safe body positioning
- DO NOT force
- End-of-life wishes

Support with Feeding

Figure 3



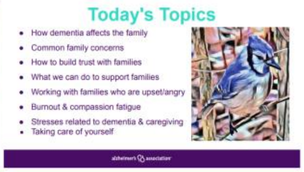
Module 6: Approaching Personal Care - Knowing the Person

Content Area	Learning Objectives	Curriculum	Performance Measure	Pre-test Questions
Dementia and Personal Care	-Describe two challenges that individuals with dementia face with personal care	-Dementia & Personal Care: 1. Decreased judgment and insight 2. Changes in vision 3. Difficulty with multi-step tasks		
Graded Supportive Care	-Define graded supportive care	Definition: Allows an individual to remain as active and independent as possible in their own care.	-Which of these will help make bathing easier?	-When helping an individual with dementia take a shower, what is the best way to encourage the individual to participate?
Person-Centered Care for ADL Support	-Identify 3 ways to support a person-centered care approach to ADL's	-Preferences and history -Meaningful connection -Maintaining dignity -Graded supportive care	-T or F: It is important to give the person choices when assisting with personal care -Which of these things will help you make personal care easier for the person?	-You are assisting a resident with dementia with getting dressed. This resident loves to get dressed up in nice clothes, but often gets overwhelmed when completing the task independently. Which of the following would be the best way to assist this individual? -Which of the following will help make bathing easier when working with an individual with dementia? -When assisting a person with dementia in their dressing routine, it is most efficient to:
Doing Care *With* the Person	-Identify two benefits of doing care *with* a person	-creates positive emotion -utilizes remaining skills -maintains independence -creates social connections -promotes dignity, respect and choice	-If you are assisting with a shower and the person yells, "Stop it! Don't!", you should: -To help an individual brush their teeth, which of these is best? -T or F: It is best if we always pick out all of an individual's clothes for the day	-If you are assisting an individual with dementia with a shower and the person yells, "Stop it! Don't!" you should: -To help a resident with dementia brush their teeth, which of these is best?
Spend 5 to Save 20	-Understand the meaning of the "Spend 5 to Save 20" rule			

Figure 4.1

Supporting Families and Caring for Ourselves

Module 9



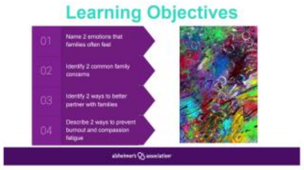
Today's Topics

- How dementia affects the family
- Common family concerns
- How to build trust with families
- What we can do to support families
- Working with families who are upset/angry
- Burnout & compassion fatigue
- Stresses related to dementia & caregiving
- Taking care of yourself

How Dementia Affects the Family

Common Family Concerns

- Trusting others to provide care to their loved ones
- Prior negative experience with outside care providers
- Worry about repercussions from voicing concerns about care quality



Learning Objectives

01 Name 2 emotions that families often feel
02 Identify 2 common family concerns
03 Identify 2 ways to better partner with families
04 Describe 2 ways to prevent burnout and compassion fatigue

Person-Centered Care
Self Discovery

My self-care includes ●●●

Build Trust With Families

Empathy vs. Sympathy

How do families respond to a terminal diagnosis?

Reflect back on a time you were upset or angry on behalf of someone you love.

How did you respond?

How did that make you feel?

Working with Families Who are Upset or Angry

1 Remain calm & professional

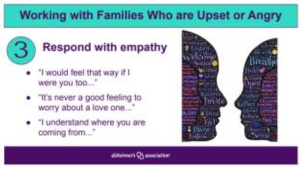
- Take a deep breath and count the 3 before responding
- Remember their concerns aren't personal

Figure 4.2

Working with Families Who are Upset or Angry

2 Acknowledge a family's concerns and emotions

- "I'm so sorry that you feel that you're feeling this way..."
- "I can tell you're quite frustrated by this..."
- Saying you are sorry doesn't mean it was your fault, but shows you care



Working with Families Who are Upset or Angry

3 Respond with empathy

- "I would feel that way if I were you too..."
- "It's never a good feeling to worry about a love one..."
- "I understand where you are coming from..."

Burnout

Tends to develop over time

Emotional and physical exhaustion, feelings of negativity and indifference and feeling like you're not getting the job done

Compassion Fatigue

- Caused by feelings of empathy
- The result of providing continuous care to individuals experiencing serious illness
- Typically comes on suddenly

Working with Families Who are Upset or Angry

4 Don't blame the person living with dementia

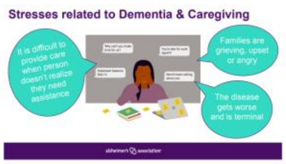
- It's *always* the responsibility of the care partners to care for and communicate appropriately with the individual with dementia

Working with Families Who are Upset or Angry

Next Steps

If you cannot answer a question, let them know and connect them to someone who can help

If they are still upset, notify your supervisor



Stresses related to Dementia & Caregiving

Juggling too much?

Responding with Empathy: What we *can* do

Provide Updates
Involve the Family
Offer Support
Be Consistent
Work as a Team

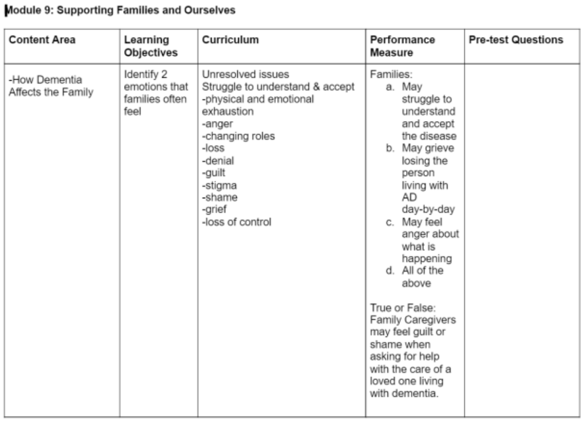
How does being a care partner impact your everyday life?

Taking Care of Yourself

- Don't be afraid to ask for help
- Know when to say "no"
- Build healthy habits
- Know your boundaries
- Advocate for your own needs

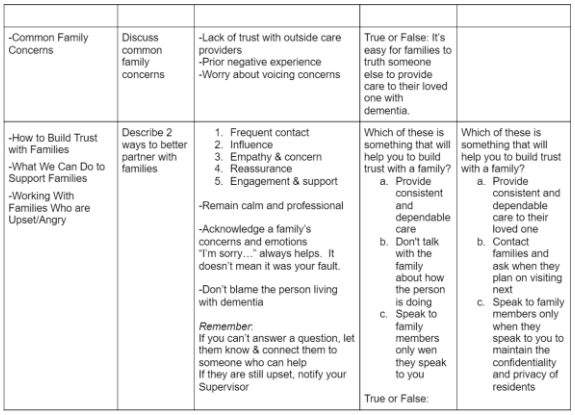
How do you take care of yourself?

Figure 5

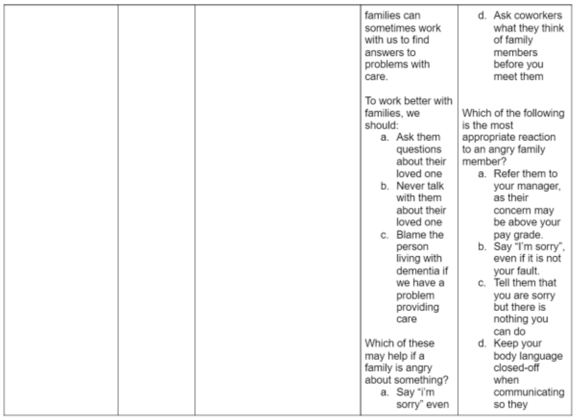


Module 9: Supporting Families and Ourselves

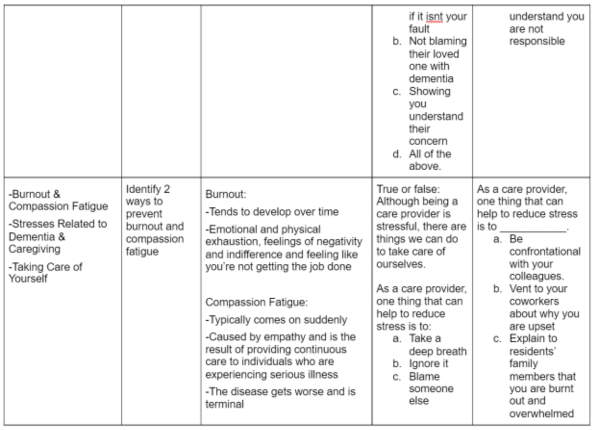
Content Area	Learning Objectives	Curriculum	Performance Measure	Pre-test Questions
-How Dementia Affects the Family	Identify 2 emotions that families often feel	Unresolved issues Struggle to understand & accept -physical and emotional exhaustion -anger -changing roles -loss -denial -guilt -stigma -shame -grief -loss of control	Families: a. May struggle to understand and accept the disease b. May grieve losing the person living with AD day-by-day c. May feel anger about what is happening d. All of the above True or False: Family Caregivers may feel guilt or shame when asking for help with the care of a loved one living with dementia.	



