



**DEMENTIA  
TRAINING**  
STUDY CENTRES

# Advancing practice in the care of people with dementia

Education modules 3rd Edition -  
Facilitator Guide



The Dementia Training Study Centres are funded by the Australian Government Department of Social Services. Visit [www.dss.gov.au](http://www.dss.gov.au) for more information.

# Advancing Practice in the Care of People with Dementia: Facilitator Guide

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### Important note

This Facilitator's Guide is designed to be used in conjunction with Advancing practice in the Care of People with Dementia core education modules ([www.dtsc.com.au](http://www.dtsc.com.au))



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### Introduction

This Facilitator Guide has been developed to provide health educators or senior clinicians in all health care settings with a comprehensive education program covering core dementia knowledge suitable for health professionals from all disciplines who care for people with dementia. The guide utilises and compliments the content of the Dementia Training Study Centres' core education modules to provide educators or senior clinicians with a prepared workshop or collection of education sessions.

The core modules are available on-line at [www.dtsc.com.au](http://www.dtsc.com.au) or in hard-copy from [r.brown@latrobe.edu.au](mailto:r.brown@latrobe.edu.au).

### Program aim

The aim of this education program is to provide participating health professionals with the core knowledge required to provide quality, evidence-based care to people with dementia.

### Learning outcomes

On completion participants will:

- ▶ be able to define what is meant by dementia
- ▶ have insight into the different types of dementia
- ▶ be able to describe the symptoms of dementia
- ▶ be able to describe options for treatment and interventions
- ▶ be able to discuss the factors which contribute to Behavioural and Psychological Symptoms of Dementia (BPSD)
- ▶ understand how to respond to Behavioural and Psychological Symptoms of Dementia (BPSD)
- ▶ be able to discuss the benefits of person-centred approaches to the care of people with dementia
- ▶ be able to describe how the physical environment can support quality care for people with dementia
- ▶ be able to implement strategies to promote best practice care for people with dementia

### Program delivery

#### Target audience

The DTSC core education modules are designed for health professionals and health care students from all disciplines and care settings.

#### Resources

You will need the following resources to deliver the modules:

- ▶ Access to DTSC core education modules online or in hard copy
- ▶ Facilitator guide
- ▶ Computer and Data projector and/or printed copies of the presentation slides
- ▶ Whiteboard/butcher's paper and pens

Information about additional resources required for specific sessions is provided in the relevant sections of the guide.



## Participant resources

Participants will benefit from access to the DTSC core education modules

## Symbols

The following symbols are used throughout the Facilitator's guide:



Suggested session timing



Slide Presentation



Participant or group activity



Key message

## Program structure

The modules are designed to be delivered either as a full day workshop or as six, hour long education sessions which each build upon the previous session.

## Session overview

The suggested six sessions are:

Session 1: Overview of dementia

Session 2: Diagnosing dementia

Session 3: Treatment and intervention options 1

Session 4: Treatment and intervention options 2

Session 5: Philosophy of care

Session 6: Therapeutic communication and Dementia friendly environments

## Workshop program

The suggested program for a full day workshop is:

8.30 - 9.00	Registration
9.00 - 9.15	Welcome, introductions and workshop overview
9.15 - 10.15	Session 1: Overview of dementia
10.15 - 11.15	Session 2: Diagnosing dementia
11.15 - 11.30	Morning tea
11.30 - 12.30	Session 3: Treatment and intervention options 1
12.30 - 1.30	Session 4: Treatment and intervention options 2
1.30 - 2.00	Lunch
2.00 - 3.00	Session 5: Philosophy of care
3.00 - 3.15	Afternoon tea
3.15 - 3.45	Session 6: Therapeutic communication
3.45 - 4.15	Session 6: Dementia friendly environments
4.15 - 4.30	Summary and close

## Session guides

### Workshop/session welcome, introduction and program overview



15 minutes

Welcome, Introductions and 'Housekeeping'



Activity

Conduct an "Ice-breaker" activity of your choice  
If conducting full workshop refer to the workshop learning outcomes slide.



Workshop title  
and learning  
outcomes slide  
or relevant  
session title  
slide

If conducting a single session refer to the relevant session title slide



## Session 1: Overview of dementia



Slides 3-28 Learning outcomes:



60 minutes

- ▶ Have knowledge of the basic functions of the brain
  - ▶ Differentiate the effects of normal and pathological ageing on the brain
  - ▶ Have knowledge of what dementia is and the different types of dementia
- Video clip explaining changes in the brain*

### Modules 1, 2 and 9

**Slides 4-6** The statistics in these slides provide a background to the prevalence of dementia worldwide, in Australia and the impact of this globally. The purpose is to provide context and demonstrate why it is important for all health professionals to have some understanding and knowledge about dementia and how to care for persons with dementia.



