

## Policy and Practice Note / Note de politique et pratique

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# Championing Dementia Education: Adapting an Effective Scottish Dementia Education Program for Canadian Acute Health Care Providers

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## Résumé

L'augmentation du nombre de personnes atteintes d'un trouble neurocognitif majeur et leur taux d'hospitalisation plus élevé nécessitent des soins de courte durée appropriés et efficaces. Or, les milieux de soins de courte durée ont des répercussions négatives chez cette population. Au Canada, la formation des prestataires de soins de courte durée sur le trouble neurocognitif majeur est insuffisante. L'Écosse offre actuellement aux prestataires de soins de santé un programme de formation sur le trouble neurocognitif majeur, le *Scottish National Dementia Champions Programme*. L'objectif de cette note sur les politiques et pratiques est de présenter le travail collaboratif d'experts écossais et de parties prenantes canadiennes qui a mené à l'adaptation du programme *Dementia Champions* au contexte canadien. À ce jour, cette initiative comprend : (a) une analyse du contexte de formation associé au trouble neurocognitif majeur au Canada pour les prestataires de soins de courte durée, (b) des entretiens avec des intervenants clés, et (c) les résultats d'une réunion de planification de deux jours. Les résultats de ce travail collaboratif sont utilisés pour guider les prochaines étapes de développement du programme canadien de formation sur le trouble neurocognitif majeur et sa mise en place dans un programme pilote.

## Abstract

With increasing numbers of persons living with dementia and their higher rates of hospitalizations, it is necessary to ensure they receive appropriate and effective acute care; yet, acute care environments are often harmful for persons with dementia. There is a lack of dementia education for acute health care providers in Canada. Scotland presently delivers a dementia education program for health care providers, known as the *Scottish National Dementia Champions Programme*. The objective of this Policy and Practice Note is to present the collaborative work of Scottish experts and Canadian stakeholders to adapt the Dementia Champions Programme for use in Canada. This work to date includes: (a) an environmental scan of Canadian dementia education for acute health care providers; (b) key informant interviews; and, (c) findings from a two-day planning meeting. The results of this collaborative work can and are being used to inform the next steps to develop and pilot a Canadian dementia education program.

## Introduction

In Canada, approximately 7 per cent of older persons over the age of 65 years have some form of dementia, with around 76,000 new cases diagnosed each year (Public Health Agency of Canada, 2017). Older persons with dementia have twice as many co-morbid conditions as those without

dementia and are at increased risk for other health issues, including falls, infections, and stroke (Poblador-Plou et al., 2014; World Health Organization, 2019). Indeed, research has shown that persons with dementia are more likely than those without to be admitted for emergency hospitalization (Canadian Institute of Health Information, 2018; LaMantia, Stump, Messina, Miller, & Callahan, 2016; Sommerlad et al., 2019). With increasing numbers of persons living with dementia and higher rates of hospitalization, it is necessary to ensure they receive appropriate and effective acute care. In this Policy and Practice Note, we present our international, collaborative work to bring a dementia education program for acute health care providers (HCPs) to Canada. Herein we present: (a) an overview of the program; (b) results from a national environmental scan; (c) key informant interviews; and (d) findings from a two-day meeting to begin initial work towards adaptation.

Research suggests that acute care environments are often harmful for persons with dementia (Dewing & Dijk, 2016). Commonly identified issues include lack of privacy, noise, overcrowding, loss of independence, difficulty in wayfinding, boredom and lack of meaningful activities, unmet needs, and bed/ward moves (Clissett, Porock, Harwood, & Gladman, 2013; Digby & Bloomer, 2014; Hung et al., 2017; Jurgens, Clissett, Gladman, & Harwood, 2012; Moyle, Bramble, Bauer, Smyth, & Beattie, 2016; Parke et al., 2017; Prato, Lindley, Boyles, Robinson, & Abley, 2019). Persons with dementia may also feel devalued and disempowered when acute HCPs do not include them in conversations or respect their wishes for care (Hung et al., 2017). Families also report unmet expectations regarding personalized care and the maintenance of their relative's dignity, physical comfort, privacy, identity, and safety (Jurgens et al., 2012). Acute HCPs often appear focused on medical treatment and task-oriented care while not necessarily meeting the person's fundamental care and broader psychosocial needs (Jurgens et al., 2012; Moyle et al., 2016). In addition to the well-being of the person with dementia, families have identified communication with acute HCPs as a major issue (Jurgens et al., 2012; Moyle et al., 2016).

Acute HCPs describe many of the same issues, recognizing and aiming to minimize the disorientation that persons with dementia often experience, and acute HCPs work to create a safe environment, establish positive relationships, and attempt to initiate activity routines (Hynninen, Saarnio, & Isola, 2014; Pinkert et al., 2018). Prato et al. (2019) reported that acute HCPs felt it was important to practise person-centred care and empower persons with dementia, yet this did not always occur.

The busy pace of wards and understaffing affects the amount of time that acute HCPs can spend interacting with persons with dementia, who are perceived to require more time and effort for care than other persons (Coffey et al., 2014; Houghton, Murphy, Brooker, & Casey, 2016; Hynninen et al., 2014; Pinkert et al., 2018). Acute HCPs also report inadequate dementia care training, resulting in reduced confidence and capability to effectively care for persons with dementia (Coffey et al., 2014; Cowell, 2010; Dewing & Dijk, 2016; Hynninen et al., 2014; Pinkert et al., 2018).

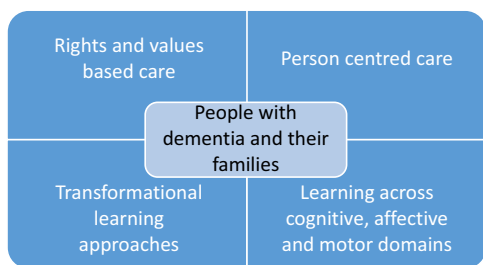
Given these concerns, there have been calls for enhanced dementia education and development of standards and core competencies for acute HCPs (Canadian Academy of Health Sciences, 2019; Houghton et al., 2016; Hynninen et al., 2014). Indeed, improving dementia care is an identified priority for Canada (Alzheimer Society of Canada, 2019) and is reinforced by Canada's National Dementia Strategy principles (Public Health Agency of Canada, 2019). Moreover, there is a clear need for efforts to go beyond educating individuals and enable positive changes at

unit, department, and organizational levels (Moyle, Borbasi, Wallis, Olorenshaw, & Gracia, 2010; Pinkert et al., 2018).

Acute HCPs have access to few effective dementia education programs (Gkioka et al., 2020). One program in Canada described acute care staff's experience with Gentle Persuasive Approaches (GPA), a program developed for long-term care staff to improve hands-on dementia care (Gkioka et al., 2020; Hung et al., 2019). GPA was evaluated in an acute care hospital in Ontario and had a positive effect on staff self-efficacy; however, the impact on patient health was not assessed (Martin et al., 2016). While important, the GPA program does not involve the sufficient training intensity that Gkioka et al. (2020) suggest is necessary to make changes at the organizational level in culture and practice within acute care settings. Moreover, the GPA was not designed for acute care settings. To the best of our knowledge, no extensive dementia education program, specifically for acute HCPs, exists in Canada, despite the need for such a program.