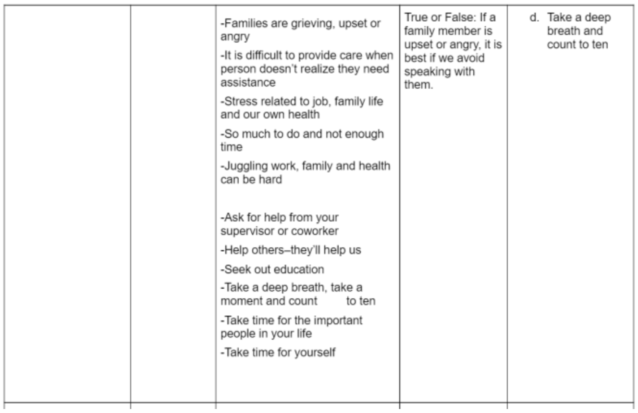
-Common Family Concerns	Discuss common family concerns	-Lack of trust with outside care providers -Prior negative experience -Worry about voicing concerns	True or False: It's easy for families to truth someone else to provide care to their loved one with dementia.	
-How to Build Trust with Families -What We Can Do to Support Families -Working With Families Who are Upset/Angry	Describe 2 ways to better partner with families	1. Frequent contact 2. Influence 3. Empathy & concern 4. Reassurance 5. Engagement & support -Remain calm and professional -Acknowledge a family's concerns and emotions "I'm sorry…" always helps. It doesn't mean it was your fault. -Don't blame the person living with dementia *Remember*: If you can't answer a question, let them know & connect them to someone who can help If they are still upset, notify your Supervisor	Which of these is something that will help you to build trust with a family? a. Provide consistent and dependable care b. Don't talk with the family about how the person is doing c. Speak to family members only wen they speak to you True or False:	Which of these is something that will help you to build trust with a family? a. Provide consistent and dependable care to their loved one b. Contact families and ask when they plan on visiting next c. Speak to family members only when they speak to you to maintain the confidentiality and privacy of residents



			families can sometimes work with us to find answers to problems with care. To work better with families, we should: a. Ask them questions about their loved one b. Never talk with them about their loved one c. Blame the person living with dementia if we have a problem providing care Which of these may help if a family is angry about something? a. Say "i'm sorry" even	d. Ask coworkers what they think of family members before you meet them Which of the following is the most appropriate reaction to an angry family member? a. Refer them to your manager, as their concern may be above your pay grade. b. Say "I'm sorry", even if it is not your fault. c. Tell them that you are sorry but there is nothing you can do d. Keep your body language closed-off when communicating so they

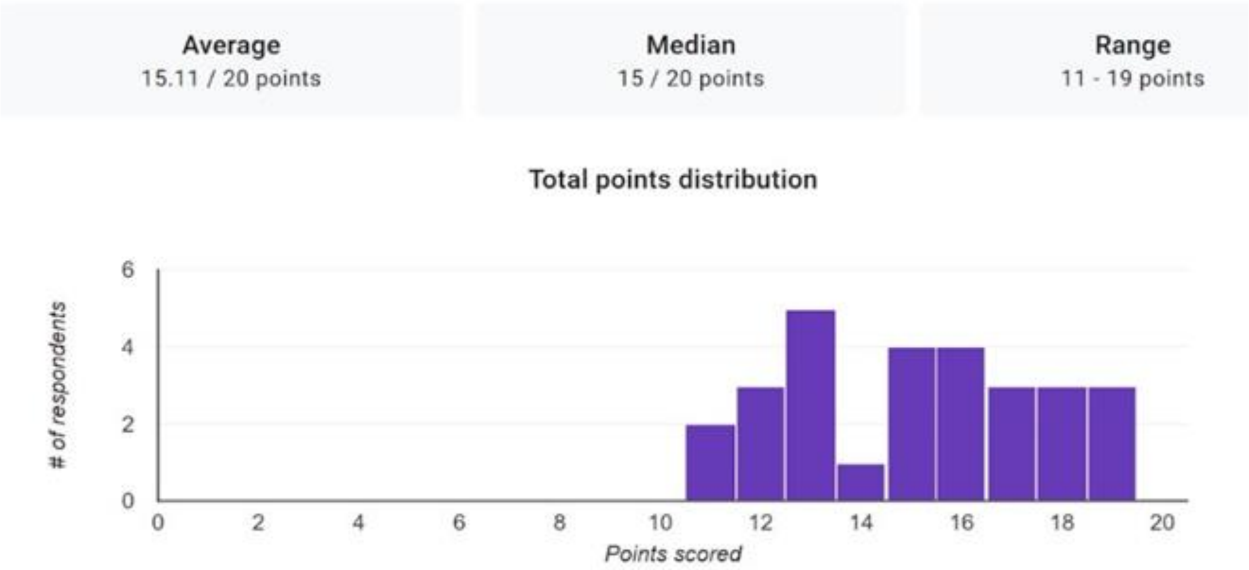


			if it isnt your fault b. Not blaming their loved one with dementia c. Showing you understand their concern d. All of the above.	understand you are not responsible
-Burnout & Compassion Fatigue -Stresses Related to Dementia & Caregiving -Taking Care of Yourself	Identify 2 ways to prevent burnout and compassion fatigue	Burnout: -Tends to develop over time -Emotional and physical exhaustion, feelings of negativity and indifference and feeling like you're not getting the job done Compassion Fatigue: -Typically comes on suddenly -Caused by empathy and is the result of providing continuous care to individuals who are experiencing serious illness -The disease gets worse and is terminal	True or false: Although being a care provider is stressful, there are things we can do to take care of ourselves. As a care provider, one thing that can help to reduce stress is to: a. Take a deep breath b. Ignore it c. Blame someone else	As a care provider, one thing that can help to reduce stress is to ___________. a. Be confrontational with your colleagues. b. Vent to your coworkers about why you are upset c. Explain to residents' family members that you are burnt out and overwhelmed



		-Families are grieving, upset or angry -It is difficult to provide care when person doesn't realize they need assistance -Stress related to job, family life and our own health -So much to do and not enough time -Juggling work, family and health can be hard -Ask for help from your supervisor or coworker -Help others–they'll help us -Seek out education -Take a deep breath, take a moment and count to ten -Take time for the important people in your life -Take time for yourself	True or False: If a family member is upset or angry, it is best if we avoid speaking with them.	d. Take a deep breath and count to ten

Figure 6



Average	Median	Range
15.11 / 20 points	15 / 20 points	11 - 19 points

Figure 7

28 responses

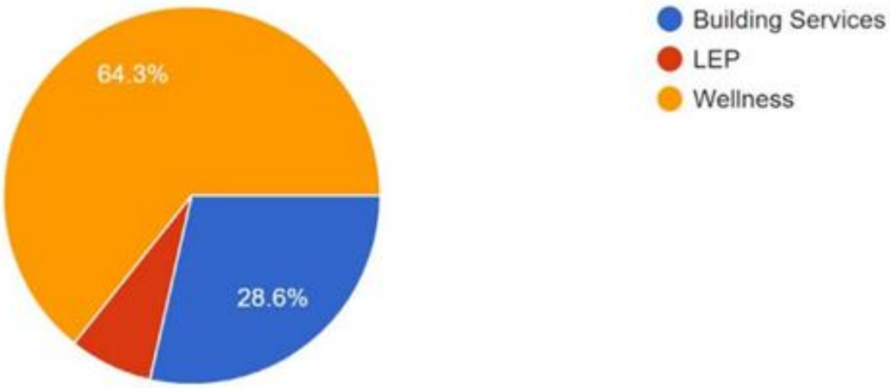
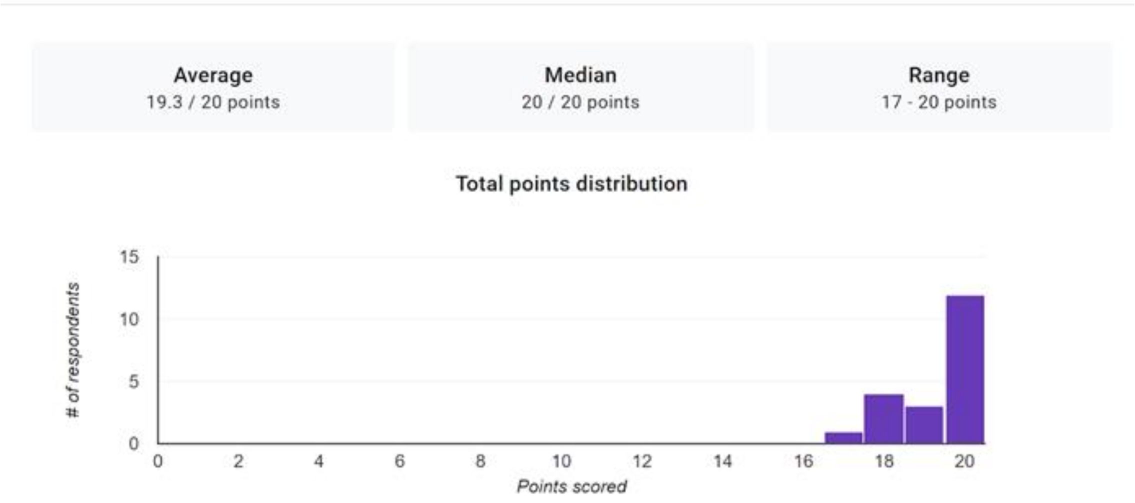


Figure 8



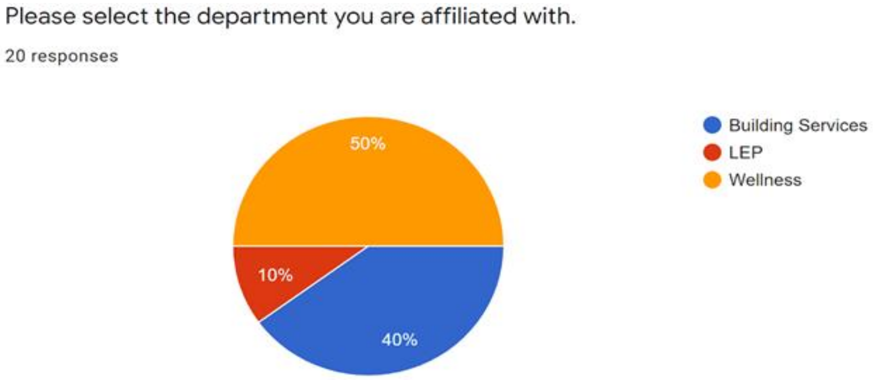
Average
19.3 / 20 points

Median
20 / 20 points

Range
17 - 20 points

Total points distribution

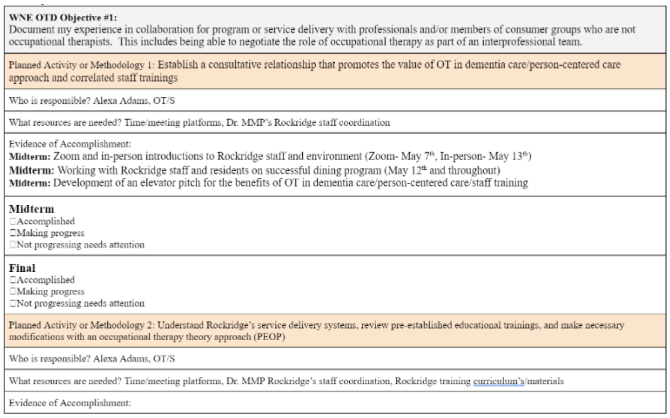
Figure 9



Please select the department you are affiliated with.

