Education and Training in Dementia Care

A person-centred approach

Claire Surr, Sarah Jane Smith, and Isabelle Latham

Contents

General preface

The dementia field has developed rapidly in its scope and practice over the past 25 years. Many thousands of people are diagnosed with dementia each year. Worldwide, the trend is that people are being diagnosed at much earlier stages. In addition, families and friends increasingly provide support to those affected by dementia over a prolonged period. Many people, both those diagnosed with dementia and those who support them, have an appetite to understand their condition. Care professionals and civic society also need an in-depth and nuanced understanding of how to support people living with dementia within their communities over the long term.

The *Reconsidering Dementia* book series sets out to address this need. It takes its inspiration from the late Professor Tom Kitwood's seminal text *Dementia Reconsidered* published in 1997, which, at the time, revolutionised how dementia care was conceptualised. The book series editors worked together on the second edition of this book entitled *Dementia Reconsidered Revisited: The Person Still Comes First.* This 2019 publication was a reprint of the original text by Tom Kitwood alongside contemporary commentaries for each chapter written by current experts. Many topics in the field of dementia care, however, were simply unheard of in Kitwood's lifetime. The subsequent titles in this series are cutting-edge scholarly texts that challenge and engage readers to think deeply. They draw on theoretical understandings, contemporary research, and experience to critically reflect on their topic in great depth.

This does not mean, however, that they are not applicable to improving the care and support to those affected by dementia. As well as the scholarly text, all books have a 'So what?' thread that unpacks what this means for people living with dementia, their families, people working in dementia care, policy-makers, professionals, community activists, and so on. Too many books focus on an academic audience *or* a practitioner audience *or* a student audience *or* a lived experience audience. In this series, the aim is to try to address these perspectives in the round. The *Reconsidering Dementia* book series attempts to bring together the perspectives of professional practice, scholarship, and the lived experience as they pertain to the key topics in the field of dementia studies.

This book series is jointly commissioned and edited by Professor Dawn Brooker MBE and by Dr Keith Oliver. Dawn has been active in the field of dementia care since the 1980s as a clinician and an academic. She draws on her experience and international networks to bring together a series of books on the most pertinent issues in the field. Keith is one of the foremost international

advocates for those living with dementia. He also brings an insightful perspec-
tive of his own and others' experience of what it means to live with dementia
gained since his diagnosis of Alzheimer's Disease in 2010.

Series Editors: Dawn Brooker and Keith Oliver

Preface

One of the titles that Dawn and Keith wanted to commission early on was this book on *Education and Training in Dementia*. Every time an issue is identified as difficult in the field of dementia, training is recommended as a solution. The authors of this book have all undertaken in-depth research into the *how*, the *what*, and the *why* of training and education in the many contexts in which people affected by dementia find themselves. Their knowledge and passion for utilising training in the very best way to improve the lived experience of dementia comes through on every page. It will be a must-read text for all those involved in training and education about dementia worldwide.

Additional thoughts from Keith Oliver

It has been an honour and a privilege for me as a person living with dementia to fulfil the role of co-editor for Claire, Izzy, and Sarah's book, and from their clear introduction to the book I was drawn in and hooked by their knowledge, experience, and combined style of writing. Since sharing my brain with Alzheimer's Disease, I have had many good days and weeks, but frustration and challenge is never far away, lurking in what I describe as the fog of my dementia. However, as a former headteacher and local authority education schools adviser, it is in my DNA to recognise the importance of meaningful staff development and training. In my former life, this led to benefits to all stakeholders – children, parents, colleagues, and the school community generally; now this recognition is equally important to me as I strive to be an Alzheimer's Society Ambassador or NHS Dementia Envoy. When reading and co-editing this book, whilst learning an enormous amount, I was always mindful of the range of strategies that those delivering training need to consider, and then adopt, whilst focusing upon the needs of those receiving the training who would then return to their place of work better skilled, better motivated, and even one hopes inspired to 'climb further mountains', because when you reach the summit the view is spectacular, and the rewards for trainers and those receiving the training can be immense.

1 | Introduction

> *'This book is predicated on the assumption that good quality training and education is embedded in a person-centred approach.'*

This book seeks to provide an evidence-based, practical resource for people intending to develop, deliver, review or commission **education** and **training** for the dementia workforce. It is aimed at those working in health and social care services and private and **third sector** organisations who are responsible for, or interested in, training and development for their staff, as well as commissioners of training.

In the last 20 years, since Tom Kitwood first published his seminal text *Dementia Reconsidered* (1997), there have been significant advances in our understanding of how to interact with and provide care for people living with dementia together with their family and friends. The evidence base for how to provide care for people with dementia has grown significantly. Despite this, until recently there has been less evidence of how to provide training and education for the dementia workforce.

This book has developed from our collective passion, as authors, for dementia education, training and workforce development, and the work we have undertaken throughout our careers, to understand what makes good dementia training and how to implement this to impact positively on care for people living with dementia. All three authors have designed, delivered, and evaluated many dementia-specific education and training programmes for staff working across the full spectrum of dementia care services and roles. We have also undertaken formal, broader research on dementia workforce development and impactful approaches to their **learning** and development. We recognised that there was a gap in evidence-based information about how to design, deliver, implement, and evaluate dementia training. This book aims to fulfil this gap by drawing on a range of evidence from our own research and experience, as well as real-life examples from across the sector.

The content of this book is rooted in the person-centred perspective first described by Tom Kitwood (1997) and subsequently developed by proponents of **person-centred care**. The book comprises a range of practical information including up-to-date international research evidence, case studies, and vignettes. The book covers best-practice approaches to the design, delivery, and implementation of formal programmes of dementia training and education as well as considering the importance of informal routes and mechanisms for workforce development. The authors of this book have been extensively and closely involved in research concerning dementia education and training, with a particular interest in what 'good' dementia training looks like. To this end, the

book looks at the practice context and setting conditions required for successful training outlining individual, service, and organisational level factors that those responsible for workforce development should consider. It addresses approaches to driving and transforming practice change through training and workforce development, including consideration of ways those responsible for training may assess and evidence its impact and fully integrate the lived experience of dementia throughout provision, alongside barriers and pitfalls such as organisational issues and complexities in the makeup of the workforce.

This book has two parts. Part 1 (Chapters 2–7) focuses on the broader theory underpinning approaches to dementia training and the application of this in different health and social care settings. It also outlines the evidence for the efficacy of different training approaches currently used in these settings.

Chapter 2, 'The design and delivery of formal dementia training and education', introduces the broader theory and research evidence around the design and delivery of formal education and training to adult **learners**. It considers how to involve **people directly affected by dementia** in training, the theoretical underpinnings of adult learning, and the evidence base underpinning some of the more commonly used methods such as face-to-face delivery, experiential and **simulation methods**, and in-practice learning approaches.