A dementia education program designed specifically for acute HCPs that has evidence for effectiveness is delivered in Scotland. The Scottish National Dementia Champions Programme (herein referred to as the *Programme*) equips acute HCPs with the knowledge, values, and skills needed to provide high-quality dementia care and support them to lead change in their care areas (Banks et al., 2014). Evaluation has shown that the Programme has a measurable impact on participants' knowledge of dementia, approaches to care, and confidence in their ability to achieve the Programme's learning outcomes (Jack-Waugh et al., 2018). A Mental Welfare Commission for Scotland report (2018) highlighted the clear benefits of additional access to resources for other staff, persons with dementia, and carers. The Programme was developed to provide enhanced education that considers the complex systems that exist in the acute care context. Surr et al.'s (2017) systematic review identified several criteria of effective dementia education (e.g., relevant to participants' role, encompasses in-person participation, taught by an experienced facilitator, has greater than eight hours of sessions); the Programme includes all of them. Given its rigorous development and focus on both individual education and broader practice/organizational change, the Programme could potentially address dementia education gaps for acute HCPs in Canada.

The Programme was commissioned as part of Scotland's first dementia strategy, in response to the poor acute care that persons with dementia were experiencing (Alzheimer's Society, 2009; Elvish et al., 2018; The Royal College of Psychiatrists, 2011). Funded by the Scottish Government in collaboration with the National Health Service Education for Scotland, and the Scottish Social Services Council, the Programme has been running since 2011. The University of the West of Scotland led the design and delivery of the Programme in partnership with Alzheimer Scotland. The Programme's underlying pedagogical approach is described by Jack-Waugh et al. (2018) and illustrated in Figure 1. Human rights, values-based care, and an understanding of the social model of disability (Durrell, 2014) form the Programme's theoretical spine (Jack-Waugh et al., 2018). Its pedagogy is informed by transformative learning theory, working with the affective (heart), cognitive (head), and psychomotor (hands) domains (Singleton, 2015). A collaborative approach to delivery has been central to enacting the Programme's ethos; persons with dementia, family carers, and health and social care practitioners are all part of the education team. The Programme is grounded in Kitwood's (1997) theoretical perspective of person-centred care for persons with dementia. The principles of valuing persons with dementia and their carers,



**Figure 1.** Pedagogy of the Dementia Champions Programme.  
(Source: Jack-Waugh et al., 2018)

treating them as individuals, seeing the world from the person with dementia's perspective, and creating a positive social environment that promotes their well-being (Brooker, 2003) are all foundational to the Programme's goals and teachings.

The Programme's main objective is to provide enhanced dementia care education to HCPs, supporting them to lead change in acute care settings that will improve care for persons with dementia and their families. The six-month program includes a blended educational program with pre- and post-reading for the five in-person study days and half-day community placement; three written assignments; and development of a collaborative change plan to improve dementia care in their care setting. In sum, the Programme's unique elements include: (a) recognizing the challenges in acute care settings; (b) using a rights-based approach; (c) having persons living with dementia as an integral part of the teaching team; (d) partnering with family carers; and (e) disseminating the champions' developed activities to benefit their colleagues. The Programme's learning outcomes and topics covered in the teaching sessions are listed in Tables 1 and 2, respectively.

To date, over 1,000 qualified health and social care professionals have completed the Programme in Scotland. Approximately 70 per cent of participants are qualified nurses; other participants include allied health professionals (e.g., occupational therapists, physiotherapists, speech and language therapists, podiatrists, dietitians), nurse educators, managers (discharge and patient flow), and hospital social workers. There is evidence that some champions have made demonstrable practice improvement, such as implementing "Getting to Know Me" (Alzheimer Scotland, 2015), to provide more person-centred care, improving pharmaceutical support, environmental design and change, increased partnership with families, delirium prevention, personal music, a bedside vascular service, creation of quiet spaces and gardens, activity boxes, and dementia cafés (Jack-Waugh et al., 2018). Developing examples of some of the Dementia Champions' actions can be accessed through #oneweething and the Blog: <https://letstalkaboutdementia.wordpress.com/>.

### Adapting the Programme for Canada

Providing comprehensive dementia care education to acute HCPs will increase their capacity to provide optimal care to persons with dementia, which is one of the priorities identified in Canada's National Dementia Strategy (Public Health Agency of Canada, 2019). The Programme's focus on individual dementia care education together with a broader practice and system change is unique. This program was chosen for adaptation in Canada because of these focuses, its grounding in best practices, its success

in Scotland, and the generosity of our Scottish colleagues in sharing their knowledge throughout the adaptation process. The fit between the Programme and philosophical goals of dementia care in Canada, specifically the strong grounding in person-centred care and inclusion of persons with dementia and carers as peer educators (Jack-Waugh, 2018), are also fundamentally important.

Co-production is embedded within our work via Hawkins et al.'s (2017) framework for the co-production of an intervention entailing three stages: (a) evidence review and stakeholder consultation; (b) co-production of intervention content; and (c) prototyping the new intervention. This Policy and Practice Note presents the first stage of evidence review and stakeholder consultation, which included three steps: (1) an environmental scan to examine existing dementia education for Canadian acute HCPs; (2) key informant interviews with two carers and one person with dementia about their experiences of acute care and issues needing attention, to hear from those with recent lived experience; and (3) a planning meeting with various experts – including our Scottish collaborators (AJW and RM) – to establish program principles, priorities, learning outcomes, pedagogical approaches, and content for a Canadian program. These steps (along with a literature review) constitute an evidence review and stakeholder consultation, laying the groundwork for co-producing intervention content. The process and outcomes of each step are described below. Ethical approval for each step was received from the Research Ethics Board of the University of Saskatchewan.

### Adaptation Activities and Findings

#### Environmental Scan of Current Canadian Programming

The purpose of the environmental scan was to examine the literature and publicly available information (Graham, Evitts, & Thomas-MacLean, 2008) guided by the work of Choo (1999) to identify currently available Canadian dementia education programs for acute HCPs. Strengths, limitations, and gaps of the programs were also considered.

#### Methods

Data for the environmental scan (Choo, 1999; Graham et al., 2008) included correspondence ( $n = 4$  telephone interviews,  $n = 4$  e-mail communications) with Alzheimer Society staff from across Canada between November 2019 and February 2020. Since most dementia education occurs either directly or in partnership with Provincial/Territorial Alzheimer Societies, they were considered the key experts to consult. Alzheimer Society offices were contacted by e-mail, and participating staff were asked to provide their perspectives on challenges/needs faced by persons with dementia when in acute care. They were also asked to identify any existing dementia education program for Canadian acute HCPs offered by their organization or others, and describe what they thought would be essential to include in such a program. Data from the staff were transcribed and analysed for salient content using a thematic analysis approach (Braun & Clarke, 2006). Other data on existing programming were obtained via a Google search conducted between September 2019 and January 2020, using the terms "Canada", "dementia education", "workshops", and/or "online/webinar".