20 responses

Figure 10



WNE OTD Objective #1: Document my experience in collaboration for program or service delivery with professionals and/or members of consumer groups who are not occupational therapists. This includes being able to negotiate the role of occupational therapy as part of an interprofessional team.
Planned Activity or Methodology 1: Establish a consultative relationship that promotes the value of OT in dementia care/person-centered care approach and correlated staff trainings
Who is responsible? Alexa Adams, OT/S
What resources are needed? Time/meeting platforms, Dr. MMP's Rockridge staff coordination
Evidence of Accomplishment: **Midterm:** Zoom and in-person introductions to Rockridge staff and environment (Zoom- May 7th, In-person- May 13th) **Midterm:** Working with Rockridge staff and residents on successful dining program (May 12th and throughout) **Midterm:** Development of an elevator pitch for the benefits of OT in dementia care/person-centered care/staff training
Midterm ☐Accomplished ☐Making progress ☐Not progressing needs attention
Final ☐Accomplished ☐Making progress ☐Not progressing needs attention
Planned Activity or Methodology 2: Understand Rockridge's service delivery systems, review pre-established educational trainings, and make necessary modifications with an occupational therapy theory approach (PEOP)
Who is responsible? Alexa Adams, OT/S
What resources are needed? Time/meeting platforms, Dr. MMP Rockridge's staff coordination, Rockridge training curriculum's/materials
Evidence of Accomplishment:

Appendix 2: Scholarly Report

Shannon O’Neill

Western New England University

Doctor of Occupational Therapy Program

29 July, 2021

RESEARCH/PROJECT TABLE OF CONTENTS

I. Executive Summary

The Western New England University (WNE) Doctoral Experiential (DEx) is designed to assess and serve the needs of the population and setting of a community partner organization. Under the faculty mentorship of Dr. Cathy Dow-Royer, Ed. D., OTR/L, WNE OTD students teamed up with Dr. Marilyn Micka-Pickunka, Ed. D., OTR/L, owner of Still Me Dementia Care and the Interim Director of Education and Training at Rockridge Retirement Community. The doctoral experiential is divided into three phases: preparatory, proposal writing, and implementation. The preparatory and proposal phases of this project occurred simultaneously from January-March 2021. The WNE OTD students (TeamWNEU) began a literature review on dementia care excellence and wrote preliminary DEx proposals. The initial proposal provided a rudimentary outline for individual projects based on the needs of individuals with dementia identified in their literature reviews. After completing their Level II Fieldwork requirements, TeamWNEU entered the implementation phase of the DEx project, which occurred over a 14 week period, from April-July 2021. A needs assessment was conducted and identified interprofessional care partner education as an area of weakness within the organization. Students used the information gained from the needs assessment to update their literature reviews and tailor their DEx proposals into individual projects that would meet the needs of Rockridge Retirement Community. This report highlights one project conducted by TeamWNEU which sought to address the needs of individuals with dementia and their care partners.

II. Interprofessional Practice and Care Partner Education for Dementia Care Excellence

Problem Statement

Care partners of people with dementia are critical to the quality of life of the care recipients. Care partners face many obstacles as they balance caregiving with other demands, including staffing shortages resulting in overtime hours and their own relationships and responsibilities outside of the work environment (Brodaty & Donkin, 2009). Care partners are at increased risk for burden, stress, depression, and a variety of other health complications. The effects on caregivers are diverse and complex, and there are many other factors that may exacerbate or ameliorate how caregivers react and feel as a result of their role. Numerous studies report that caring for a person with dementia is more stressful than caring for a person with a physical disability (Brodaty & Donkin, 2009).

Among the challenges that dementia presents to both family and staff care partners, the most significant may be its impact on communication. Care partners typically have a long history of interpersonal communication habits which they relied on prior to the onset of the disease or during its early stages. When confronted with the consistent cognitive transitions of the person with dementia, there are very limited resources available to care partners that describe how they could alter their own communication behavior to accommodate the needs of their loved one, and even if they do, they may not know how to accommodate effectively. *While the cognitive impairments and limitations experienced by individuals with dementia are widely studied, there are limited resources available to care partners on how an individual's cognitive level can be* *used as a tool to help promote meaningful engagement in activities. The resources that are available are outdated and do not appeal to the adult learner. Furthermore, staffing shortages, schedule constraints, and willingness to participate in supplemental training in addition to the high demands of their job impact care partners' ability to access education on dementia care excellence.*

Significance of the Problem for OT

Occupational therapy practitioners, through their academic curricula, expertise in activity analysis, and work with older people in various settings, approach dementia as a condition that affects occupational performance (AOTA, 2017). Practitioners work with care partners, including family members, concerned others, and those in the early stages of the disease to address the functional implications of dementia. Occupational therapists evaluate persons with dementia to determine their strengths, impairments, and performance areas needing intervention (Schaber & Lieberman, 2010). Remediation of cognitive performance is unlikely and therefore not a productive approach to dementia care excellence. Practitioners instead focus on habilitation rather than *re*habilitation, where the emphasis is placed on abilities that remain with the individual rather than what has been lost. This model may result in their demonstrated improved function through compensation or adaptation and aligns well with the philosophy of person-centered care.

In response to rising dementia rates, stakeholders including health professionals, long-term-care organizations, and the federal government emphasize workforce care partner education to improve outcomes for people with dementia and decrease care partner burden (Weiss et al., 2017). According to the Workforce Development Workgroup of the National Research Summit on Dementia Care, educating and training the workforce is a broad initiative involving a diverse team of informal and formal care partners (Weiss et al., 2017). However, despite robust evidence for effective dementia care strategy and ample educational programs designed to disseminate knowledge, care partner teams struggle to apply research-informed interventions in practice (Burke & Gitlin, 2012).

Purpose of Project

The purpose of this project is to explore the implementation of a care partner education intervention program to determine knowledge gained on dementia care excellence.

Theory/Models

The theory and models used in the project include Adult Learning Theory, Allen's Cognitive Levels, the Person-Environment-Occupation-Performance model, Person-centered Care, Habilitation Therapy, Reminiscence Therapy, and Interprofessional Collaborative Practice model, all of which are explored in detail in the following section.

Project/Study Question

How does providing an educational intervention to interprofessional care partners on a memory care unit at an assisted living residence result in knowledge gained on dementia care excellence?

III. Literature Review

Introduction to Dementia

The Center for Medicare & Medicaid Services (CMS) has identified individuals with dementia as a high priority population in need of quality improvement (Wong & Leland, 2018).

The Alzheimer's Association describes dementia as a general term which covers a wide range of specific medical conditions. These conditions result in the loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life (Alzheimer Association, 2020). Disorders that fall under the term dementia are caused by abnormal brain changes and include Alzheimer's disease, which makes up 60 to 80 percent of dementia cases. Other disorders which present with dementia include Lewy Body Dementia, Vascular Dementia, and Frontotemporal Dementia, all of which make up 5 to 10 percent of dementia cases. Diagnoses such as Parkinson's and Huntington's disease make up the rest (Alzheimer Association, 2020). At a global level, around 50 million people have dementia. The total number of people with dementia is projected to reach 82 million in 2030 and 152 million in 2050 (Kristensen & Peoples, 2020). The CMS initiative emphasizes enhancing client outcomes and overall quality of life through person-centered approaches.

Dementia caregiving varies from other health issues in the duration of disease, progressive nature of disability, the fact that many caregivers are themselves old with possible disease or disability, and the lack of disease modifying treatments (WHO, n.d.). Due to the progressive nature of the disease, the level of support increases as the disease progresses, starting with support for instrumental activities of daily living (household, financial and social activities) and expanding to include personal care and eventually almost constant supervision (WHO, n.d.). The severity of cognitive impairments and challenging behavior, the presence of comorbid physical and psychological problems, the custom and habits of the individual with dementia, and their personality and significant relationships determine the extent and level of care an individual requires as they progress through the disease. Occupational therapy practitioners in particular are well suited to be part of the interprofessional dementia care team. The Occupational Therapy

Practice Framework 3 (OTPF3) identifies client factors such as mental functions, problem-solving, perception, and process skills as areas specific to the OT scope of practice. Enhancing function, promoting relationships and social participation, and finding ways for those with dementia to enjoy life reflect the nature of occupational therapy practice and its emphasis on client-centered care.

Occupational Therapy & Dementia Care Excellence

The profession of occupational therapy is founded on the principles of client-centered care, facilitation of individual choice, and promotion of optimum performance (Fazio, Pace, Flinner, & Kallmyer, 2018). In essence, client-centered practice is a process in which the client is the focal point around which occupational therapy treatment evolves (Maitra & Erway, 2006). As a result, occupational therapy practitioners are experts at supporting society's older adults and maximizing quality of life for those living with dementia and their care partners. With 30% of occupational therapists and 55% of occupational therapy assistants working in long-term care facilities, the workforce in this setting is larger than almost any other practice area (Rafeedie, Metzler & Lamb, 2018). Through their diverse academic curricula, expertise in activity analysis, and work with older adults in numerous settings, occupational therapy practitioners approach dementia as a condition which progressively affects occupational performance, or an individual's ability to participate in everyday tasks including "activities of daily living" (ADLs) and "instrumental activities of daily living" (IADLs). The occupational therapy evaluation process for persons with dementia focuses on an individual's strengths and impairments to identify performance areas in need of intervention.

According to the 2018 Alzheimer's Association Dementia Care Practice Recommendations, person-centered care provides the underlying philosophy to dementia care and is essential to its practice (Fazio, Pace,Flinner, & Kallmyer, 2018). Similar to the concept of "client-centered care" in occupational therapy, person-centered care is a philosophy of care built around the needs of the individual and is contingent upon knowing the person through an interpersonal relationship. Both client and person-centered care challenge the traditional medical model of care, which tends to focus on processes, schedules, and organizational needs, rather than the needs of the individual. The nearly identical foundations of occupational therapy practice and philosophy of dementia care excellence highlight the distinctive and complimentary value of occupational therapy for dementia care and dementia care training.