*The number of people who are living with dementia means health professionals in almost all care settings will provide care to people with dementia.*

**Slides 7-9** The brain, cognition and age related change. These slides provide a basic overview of the structure of the brain to act as a reminder to participants.

❖ *Stress that this is basic and intended only as a reminder for participants.*

**Slides 10-11** These slides provide background to what is meant by cognition and normal age related changes to cognition. A definition of cognition is included as it is a term frequently used but very often not explained. The aim therefore is to get a common understanding across the participant group.

**Slide 12** Here dementia is introduced.



*The difference between the normal age related changes on slide 11 and pathological changes in dementia: dementia is not normal ageing.*

**Slide 13** This slide refers to the 2013 Diagnostic and Statistical Manual of Mental Disorders' revised terminology (American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders, (5th ed.). (DSM-V). Arlington: American Psychiatric Association).

Reasons given for the change in terminology are to reduce the stigma associated with the word 'dementia and to better include younger people as dementia is seen primarily as a disease of old age.

**Slide 14** Slide 14 uses the typical course for Alzheimer's Disease to depict the impact of dementia on the individual.



*Dementia is now being recognised as a terminal condition*

*Slides 15-18* These slides provide a brief overview of the most common types of dementia (Alzheimer's disease, Vascular dementia, mixed dementia, Dementia with Lewy Bodies and Fronto-temporal dementia).

Slide 16 Demonstrates the impact of Alzheimer's Disease on the brain.

❖ *Emphasise that this picture demonstrates that a brain affected by Alzheimer's disease cannot possibly function normally and therefore explains why the person can't do things.*

❖ *Broken leg analogy*

❖ *There are video clips available through social media platforms such as YouTube which explain the pathology and changes in the brain in Alzheimer's Disease*

*Slides 19-20* These two slides introduce what is meant by the term 'younger onset dementia', how it is experienced and the more typical diagnostic subtypes.

*Module 9*



*Younger onset Alzheimer's disease is more often inherited. There is also Familial Alzheimer's disease.*

*Slides 21-26* Describe each lobe of the brain, its function and the impact of damage to each.



*The person's responses and behaviour are a result of changes in the brain.*

❖ *Refer to brain and behaviour DVD- AA local office*

*Slides 27-28* Dementia Risk Factors

A number of factors that increase the risk of dementia have been identified.

❖ *Explore with the group their understanding of these risk factors (age, lifestyle, genetics)*

The risk reduction strategies recommended by Alzheimer's Australia are promoted here. It directs the participants to the web and app based resources.

❖ *Explore the groups level of knowledge of these risk reduction strategies and the fact that these should be started as early as your 40's and throughout your remaining lifetime.*

❖ *Direct the group to the following resources: Your Brain Matters website [www.yourbrainmatters.org.au](http://www.yourbrainmatters.org.au) and Brainy app*





## Session 2: Diagnosing Dementia



Slides  
30-46

Learning outcomes:



60  
minutes

Module 3

Copies of cognitive  
assessment tools

- ▶ Understand the differential diagnoses of dementia
- ▶ Understand the importance of differentiating between the various types of dementia
- ▶ Debate issues relating to early diagnosis of dementia
- ▶ Identify the diagnostic criteria for dementia
- ▶ Understand the steps involved in diagnosing dementia
- ▶ Have an understanding of the various screening instruments and assessment tools which can be applied in the diagnostic process

**Slides 31-33** The following slides review the symptoms reasonably typical of the more prevalent, Alzheimer's Disease. These symptoms are then reviewed in the context of the DSM-IV and newer DSM-V diagnostic criteria.



*The change of terminology from dementia to minor or major neurocognitive disorder is revisited following the introduction of this changed terminology in session 1, slide 13. The term 'Dementia' remains in common use*

**Slides 34-36** Here we see that in order to establish a diagnosis, a number of activities must be undertaken.



*Ruling out reversible causes of cognitive impairment is an early step in the diagnostic journey.*

**Slide 34** ❖ *Direct the participants to view the different features of dementia, delirium and depression listed in [table 3.1 of the manual].*

Slide 35 Provides a helpful delirium screen sourced from Alzheimer's Australia.