#### Findings

The environmental scan's findings include: (a) challenges, needs, and priorities of persons with dementia in acute care shared by

**Table 1.** *Dementia Champions Programme* learning outcomes

People who have completed the Dementia Champions education program will be able to, in accordance with their job description, roles, and responsibilities:
1. Understand, recognize, and respond to the impacts of the physical, emotional, social, cultural, and spiritual environment on the maintenance of rights, choice, identity, dignity, participation, and equity for the person with dementia in acute hospital settings.
2. Understand, identify, and respond with evidence informed best practice, to the physical and mental health issues that may affect the individual course of a person's journey before, during, and after receiving care in the acute hospital environment.
3. Understand and identify the complexities associated with dementia in the acute hospital setting that may have legal and ethical implications and act to safeguard the best interests of people with dementia, families, and carers.
4. Understand, apply, and evaluate a range of approaches to reduce stress and distress and promote ability, strengths, and quality of life for the person with dementia, paying particular attention to demonstrating kindness, empathy, enablement, partnership working, and compassion.
5. Understand and implement leadership and change agent skills and knowledge to enhance and improve the care of the person with dementia in every area of their influence, utilizing existing and developing quality improvement systems, sharing good practice forums and knowledge networks.

(Source: Banks *et al.*, 2014)

**Table 2.** *Dementia Champions Programme* sessions

Day	Morning session	Afternoon session
One	Welcome Hearing the voice of people living with dementia	Expectations of the Programme
Two	Assessment and identification of well-being and ill-being	The dementia journey: person-centred planning, support, and risk enablement
Three	Working with stressed and distressed behaviour	Care Empathia
Four	Palliative approaches	Work as equal partners with families, friends, and carers
Five	Moving on as a Dementia Champion	Expert master classes (legal issues, supportive technologies, and Introduction to Positive Approach to Care) End day with <i>Musical Minds</i> performance
Graduation and celebration		

Source: Banks *et al.*, 2014.

Alzheimer Society staff; and (b) current education programs for acute HCPs on offer in Canada as identified by staff and the Google search, and components/elements that should be included in an education program for acute HCPs (Surr *et al.*, 2017).

**Challenges, needs, and priorities of persons with dementia in acute care.** Alzheimer Society staff perceived persons with dementia and their carers as facing stigma, disabling built environments, limited HCP understanding and knowledge of dementia, and a lack of person-centred care. Staff felt persons with dementia were misunderstood by acute HCPs, “who often have stereotypic and stigmatized images in their heads of what a person with dementia looks like” (telephone interview). By identifying as a person with dementia, a person may be ignored or communicated to differently, and unrelated symptoms may be assumed to be “just dementia, this is nothing more” (telephone interview). Staff also felt that persons with dementia and their carers may not disclose a dementia diagnosis to acute HCPs to avoid misdiagnosis and mismanagement of illness or pain.

Staff-cited gaps in acute HCPs' dementia-related knowledge included lack of systematic protocols for supporting persons with dementia in acute care, absence of training to identify persons with dementia and their symptoms, lack of clarity around effective communication with persons with dementia, and inappropriate use of physical and chemical restraints. For example, staff shared stories such as HCPs “using straps to tie [a person] to the bed, which is very alarming to see a family member tied down like that, and of course resorting to medications to calm [a person with dementia] down” (telephone interview) instead of trying to

determine and address their needs. A lack of person-centred approaches to care, with the predominance of a general *one size fits all* approach, insufficient continuity of care, and inadequate communication between acute HCPs and families were identified. The challenges and unmet needs staff identified are consistent with the reviewed literature, suggesting these issues remain in Canadian acute care environments.

Staff identified elements of acute care that could be improved to address the above issues. They emphasized that care should be provided by HCPs who have received enhanced experiential simulated learning of dementia, because persons with dementia “should be cared for by a team who has received the proper education/training” (e-mail communication). They stressed the need for acute HCPs to be educated about dementia (e.g., types, diagnosis, treatments, and symptoms). Staff felt that acute HCPs should know how to: (a) support persons with dementia; (b) provide person-centred care; (c) connect families with dementia support services; (d) work in partnership with families/carers; and (e) improve communication about the person's needs, likes, and abilities. Staff also felt that preparing persons with dementia and carers for acute care could be helpful. For example, carers could create a written summary with the person with dementia about their most critical health care needs, current abilities, and likes and dislikes that could be brought into acute care and shared with HCPs. Staff identified the Alzheimer Society's *First Link* as another resource that could help prepare families for acute care settings (McAiney, Hillier, Stolee, Harvey, & Michael, 2012).



Lastly, staff felt built environments should be modified to be more enabling and dementia-friendly. Acute care environments by design are clinical spaces, often very bright with shiny hard surfaces, noisy, and difficult to navigate. Without adaptations for persons with dementia, environments can be both distressing and disabling. Staff identified several potential modifications, including clear wayfinding signage, lighting to improve visibility and reduce glare, access to quiet spaces/rooms, consistent use of visible staff name tags, and standard uniforms “that make staff recognizable” (telephone interview). Overall, staff felt that improving acute care experiences for persons with dementia and their carers would require a significant culture shift within organizations.

**Current education programs for acute HCPs.** We identified 16 educational programs in Canada that incorporate dementia education accessible to acute HCPs. Table 3 describes the location, audience, curricula, accessibility, and cost of these programs. Dementia care was the specific focus of six programs, although all included a dementia-related component. The other programs focused more broadly on persons living with dementia, psychiatric, and cognitive disorders; those in palliative care; and older persons in general. The target audience of most programs was HCPs working in a range of settings; no program was specifically focused on acute HCPs. Six program websites did not provide specific information about dementia-related curricula, and four programs could be accessed online only. Of the seven program websites that included curricula, commonly covered topics were screening, diagnosis, communication, and brain and behaviour changes. Less often, curricula included topics such as self-protection strategies for HCPs, strategies for risk situations, action planning, and general information on aging. Some of the components of effective dementia education were clearly part of identified programs (Surr et al., 2017): 10/16 programs offered face-to-face courses (3 did not specify), 10 included course options that had a total duration of eight hours (3 did not specify), 6 provided individuals with a structured tool (10 did not specify), 6 included interactive learning (7 did not specify), 5 were delivered by an experienced facilitator (10 did not specify), 4 supported the application of learning in practice (6 did not specify), and 1 noted that programs were oriented to be relevant to the learner (15 did not specify).

Findings from this environmental scan suggest that dementia education for Canadian acute HCPs is limited and piece-meal across the country, and not geared specifically towards acute care. Moreover, while some programs are grounded in concepts of person-centred care and include a focus on understanding persons with dementia and their needs, none address the concern that education of learners should tackle broader shifts in practices, policies, and organizational cultures within acute care (Moyle et al., 2010; Pinkert et al., 2018). This illustrates the need for a Canadian program that supports acute HCPs to both increase their knowledge of dementia, and lead and implement change on a broader scale (Surr et al., 2017).