Person-Centered Care

Person-centered care is a philosophy of care built around the needs of the individual and contingent upon knowing the unique individual and interpersonal relationship (Fazio, Pace, Flinner, Kallmyer, 2017). Person-centered care is a holistic and integrative approach designed to maintain well-being and quality of life for people with dementia. The Person-centered care philosophy recognizes that individuals have unique values, personal history, and personality and that each person has an equal right to dignity, respect, and to participate fully in their environments (Alzheimer's Society, n.d.). Person-centered care emphasizes the individual rather than their condition, and the individuals' strengths and abilities rather than their functional losses. At the core of person-centered care is the self—who we are, our values and beliefs, etc. Recognizing and maintaining selfhood is key to person-centered care. When a person is seen as diminished due a decline in cognitive functioning, they may be treated as if they were no longer a human being and in nonhuman ways (Fazio, Pace, Flinner, & Kallmyer, 2017). Fazio, Pace, Flinner, & Kallmyer (2017), suggest that some of the most disabling effects of brain disease are to be found not in functional impairment but in the threats to one's self and personhood. These authors suggest personhood is dependent on other people. Recognizing that selfhood persists, learning about the complete self, and finding ways to maintain selfhood through interactions and conversations are fundamental components of person-centered care for people with dementia (Fazio, Pace, Flinner, & Kallmyer, 2017).

Person-centered care is founded on an interactive process, in which people with dementia are active participants in their own care throughout the various stages of the disease (Alzheimer's Society, n.d.). Under the person-centered care model, care partners play an essential role in ensuring the health and wellbeing of their loved ones. The ultimate goal of person-centered care is to create a dynamic partnership between care home staff, people with dementia, and their families (Alzheimer's Society, n.d). It is through this partnership that person-centered care enhances the quality of life and the quality of care of people with the disease. Services and supports are designed and delivered in a way that is integrated, collaborative, and mutually respectful if all persons involved. Person-centered care is an important component to providing quality dementia care as it facilitates an individual's ability to retain personal worth, provides decision-making opportunities, and promotes a feeling of independence (Wong & Leland, 2018).

Person-Environment-Occupation (PEO) Model

The Person-Environment-Occupation (PEO) Model was developed to provide a framework for delivering occupational therapy services that encompass a client-centered approach addressing three components: the person, the environment, and the occupation (Wong & Leland, 2018). The person refers to an individual with a unique set of identities, experiences, and abilities; the environment is a broad domain that comprises physical, social, cultural, and socio-economic factors; and the occupation refers to the functional tasks and activities that the individual engages in. The PEO Model was created around the theory that interaction of the person, environment, and occupation facilitates participation (Wong & Leland, 2018). If there is a good fit amongst these constructs, meaningful participation increases, whereas a poor fit can threaten engagement or performance. The fit between the PEO interactions is defined by the quality of a person's experience with regard to their level of satisfaction and functioning (Wong & Leland, 2018). According to Wong & Leland (2018), the interconnected relationship presented in the PEO Model can provide a framework for understanding people with dementia and providing client-centered care. By encompassing the person with the occupation and the nursing home environment, different factors interact as barriers or facilitators to providing quality care (Wong & Leland, 2018). As a result, the PEO Model can be used to understand and develop person-centered interventions for people with dementia.

Life stories

A life story is the story about a person's entire life. A life story is usually related orally, although it may be written by the story teller (Wicks & Whiteford, 2003). According to Wicks & Whiteford (2003), the definition of a life story is "...the story a person chooses to tell about a life he or she has lived, told as completely and honestly as possible, what is remembered of it, and what the teller wants others to know of it". The content of a life story includes descriptions and explanations of a person's activities, experienced within different natural contexts, at each stage of life. A life story is also a personal interpretation of the storyteller's own experiences (Wicks & Whiteford, 2003). As such, a life story cannot be verified or withstand the test of reliability or representativeness. Although a life story does not reveal the past as it actually was, aspiring to a standard of objectivity, it does provide the truth of experience. Experiences can be understood by appreciating the contexts that shaped them and the worldviews that informed them (Wicks & Whiteford, 2003).

There are three significant reasons life stories are important inclusions to the repertoire of occupational therapy practice. First, the use of life stories preserves the integrity of individuals, accepts individuals' experiences as credible, and recognizes that individuals interact within a variety of contexts over time. Second, there is a strong connection between stories and occupation, in that stories are accounts of people's occupations, and it is through stories that people give meaning to their occupational experiences (Wicks & Whiteford, 2003). As occupational therapy is founded on the claim that occupation affects the health of individuals and the primary role of occupational therapy is to enable people to participate in meaningful occupation, then it is essential that occupational therapy research is occupation-based and incorporates the use of stories (Wicks & Whiteford, 2003). Life stories are particularly useful and relevant to occupational therapy practice because they can provide rich information about the range and form of occupations in which people participate. Life stories can also augment understanding about the meaning, experience and function of occupation throughout a person's life course (Wicks & Whiteford, 2003). Such understandings can be incorporated into the occupational therapy knowledge base, and used to enhance occupation-focused practice. Given the recent renaissance of occupation, and the growing awareness that occupation 'is the core of human experience and offers potential for growing, healing and connecting with others', occupational therapy can lead the way in promoting occupation for health (Wicks & Whiteford, 2003). Third, all life stories are set within contexts of time and place. Hence, a life story can provide researchers with a contextual framework within which to understand a person's occupational experiences. This reason is particularly relevant for occupational therapists, given

the dynamic interrelationships between person, environment and occupation (Wicks & Whiteford, 2003). The fourth reason for occupational therapists to use life stories is that the people who share their life stories in occupation-based research studies receive many personal benefits. *The various advantages gained by the life storyteller include: a clearer perspective on personal experiences and feelings; improved self-knowledge, self-image and self-esteem; satisfaction and pleasure from sharing one's own story; opportunity to release or purge certain burdens, and validate personal experience; and the acquisition of a sense of community* (Wicks & Whiteford, 2003). Essentially, sharing life stories enables people to become increasingly conscious of their own actions and situations in the world (Wicks & Whiteford, 2003).The following quote encapsulates the essence of empowerment through storytelling:
"Telling our story enables us to be heard, recognised and acknowledged by others. Story makes the implicit explicit, the hidden seen, the unformed formed and the confusing clear" (Atkinson, 1998, p. 7).

Allen's Cognitive Level Framework

Allen's Cognitive Level Screen (ACLS) is an evidence-based, standardized screening assessment of functional cognition developed within the framework of the cognitive disabilities models. The ACL evaluates the ability of an individual to make decisions, function independently, safely perform basic skills, and learn new abilities. The ACL framework defines 6 levels and 52 modes of performance to define the range of cognitive function and disability; (1) automatic function; (2) postural actions; (3) manual actions; (4) goal-directed actions; (5) exploratory actions; (6) planned actions. The framework focuses on the role of cognition, the role of habits and routines, the effect of physical and social contexts, and the analysis of activity demand. The ACLS and framework applies to all performance areas of the Occupational Therapy Practice Framework, including activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation (Cole & Tufano, 2008). Limitations in cognitive abilities create predictable safety issues in daily occupations and have been used to guide decisions regarding the clients' ability to live independently, demonstrate autonomy in being self-directed, and show competence in managing one's own affairs (Cole & Tufano, 2008).

The ACL framework uses the concept of task equivalence to identify daily life activities that have similar physical and cognitive demands based on task analysis (Cole & Tufano, 2008). The ACLS uses leather lacing stitches which have been researched and found to be "equivalent" to various daily tasks. Task analysis is a method of determining the complexity of an activity by separating the activity into steps and determining the physical and cognitive functional capacities required to perform each step (Cole & Tufano, 2008). The task demand includes the materials, equipment, instructions, assistance, and skills necessary to accomplish a task. According to Cole & Tufano (2008), the demands of a task or activity are derived from the task analysis together with conceptual factors. The task environment is the setting in which the task is performed, including furniture and seating, lighting, temperature, placement of supplies, equipment available, positioning of clients, assistance available and other relevant attributes affecting occupational engagement (Cole & Tufano, 2008). The ACL framework provides specific guidelines for structuring the task environment at each cognitive level and mode to optimally facilitate a client's best ability to function. The ACLS and framework therefore provide the foundation for designing care partner interactions based on their loved ones identified cognitive level. The portion of the environment at which clients are aware at different cognitive levels is as follows: (1) self, internal cues; (2) body; (3) arm's reach; (4) visual fields; (5) immediate task environment; (6) potential task environment (Cole & Tufano, 2008). In understanding where their loved one falls on this scale, care partners can work with their loved one's interprofessional care team to design the optimal environment for meaningful and satisfying interactions.

Dementia Care Partners

The term "care partner" has been defined as "an unpaid, nonprofessional care assistant, usually a family member, who assumes primary responsibility for assisting a chronically impaired individual with the management of their health" (Bennett, Wang, Moore & Nagle, 2016). While this definition of care partner is popular, the term has been expanded to include any individual who is a stakeholder in the care of the patient; this most commonly includes partners, friends, neighbors, and others who provide or manage the care of the person with a serious illness or disability (Bennett et al., 2016). At the Rockridge Retirement Community specifically, the term "care partner" refers to all staff including "resident care assistants".

Each person with dementia has a unique set of abilities and care needs that change over time as the disease progresses. The cognitive impairments experienced by individuals with dementia require care partners to constantly adjust the level of support they provide, starting with support for instrumental activities of daily living (household, financial and social activities) and expanding to include basic activities of daily living and personal care tasks such as bathing, dressing, and self-feeding. Due to the dynamic and demanding requirements of caring for an individual with dementia, multiple studies have confirmed that dementia care partners endure higher levels of caregiver burden than non-dementia caregivers (Alzheimer's Association, 2021). The 2021 Alzheimer's disease Facts and Figures published by the Alzheimer's Association reports that nearly 60 percent of dementia caregivers rate their emotional stress levels as high or very high. Consistently high stress levels directly contribute to the development of care partner burnout and negatively impact both physical and mental health. A meta-analysis of several studies on mental health disorders among Alzheimer's and other related dementia care partners found that the prevalence of depression was 34 percent and anxiety was 43.6 percent (Sallim, Sayampanathan, Cuttilan, & Ho, 2015). Without strong support systems in place, Alzheimer's care partner burnout can set in, jeopardizing the physical and mental health of care partners and dementia patients alike.