*It is important to look for differential diagnosis to rule out reversible causes of cognitive decline*

**Slide 37** This slide reveals the positives and negatives of early diagnosis.

**Slides 38-46** The following slides briefly introduce a number of screening tools that are available to assist in the recognition of cognitive impairment in any care setting.



*Screening tools used in isolation will not provide a diagnosis of dementia. They can help assess the presence of cognitive impairment.*

❖ *Direct participants to the following websites for more detailed information about the screening tools listed in this session*

AMTS: <http://www.racgp.org.au/your-practice/guidelines/silverbook/tools/abbreviated-mental-test-score/>

GPCOG: <http://www.gpcog.com.au>

KICA: <http://www.wacha.org.au/kica.html>

RUDAS: <https://fightdementia.org.au/about-dementia-and-memory-loss/cultural-diversity/dementia/culturally-appropriate-dementia-assessment-tools/rowland-universal-dementia-assessment-scale>

Dementia Outcomes measurement suite: [www.dementia-assessment.com.au](http://www.dementia-assessment.com.au)



## Session 3: Treatment and intervention options



Slides 47- 60 Learning outcomes:



60 minutes

Modules 4, 5 and 10

- ▶ Discuss the options for both treatment and care of the person with dementia
- ▶ Critique the role of pharmaceuticals in the care of people with dementia
- ▶ Demonstrate an understanding of legal considerations involved in the care of people with dementia
- ▶ Discuss concepts of safety and risk
- ▶ Demonstrate an understanding of why physical restraint is to be avoided in the care of people with dementia
- ▶ Demonstrate an understanding of the issues surrounding sexual expression in older people with dementia

*Slides 48-50* Dementia is a complex condition which requires a holistic approach that addresses the physical, biological, psychosocial and functional needs of the individual. These slides introduce the pharmacological and non-pharmacological treatment and interventions that are currently available.



**Activity:** *Discuss the role and use of cognitive enhancers in the management of dementia.*

*Explore with the participants if either of these approaches (pharmacological or non-pharmacological) dominate in their area of practice. If so, is there a difference according to the context of care? Is there a difference according to the health professional knowledge, beliefs and attitudes towards dementia?*

*Ask the group to identify and describe some of the non-pharmacological (psychosocial) interventions that they are aware of, or are using in practice.*



*All pharmacological treatments bring a risk of side effects. They should not be considered a substitute for non-pharmacological approaches – they should be considered together.*

*There is evidence (although limited in some areas) that non-pharmacological interventions improve the quality of life for people with dementia and those that care for them.*

*Slide 51* The following slide provides an over view of the social and lifestyle considerations that need to be considered as part of the holistic approach to dementia care.

*Slides 52-53* **Legal considerations:** Many legal issues pertain to the care of people with dementia, the main focus of which concerns the ability of the person to make informed decisions. Health professionals require the skills and knowledge to manage situations that call for a determination of cognitive ability.

- ❖ *Establish the participants understanding of the differences in the terms 'capacity' and 'competency'*
- ❖ *What type of issues arise in clinical practice that require consideration of the person's capacity?*



*The words 'capacity' and 'competency' are often used interchangeably to say a person's decision-making is impaired. However there is a clinical versus legal distinction. The word 'capacity' reflects a medical assessment about whether a person has the capability to understand and make decisions. Whereas the word 'competent' is a legal expression which means a person has been determined to as competent to make the decision and their decision has legal standing.*

Dementia is a progressive disease and it can be expected that decision-making capacity will deteriorate over time. Forward planning is a proactive approach that enables the person with dementia to contribute to key life decisions.

- ❖ *Ensure the participants are able to discuss the differences between powers of attorney and advance care plans.*
- ❖ *Outline the key life decisions that can reasonably be predicted and the benefits of forward planning.*
- ❖ *Consider the issue of medical treatment and capacity when the person with dementia does and does not have a [medical] power of attorney.*

**Safety and risk:** Health practitioners need to identify and manage risk BUT take account of the whole person and choice.

- ❖ *Reflect on how clinicians can respect the rights and autonomy of the person who is not able to make decisions about their safety*

**Restraint:** Health practitioners have a responsibility to ensure individual rights are upheld and quality care is provided. The use of restraint is an affront to human rights, dignity, autonomy and choice.

- ❖ *Consider some of the reasons that restraint is used. Then discuss the legal ramifications and unwanted side effects of restraint use.*

**Driving:** Driving competence is a complex social, clinical and legal matter which requires a skilled and sensitive approach by the clinicians involved.