### Lived Experience Interviews

The purpose of the key informant interviews was to provide a means for planning meeting participants to hear the experiences of persons with dementia and carers, and identify any additional issues that may be unique and important to address in the Canadian dementia education program for acute HCPs.

### Methods

Semi-structured, face-to-face interviews were conducted with three key informants (one man living with dementia and his wife carer, and an additional woman carer) recruited through the Alzheimer Society of Saskatchewan, who had experienced an acute care admission within the last 12 months. Given that the purpose of our key informant interviews was to hear about recent acute care experiences (not to provide information about acute care experiences that is generalizable to all persons with dementia and carers), the small number of participants was deemed sufficient. Informants were asked questions like: “Can you please describe your recent experience in the hospital?” “What do you think needs to change to better support people with dementia and family carers who are accessing hospital care?” “What is most important for health care providers working in hospitals to know about what it is like to be a person with dementia or a family carer of a person with dementia going to the hospital for care?” Interviews were held in informants’ homes and were audio-recorded then transcribed. Thematic analysis was conducted to identify key elements of informants’ experiences (Braun & Clarke, 2006). Analysis involved an iterative process (undertaken by SP and KH), whereby transcripts were read and re-read for key aspects of the informants’ experiences; then coding was performed to capture key elements in the data, developing and refining themes in collaboration with AJW to highlight the salient elements of the informants’ experiences.

### Findings

Key informants highlighted the importance of three things: the need for frequent and effective communication from acute HCPs, the nature of acute care environments, and the need for person- and family-centred care. First, informants spoke at length about the significance of regular contact with and communication from providers. A communication **vacuum** was the biggest problem in their acute care experiences; they described missed opportunities to connect with doctors and lack of sufficient communication from nurses:

I never met the doctor that was supposed to be looking after him. The nurses wouldn't tell me a lot. I wasn't happy with it, but he was being looked after and that was the most important thing to me... I just thought there was a lack of communication. I'd want some information and I didn't get it. 'He's doing fine' or something like that. I wanted to know exactly. (Carer #1)

Carers desired clear communication about how the person was doing when they were not there, medical information from supervising doctors, and chart updates. They wanted this communication on a regular and ongoing basis and did not want to have to “chase down” acute HCPs to get it – an often unsuccessful endeavour. Communication was considered crucial because the symptoms of dementia made it difficult for the person to remember and effectively communicate details to their carers.

It was also important that communication be concrete, effective, and accessible. For example, our informant with dementia identified the value of having printed information to supplement verbal communication: *Actually giving documents or a note of something, saying this is what we have discussed. So it doesn't just go in one ear and out the other, because I have a hard time retaining things sometimes.* One carer noted that she also appreciated when acute HCPs were patient with her loved ones when they did not understand or forget information.

**Table 3.** Canadian resources for dementia education

Resource/website URL(s)	Description	Location	Audience	Accessibility	Cost in CAD
Behavioural symptoms <a href="https://www.amilia.com/store/en/iugm/shop/programs/37999">https://www.amilia.com/store/en/iugm/shop/programs/37999</a>	Behavioural symptoms include continuing education opportunities provided by the University Institute of Geriatrics of Montreal. Two courses were advertised in March, 2020 (Behavioral and Psychological Symptoms of Dementia/Behavioral, Psychiatric, and Neurocognitive Disorders).	QC	Healthcare professionals	Online training series <i>{program may no longer be available as of April 2021}</i>	\$250–\$300
Best Friends Approach <sup>b,c,d,f,g</sup> <a href="https://bestfriends.healthpropress.com/training/introductory-training/">https://bestfriends.healthpropress.com/training/introductory-training/</a> <a href="https://bestfriends.healthpropress.com/training/advanced-training/">https://bestfriends.healthpropress.com/training/advanced-training/</a> <a href="https://bestfriends.healthpropress.com/training/master-trainer-certification/">https://bestfriends.healthpropress.com/training/master-trainer-certification/</a>	Introductory, advanced, and master trainer certification training options are offered by the Health Professions Press in the United States. The training involves a humanistic, relationship-based model to care for individuals living with Alzheimer's disease or dementia. In-person group training is led by an expert in the Best Friends Approach, and is offered as half-day, full day, or two-day training sessions.	Across Canada (American content)	Not specified	In-person group training sessions	\$1,700–\$5,500 (currency not specified)
Centre Montessori Alzheimer <sup>b,d,f</sup> <a href="https://montessori-alzheimer.com/boutique/fr/formations-c74/">https://montessori-alzheimer.com/boutique/fr/formations-c74/</a>	This intensive training in the Montessori Method adapted for older persons with dementia is offered over two days. It is intended for all professionals working with older people at home, in institutional and community settings, as well as caregivers.	French Canada	Healthcare professionals and/or caregivers	In-person workshops Training option 1 Training option 2	\$420 \$120 for virtual Zoom training \$1,500 per group of 12 people for two-day, in-person training
Dementia Care Training <sup>b,c,d,e,f,g</sup> <a href="https://alzheimer.ca/pei/en/dct">https://alzheimer.ca/pei/en/dct</a>	The Dementia Care Training program involves two 2-day courses. The first course involves understanding dementia, U-First approaches, person-centred care, and more. The second course focuses on application of U-First principles, Montessori's DementiaAbility Methods, LGBTQ care guidelines, and more.	PEI	Healthcare professionals	In-person training program	\$300
Dementia Certificate Program <sup>b,d,e</sup> <a href="https://alz.to/courses-learning-programs/dementia-certificate-program/">https://alz.to/courses-learning-programs/dementia-certificate-program/</a>	The Dementia Certificate Program includes two programs: dementia care training (4 sessions) and behavioural support training (2 full days). Individuals become familiar with U-First approaches, person-centred care, management of responsive behaviours, and various other skills.	Toronto, ON	Healthcare professionals	In-person training program or online	\$150, in-person \$75, online
ECHO <sup>a</sup> Care for the Elderly- Dementia Series <sup>d</sup> <a href="https://baycrest.echoontario.ca">https://baycrest.echoontario.ca</a> <a href="https://baycrest.echoontario.ca/care-of-the-elderly/didactic-curriculum/winter-2021-echo-care-of-the-elderly-dementia-series-curriculum/">https://baycrest.echoontario.ca/care-of-the-elderly/didactic-curriculum/winter-2021-echo-care-of-the-elderly-dementia-series-curriculum/</a>	The ECHO-dementia series is an educational resource via videoconference that covers one session topic per week, for six weeks. Some topics include responsive behaviour, screening and assessment, and psychosocial care. Each session is led by a specialist in the specific topic area and includes patient cases.	Fall 2019 in ON	Primary healthcare providers	Online education curriculum	Free (funded by Ministry of Health and Long-Term Care)
The Emergency Management, Frailty, Dementia & Disasters e-Learning Program <a href="https://brainxchange.ca/Public/Resource-Centre-Topics-A-to-Z/Emergency-management-frailty-dementia-and-disast.aspx">https://brainxchange.ca/Public/Resource-Centre-Topics-A-to-Z/Emergency-management-frailty-dementia-and-disast.aspx</a>	The e-learning program contains 4 modules (emergency management, preparation, response, and recovery and mitigation) that take approximately 20 minutes each to complete. The modules are emergency- and disaster-related, and aim to inform individuals of the vulnerabilities persons with dementia may face in these situations	Across Canada	Healthcare professionals, administrators, and policy makers	Online information modules <i>{program may no longer be available as of April 2021}</i>	Free