In 2018 alone, 16.3 million families and friends called "informal caregivers" (ICGs) provided 18.5 billion hours of unpaid care to people with Alzheimer's and other dementias, which valued about $234 billion. Informal caregivers of individuals with cognitive decline experience high rates of burden and depression. Although caregiver support groups exist, tangible supports are rarely provided. A randomized controlled trial was conducted in which individualized OT interventions were provided for three months to support caregiving challenges faced by caregivers of people with dementia. The interventions included illness education, training for safe transfers, medication and appointment organization, exercise methods, and more. The study found that the occupational therapy interventions were effective in decreasing depression and mental fatigue and increasing confidence to provide for the next six months, despite the worsening cognitive status of their care recipients. This research suggests that providing ongoing education and support to care partners of people with dementia may decrease the negative mental and physical impacts of caregiving.

Communication is a dynamic and evolving aspect of dementia care. Care partners and individuals with dementia both report difficulty maintaining good communication throughout the dementia disease course (Small & Perry, 2013). According to Small & Perry (2013), difficulty in communication has been shown to be associated with conflict in relationships, social isolation and depression, burden and stress for care partners, and an increased need to seek outside care support. Because dementia brings about considerable changes in cognitive and psychosocial functioning, care partners may find that the communication skills they previously relied on are no longer adequate to meet the new challenges their loved ones face throughout the disease course. Research suggests that care partners' perceptions of how they communicate with a person who has dementia do not always coincide with their actual communication behaviors, and that some of these behaviors are not conducive to positive communication outcomes. In a survey of 112 family care partners of persons with dementia on their medical, educational, and psychological needs, the desire to develop effective care partner-to-patient communication skills was the most frequently expressed need by responders (Small & Perry, 2013). For these reasons, there is a need to provide care partners with education and training that will enable them to develop a greater awareness of and sensitivity to their own communicative behaviors and how these shape the quality of their interactions with persons who have dementia and to provide new skills and strategies for fostering positive communication.

Adult Learning Theory for Care Partner Education

Providing training and planned learning experiences to practitioners and community partners is fundamental to effective public health. The extent to which principles of adult learning currently guide such training is unknown and likely varies widely. There are numerous theories and models that seek to describe or explain how adults learn. Bryan. Kreuter, & Brownson (2009) sought to introduce five principles of adult learning that would facilitate adult learning, collaborative efforts, and mutual respect between agencies, practitioners, and community partners. The five principles include: (1) adults need to know what they are learning; (2) adults are motivated to learn by the need to solve problems; (3) adults' previous experience must be respected and built upon; (4) adults need learning approaches that match their background and diversity; (5) adults need to be actively involved in the learning process.

Occupational Therapy and Consultation

Consultation occurs between the consultee and the consultant in order to foster beneficial change in a referred client (Dudgeon & Greenberg, 1998). The consultant can have either indirect influence, through collaboration with consultees, or direct influence on the client. Consultation has been characterized somewhat differently across professions. According to Dudgeon & Greenberg (1998), consultation in medicine is often characterized by an expert or second opinion or a specialist's counseling and recommendation as part of a comprehensive care plan. In education, consultation is usually described as a collaborative model of problem solving around shared concerns. In occupational therapy, consultation has been characterized by the interaction between two or more parties who engage in collaborative efforts (Dudgeon & Greenberg, 1998). Providing consultation to colleagues and systems has emerged as a routine expectation of occupational therapy practitioners in various settings (Dudgeon & Greenberg, 1998). Shifts in practice have tended to place specialists, such as occupational therapy practitioners, in roles outside the tradition of direct service to clients and their families. According to Dudgeon & Greenberg (1998), three broad types of consultation have emerged in occupational therapy: case or client centered, education or colleague centered, and (c) system or program development based. Client-centered concerns are the most common use of consultation in occupational therapy. Colleague consultation approaches often emerge from case management challenges, and are used to address personnel preparation needs. System, or program consultation is most commonly associated with new program development or with business and industry. Dudgeon & Greenberg (1998) considered the use of consultation as an inherent part of occupational therapy practice.

Various approaches to consultation have been described and subsequently contrasted in the literature, with the collaborative and expert approach emerging as themes. The collaborative approach is characterized by partnership and agreement, whereas the expert approach is depicted as the consultant taking control and influencing identification of problems and management of interventions. Common relationships can emerge between consultant and consultee regarding problem identification and intervention actions. Relationships that are formed and followed depend on the relative perspectives, knowledge, skills, experiences, and resources of the consultant, consultee, and client. Four different types of relationship patterns have been identified in the literature: consultee led, consultant led, partnership, and programmatic. Consultation is a technical skill that involves dynamic human relationships in an ever-changing environment.

Interprofessional Practice

The Patient Protection and Affordable Care Act. The Patient Protection and Affordable Care Act (ACA) is the comprehensive healthcare reform law enacted in March 2010 to combat the developed worlds' most dysfunctional healthcare system. The ACA has three primary goals: to make affordable health insurance available to more people, to expand the Medicaid program to cover all adults with income below 138% of the federal poverty level, and to support innovative medical care delivery methods designed to lower the cost of health care overall (U.S. Center for Medicare and Medicaid, 2019). Primary care is a key theme of the ACA and is defined as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (Metzler, Hartmann & Lowenthal, 2012). Interprofessional collaboration lies at the center of these reform efforts, particularly in the advancement of Patient Centered Medical Homes (PCMH). Interprofessional collaboration is defined as " the partnership between a team of health providers and a client in a participatory collaborative and coordinated approach to shared decision making around health and social issues" (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011). Elements of collaborative practice include responsibility, accountability, coordination, communication, cooperation, assertiveness, autonomy, and mutual trust and respect (Bridges et al., 2011). It is this partnership that creates an interprofessional team designed to work on common goals to improve patient outcomes in the patient centered medical home (PCMH). In the PCMH, or the medical home model, the patient has a personal healthcare provider trained at administering first contact, continuous, and comprehensive care. The personal provider leads a team of interprofessional care providers at the practice level who collectively care for the patient throughout their life. The team coordinates care across all elements of the healthcare system and through the patients' lifespan (Center for Medicare & Medicaid Services, 2019). The PCMH is accountable for meeting both physical and mental health needs of patients with a focus on prevention and wellness, treatment of acute illness/injury, and the continuous care and management of chronic medical conditions (U.S. Department of Health, 2019).

Interprofessional Collaboration

Collaboration is a term commonly used in research, clinical practice, and health professions education. Interprofessional collaboration occurs when 2 or more professions work together to achieve common goals and is often used as a means for solving a variety of problems and complex issues (Green & Johnson, 2015). There are collaborations in almost every aspect of health, such as patient advocacy and health care collaborative, collaborative learning, interprofessional collaboration in practice and in education, health care value collaborations, business collaborations, collaborative efforts in research and funding (Green & Johnson, 2015). The benefits of collaboration allow participants to achieve together more than they can individually, serve larger groups of people, and grow on individual and organizational levels. Collaborating usually provides a means for organizations, institutions, or professions to achieve more than they can on their own. Business has used collaboration for many years to share costs, spread risk, and reduce supply chain uncertainty while forming strategic economic alliances that also serve as fertile grounds for innovation and learning (Green & Johnson, 2015). Collaboration potentially reduces self-sufficiency in environments demanding great flexibility and innovation. According to Green & Johnson (2015), there are 12 benefits to collaboration: (1) opportunities to learn and go beyond traditional ways of thinking; (2) access to people we would not normally reach in order to serve a larder body of people; (3) potential to develop lifelong relationships and bonds that may be beneficial in the future; (4) gain from the wisdom of others; (5) access the new resources and the potential to develop new skills; (6) increased productivity through doing more work in less time; (7) sharing recognition and accolades; (8) association with others who are successful; (9) association with others who are successful; (10) improved access to moneys as some funding bodies only support collaborative projects; (11) cross fertilization across disciplines; (12) the "pooling knowledge for tackling large and complex problems".

According to the World Health Organization, "collaborative practice in health-care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, careers and communities to deliver the highest quality of care across settings" (WHO, 2010). Interprofessional collaborative practice (IPCP) involves more than different health care providers applying their unique skills and knowledge to the management of an individual. Collaboration occurs when individuals have mutual respect for one another and one another's professions and are willing participants in a cooperative atmosphere. It has been suggested that IPCP is different from interdisciplinary, multidisciplinary, and transdisciplinary practice, all terms used within the recent past to denote care provided by more than 1 health care provider for the benefit of a patient. While these practices are indeed noteworthy for their contributions to health care, the unit of study is a single patient and the model is focused on the health care provider(s), whereas the unit of study in IPCP is often a community of patients and the model is focused on improving health outcomes.

Reminiscence Therapy

Reminiscence Therapy (RT) involves the discussion of past activities, events and experiences with another person or group of people, usually with the aid of tangible prompts such as photographs, household and other familiar items from the past, music and archive sound recordings (Woods, Spector, Jones, Orrell, & Davies, 2005). Reminiscence therapy is one of the most popular psychosocial interventions in dementia care, and is highly rated by staff and participants. According to Woods, Spector, Jones, Orrell, & Davies (2005), there is some evidence to suggest it is effective in improving mood in older people without dementia. Its effects on mood, cognition and well-being in dementia are less well understood. Reminiscence groups typically involve group meetings in which participants are encouraged to talk about past events at least once a week. Life review typically involves individual sessions, in which the person is guided chronologically through life experiences, encouraged to evaluate them, and may produce a life story book. Family care-givers and other care partners are increasingly encouraged to be involved in reminiscence therapy.