Chapter 3, 'Informal ways of learning', considers learning in the workplace, revealing possibilities for influencing practice that remain somewhat untapped. It covers the theory and practice of **informal learning** as an opportunity to improve person-centred care, in different dementia care settings.

Chapter 4, 'Learning and development in care homes', addresses the extensive literature on training that is provided to the dementia workforce in **care homes**. Care homes are recognised as a crucial part of the system of care available for people affected by dementia. However, they also present unique challenges. This chapter outlines the challenges of training in care home settings and gives examples of methods used successfully to provide training for this diverse workforce.

Chapter 5, 'Learning and development in primary care', covers the current challenges of providing dementia-specific training for practitioners based in **primary care**, who have long been identified as being ideally positioned to respond to the needs of people living with dementia but have tended to have had limited opportunities for dementia training. Some examples from practice are presented, which may be useful for those developing or delivering training in this setting.

Chapter 6, 'Learning and development in acute hospitals', describes training provided to the hospital workforce in order to deliver good quality person-centred hospital-based care to people with dementia. It explores the evidence on delivery of dementia training in acute hospital settings and provides guidance on best practice for those designing, delivering, and implementing dementia training in this setting.

Chapter 7, 'Learning and development in community settings', describes training that is provided for the workforce delivering care for people living with dementia and their **caregivers** in their own or family home or supported

accommodation. With many people with dementia living in community settings, this chapter reviews the evidence base for training the workforce responsible for supporting individuals in formalised and non-formalised ways.

Part 2 (Chapters 8–10) focuses on the theory and evidence underpinning the implementation of effective training and education for the dementia workforce. This includes practical considerations related to the contextual issues associated with the successful implementation of learning in practice (e.g. individual learner, setting, and organisational factors). It also considers ways of evaluating the impact of training.

Chapter 8, 'The person at the centre of the learning experience', examines the individual learner level factors that are important for supportive and successful learning. In doing so, it addresses the implementation of formal training and informal learning for the purposes of delivering person-centred care.

Chapter 9, 'Training implementation and driving practice and culture change', explores the conditions necessary for formal and informal learning and development to be used as a driver for practice change to support delivery of person-centred dementia care. It considers the role of 'implementation science' and provides an overview of models for considering how to optimally implement practice change through programmes of work that include training.

Chapter 10, 'Measuring and evidencing the impact of training', outlines models and methods that may be useful to adopt when evaluating the impact of a programme of dementia training, education or other workforce development activities.

Chapter 11, 'The future for dementia training and education', provides a summary of the book as a whole and draws together the take-home messages and implications for research and practice.

Tying these strands together throughout the book will be integration of the lived experience of dementia into training and education, and the continued relevance and need for Kitwood's concepts of person-centred care.

The landscape of dementia care

Dementia care is an umbrella term for the care and support provided to people living with dementia in any setting or context. The settings and contexts in which care is provided vary according to *who* is providing the care and *where* the care is being provided. Care can be provided by a variety of people, including paid health care professionals or **paraprofessionals** (**formal care**), as well as family and friends (**informal care**). The **World Health Organisation** (WHO) estimates that informal caregivers spend around 5 hours a day providing care for people with dementia, and that 50 per cent of the cost of care is attributable to this. The nature of this care can have a significant impact on the people providing it, with often negative psychosocial and health-related impacts because of the burden. Whilst the negative impact on informal caregivers is universal, there is a disproportionate impact on women, who provide around 70 per cent of caregiver hours (WHO 2021).

Improved formal care provides the opportunity to reduce the impact – both financial and psychological – on informal caregivers. Formal dementia care refers to care that is provided by staff employed within settings such as hospital or residential care, or care provided in people's own homes or in other places in their communities.

This book will primarily focus on training in formal care settings for the dementia workforce. That is not to say that those delivering informal or unpaid care do not require skills, knowledge or training to undertake their role. However, their training needs and the methods and mechanisms for providing this are commonly different from providers of formal paid care. Improved training for the dementia workforce has the potential to improve care outcomes for people living with dementia, as well as reduce the negative burden on the informal caregiver.

Person-centred care

Throughout this text we will refer to person-centred care as the gold standard of care for people living with dementia. This book assumes that the goal of training for the dementia workforce is ultimately the delivery of good quality person-centred care. It is useful to recognise where this term comes from, what it means in practice, and the role that it occupies when we think about good dementia care practice.

The term person-centred care is as used in the context of dementia derived from the concept of **personhood** – first ascribed to people living with dementia by Kitwood (1997). In *Dementia Reconsidered*, Kitwood defined personhood as 'a standing or status that is bestowed upon one human being, by others, in the context of relationship or social being' (1997, p. 8). He argued that despite the impact that dementia can have on a person's cognitive function, there is no resultant degradation of the individual as a person (i.e. their personhood remains intact). Kitwood suggested that personhood is constructed by an individual's interaction and relationship with other people and argued it was only lost if others failed to acknowledge it. When he first wrote about this, Kitwood's account that personhood was maintained by people living with dementia flew in the face of the predominant biomedical views of the condition, which positioned individuals living with dementia as experiencing a loss of self, due to the disease process. Kitwood acknowledged that whilst the disease processes can impact the experience of a person, personhood is not tied to this experience. He also highlighted the need for those caring for people living with dementia to have knowledge about and empathy with those with the condition to support and maintain personhood.

The impact this definition of personhood has had on the delivery of care for people living with dementia is significant. Kitwood's model implied that the ways in which care is delivered can either enhance or undermine personhood. Social interactions and environments that undermine personhood, either intentionally or unintentionally, are described as 'malignant social psychology'. For example, Kitwood described the practice of talking in the presence of a person

as if they were not there as a type of malignant social psychology he called *ignoring*. Overall, Kitwood described 17 ways in which personhood could be undermined by social environments and interactions.

On the other hand, he described ways of interacting that enhance personhood called 'positive person work'. For example, Kitwood described the process of *recognition*, either by recognising a person by simply using their preferred name or by careful active listening as a means of endorsing someone's personhood.

Further examples of positive person work and malignant social psychology are described in the *Dementia Reconsidered* text. Through raising awareness of positive person work and training the dementia workforce to adopt positive person practices, the delivery of *person-centred care* (care that supports personhood) is facilitated.