(Continued)

Table 3. Continued

Resource/website URL(s)	Description	Location	Audience	Accessibility	Cost in CAD
	and effective care for this population in an emergency.				
Gentle Persuasive Approaches (GPA) <sup>bcdefg</sup> <a href="https://ageinc.ca/gpaadp/gpa-certified-coach/gpa-certified-coach-training/">https://ageinc.ca/gpaadp/gpa-certified-coach/gpa-certified-coach-training/</a> <a href="https://ageinc.s3.amazonaws.com/uploads/2020/12/IntegratedGPA-Flyer_IncludesVirtualClassroom_Nov2020.pdf">https://ageinc.s3.amazonaws.com/uploads/2020/12/IntegratedGPA-Flyer_IncludesVirtualClassroom_Nov2020.pdf</a> <a href="https://s3.ca-central-1.amazonaws.com/ageinc/uploads/2018/03/AGE_CourseDescription_GPAeLEARNING.pdf">https://s3.ca-central-1.amazonaws.com/ageinc/uploads/2018/03/AGE_CourseDescription_GPAeLEARNING.pdf</a> <a href="https://ageinc.s3.amazonaws.com/uploads/2018/05/AGE_CourseDescription_GPABASICS.pdf">https://ageinc.s3.amazonaws.com/uploads/2018/05/AGE_CourseDescription_GPABASICS.pdf</a>	GPA Basics is a session led by certified GPA coaches covering 4 education modules over a 7.5-hour day related to person-centred dementia care. The curriculum is provided by AGE Inc. (a not-for-profit organization for dementia education) and is offered as in-person sessions, online (incomplete), or through a combination of in-person and online material. GPA recharged is offered as a 2-hour review of the GPA Basics program.	Across Canada	Interdisciplinary healthcare staff	In-person or online sessions	\$21, in-person GPA basics \$6, in-person GPA recharged \$90, GPA eLearning \$32.50–\$94.50 Integrated GPA (in-person and online) \$900, in-house coach delivery
Mieux intervenir, ça s'apprend <sup>d</sup> <a href="https://alzheimer.ca/en/federationquebecoise/We-can-help/Programmes_et_services/Programme_de_formation_professionnelle">https://alzheimer.ca/en/federationquebecoise/We-can-help/Programmes_et_services/Programme_de_formation_professionnelle</a>	A variety of course options are available within this Alzheimer's education program. These courses include a 30-hour course covering a person-centred care approach, 12-hour and 9-hour courses on daily help, a 6-hour course covering meaningful interactions, and a 15-hour course specifically for long-term care managers.	Training Education QC	Health care professionals	In-person courses {Program may no longer be available as of April 2021.}	\$10 per participant per hour
Pallium Canada LEAP courses <sup>b,c,d,f</sup> <a href="https://www.pallium.ca/courses/">https://www.pallium.ca/courses/</a> Leap Hospital: <a href="https://www.pallium.ca/wp-content/uploads/2019/09/Pallium-LEAP-Hospital_one-pager.pdf">https://www.pallium.ca/wp-content/uploads/2019/09/Pallium-LEAP-Hospital_one-pager.pdf</a>	Pallium Canada offers a variety of Learning Essential Approaches to Palliative Care (LEAP) courses in the form of interactive modules or in-person one day or two-day sessions. LEAP courses are not dementia focused; rather, they are broadly targeted towards palliative care. For example, LEAP hospital is an educational course for health care professionals concerning palliative care in hospital settings.	Across Canada	Health care professionals	In-person courses, online courses, or blended courses	Not available
PIECES™ <sup>d</sup> <a href="http://pieceslearning.com">http://pieceslearning.com</a> <a href="http://pieceslearning.com/p-i-e-c-e-s-learning-development-program/">http://pieceslearning.com/p-i-e-c-e-s-learning-development-program/</a> AB: <a href="http://pieceslearning.com/alberta/">http://pieceslearning.com/alberta/</a> BC: <a href="http://pieceslearning.com/british-columbia/">http://pieceslearning.com/british-columbia/</a> MB: <a href="http://pieceslearning.com/manitoba-2/">http://pieceslearning.com/manitoba-2/</a> NS: <a href="http://pieceslearning.com/nova-scotia/">http://pieceslearning.com/nova-scotia/</a> ON: <a href="http://pieceslearning.com/ontario/">http://pieceslearning.com/ontario/</a> SK: <a href="http://pieceslearning.com/saskatchewan/">http://pieceslearning.com/saskatchewan/</a>	The PIECES™ learning and development programs address (P)hysical, (I)ntellectual, and (E)motional health, is centred on maximizing individuals' (C)apabilities, and considers the patient's (E)nvironment and (S)ocial self. There are multiple in-person programs varying in length offered throughout Canada under the PIECES™ model. PIECES™ programs aim to improve the care of older individuals with complex needs, including, but not limited to, people living with dementia. Program delivered differently across provinces (e.g., 32 hours of content in MB versus 24 hours of content in NS).	BC, AB, SK, MB, ON, NS	A variety of health care providers	In-person or online workshops	Not available
Practice support program – Doctors of BC <sup>a,b,e,g</sup> <a href="https://gpscbc.ca/what-we-do/practice-supports/psp/learning-opportunities">https://gpscbc.ca/what-we-do/practice-supports/psp/learning-opportunities</a> <a href="https://www.doctorsofbc.ca/managing-your-practice/quality-improvement/practice-support-program-ppsp">https://www.doctorsofbc.ca/managing-your-practice/quality-improvement/practice-support-program-ppsp</a>	This program is targeted towards improving doctors' care approaches. "Learning Opportunities" are available to Doctors in BC in the form of in-person, online, or mixed sessions. Although the program is not focused on dementia, dementia management is one of the key learning topics.	BC	Doctors and their teams	In-person, online, or blended learning	Not available
SafeCare BC – various dementia workshops <sup>b,d</sup> <a href="https://www.safecarebc.ca/programs/workshops-events/">https://www.safecarebc.ca/programs/workshops-events/</a> <a href="https://www.safecarebc.ca/course-descriptions/">https://www.safecarebc.ca/course-descriptions/</a>	Three types of workshops related to dementia are identified: Supporting persons with intellectual disabilities and dementia (pilot), Creating connections: Working with persons with dementia, GPA: Basics. A range of skills for dementia care is	BC	Ranges from anyone to health care professionals	In-person workshops	\$35 (member), \$100 (non-member)

(Continued)