Habilitation Therapy

One approach to treating individuals with dementia from a person-centered model is habilitation therapy. The aim of habilitation therapy is not to restore people with dementia to what they once were (i.e., *re*habilitation), but to maximize their functional independence and morale (Reia, 1999). While rehabilitation models focus on assisting individuals in returning to their level of functioning prior to illness or injury, the habilitative model instead emphasizes maximizing the functional independence at the individual's current level (Reia, 1999). For those who have experienced a significant decline in cognitive functions, Reia (1999) argues that one of the best ways to maximize functional independence is to elicit positive emotions throughout the day. This is particularly helpful because the ability to feel emotions does not diminish with dementia (Riea, 1999). Riea (1999) argues that there are 5 domains

The Centers for Medicare & Medicaid Services (CMS) led an innovation study in 2013 to help determine whether habilitation therapy techniques could be utilized to help manage dementia-related behaviors. In this study, 30 Massachusetts nursing homes participated in the project over a 12-month period. The project involved the creation of an interdisciplinary behavior team, habilitation therapy training, various check-ins, and monthly collection of process and measure data. The primary intervention during this study was the provision of 10 hours of habilitation therapy training to staff, as well as the utilization of interdisciplinary behavior teams to help track and understand resident behaviors. Researchers were interested in looking at the connection these interventions have to quality measures including the use of antipsychotic medications, the experience of depression symptoms, and the frequency of falls, urinary tract infections, and the use of physical restraint (Fitzler et al., 2016) At the end of the 12-month period in which the habilitation therapy interventions were implemented, it was found that participating facilities showed improvement on 9 of the 12 reported measures (Fitzler et al., 2016). The most notable impact was seen in a 42.03% decrease in self-reported resident-on-staff alterations (Fitzler et al., 2016). These results demonstrate the value of training staff members in habilitation therapy as part of quality improvement programs at nursing homes.

Self-feeding and Nutrition

As people age, self-feeding is an activity of daily living (ADL) that can be affected due to a variety of medical conditions that impact motor and/or processing skills (Swiech, Sullivan & Helfrich, 2020). The Occupational Therapy Practice Framework defines feeding as “setting up, arranging and bringing food [or liquid] in from the plate or cup to the mouth; sometimes called self-feeding” (AOTA, 2014, p.S19). According to Swiech, Sullivan & Helfrich (2020), Individuals with cognitive or physical dysfunction can decline in independence with self-feeding tasks due to their condition. Conditions that may impact self-feeding independence include, but are not limited to: arthritis, Parkinson’s disease, dementia, cerebral vascular accident (CVA), multiple sclerosis, limitations of active range of motion in bilateral upper extremities, decreased fine motor control in hands, decreased vision, and difficulty concentrating during tasks. Occupational therapists can positively influence a person's independence with self-feeding through the use of their unique skills by adapting the equipment and the environment, and/or educating the client and their care partners on compensatory techniques.

According to Swiech, Sullivan & Helfrich (2020), maintaining respect while assisting with self-feeding by helping only when necessary and sitting next to the client as opposed to standing over them is essential for client success. Because self-feeding is a time for social interaction, the authors suggest maintaining a conversation with the client while focusing on the meal if it is safe to do so. Positioning for self-feeding is essential to prevent aspiration or choking. When addressing feeding, the first priority is to ensure that the individual is sitting upright without any lateral lean (Swiech, Sullivan & Helfrich, 2020). During self-feeding tasks, the client should be sitting as far back in their chair as possible with their knees bent at 90 degrees. Their feet should be either resting on the floor or the footrests of their chair if applicable. Clients should be as close as possible to the table to minimize the amount of food that falls onto the lap. This position also discourages slouching, which can interfere with swallowing.

According to Swiech, Sullivan & Helfrich (2020), a decline in one’s ability to self-feed does not necessitate total assistance from a caregiver. In some cases, providing small verbal cues or slight physical assistance can help increase independence. Swiech, Sullivan, & Helfrich state that it is essential to encourage independence with a self-feeding task before jumping in to help. Clients who may be easily distracted in larger dining areas may require increased verbal cues and prompting. The researchers suggest that if an individual has stopped eating due to distractions, reminding them to continue eating and redirecting them to their task is an appropriate cue. The same technique of verbal cuing can be effective if the client uses their fingers versus utensils, or they use incorrect utensils. Simple prompts for using utensils, or ensuring appropriate utensil choice, may be enough to assist the client in increasing their independence in self-feeding, without physical assistance.

Complex nutritional problems arise in dementia over the course of the disease with the progressive decline in cognitive and behavioral functions, finally losing the ability to independently function physically (Swiech, Sullivan & Helfrich, 2020). Thus due to mental and cognitive impairments, physical disabilities and psychological factors (depression and agitation), people living with dementia have difficulties associated with eating and drinking. These include partial or complete help and support required to eat as skills may be lost (access food to mouth), decreased sense of thirst and the ability to chew (Swiech, Sullivan & Helfrich, 2020). Nutrition-related complications in dementia can contribute to stress and caregiver burden. In addition this burden can develop into a cycle that can increase the risk of poor eating behavior and weight loss. Nutritional interventions that enable improvements in food and drink intake offer an opportunity to interrupt the potential risk of weight loss, undernutrition and dehydration, the consequent decline in cognition as well as alleviating the associated care burden.

A number of recently published articles have reviewed the current research on interventions aiming to improve food and drink in people with dementia including those living in long term residential care. Interventions that modify food and drink include—oral nutritional supplements, assistance with eating and drinking, managing swallowing problems as well as those that offer environment-related interventions during mealtimes including eating location and arrangement, ambient sounds and music, aroma, temperature and lighting and food presentation. However there is no definitive evidence on the effectiveness and sustainability of such interventions to improve the nutritional health and wellbeing of people living with dementia in long term care settings or the potential to reduce cognitive decline in dementia.

IV. METHODOLOGY

Project Design

An educational program evaluation design was used to test knowledge gained by interprofessional care partners following a dementia care excellence educational intervention utilizing adult learning theory. A single group pre-/posttest design was used to measure the effectiveness of using adult learning theory as the basis for creating and administering an educational intervention regarding dementia care to interprofessional care partners at the Rockridge Retirement Community.

Participants

Two sampling methods were used to determine participants in the educational intervention program. A convenience sampling method was used to recruit participants based on their availability and willingness to take part in the educational training program. The educational intervention was offered to all Rockridge Retirement Community staff and departments, including: Wellness Resident Care Assistants, Life Enrichment Programing, Dining Services, Building Services, and the administration. A small portion of participants were recruited via the purposive sampling method, as these individuals were required to participate in educational training based on the terms of their contract as new hires. The participants were not required to answer further demographic questions besides their respective departments. The data were collected at two points: prior to the beginning of the educational intervention (n=28), and immediately after completion of the educational intervention (n=20).The participants who completed the entire educational intervention program were administered the post-test evaluation. A breakdown of participants who participated in the pretest, educational intervention, and posttest by department can be seen in Figure A1 and B1.

Program

The educational intervention program was modified from the standardized Alzheimer’s Association Person-Centered Dementia Care Training Curriculum. The intervention program utilized a pretest/posttest design to measure knowledge gained from the educational intervention. The educational intervention consisted of nine training modules intended to educate interprofessional care partners on dementia care excellence. The educational intervention categories are represented in Table 1. Student researchers worked with the Interim Director of Education and Training to determine which individual module each would be responsible for editing. The modified educational materials utilize adult learning theory to address the needs identified for the subject population. In order to ensure consistency throughout the editing process, the student researchers edited Module one A & B as a group. During this process, they developed guidelines for editing to ensure consistency when working on their individual modules. The guidelines addressed formatting, font size, color, and overall theme. Additionally, students were instructed to use various multimedia in format of short videos, or “TikToks”, GIFs, audio clips, and more to the educational intervention in accordance with adult learning theory implementation. The student researchers utilized a curriculum matrix design to ensure dementia care practice content was adequately covered in each individual module and reflected in the assessment tool. Although each student researcher was responsible for the initial edits to their specified modules, each module was then edited by the entire research group to ensure consistency. Student researcher S.O., OT/s was individually responsible for Module 6 B and Module 9. Module 6 B was eventually combined with 6 A during the editing process.

The educational intervention was mandatory for all new staff in order to meet the Executive Office of Elder Affairs Assisted Living Residence state regulations for new hires, but not mandatory for those already employed at Rockridge who had completed their orientation requirements at the time they were hired. Participants from Building Services, Life Enrichment Programming, and the Wellness department volunteered to participate in the training, which took place during paid working hours. The full educational intervention occurred over a six week span. The first week, participants took the pretest (See Figure A1.) and were oriented to the program. Over the next four weeks, participants attended weekly sessions where they were taught up to three modules at a time. Twenty members of Rockridge Retirement Community staff participated in the completed educational intervention. An additional intervention opportunity was offered as a condensed, accelerated version of the nine training modules. The condensed educational intervention occurred over two days, in which six members of staff participated in and completed. A posttest (See Figure B1.) was administered after the completion of the nine training modules. Quantitative data were collected to assess the percentage of questions participants scored correctly in both the pre- and posttest (See Figure A2. & B2).