In his earlier work (1995), as well as in *Dementia Reconsidered* (1997), Kitwood recognised the role of organisational cultures in influencing outcomes for people living with dementia. Organisational culture is not a new concept or an understudied one, but it is complex, which perhaps explains its continued complicating presence alongside efforts to improve practice. He emphasised the need to transform to a 'new' culture to support the personhood of people living with dementia. Importantly, he described the habits of practice and ways of working that formed the basis of the current culture, which undermined person-centred practice (Brooker and Latham 2016; Kitwood 1997). In so doing he highlighted a key factor contributing to organisational culture's pervasive influence. Non-person-centred practice is not as simple as deliberately poor or harmful actions (i.e. malignant social psychology) carried out by individuals. Instead, it most often occurs through habitual and unquestioned day-to-day interactions, shaped unknowingly by the decision-making and problem-solving of many different actors in any organisation. Improving that practice therefore requires an understanding of these hidden processes and unknown actors. Organisational culture is complex to define and control because it is not one, easily observable and identifiable thing; it is *everything* that occurs within an organisation. These issues are explored more fully in Chapter 8.

Kitwood's theories of person-centred care were subsequently expanded into a four-part definition designed to be accessible to the **dementia care workforce** (Brooker 2004; Brooker and Latham 2016; NICE 2018). The definition uses a VIPS acronym (as in 'very important persons') as a useful aid to remembering the key principles of person-centred care as espoused by Kitwood.

> **V: V**alue people with dementia and those who care for them, promoting their citizenship rights and entitlements regardless of age or cognitive ability.
>
> **I:** Recognise people's **I**ndividual lives, appreciating that all people with dementia have a unique history and personality, physical and mental health, and social and economic resources, and these will affect their response to neurological impairment.

P: Look at the world from the **P**erspective of the person with dementia, recognising that each person's experience has its own psychological validity, that people with dementia act from this perspective, and that empathy with this perspective has its own therapeutic potential.

S: Recognise that all human life, including that of people with dementia, is grounded in relationships, and that people with dementia require an enriched and supportive **S**ocial environment environment which both compensates for their impairment and fosters opportunities for personal growth.

Inherent to achieving person-centred care is a need for good quality relationships between those providing care, the person living with dementia, and their family and friends. In some applications of person-centred care, the relational can be overlooked, resulting in services that provide individualised care but ignore the more complex emotional and social components that are essential for supporting personhood (Nolan et al. 2004; Venturato et al. 2011). For example, a patient can have an individualised plan of care that meets their individual health needs, but if the hospital does not simultaneously enable staff to communicate in ways that make the patient feel safe or recognise their spouse's role in maintaining their sense of self, then they are not providing person-centred care.

Relationship-centred care is a recognised approach that has developed in response to this issue, with the aim of emphasising the importance of relationships to providing good quality care. Relationship-centred care notes the interdependent nature of relationships between the person living with dementia, their family and friends, and those who provide care. Efforts to support the personhood of a person living with dementia will be undermined if those important to them and those who are providing their care and support are not also emotionally and physically supported (Brown Wilson et al. 2013; Dewar and Nolan 2013; Nolan et al. 2006; Soklaridis et al. 2016). For proponents of relationship-centred care, without this holistic approach to relationships, achievement of the goal of person-centred care (maintained personhood) is not possible. Models such as the Senses Framework have been developed to help service providers consider their care provision from a relationship-centred perspective (Nolan et al. 2006). When we refer to person-centred care in this book, we consider relationships, and enhancement of them, as an essential component.

More recently, the person-centred philosophical stance has also developed in ways that present social citizenship and rights-based models of dementia which place emphasis on the voice and the human rights of the person living with dementia. People living with dementia report feeling marginalised in and by society (ADI 2019). Social citizenship approaches assume that it is the responsibility of society to ensure that people with dementia are not excluded because of their cognitive changes or disability. Bartlett (2022) frames this as a cognitive accessibility issue, such that inclusive social citizenship relies on access to systems, products, services, and environments despite cognitive

disability. In other words, society (including its systems, services, and environments) should be structured in ways that are accessible to people with or without cognitive impairment. This might include adapting physical spaces, such as the use of signage, as well as making changes to social interactions, such as not speaking too quickly.

A rights-based approach is best represented by the work of people living with dementia and the growing number of people with dementia who are self-advocating and speaking up publicly through dementia advocacy groups. Dementia Alliance International is an international dementia advocacy group whose core beliefs (presented in Box 1.1) reflect a human rights-based approach.

Kate Swaffer, Dementia Alliance International Chair, has detailed a shift in dialogue from medicalised approaches to dementia towards human rights-based approaches and understanding and recognising dementia as a disability (Swaffer 2018). In a 2018 article, Swaffer describes the importance of international guidance and policy, such as the WHO Global Disabilities Action plan, to ensure that people living with dementia are recognised both locally and internationally in policy and law (Swaffer 2018).

Box 1.1 Dementia Alliance International core beliefs

- People living with dementia deserve quality of life and appropriate support to live their pre-diagnosis lives.
- Everyone has the possibility of having value every day of their lives, no matter what stage of the disease they are at.
- Well-being (quality of life) with dementia is possible.
- People with dementia must be included in all decisions affecting them: 'nothing about us, without us'.
- People with dementia are role models for each other and should learn from each other.
- People with dementia and the wider community must focus on what people with the disease *can* do rather than on what they *cannot* do, through all stages of the disease.
- Language must not devalue people with dementia.
- People with dementia still have capacity.

In the context of this book, we will consider person-centred care in its broadest sense, as care that supports an individual's personhood, recognises the importance of their relationships, and places them at the centre of the care they receive. We incorporate principles of citizenship that have grown from human rights movements by reiterating the importance of involving people affected by dementia as partners in the development, delivery, and evaluation of dementia education and training.

Dementia training for the formal dementia care workforce

The dementia care workforce refers to anyone providing formalised dementia care across health and social care services, including medical and health care professionals as well as a range of role titles (care assistants, care workers, well-being workers, support workers, etc.) that exist nationally and internationally for social care workers and paraprofessionals. Paraprofessionals are members of the dementia workforce who may not have a professional registration (such as a nurse or social worker will have). A range of terminology exists to refer to paraprofessionals. However, using terms such as 'non-qualified', 'untrained' or 'non-professional' for this group are misleading since, as this book outlines, paraprofessionals are in receipt of a range of training, and are often highly skilled and knowledgeable.

The breadth of professionals and paraprofessionals included in the dementia workforce is matched only by the array of training courses, frameworks, and recommendations that exist for these roles. However, this can complicate the creation of guidance for a workforce that can, for some roles, lack national professional bodies, universally recognised qualifications, clear career pathways, and tends to be viewed in generic rather than specialist terms.

Standards and frameworks for dementia training

Over the last decade, developments internationally have seen an increased profile of dementia training and advocacy for clearer and mandated training requirements for the workforce – both professional and paraprofessional. However, these still vary substantially across the world, relying most often on aspiration rather than government or regulatory instruction.