Table 3. Continued

Resource/website URL(s)	Description	Location	Audience	Accessibility	Cost in CAD
	targeted, depending on the workshop. Workshops range from half-day to full-day time slots.				
Supportive Pathways – Carewest <sup>b,f, g</sup> <a href="https://carewest.ca/dementia-care-training/">https://carewest.ca/dementia-care-training/</a>	Train the Trainer two-day sessions are offered every two months in the city of Calgary, Alberta, to individuals in health care management. Off-site group sessions are also available and have been completed in BC and Northwest Territories. The sessions are based on Supportive Pathways education, with the goal of enhancing quality of life for those living with dementia and encouraging family involvement.	AB	Health care educators, managers, and professionals	In-person sessions	Not available
Teepa Snow's Positive Approach to Care: Becoming Dementia Aware <sup>c</sup> <a href="https://teepasnow.com/product/becoming-dementia-aware-online-course/">https://teepasnow.com/product/becoming-dementia-aware-online-course/</a> <a href="https://teepasnow.com/product/becoming-dementia-aware-online-course/">https://teepasnow.com/product/becoming-dementia-aware-online-course/</a> <a href="https://teepasnow.com/services/on-site-training/one-day-public-skills-champion-course/">https://teepasnow.com/services/on-site-training/one-day-public-skills-champion-course/</a> <a href="https://teepasnow.com/services/online-learning/webinars/">https://teepasnow.com/services/online-learning/webinars/</a>	This online course is rooted in Teepa Snow's Positive Approach to Care (PAC). This course is accessible to anyone at any time through Teepa's website. The course curriculum consists of topics such as the brain, responding to changes, the positive physical approach, PAC skills, caring for all, and PAC team songs.  Teepa Snow also offers free webinars on topics such as dementia care and care partner support. On-site training is also offered but has currently transitioned to an online format to align with COVID-19 restrictions. Finally, an online PAC champions course covers the Positive Physical Approach, Hand-under-Hand, GEMS states, and GEMS state recognition.	Across Canada (American content)	Open to anyone	Online training course	\$136, online PAC course \$67, online Champion course Free webinars
U-First <sup>b,g</sup> <a href="http://u-first.ca/about-u-first/">http://u-first.ca/about-u-first/</a> <a href="http://u-first.ca/training-registration/">http://u-first.ca/training-registration/</a>	U-First aims to help frontline staff understand the behaviour of people living with dementia and form common knowledge, language, and values relating to the care process. The program is offered as a three-week online course or a six-hour, in-person workshop	SK, ON, PEI	Frontline staff involved with dementia care	In-person or online workshops	\$75, online \$75, SK Free, ON Cost not available, PEI

<sup>a</sup>Content relevant to participant's role.

<sup>b</sup>Face-to-face instruction.

<sup>c</sup>Experienced facilitator.

<sup>d</sup>Content > 8 hours.

<sup>e</sup>Apply learning to practice.

<sup>f</sup>Structured guide.

<sup>g</sup>Interactive learning.



Secondly, the acute care experience was improved when the setting was “homey” and had windows so the person with dementia could look outside. Crowded, dingy, and depressing environments were problematic, as were lighting and noise:

I find that I need the calm and you're in a ward with a whole bunch of other people... You're just having a nap and more visitors come in. That really gets me going. It's a hectic environment to be in... I find it stressful. (Person with dementia)

One carer suggested that not having a quiet space, sharing a room with other patients, and disrupted sleep exacerbate emotions like anxiety, agitation, fear, and uncertainty that persons with dementia may experience in acute care. She suggested this should be mitigated by more attention to the allocation of persons with dementia to particular spaces, and a more personalized approach to care.

Finally, it was clear that a person- and family-centred approach to care was important. Informants appreciated opportunities for personal connection with acute HCPs wherein they felt valued: *That really does go a long way when you're seeing the same people, and they know you, and you have the sense that they know you... I think connection is really, really important* (Carer #2). Feeling a connection was closely tied to communication and not feeling like information was withheld, as well as interactions where HCPs were patient, kind, and understanding. It was important to carers to be involved in the care of the person with dementia via communication with acute HCPs, so that care was family-centred. Although informants were satisfied with the medical care persons with dementia received, one of the carers was distressed by instances where her husband's fundamental needs and human rights were not met: *He used to say he had to go to the bathroom, they'd say 'well he has to wait until one o'clock, he can't go because it takes two of us to sit him in the bathroom', I always found that hard* (Carer #1). Other issues were the need for comfort in the acute care environment, stability (not being repeatedly moved to different environments), and support maintaining mobility.

The experiences of informants were consistent with the broader literature (e.g., Clisset et al., 2013; Hung et al., 2017; Jurgens et al., 2012; Moyle et al., 2016). In particular, the importance of regular and appropriate communication that is not only effective in conveying information but also engenders a person- and family-centred approach was highlighted. Hearing informants' experiences reaffirm these critical aspects for education and change in practice.

### Planning Meeting

The purpose of the planning meeting, held over two days in February 2020, was to bring experts ( $n = 19$ , academics from across Canada, community stakeholders from the Alzheimer Society of Saskatchewan and older adult community services, acute care clinicians such as nurses and a psychologist, and a couple living with dementia) together to collaborate on how to adapt the Dementia Champions Programme to the Canadian context. Those who could not attend in-person ( $n = 3$ ) participated via Webex. The objectives were to: (a) establish Canadian priorities for dementia education; and (b) use these priorities to adapt the overarching learning outcomes and individual sessions of the Programme. SP, AJW, and RM collated pre-meeting information to share with the participants, including a summary of the environmental scan described above, the executive summary of Canada's National Dementia Strategy, and a summary of the Programme objectives.

Detailed agendas were created for each day to guide and inform the meeting process.

### Day one

Priorities for acute HCP dementia education in Canada were established using an adapted Nominal Technique (American Society for Quality, 2019). First, participants watched a video (created by KH and SH) that shared our key informants' experiences in acute care. This was important to ensure their experiences and issues were foreground in discussions of priorities, and to reflect the importance of involving persons with dementia and carers as peer-educators.

The group then deliberated and voted on main priorities. Participants were asked, “In light of your dementia research, education, and/or practice experience, if you were to design a dementia education programme for professional healthcare staff working in acute care settings what would your top three priorities need to include?” Participants wrote their priorities on sticky notes and added them to a blank wall chart for the group to view (those participating by Webex e-mailed their priorities to be added). Priorities were thematically grouped on the wall chart by two collaborators (SP and AJW). Participants discussed these themed priorities then voted (via sticky notes) for the three they believed were most important. Voting and subsequent discussion showed that participants felt a person- and family-centred approach was crucial as a philosophy for care and should ground all other priorities. With that established, another round of voting was held that established the following key priorities: (a) communicating effectively, (b) working with responsive behaviours, (c) understanding different dementias, (d) creating supportive environments, and (e) identifying leadership qualities that lead to advocacy (Figure 2 captures this process of establishing these priorities).