Table 1

Educational Intervention Training Modules	**Dementia Care Excellence Content**
Module 1: Understanding Dementia: Caring for the Individual (TeamWNEU)	Person-centered care (PCC) Aging Memory, Alzheimer's, and Dementia Mild Cognitive Impairment Risk Factors for Dementia Anatomy of the Brain Stages of Alzheimer's Disease
Module 2: Person-Centered Care Model: Habilitation Therapy (A.A.)	Person-centered care (PCC) Habilitation therapy Habilitation therapy domains

Module 3: Person-Centered Assessment: Knowing the Individual (A.A.)	4 Components of Person-centered Care Person-centered Care through assessments Utilizing Life Histories 6 Domains of an Assessment Assessment Process Care-partner Communication
Module 4: Communication Skills: Creating a Positive Social Environment (C.A.)	Dementia-related Changes in Communication Behavior as Communication Nonverbal Communication 5 Strategies that Reinforce Person-centered Communication
Module 5: The Physical Environment Makes a Difference (B.E.)	Person-centered Environments Vision & Dementia Auditory Processing & Dementia Modification of the Environment to Promote Success in ADLs
Module 6: Approach to Personal Care: Knowing the Person (B.E. & S.O.)	Dementia & Personal Care Graded Supportive Care Person-centered Care Approaches for ADLs Doing Care *With* a Person vs. *To* a Person
Module 7: Activity-Based Person-Centered Care (A.A.)	Meaningful and Appropriate Engagement Activity-based Person-centered Care Sensory Engagement Practices Environmental Interventions Psychosocial Activities

Module 8: Behavior as Communication: Understanding and Responding (C.A.)	Responsibilities of care partners Common dementia-related behavioral expressions Identifying the cause or trigger of behavioral expressions Commonly observed dementia-related behaviors Internal vs. external triggers Behavioral expression logs De-escalating behavioral expressions
Module 9: Supporting Families and Caring for Ourselves (S.O.)	How dementia affects the family Common family concerns How to build trust with families What we can do to support families Working with families who are upset/angry Burnout & compassion fatigue Stresses related to dementia & caregiving Taking care of yourself

Instrument and Data Collection

The data were collected through pre- and post parallel testing. Along with being responsible for modifying the content within their assigned modules, each group member was responsible for modifying the corresponding assessment questions. The student researchers utilized a curriculum matrix design to ensure that the content covered in the original modules were associated with assessment questions in the modified educational intervention. The original assessment included ten questions in various formats, including multiple choice and true/false style questions. The researchers used the content from the original assessment to develop forty multiple choice questions with four answer options. The student researchers eliminated any true/false style questions and questions formatted with double negatives. The certified Alzheimer Association Person-Centered Dementia Care Training Program facilitator divided the forty multiple choice questions into two, twenty question quizzes. The certificated facilitator administered the pre-test one to two weeks prior to the educational intervention commencement, as determined by staff availability and the test facilitator's schedule. After all participants completed the nine module educational intervention, the certified facilitator administered the post-test instrument.

Data Analysis

Quantitative data were collected to assess the percentage of questions participants scored correctly in both the pre- and posttest. The assessment was stored using Google Forms on a protected Google Drive account to summarize participant pretest and posttest scores regarding educational intervention retention. In addition to utilizing the functions available on Google Forms, Google Sheets was utilized for the comparison of pre-and post- test scores by department. The data collected were analyzed to compare pre-and posttest scores by department to determine if there was growth after the educational intervention.

V. Results

There were significant changes to the participants' pre-post scores after completing the Alzheimer's Association training. In figure one the scores of the pre-test are shown. The pre-test scores were an average score of 76% with the correct answers ranging from 11-19 out of 20. Shown in Figure 2 are the post test scores, the average score was 97% with correct answers ranging from 17-20 out of 20. Each participant that completed the test had scored higher on the post-test. Indicating a positive correlation of using adult learning theory when testing dementia care educational training retention in staff.

Data Organized in Graphs/Charts

Figure A: Pretest data analysis

Figure A1:

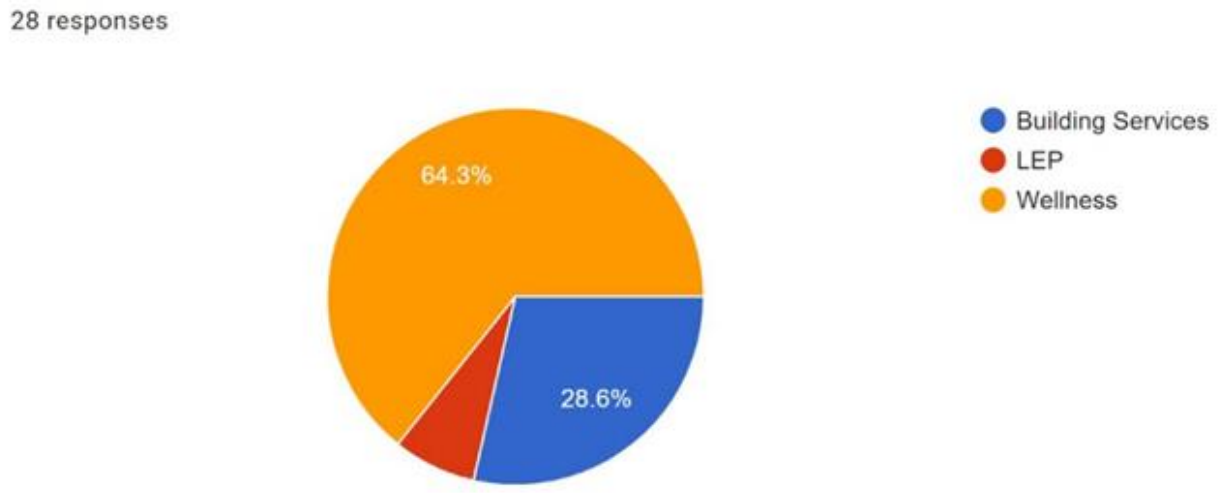


Figure A1: The following chart represents percent of staff department participations in the educational intervention pretest.

Figure A2:

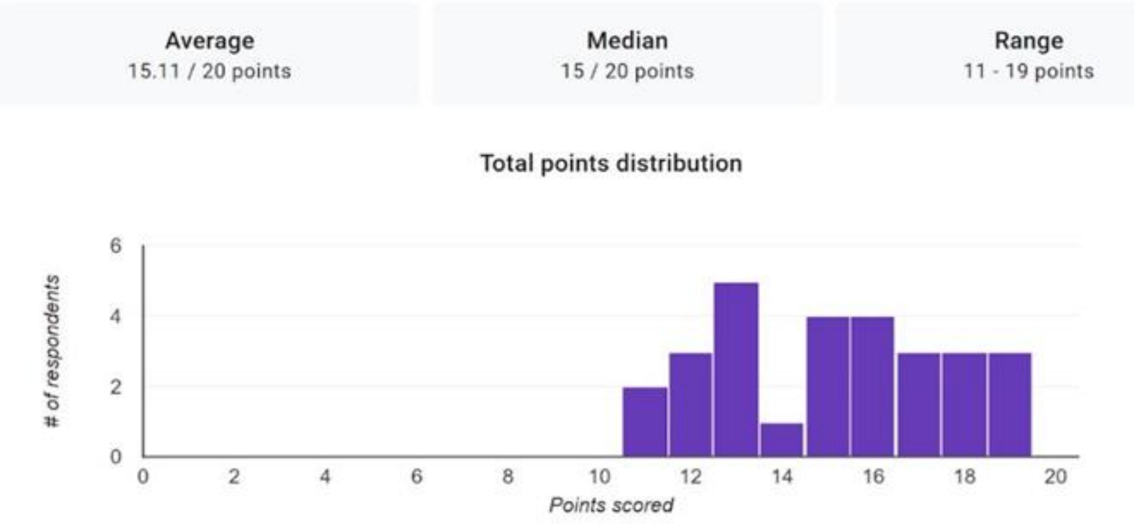
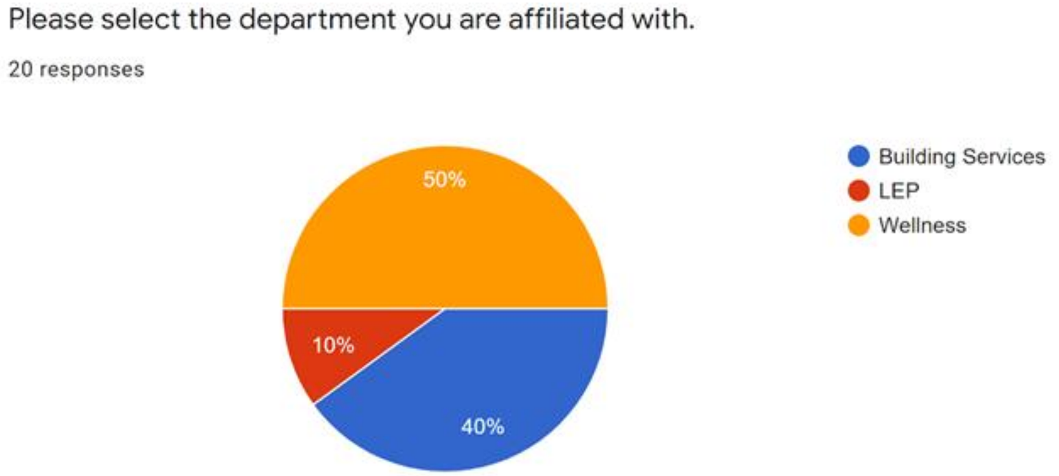


Figure A2: The following chart represents the number of correct answers selected by participants on the dementia care educational intervention pretest.

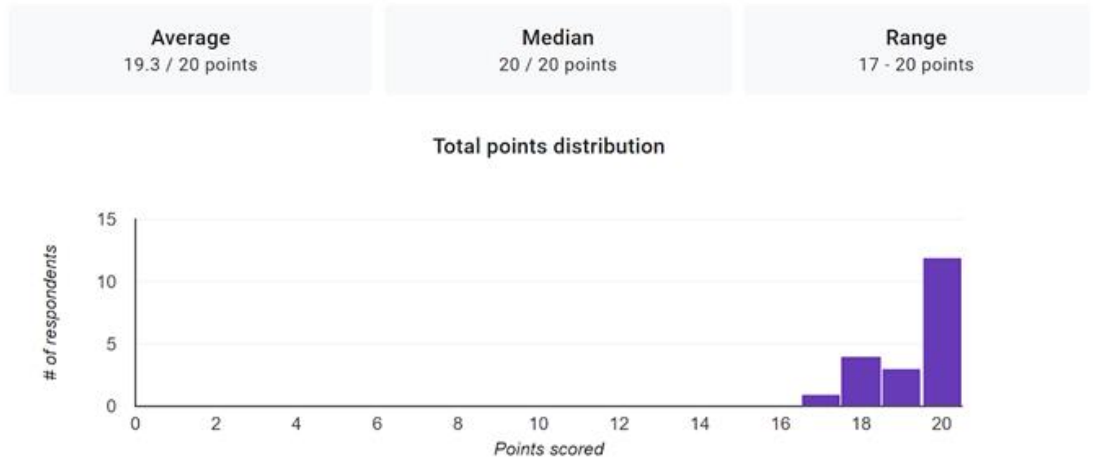
Figure B. Post data analysis



Please select the department you are affiliated with.

20 responses

Figure B1: The following chart represents percent of staff department participations in the educational intervention posttest.