In general, the implementation of training standards is managed within country-specific health care systems and governing structures. However, in recognition of the importance of driving up global standards of dementia education and training, Alzheimer's Disease International (ADI) launched an accreditation process through which any global training provider can apply to earn ADI accreditation, which indicates that training has reached the ADI standards (ADI n.d.). The standards assess the design and delivery methods of training programmes as well as the presence of essential dementia-specific content. This type of global initiative speaks to the importance of using agreed benchmarking to drive up and ensure the quality of training – but still relies on the motivation of training providers to demonstrate the quality of their provision, rather than being a mandated activity.

Examples of country-specific activities illustrate the significant variation in the adaption of frameworks and standards globally. In Australia, there are no minimum standards or mandatory requirements for dementia training for the care home workforce (McCabe 2019). Nonetheless, the

development of Dementia Training Australia (a nationwide government-funded consortium), the revision of the aged-care quality standards against which services are registered (Aged Care Quality and Safety Commission 2018), and a workforce strategy calling for the re-framing of qualifications and skills frameworks to include dementia and person-centred care (Aged Care Workforce Strategy Taskforce 2018), suggest movement in this direction.

In the USA, requirements for training vary greatly by state for both personal care assistants and long-term care facilities. A survey of state standards showed 28 of 50 states had no laws requiring dementia training in nursing homes and eight had none for assisted living facilities, with 14 states only requiring it within specialist memory care facilities (Burke and Orlowski 2015a). Thirteen states had laws related to dementia training for personal care assistants (regulating this through licensing of individuals rather than facilities). These set minimum standards and curriculum content, including addressing basic dementia awareness, communication, social and psychological needs, behaviour, and working with families (Burke and Orlowski 2015b). The Alzheimer's Association issued best practice recommendations for long-term care, including guidance for a thorough induction and training programme for new staff and ongoing training built around the principles of person-centred dementia care (Fazio et al. 2018; Gilster et al. 2018), although this remains aspirational for some states.

In some countries at least, dementia-specific training standards have advanced significantly in the last 20 years with the development of frameworks to help guide the content and standards of training. Academics from the UK Higher Education for Dementia Network (HEDN), who are individuals with an interest in university dementia education, published one of the earliest curricula for pre-qualifying dementia education (Pulsford et al. 2007), updated in 2014; Scotland became the first of the UK nations to publish a national framework for dementia education and training content (NHS Education for Scotland and the Scottish Social Services Council 2011), with England (Skills for Health 2018), Wales (Care Council for Wales 2016), and Northern Ireland (Health and Social Care Board 2016) following suit. Now those providing dementia education or training for the dementia care workforce across the UK are expected to ensure this is aligned with the relevant framework for their home nation.

These UK frameworks have also been incorporated into national guidelines on dementia. In England, the **National Institute for Health and Care Excellence (NICE)** has recommended that all staff within care and support providers should receive training in person-centred care for people living with dementia. NICE specifies that those with direct care responsibilities should receive additional face-to-face training (including opportunities for feedback and case-specific discussion) on specific issues such as communication, responding to **distressed behaviours** and approaches for those with severe dementia (NICE 2018). Whilst not mandatory, NICE guidelines hold significant weight in health and care service commissioning, particularly for regulated

services such as hospitals and care homes. The NICE Guideline in the UK has been informed by:

- evidence about what kind of training approaches may be best for the dementia workforce based on the 'What Works' study (Sass et al. 2019; Smith et al. 2019; Surr et al. 2017a, 2020);
- the Dementia Training Standards Framework (Skills for Health 2018), which describes subjects and learning outcomes that training should address;
- and the Scottish Promoting Excellence framework (NHS Education for Scotland and the Scottish Social Services Council 2011), which describes values important for the dementia workforce.

In doing so, the NICE Guideline moves beyond general descriptions of person-centred care to specific issues of care; considering both induction and ongoing continuing professional development; and addressing matters of training delivery methods as well as content. For example, it is recommended to use face-to-face training with opportunities for follow-up.

One benefit of training frameworks is that they provide a standardised, comprehensive overview of what those providing different services should know and be able to do if they are to provide good quality care to people living with dementia. On the other hand, the comprehensive nature of such frameworks can also provide a barrier to implementation in time- and resource-poor services. To address this, some frameworks suggest tailoring the knowledge and **competencies** to specific job roles. In England, for example, the Dementia Training Standards Framework has been divided into three tiers. Tier 1 comprises a single topic – 'dementia awareness' – and should be achieved by all staff working in all roles across health and social care. This includes staff in non-clinical roles such as administration, catering, cleaning, and transport. Tier 2 is for those who have regular contact with people with dementia in their role and includes 11 additional core topics (e.g. 'person-centred dementia care', 'health and well-being in dementia care', 'end-of-life dementia care'). Tier 3 is for those working in managerial and leadership roles and includes additional learning outcomes across the core topics at Tiers 1 and 2, plus two additional topics ('research and **evidence-based practice**' and 'leadership in transforming dementia care').

However, the Dementia Training Standards Framework still includes a significant amount of content, which would not be feasible for most health and social care providers to cover in relevant depth in their provision for all staff. Not all staff working in roles with direct contact with people living with dementia require the same degree of knowledge across all the subject areas either. For example, someone working in memory assessment and diagnostics services would not need the same in-depth knowledge of end-of-life dementia care as someone working in a care home or acute hospital setting. Likewise, care home staff might need a less in-depth knowledge of dementia risk reduction and prevention, which might be more essential for staff working in primary care services.

Training needs analysis

It may be advantageous for organisations to take ownership of how national frameworks or standards are applied within their organisation through conducting a **training needs analysis (TNA)** for different roles across their organisation. This aims to aligns their training strategy and implementation plan with wider organisational goals, quality assurance mechanisms and the professional requirements of staff groups and individual staff members. This would include identifying the priority subject areas and learning outcomes for a particular job role. This could be coupled with development of individual learning needs assessment for each staff member as part of induction or annual performance review processes, to enable prioritisation of training identified as essential for their role. Tailoring training to the specific setting, role, and prior educational experience of staff has been consistently identified as more effective than a one-size-fits-all approach when evaluating dementia education and training within different service settings (Cunningham et al. 2020). Thus, there is strong evidence to support the case for conducting an organisational TNA based on existing training frameworks and using this to inform development of an organisational training strategy. This can then be implemented through tailored training provision that is designed specifically for the organisation and its staff.

A further limitation of using off-the-shelf frameworks is that the training is only as robust as the framework itself. This relies upon the integrity of the process for the development of the frameworks, and the expertise that has fed into them. This book is predicated on the assumption that good quality training and education is embedded in a person-centred approach. Therefore, the degree to which a particular framework reflects this philosophy will affect how well it will enhance development of a dementia training programme. For example, one might need to review the degree to which the standards are designed to maintain the personhood of an individual with dementia (Kitwood 1997), promote relationships, or endorse the rights of people living with dementia.