Once Canadian priorities were drafted, we heard from WD about how to effectively adapt interventions; this was important so the group recognized the need to maintain the fidelity of the Programme while reflecting the principles of Canada's National Dementia Strategy, health care system, professional education, and values. We continued with a presentation on the Programme's five overarching learning outcomes (AJW). We then used an adapted *World Café* (The World Café, 2020) approach to adapt the outcomes to a Canadian context, bearing in mind the identified Canadian priorities. Five flipcharts, each listing individual outcomes, were placed on five tables. Participants moved about the room (in five-minute intervals) between the flipcharts to discuss written feedback on adapting the Scottish learning outcomes. The adapted outcomes for Canada can be viewed in Table 4. The Canadian learning outcomes incorporate differing **action** words (e.g., instead of “understand and identify” we used “promote” for learning outcome #3), yet align with Scottish learning outcomes as our identified priorities were largely reflected in the Scottish program. We refined the learning outcomes and incorporated language common to Canada (e.g., learning outcome #4 “responsive behaviours”). The day ended with a participatory example of simulated experiential learning of one pedagogical approach used in the Programme, lead by RM. These activities sensitized participants to the work ahead in adapting the Programme's individual sessions.

### Day two

We began with a detailed overview of the Programme (presented by RM) and moved onto the individual program sessions. Participants worked in small groups to consider the content of each session (two per day, for five days) that makes up the Programme. We displayed



publicly accessible; regardless, no dementia programs in Canada exist that are comparable to the Programme. Our work from the planning meeting is significant to moving forward with a Canadian program.

The results of this planning meeting are now being used to inform the next stage of co-production, which is the co-development of the content of the Canadian dementia education program for acute HCPs (Hawkins et al., 2017). Once the core development group (SP, MB, RM, AJW, KH, LH, JB, and NR) creates an initial program and implementation plan, these will be shared with key stakeholder groups for additional input. Of importance is to explore offering online/virtual options for program delivery, given the vastness of Canada as well as the issues the coronavirus disease (COVID-19) pandemic revealed. We will hold two focus groups with persons living with dementia and their carers, as well as a focus group with frontline acute HCPs to ensure the utility and acceptability of the Canadian program. Future research endeavours (that reflect the third stage of co-production) include acquiring funding to pilot and evaluate the Canadian program. We will further develop and maintain our website (see <https://www.dementiachampionscanada.com/>) to make our work visible and accessible to people who would benefit from a dementia education program for acute HCPs.

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## References

- Alzheimer Scotland. (2015). *Getting to know me*. Retrieved 5 April 2020 from <https://www.alzscot.org/our-work/dementia-support/information-sheets/getting-to-know-me>
- Alzheimer's Society. (2009). *Counting the cost of caring for people with dementia on hospital wards*. Retrieved 5 April 2020 from [https://www.alzheimers.org.uk/sites/default/files/2018-05/Counting\\_the\\_cost\\_report.pdf](https://www.alzheimers.org.uk/sites/default/files/2018-05/Counting_the_cost_report.pdf)
- Alzheimer Society of Canada. (2019). *Your guide to Canada's national dementia strategy*. Retrieved 5 April 2020 from <https://alzheimer.ca/en/Home/Get-involved/Advocacy/National-dementia-strategy-guide#what-is-a-national-dementia-strategy>
- American Society for Quality. (2019). *What is nominal group technique?* Retrieved 5 April 2020 from <https://asq.org/quality-resources/nominal-group-technique>
- Banks, P., Waugh, A., Henderson, J., Sharp, B., Brown, M., Oliver, J., & Marland, G. (2014). Enriching the care of patients with dementia in acute settings? The Dementia Champions Programme in Scotland. *Dementia*, 13(6), 717–736. doi:10.1177/1471301213485084
- Bayly, M., Peacock, S., Jack-Waugh, A., & MacRae, R. (2020). *Adapting the Scottish dementia champions programme: 2020 planning meetings*. Lay summary. Retrieved 5 April 2020 from <https://www.researchgate.net/publication/339386968>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. doi:10.1191/1478088706qp063oa
- Brooker, D. (2003). What is person-centred care in dementia? *Reviews in Clinical Gerontology*, 13(3), 215–222. doi:10.1017/S095925980400108X
- Canadian Academy of Health Sciences. (2019). *Improving the quality of life and care of persons living with dementia and their caregivers*. Retrieved 5 April 2020 from <https://www.caahs-acss.ca/wp-content/uploads/2019/01/Report.pdf>
- Canadian Institute for Health Information (2018, June 26). *Dementia in Canada*. Retrieved 5 April 2020 from <https://www.cihi.ca/en/dementia-in-canada>
- Choo, C. W. (1999). The art of scanning the environment. *Bulletin of the American Society for Information Science and Technology*, 25(3), 21–24.
- Clissett, P., Porock, D., Harwood, R. H., & Gladman, J. R. F. (2013). The challenges of achieving person-centred care in acute hospitals: A qualitative study of people with dementia and their families. *International Journal of Nursing Studies*, 50, 1495–1503. doi:10.1016/j.ijnurstu.2013.03.001
- Coffey, A., Tyrrell, M., Buckley, M., Manning, E., Browne, V., Barrett, A., & Timmons, S. (2014). A multicentre survey of acute hospital nursing staff training in dementia care. *Clinical Nursing Studies*, 2(4), 39–46. doi:10.5430/cns.v2n4p39
- Cowell, F. (2010). Care of older people with dementia in an acute hospital setting. *Nursing Standard*, 24, 42–48.
- Dewing, J., & Dijk, S. (2016). What is the current state of care for older people with dementia in general hospitals? A literature review. *Dementia*, 15(1), 106–124. doi:10.1177/1471301213520172
- Digby, R., & Bloomer, M. J. (2014). People with dementia and the hospital environment: The view of patients and family carers. *International Journal of Older People Nursing*, 9, 34–43. doi:10.1111/opn.12014
- Durell, S. (2014). How the social model of disability evolved. *Nursing Times*, 110(50), 20–23. <http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2012829924&site=ehost-live>.
- Elvish, R., Burrow, S., Cawley, R., Harney, K., Pilling, M., Gregory, J., & Keady, J. (2018). 'Getting to Know Me': The second phase roll-out of a staff training programme for supporting people with dementia in general hospitals. *Dementia*, 17(1), 96–109. doi.org/10.1177/1471301216634926
- Gkioka, M., Schneider, J., Kruse, A., Tsolaki, M., Moraitou, D., & Teichmann, B. (2020). Evaluation and effectiveness of dementia staff training programs in general hospital settings: A narrative synthesis with Holton's Three-level Model applied. *Journal of Alzheimer's Disease*, 78, 1089–1108. doi.org/10.3233/JAD-200741
- Graham, P., Evitts, T., & Thomas-MacLean, R. (2008). Environmental scans: How useful are they for primary care research? *Canadian Family Physician*, 54(7), 1022–1023.
- Hawkins, J., Madden, K., Fletcher, A., Midgley, L., Grant, A., Cox, G., ... White, J. (2017). Development of a framework for the co-production and prototyping of public health interventions. *BMC Public Health*, 17, 689. doi:10.1186/s12889-017-4695-8
- Houghton, C., Murphy, K., Brooker, D., Casey, D. (2016). Healthcare staffs' experiences and perceptions of caring for people with dementia in the acute setting: Qualitative evidence synthesis. *International Journal of Nursing Studies*, 61, 104–116. doi:10.1016/j.ijnurstu.2016.06.001
- Hung, L., Phinney, A., Chaudhury, H., Rodney, P., Tabamo, J., & Bohl, D. (2017). "Little things matter!" Exploring the perspectives of patients with dementia about the hospital environment. *International Journal of Older People Nursing*, 12(3), e12153. doi:10.1111/opn.12153
- Hung, L., Son, C., & Hung, R. (2019). The experience of hospital staff in applying the Gentle Persuasive Approaches to dementia care. *Journal of Psychiatric Mental Health Nursing*, 26, 19–28. doi:10.1111/jpm.12504
- Hynninen, N., Saarnio, R., & Isola, A. (2014). The care of older people with dementia in surgical wards from the point of view of the nursing staff and physicians. *Journal of Clinical Nursing*, 24, 192–201. doi:10.1111/jocn.12669
- Jack-Waugh, A., Ritchie, L., MacRae, R. (2018). Assessing the educational impact of the dementia champions programme in Scotland: Implications for evaluating professional dementia education. *Nurse Education Today*, 71, 205–210. doi:10.1016/j.nedt.2018.09.019
- Jurgens, F. J., Clissett, P., Gladman, J. R. F., & Harwood, R. H. (2012). Why are family carers of people with dementia dissatisfied with general hospital care? A qualitative study. *BMC Geriatrics*, 12(57), 1–10. doi:10.1186/1471-2318-12-57
- Kitwood, T. M. (1997). *Dementia reconsidered: The person comes first*. Open University Press.
- LaMantia, M. A., Stump, T. E., Messina, F. C., Miller, D. K., & Callahan, C. M. (2016). Emergency department use among older adults with dementia. *Alzheimer Disease & Associated Disorders*, 30(1), 35–40. doi:10.1097/WAD.0000000000000118
- Martin, L. S., Gillies, L., Coker, E., Pizzacalla, A., Montemuro, M., Suva, G., & McLelland, V. (2016). An education intervention to enhance staff self-efficacy to provide dementia care in an acute care hospital in Canada: A nonrandomized controlled study. *American Journal of Alzheimer's Disease and Other Dementias*, 31(8), 664–677.
- McAiney, C.A., Hillier, L., Stolee, P., Harvey, D., & Michael, J. (2012). 'Throwing a lifeline': The role of First Link™ in enhancing support for individuals with