Average
19.3 / 20 points

Median
20 / 20 points

Range
17 - 20 points

Figure B2: The following chart represents the number of correct answers selected by participants on the dementia care educational intervention posttest.

Figure 2. Posttest Data

Conclusion

This research study utilized an educational program evaluation design to assess knowledge gained by participants regarding person-centered dementia care excellence. The educational intervention utilized adult learning theory to appeal to the target audience of dementia care partners. Inclusion of adult learning theory involved redesigning the modules to fit the visual and content length suggestions for adult learners, while including multimedia, evidenced-based information, personal reflection activities, interactive simulations, and corresponding workbook materials. The original pre-tests were administered prior to the training and the average score for the pretest was 76% with scores ranging from 11-19 out of 20. The participants then began their training and were given educational resources such as a workbook tailored to the updated modules. Upon completion of the revised Alzheimer's Association training curriculum, the participants completed a parallel post-test with average scores of 97%, with correct answers ranging from 17-20 out of 20. The results from this study suggest that utilizing adult learning theory in staff educational programming may result in knowledge gained for dementia care partners.

VI. Discussion

The present study investigated the effects of using adult learning theory on knowledge gained when educating staff care partners on dementia care best practices. The educational intervention was implemented through a redesigned version of the Alzheimer's Association training curriculum to ALR care partners. The researchers modified the Alzheimer's Association curriculum by redesigning the modules to fit the visual and content length suggestions for adult learners, while including multimedia, evidence-based research, personal reflection activities, interactive simulations, and corresponding workbook materials. The researchers tested knowledge retention by administering a pretest and parallel posttest. The study results indicated a 21% average increase of knowledge retention for care partners, after completion of the redesigned Alzheimer's Association dementia care practice curriculum. One participant did not complete the posttest, this data was rejected from our final result calculations due to error.

Adult learning theory hypothesizes the learner will retain more educational information if the educator allows for an autonomous and self-directed learning experience (Loeb, 1991; Tough, 1971). For the purpose of this project, the researcher took the proposed adult learning cycle of activity, reflection, theory, and pragmatism, and applied these educational practices to the content used in care partner training (Langer, 2002). Based on the hypotheses of adult learning theory, the researchers expected these results.

Practical Implications. The advisability of incorporating adult-learning theory practices to redesign the educational curriculum of learners in healthcare settings is the most relevant practical implication of the present study. The facilitator of the redesigned Alzheimer’s Association dementia care excellence training modules noted increased alertness and participation of the care partners, during the training sessions. Increased utilizations of adult learning theory in institutional and organizational education and training curriculums, could improve information retention of adult learners.

Limitations and future research. This present study serves as a pilot study for use of adult learning theory to assess knowledge gained regarding best dementia care practices. Due to time constraints, the researchers were unable to submit this study to the Institutional Review Board (IRB) to coordinate various control groups and research rigor.

For future research, it would be beneficial to utilize a control group that was tested on information retention of the original Alzheimer's Association training curriculum that lacked adult learning theory. Additionally, it would be useful to employ a larger sample size, and increased departmental diversity to assess how beneficial adult learning theory improves dementia care for non-direct care partners.

In conclusion, this is one of the few studies that show the effectiveness of implementation of adult learning theory for dementia care training. As a result of the positive outcomes of dementia care partner information retention when using adult learning theory, the researcher believes it would be advantageous that further studies investigate adult learning theory for other populations with poor health and quality of life outcomes.

References

Alzheimer’s Association (2020). *Retrieved from* https://www.alz.org/alzheimers-dementia/what-is-dementia

American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*, 68(Suppl. 1), S1-S48.

Assisted Living Federation of America. (n.d.). What is assisted living? Retrieved from http://www.alfa.org/alfa/Assisted_Living_Information. Asp

Atkinson, R. (1998). The life story interview (qualitative research methods). Thousand Oaks, CA: Sage

Bennett, P. N., Wang, W., Moore, M., & Nagle, C. (2017). Care partner: A concept analysis. Nursing outlook, 65(2), 184–194. https://doi.org/10.1016/j.outlook.2016.11.005

Brodaty, H., & Donkin, M. (2009). Family caregivers of people with dementia. *Dialogues in clinical neuroscience*, *11*(2), 217–228. https://doi.org/10.31887/DCNS.2009.11.2/hbrodaty

Bryan, R., Krueter, M., Brownson, R. (2009). Integrating adult learning principles into training for public health practice. *Health Promotion Practice*. October 2009 Vol 10, No. 4, 557-563

Burke, J. P., & Gitlin, L. N. (2012). How do we change practice when we have the evidence? American Journal of Occupational Therapy, 66, e85–e88. https://doi.org/10.5014/ajot.2012.004432

Cole, M. B., & Tufano, R. (2008). *Applied theories in occupational therapy: A practical approach.* Thorofare, NJ: Slack, Inc.

Dudgeon, B., & Greenberg, S. (1998). Preparing students for consultation roles and systems. *American Journal of Occupational Therapy*, November/December 1998, Vol. 52, 801-809. https://doi.org/10.5014/ajot.52.10.801

Fazio,S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The Fundamentals of Person-Centered Care for Individuals With Dementia, *The Gerontologist*, Volume 58, Issue suppl_1, February 2018, Pages S10–S19, ttps://doi.org/10.1093/geront/gnx122

Fitzler, S., Raia, P., Buckley, F. O., Jr, & Wang, M. (2016). Does Nursing Facility Use of Habilitation Therapy Improve Performance on Quality Measures?. *American journal of Alzheimer's disease and other dementias*, *31*(8), 687–692. https://doi-org.wne.idm.oclc.org/10.1177/1533317516662335

Francis, T., Tomita, M., Binkewicz, K., Dinatale, K., Anderson, V., Grandolph, L., Tse, D., Vasisko, S., & Grandoloph, L. (2020). Effects of OT-Based Interventions to Reduce Perceived Burden and Depression of Caregivers of Older Adults With Dementia. *The American Journal of Occupational Therapy*, August 2020, Vol. 74, Supplement 1. DIO https://doi.org/10.5014/ajot.2020.74S1-PO3405

Green, B. N., & Johnson, C. D. (2015). Interprofessional collaboration in research, education, and clinical practice: working together for a better future. *The Journal of chiropractic education*, *29*(1), 1–10. https://doi.org/10.7899/JCE-14-36

Kelsey, S., Laditka, S., & Laditka, J. (2009, July 24). Dementia and transitioning from assisted living to memory care units: perspectives of administrators in three facility types. *The Gerontologist*, *50*(2), 192 – 203. https://doi.org/10.1093/geront/gnp115

Lieb, S. (1991). Principles of adult learning. Retrieved May 19, 2006, from http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/adults-2.ht

Maitra, K. K. & Erway, F. (2006). Perception of client-centered practice in occupational therapists and their clients. American Journal of Occupational Therapy, 60, 298–310.

Murphy, J. L., Holmes, J., & Brooks, C. (2017). Nutrition and dementia care: developing an evidence-based model for nutritional care in nursing homes. *BMC geriatrics*, *17*(1), 55. https://doi.org/10.1186/s12877-017-0443-2

Rafeedie, S., Metzler, C., & Lamb, A. J. (2018). Health Policy Perspectives—Opportunities for occupational therapy to serve as a catalyst for culture change in nursing facilities. American Journal of Occupational Therapy, 72, 7204090010. https://doi.org/10.5014/ajot.2018.7240003

Ray, C. A., Ingram, V., & Cohen-Mansfield, J. (2015). Systematic review of planned care transitions for persons with dementia. Neurodegenerative Disease Management, 5(4), 317+. Retrieved from https://linkgale.com.wne.idm.oclc.org/apps/doc/A428761620/HRCA?u=mlin_w_westne w&sid=HRCA&xid=6fa0b17d

Reia , P. (1999). Habilitation therapy: a new starscape. In *Enhancing the Quality of Life in Advanced Dementia* (pp. 21–37). essay, Brunner/Mazel Publishing Co.

Rockridge (2020). RockridgeMA.org. Retrieved January 21, 2021, from https://www.rockridgema.org

Sallim, A. B., Sayampanathan, A. A., Cuttilan, A., & Ho, R. (2015). Prevalence of Mental Health Disorders Among Caregivers of Patients With Alzheimer Disease. *Journal of the American Medical Directors Association*, *16*(12), 1034–1041. https://doi.org/10.1016/j.jamda.2015.09.007

Schaber, P., & Lieberman, D. (2010). Occupational therapy practice guidelines for adults with Alzheimer’s disease and related disorders. Bethesda, MD: AOTA Press.

Small, J. & Perry, J. (2013). Training family care partners to communicate effectively with persons with Alzhimers disease: The TRACED Program. *Canadian Journal of Speech-Language Pathology and Audiology*. Winter 2012/2013. Vol. 36, No 4.

Swiech, P., Sullivan, A., Helfrich, C., (2020). Self-feeding with the adult population: back to the basics. American Occupational Therapy Association Continuing Education. Retrieved on May 13, 2021 from https://www.aota.org/~/media/Corporate/Files/Publications/CE-Articles/CEA_August_2020.pdf

Tough, A. (1971). The adult's learning projects. Toronto, Canada: Ontario Institute for Studies in Education.

Weiss, J., Tumosa, N., Perweiler, E., Bailey, D., Blackwell, E., Forceia, M. A., … Worstell, M. (2017). Workforce gaps in dementia education and training. Retrieved from https://aspe.hhs.gov/pdf-report/workforce-gaps-dementia-education-and-training

Wicks, A. & Whiteford, G. (2003). Value of lifestories in occupation-based research. *Australian Occupational Therapy Journal* (2003) 50, 86–91

Wong, C. & Leland, N.E. (2018). Applying the Person-Environment-Occupation Model to Improve Dementia Care. *American Journal of Occupational Therapy*

Woods B, Spector AE, Jones CA, Orrell M, Davies SP. Reminiscence therapy for dementia. Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD001120. DOI:

10.1002/14651858.CD001120.pub2.

WHO., (2010). *Framework for Action on Interprofessional Education and Collaborative Practice. Retrieved June 6, 2021 from http://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf?sequence=1*

WHO (n.d.) re*trieved from https://www.who.int/mental_health/neurology/dementia/dementia_thematicbrief_informal_care.pdf*