Elsewhere in this book, the importance of including people directly affected by dementia in the development of training is considered (Chapter 2). The extent to which the development of the framework or standards has involved people directly affected by dementia may provide a further test for how appropriate the framework is to shape a dementia curriculum. For example, the development of the Dementia Training Standards Framework in England was guided by an expert group that included people directly affected by dementia.

This book endorses the use of these standardised frameworks where they pass the test of promoting curricula that reflect person-centred values and philosophy. However, despite such frameworks being in existence, it is a limitation that we do not understand the extent to which they are applied in the real world. For example, Smith et al. (2019) conducted a UK-wide audit that highlighted the variability in the degree and nature of training across the UK using the English Dementia Training Standards Framework as a benchmark. The audit suggested that some topics and subjects were underrepresented, such as advanced dementia, research- and evidence-based practice, pharmacological interventions, equality and diversity, and end-of-life care (Smith et al. 2019).

Types of education and training

Non-dementia-specific mandatory training

Alongside dementia-specific training frameworks and guidance, the dementia workforce is often subject to other training requirements. This may include mandatory training to support the physical and health needs of individuals or related to issues such as risk or legislation. This can take the form of training provided at induction or on an ongoing basis. For the paraprofessional workforce, this type of training can be particularly significant due to their lack of pre-qualifications and the vast variation in job roles and types of employing organisation they may engage with across their careers. Within the four nations of the UK, for example, substantial work has been done to create standardised induction frameworks for adult social and health care workers across different roles and settings, including care workers for people living with dementia. The content specifics differ somewhat in each devolved nation but are broadly comparable, particularly in their implications for dementia-specific care. In England, Wales and Northern Ireland, the induction framework is standardised via regulation, whereas in Scotland induction is only recommended (Care Council for Wales 2016; Northern Ireland Social Service Council 2016; Skills for Health 2018). In Scotland, however, care workers are registered within 6 months of commencing work, a requirement of which is to be working towards a named qualification (NHS Education for Scotland and the Scottish Social Services Council 2011).

In England, this induction framework is **The Care Certificate (TCC)** standards introduced in 2015; a set of 15 generic standards relevant across health and social care designed to equip workers with introductory skills and knowledge required to provide basic care. It is implemented by employers and assessed within a workplace through observation of practice and review of knowledge (Health Education England 2014). Whilst not technically mandatory, the regulator requires all registered care services to provide an induction for new staff that meets TCC Standards within 12 weeks of taking post (Care Quality Commission 2015; Thomson et al. 2018). This is designed to aid consistency of induction processes so that staff do not have to retake induction training if they move roles. However, an **evaluation** of TCC found that whilst implementation was high across all services, social care services were significantly less likely to have implemented it than health care services. In addition, considerable variation was found in employers' methods of implementation, and this led to uncertainty over quality and devaluation of TCC. For example, 10 per cent of organisations surveyed used only **online (remote) methods of delivery**. The features associated with effective implementation included blended, practical, and participatory approaches to training and the provision of peer support and **mentoring** (Thomson et al. 2018).

Continuing professional development

Continuing professional development (CPD) describes training that is provided over and above the education required for qualification and registration

for professionals, or beyond mandatory training for paraprofessionals. Specific CPD opportunities for professionals and paraprofessionals are covered in the relevant chapters of this book. However, it is worth noting that CPD opportunities for both professionals and paraprofessionals vary internationally and are highly dependent upon the employing organisation and the regulatory environment.

CPD can be assessed or not. Non-assessed CPD opportunities might include, for example, attending meetings or workshops that are dementia specific. Examples of assessed CPD might relate to further education or higher education provided after professional registration – which should be distinguished from higher education designed to enable professional registration described in the following section.

Higher education for professional registration

In most countries, formal higher education is required to enable health care professionals to register within their specialist domains. For example, degree-level qualifications are required to register as a doctor, nurse or allied health professional in the UK and many other countries. It is not within the scope of this book to discuss in detail the delivery of dementia education in pre-registration programmes delivered within higher education. In Chapters 4–7, relevant research that may include pre-registration higher education is discussed, in the context of the setting in which learners are training to work. We do not, however, discuss pre-registration higher education exclusively in each chapter, except in summary here.

It is well established in the literature that dementia education in pre-registration qualifications is suboptimal (Scott et al. 2019; Tullo and Gordon 2013; Williams and Daley 2021). This means those qualifying as health professionals may lack the required depth or breadth of dementia knowledge and skills to deliver person-centred care. This then places a reliance on health and social care provider organisations to support development of the requisite knowledge and skills via CPD training, which as we have already identified can be limited due to time and resources. As identified in a review of pre-qualifying dementia education, a key issue in pre-registration education is the multiple ways and means of delivering education and lack of heterogeneity of content (Alushi et al. 2015). This is because different institutions may use different theoretical models and practical approaches to implement their curricula, so this is a pervasive issue when comparing any set of programmes (not just in the context of dementia training). This makes it hard to establish what dementia-specific content should be included and how best to deliver it, which is further complicated by limited evaluation of these approaches.

To this end, Williams and Daley (2021) conducted a scoping review of novel approaches to delivering dementia-specific education in pre-registration programmes, investigating the effect of the programmes on knowledge and attitudes towards dementia. Their review identified 27 studies from the USA, UK, Korea, and Australia. The programmes were targeted to medics and nurses, sometimes in combination with other health care students. The review grouped

the studies based on the main method of delivering dementia education. Five of the studies adopted a long-term experiential approach. This approach is based on the traditional placement model, but all the studies described a novel component that built on this. For example, long-term placements that focus on one individual and their family (Banerjee 2015). All placements were of more than 6 months' duration and were designed to build a relationship between people with dementia and the student. The second approach was the use of activities centred around the person with dementia. Eleven studies adopted this approach, which involved students directly interacting with people with dementia through cultural or social activities, such as storytelling. Five of the studies adopted an interprofessional education approach, involving two or more distinct groups of health care students interacting with each other (and sometimes with people with dementia too) to discuss key issues and improve their dementia knowledge and attitudes. Three studies adopted what was called an 'immersive conference style' involving direct interaction with people with dementia in a conference style format. Finally, three studies used simulation – the use of devices to mimic sensory or cognitive impairment such as wearing goggles and thick gloves to mimic visual impairment and reduced dexterity. One of the studies employed simulation through video **virtual reality**, the idea being that the experience will induce empathy for what it is to live with dementia and promote understanding. This review provides a helpful overview of the kind of methods being used in practice in pre-registration programmes, some of which are returned to in later chapters of this book.