- dementia and their caregivers. *Neurodegenerative Disease Management*, **2**(6), 623–638. doi:10.2217/nmt.12.66
- Mental Welfare Commission for Scotland. (2018). *Themed visits to people with dementia in community visits*. Scotland: Mental Welfare Commission. Retrieved 5 April 2020 from [https://www.mwscot.org.uk/sites/default/files/2019-06/dementia\\_in\\_community\\_may2018.pdf](https://www.mwscot.org.uk/sites/default/files/2019-06/dementia_in_community_may2018.pdf)
- Moyle, W., Borbasi, S., Wallis, M., Olorenshaw, R., & Gracia, N. (2010). Acute care management of older people with dementia: A qualitative perspective. *Journal of Clinical Nursing*, **20**, 420–428. doi:10.1111/j.1365-2702.2010.03521.x
- Moyle, W., Bramble, M., Bauer, M., Smyth, W., & Beattie, E. (2016). 'They rush you and push you too much... and you can't really get any good response off them': A qualitative examination of family involvement in care of people with dementia in acute care. *Australasian Journal on Ageing*, **35**(2), E30–E34. doi:10.1111/ajag.12251
- Parke, B., Boltz, M., Hunter, K. F., Chambers, T., Wolf-Ostermann, K., Adi, M. N., Feldman, F., & Gutman, G. (2017). A scoping literature review of dementia-friendly hospital design. *The Gerontologist*, **57**(4), e62–e74. doi:10.1093/geront/gnw128
- Pinkert, C., Faul, E., Saxer, S., Burgstaller, M., Kamleitner, D., & Mayer, H. (2018). Experiences of nurses with the care of patients with dementia in acute hospitals: A secondary analysis. *Journal of Clinical Nursing*, **27**, 162–172. doi:10.1111/jocn.13864
- Poblador-Plou, B., Calderón-Larrañaga, A., Marta-Moreno, J., Hanco-Saavedra, J., Sicras-Mainar, A., Soljak, M., & Prados-Torres, A. (2014). Comorbidity of dementia: A cross-sectional study of primary care older patients. *BMC Psychiatry*, **14**, 84. doi:10.1186/1471-244X-14-84
- Prato, L., Lindley, L., Boyles, M., Robinson, L., & Abley, C. (2019). Empowerment, environment, and person-centred care: A qualitative study exploring the hospital experience for adults with cognitive impairment. *Dementia*, **18**(78), 2710–2730. doi:10.1177/1471301218755878
- Public Health Agency of Canada (2017). *Dementia in Canada, including Alzheimer's disease: Highlights from the Canadian chronic disease surveillance system*. Retrieved 5 April 2020 from <https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/diseases-conditions/dementia-highlights-canadian-chronic-disease-surveillance/dementia-highlights-canadian-chronic-disease-surveillance.pdf>
- Public Health Agency of Canada (2019). *A dementia strategy for Canada: Together we aspire*. Retrieved 5 April 2020 from <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/dementia-strategy.html>
- Singleton, J. (2015). Head, heart and hands model for transformative learning: Place as context for changing sustainability values. *Journal of Sustainability Education*, **9**, 1–16.
- Sommerlad, A., Perera, G., Mueller, C., Singh-Manoux, A., Lewis, G., Stewart, R., & Livingston, G. (2019). Hospitalisation of people with dementia: Evidence from English electronic health records from 2008 to 2016. *European Journal of Epidemiology*, **34**, 567–577. doi:10.1007/s10654-019-00481-x
- Surr, C., Gates, C., Irving, D., Oyeboode, J., Smith, S. J., Parveen, S., Drury, M., & Dennison, A. (2017). Effective Dementia Education and Training for the Health and Social Care Workforce: A Systematic Review of the Literature. *Review of Educational Research*, **87**(5), 966–1002. doi:10.3102%2F0034654317723305
- The Royal College of Psychiatrists. (2011). *Report of the national audit of dementia care in general hospitals: National report*. Retrieved 5 April 2020 from <https://www.rcpsych.ac.uk/pdf/NATIONAL%20REPORT%20-%20Full%20Report%201201122.pdf>
- The World Café. (2020). *Word café method*. Retrieved 5 April 2020 from <http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/>
- World Health Organization. (2019). *Dementia*. Retrieved 5 April 2020 from <https://www.who.int/news-room/fact-sheets/detail/dementia>