Summary

As this chapter has introduced, one of the challenges is the diversity in where training is being provided and who the training is being delivered to. We have not touched on the methods and practice of training and education in this chapter. However, we acknowledge that the approaches adopted in training are incredibly varied and so will be discussed throughout this book. It is not the endeavour of this text to make one-size-fits-all recommendations for how to design, develop, and deliver dementia training. Rather, we review the evidence on sector-specific interventions before going into some of the principles and practices of training design. We have also worked with collaborators to come up with case examples from different sectors of how some of the challenges in the field are being met and to provide potential ideas for practice. The case studies illustrate themes within each chapter. Some of them implement evaluated approaches, while others demonstrate innovation in, as yet unevaluated, areas. We also hope that this book serves to raise, and answer, some questions you may have about the methods appropriate for adoption in your own dementia training practice.

8   The person at the centre of the learning experience

'It is important that facilitators create a learning environment in which learners feel welcome, supported, and which recognises not everyone arrives with confidence, excitement, and openness to learning. Flexibility is paramount.'

This chapter will explore the individual needs of learners that are important for supportive and successful learning to take place. It will include factors such as learning styles, prior educational experiences, neurodiversity, learning difficulties, physical and sensory disabilities, literacy, and culture. It is not meant to provide a comprehensive guide on how to provide training that is inclusive, supportive, and accessible to all, but instead to highlight specific issues that need to be considered when designing training. This chapter will also consider the opportunities and issues surrounding use of training explicitly as a mechanism for improving poor individual job performance.

Learning styles

Learning styles are commonly discussed in relation to tailoring the way training is delivered to the specific ways individual learners prefer to learn (Riener and Willingham 2010). An individual's learning style might be established through completing a questionnaire or learning styles test such as those listed in Table 8.1.

Before the start of the millennium, learning styles were commonly accepted as being based in evidence. However, recent research indicates there is little evidence to support the existence of learning styles, or that tailoring training to learning style improves learning (Cuevas 2015; Pashler et al. 2008; Riener and Willingham 2010; Rohrer and Pashler 2012). It may be that learners feel they have a preferred mode of learning, but evidence suggests they can learn equally as well whenf using other modes. Whilst there remains little evidence or evaluation of some learning styles models and further research is needed in this area (Riener and Willingham 2010), the current evidence base provides no support for using learning styles models to underpin how individual learners are taught.

Rather, it is suggested that those designing and delivering training should consider the most appropriate method for delivering a particular component of learning, based on learning theories (see Chapter 2). Providing variety in the

Table 8.1   Common learning styles models

| Authors	Components/styles
Kolb (1985)	Individuals prefer to learn in one of four quadrants across the dimensions of Do vs. Watch and Feel vs. Think. • Accommodators: prefer to actively do and feel an experience. • Convergers: prefer to actively do and think about an experience. • Divergers: prefer to watch and feel and experience. • Assimilators: prefer to watch and think about an experience.
Honey and Mumford (1986)	Builds on Kolb's learning styles. • Activists: enjoy having and immersing themselves in an experience. • Pragmatists: like to try out new ideas and experiment. • Reflectors: like to stand back and observe and think about experiences from different perspectives. • Theorists: like to analyse and bring together information and observations and draw logical conclusions.
Butler and Gregorc (1988)	People have natural preferences that position them in one of four combinations of: • Concrete (dealing with the here and now information via the senses) vs. Abstract (visualise and conceive beyond what can be seen) *combined with* • Sequential (preference for linear or step-by-step ways of organising information) vs. Random (information organised in chunks but without a particular order) e.g. concrete sequential learning style
Dunn and Dunn (1992, 1993)	Learning style is an individual's reaction or preference to elements across five strands of processing: • Environmental: learning environment including sound levels, lighting, temperature, and seating type/layout. • Emotional: motivation, feelings of responsibility for learning, imposed structure vs. personal choice. • Sociological: learning alone vs. with peers, with an instructor, in a routine/pattern or ad hoc. • Physiological: perceptual preferences (*auditory*, e.g. listening; *visual*, e.g. texts, pictures; *tactile*, e.g. hands-on via experiments or making models; *kinaesthetic*, e.g. experiential learning/total involvement), time of day, movement/static. • Psychological: global vs. analytic (preference for global content/concept followed by details and facts vs. details and facts building up to global content/concept), reflective vs. impulsive (preferring a thorough process to reach a conclusion vs. concluding quickly with little fear of failure). Perceptual preferences are seen as the most important aspect.

way content and materials are presented is one way to support effective learning that would accommodate a range of approaches different learners may feel more comfortable with and thus feel more inclusive. This chapter will outline a variety of dimensions on which learners will differ, which can impact on how they learn, and which those designing and delivering dementia training must consider.

Prior educational experiences

Staff working in dementia care have diverse backgrounds and experiences regarding prior educational attainment, experiences of education and training, and in the subsequent impact this may have had on their learning self-efficacy, confidence, and motivation (Hussein and Manthorpe 2012). Social cognitive theory (Bandura 1986) puts forward a triadic reciprocal framework to explain this (see Figure 8.1). It states that learners who have high self-efficacy or confidence in learning (personal processes) are more likely to engage in learning activities and to make efforts to learn (behaviours). A learner's feelings of self-efficacy are influenced by their prior experiences of education – whether they have been told they are 'bright', 'intelligent', 'academic', or, as may be the case with many learners working as paraprofessionals in non-academic sectors such as care, they are 'stupid', 'not a natural student', or 'lazy'. For those with this latter experience, their confidence in learning and thus feelings about attending training programmes are naturally impacted. This can lead to them feeling anxious, worried, and disengaged from learning or to even avoid attending training, for fear of being belittled or made to feel stupid, as they did when they received these negative messages during prior educational experiences.

It is important that facilitators create a learning environment in which learners feel welcome and supported, and which recognises not everyone arrives with confidence, excitement, and openness to learning. Flexibility is paramount. Understanding learners' existing knowledge of a topic and what they hope to gain from attending a training programme can be an important starting

Figure 8.1 Social cognitive theory's triadic reciprocal framework (based on Bandura 1986)
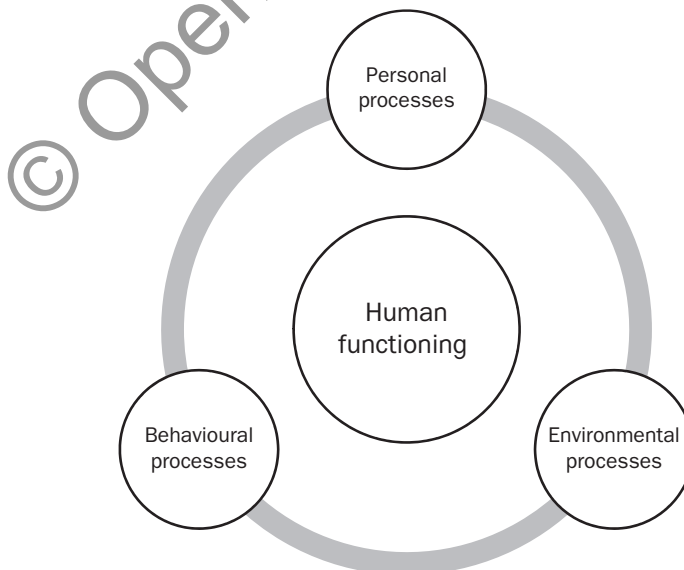
point from which to build delivery of content in a way that is tailored to both groups of learners and specific individuals. This may mean, for example, ensuring training is pitched at the right level for those attending to build confidence, and including exercises and activities that can help to assess learners' understanding, so training can progress at the right pace. Facilitators may also need to spend time building confidence, encouraging engagement, recognising and praising achievements, and undoing the damage caused by negative prior educational experiences, which may have been present since childhood for some learners. It can also be helpful to provide learners with full information about the training programme and what it will entail in advance. Box 8.1 includes examples of approaches training facilitators can adopt that may help to build learner confidence. These are things which are easier to implement in face-to-face training situations and may be more challenging to achieve where delivery is online.

Box 8.1 Approaches that can help to build learner confidence

- Help learners to feel prepared. Give learners enough information about what the training will involve so they are not unsure about or fearful of what to expect.
- Know your learner group and pitch the training at their level. This will mean advance preparation to gather the required information and may mean being flexible and able to adapt what you are doing.
- Do not put people on the spot, or force people to answer questions or speak out in front of the group as this can raise fear and anxiety levels.
- If people do speak out or share answers to questions, then encourage this and welcome their response and insights. Even if you feel the answer is incorrect, sharing is an important part of learning and feeling safe.
- If you feel an answer is incorrect, then use careful questioning and ideas from others in the group to explore alternative views. For example, you might say 'That is a really interesting answer. Can you explain more about why you think that?' Or, 'I can see exactly where you are coming from there. Situations like this are very complex and there are often different perspectives. Can you think of any alternative ways of seeing this/ approaching this situation that you also think might be helpful?' Or, 'Does anyone else in the group have a suggestion about this?'
- Ensure there is time to provide support within the session, during breaks, or at the end for anyone who seems to be struggling. For example, you might spend time with individuals when the group is completing learning activities. Having two facilitators can be helpful in such circumstances.
- Offer different approaches to learning the same content, so that confidence and skills can be built slowly. For example, talking through information in a short lecture, followed by a video and then a case study based exercise can help to build learning step by step through different methods.

- Offer praise – tell the group they are doing well, that they have given some excellent answers to the exercises, etc.
- Draw and build on their existing knowledge and expertise – think about what they already know and use that as building blocks for learning.
- Build learning activities in small steps, with tangible outcomes so both you and the learners can see their progress. Don't move on if the group is not understanding the content; find another way to go over this again.

In Chapter 2, the potential benefits of multi-disciplinary learning were discussed. One of the potential challenges of true multi-disciplinary learning (which includes management, professionally registered, non-registered clinical/care, and ancillary staff) is ensuring training content and pace is able to meet the potentially diverse needs of such cohorts; a diversity which may include prior educational experiences. Recognising that each learner brings with them unique skills and knowledge and can make a valuable contribution and then building exercises and activities within the training to draw these out is one approach. For example, case study activities may ask for different perspectives on a care scenario and can be used to explore what those in different roles within the setting contribute to the care of a person living with dementia.

Neurodiversity and learning differences

Neurodiversity means recognising we are all different in the way we think and learn. Some people's ways of thinking and learning are labelled as neurotypical, whereas others think and learn in neurologically diverse ways. All of these are natural human differences and should not be pathologised (Rentenbach et al. 2017). Barriers to learning can occur if those providing training consider only neurotypical ways of learning and do not consider or design for neurodiversity. People who identify as neurodiverse or as having a learning difference may include autistic people, those with dyslexia, dyspraxia, dyscalculia, or attention deficit (hyperactive) disorder (AD(H)D) (Pollak 2009). People living with dementia as learners, or indeed as co-educators, should also be considered as having a learning difference. The concept of adapting to neurodiversity aligns with that of person-centred care and recognising, valuing and working with the uniqueness of individuals.

Box 8.2 provides some strategies and approaches that can be helpful in providing a learning environment supportive of neurodiversity. The UK Department for Education (DfE n.d.) has developed a useful guide to teaching for neurodiversity, which provides more information about learning differences and some of the difficulties these may present for learning and considerations for those facilitating learning.

Box 8.2 Practical approaches for educators to design and deliver training that is inclusive of neurodiverse learners

- Where possible, request information on any learning needs from learners ahead of time so you can plan for these.
- Ensure regular opportunities to check in with learners individually during the training so you can see how they are getting on and can identify any additional individual needs or required support.
- Provide information in different formats, such as handouts, presentations, and discussion.
- Read out the content of any case studies or other materials that form part of exercises and summarise what you want learners to do. Never ask a particular learner to read out content to others.
- Limit the amount of text you have on any PowerPoint slides or other materials.
- Ensure any training materials and handouts are written in plain English.
- Make sure training programmes offer enough time and are not rushed or packed with too much information and content. This should include time for reflection and breaks.
- Break a training session down into chunks or shorter sections and allow time to consolidate this learning before moving on.
- Offer learner choice of how they participate in exercises or activities – working alone, in pairs, or with people they know.
- Offer quiet space outside of the training room for people to sit when taking part in exercises and activities so there is less background noise or distraction.
- Never ask a learner to answer a question in front of the group or other learners during training. Ask for volunteers to give responses and notify groups in advance if you want feedback from them so they can nominate someone who is happy to take on this role.
- Think of alternative ways learners can ask questions or respond to exercises and activities – for example, you could create an online space where they can post anonymously using apps such as Mentimeter or Padlet.

It is worth noting that some learners may have undertaken a formal assessment for learning difference needs related to autism, dyslexia, dyspraxia, or ADHD and may have clear and specific information about their learning and support needs, for example from school or university. Facilitators should provide an opportunity for people to contact them ahead of delivering a training programme, to share this so any required reasonable adjustments can be made ahead of time. However, other learners may not have had a formal assessment of their learning needs because they have remained unidentified, due to lack of availability or costs of assessment services. Therefore, it is important training programmes are designed in ways that are supportive to all and which allow flexibility in delivery.

Physical and sensory disabilities

Learning facilitators need to ensure that training is accessible for those with physical or sensory disabilities, remembering that not all disabilities are immediately visible. This might mean paying special attention to the training location, room layout, lighting, space and positioning of tables and chairs, formats of training materials, and the types of and ways exercises and activities are run. Again, it is helpful if facilitators are aware of any needs in advance so they can ensure the training room is accessible and materials are available in appropriate formats. Ideally, training sessions should always take place in venues and rooms that are accessible to wheelchair users, and are close to other facilities such as restrooms/toilets and refreshments. If a learner has a visual impairment, they may find it helpful to have materials sent to them in advance in a particular format, such as pdf, so they can familiarise themselves with the content in advance or access them on an electronic device during the session. If someone has a hearing impairment, facilitators will need to consider if there is equipment to support hearing aids (such as a hearing loop) and ensure the learner can see the presenter clearly throughout the training if they lip read. In some cases, they may need to consider using sign language interpreters.

Literacy skills and confidence

In England, approximately 17 per cent or 7.1 million people have very poor literacy skills (National Literacy Trust 2012). In the US, 19 per cent of the population has very low literacy skills and there are significant literacy gaps between adults who are White and those who are Black or Hispanic, the latter having significantly lower literacy levels (National Center for Education Statistics 2017). Globally, literacy skills vary significantly, with countries such as Japan, Finland, and the Netherlands having fewer people with low literacy proficiency and countries such as Indonesia, Turkey, and Chile having larger percentages of the population with low literacy proficiency (OECD 2016). Literacy skills and confidence will also differ by job role. Staff working in roles requiring professional training and qualifications may have higher literacy skills or confidence in reading and writing than those working in settings or roles where qualifications are not required, such as ancillary staff (cleaning, transport, or catering) or paraprofessionals. Some of the practical approaches to designing training that is inclusive of neurodiversity, such as writing in plain English or using minimal words on PowerPoint slides, can also be helpful to those who have lower literacy skills or confidence in reading. Likewise, the approaches to supporting people with different prior educational experiences are also applicable in considering training that is inclusive of those with different levels of literacy.

Culture

The dementia care workforce in many high-income countries is culturally diverse. In 2021 in England, 21 per cent of the health and social care workforce were from minority ethnic groups, compared with only 14 per cent of the population as a whole (GOV.UK 2021; Skills for Care 2021), although this varies by region of the country and staff role. Additionally, non-British workers (including those from the European Union) make up 14.6 per cent of the NHS (Baker 2021) and around 16 per cent of the social care workforce (Skills for Care 2021). In the US, there is a similar picture with the health care workforce being more ethnically diverse than the general population (29 per cent from Black, Asian, Hispanic, and other non-White ethnic groups vs. 25 per cent of the general population) (Snyder et al. 2015). Again, there are disparities by occupation, with White non-Hispanics making up a higher proportion of professionally qualified roles (Salsberg et al. 2021) and care aide roles being occupied by a more ethnically diverse workforce (Snyder et al. 2015). In Australia, foreign-born workers are estimated to comprise around one-third of the nursing and midwifery workforce, over half (53 per cent) of medical practitioners (Negin et al. 2013), and up to 37 per cent of the aged care workforce (Eastman et al. 2019; Mavromaras et al. 2017).

This cultural diversity of the workforce must be considered for several reasons. In English-speaking countries, the points raised above about prior educational experiences and literacy in English apply, particularly for those for whom English is a second or additional language. It is also important that dementia training acknowledges and is respectful of the diversity of experiences and values of this workforce. For example, stigma and understanding or beliefs about the causes of dementia can differ greatly between countries (Gauthier et al. 2021) and cultures, meaning people attending training may not share a common understanding about dementia that is aligned with that adopted in many Western high-income countries (Johnston et al. 2020). They may not share the same perceptions of the value of help-seeking (Mukadam et al. 2015), institutional care, or understand the need to deliver person-centred dementia care. They may also have personal experiences of barriers in health and care services for support for dementia or other conditions (Sagbakken et al. 2018) alongside experiences of wider societal discrimination.

Additionally, training materials such as pictures, case studies, exercises, activities, and video content used should reflect both the diverse workforce and the diversity of people affected by dementia. This should not only include cultural but other forms of diversity, including sexual orientation, disability, religion, biological sex, and gender identity. One challenge the field needs to address is ensuring that those directly affected by dementia who are involved in dementia training, either directly or indirectly, reflect the diversity of people affected by dementia who access services. In high-income Western countries such as the UK, there is currently a predominance of White, middle-class people who contribute in these ways. Whilst their engagement within dementia training is invaluable, we need to work harder to make this a more diverse, and thus more representative, voice.

Summary

This chapter has outlined several individual learner factors that are important to consider when designing and delivering dementia training. It has discussed the concept of learning styles and argued that there is little evidence that tailoring methods to an individual's specific learning style is effective at producing improved learning, although use of a variety of learning approaches is likely to be beneficial for all. It has described various individual factors that may affect learners and their confidence and ability to learn, and suggested ways training facilitators can meet their needs.

Implications for those delivering dementia training

Those delivering dementia training should:

- Ensure they consider individual factors when designing and delivering dementia training.
- Recognise the diversity of individual confidence and prior learning experiences and the impact these may have on willingness and ability to learn.
- Ensure neurodiversity and learning differences are considered and the methods used in training are inclusive for all.
- Ensure training venues, environments, and content are accessible for people with physical and sensory disabilities.
- Ensure that training content and materials are tailored to learners' literacy levels, recognising people may have low literacy or may speak English as a second or additional language.
- Recognise and be respectful of culture and diversity, understanding that this may impact understandings of dementia. Training materials should also reflect the diversity of people affected by dementia and in the workforce.
- Provide opportunities before or during training for learners to share individual learning needs and then respond to these.
- Consider the most appropriate method(s) for delivering specific knowledge or skills and adopt a variety of methods to achieve this.

Implications for managers in dementia care settings and services

Leaders and managers in hospital settings should:

- Where possible, identify or ask learners to identify any individual learning needs and provide this information, with permission, to training facilitators.
- Identify if additional support may be needed for some staff to attend training – for example, in preparation to attend or afterwards in consolidating learning and considering how they might apply it.

Implications for staff providing care, services, or support to people living with dementia

Staff working in health and social care settings should:

- Speak to their manager if they are concerned or worried about attending training, so that appropriate support can be provided.
- If they feel comfortable to do so, let their manager or the training facilitator know of any learning needs they have so the facilitator can ensure these are met.
- Let the facilitator know if training is too fast, difficult to understand ,or they are struggling or feeling left behind.

Implications for those directly affected by dementia

- People living with dementia as learners or co-educators will have similar needs to those with learning differences. Educators need to understand these and what the person living with dementia may need to support them to fully participate.
- People living with dementia who are involved in dementia training, whether directly or indirectly, should reflect the diversity of the people affected by dementia who access health and social care services.