- ❖ *Consider the issues around driving competence and the options available for assessment.*



Slide 54 Dementia, ageing, sexuality and sexual activity is often misunderstood in the aged care sector.



**Activity:** Referring to the table called Myths and Facts about Sexual Expression and Older People in module 5, ask the group to discuss generally their expectations of sexuality expression as they age. If possible, write up their answers under the headings of myths and facts.

*What do we mean by sexually inappropriate behaviours? Not to be confused with behaviours that would be considered normal when undertaken in private.*

*Discuss what strategies could be used in the workplace to break down the barriers in staff understanding of the need for sexual expression in older adults.*

Slides 55-56 Other social and lifestyle considerations that are not always easily understood are those of grief and loss, early life trauma and the impact of transition to community services and residential care. Yet they are important considerations for health professionals who aim to provide holistic and person-centred care. These slides provide a brief review of these issues.



**Grief and loss.** *It is important that health professionals acknowledge that people with dementia do experience loss and grief well into the later stages of dementia. Recognition of grief and validation of their feelings is appropriate.*

**Early life trauma.** *For some people living with dementia, problems and losses from the past (old trauma) can resurface. The person can relive the experience through 'flashbacks'. Interventions should focus on supporting the identity of the person, enabling them to trust others and to feel trusted and to facilitate psychological and emotional wellbeing.*

❖ *Briefly discuss some of the techniques that could be used to support a person with dementia who is grieving or reliving trauma (reminiscence work, validation therapy, music and art therapy)*

**Transition:** With the progressive deterioration of dementia over time, it can be expected that the person and their family are likely to connect with either community or residential services at some point. Often introduction of external assistance is due to loss of independence or inability to continue providing the care needs for the person at home.

❖ *Discuss the issues that arise from the introduction of community services or a move into residential aged care*

Slides 57-59 Informal, family carers are a relatively silent group. With the drive to support ageing at home, there is an increased need to understand the care giving role and experiences for informal carers.



*200,000 Australians are carers of a person with dementia living in the community. 57% are a spouse or partner and 36% are a son or daughter (AIHW, 2012. p.117)*





*Explore further with the group some of the characteristics of carers described by carers Victoria.*

- ▶ *Over 60% of informal carers are female*
- ▶ *Often care for more than one person*
- ▶ *The work they do is equivalent to 62% of the health and community sector budget*
- ▶ *They have the lowest level of health and wellbeing of any group in Australia*
- ▶ *They have generally higher rates of mental health problems.*

The following two slides draw out the various roles of the carer, and the way they have to adapt to the changing needs of the person they are caring for as the dementia progresses and the level of dependency increases.

❖ *Explore these roles in more depth with the group. For example, what does personal care include (continence, dental care, dressing, hygiene, meals, pain management, sleep)*



*Carers of people with dementia may themselves be older and subject to age-related health problems and disabilities. Carers may neglect their own health in favour of their caregiving responsibilities.*



## Session 4: Treatment and intervention options 2



Slides  
60-80

Learning outcomes:

- ▶ Demonstrate knowledge relating to responses to behavioural and psychological symptoms of dementia
- ▶ Demonstrate knowledge relating to therapeutic interventions in a number of clinical areas



60  
minutes

Module 4

**Slide 61** This slide provides an overview of the care considerations that will be covered in this session.

**Slides 62-65** There are a number of terms used to describe the symptoms of dementia. In this session the Behavioural and Psychological Symptoms of Dementia or BPSD will be used.

The prevalence of BPSD is high and the impact on the individual and those providing care is substantial.

**Slide 62** *In this activity, review the list of terms under the heading 'Language of BPSD' and any other you may have heard used. How appropriate are they? Does the way that behaviour is described have an impact on the individual, family, staff? Establish with the participants which they prefer to use and why.*



*It is important to ensure the language used to describe behaviours does not blame the person with dementia (e.g. problem behaviours).*

**Slides 66-67** In the following slides the principles and advantages of using non pharmacological approaches to address BPSD are discussed.

In this context, the term 'non-pharmacological' is often used interchangeably with 'psychosocial'.



*Non-pharmacological interventions are recommended as a first line approach to managing BPSD*

**Slides 68-70** These slides begin by presenting the key steps required for assessment of BPSD. They introduce two evidence based BPSD assessment pathways, one from the Dementia Behaviour Management Advisory Service, the other is Team Concept Mapping



*Identifying factors behind the behaviour change is the guiding principle to addressing behaviours..*

❖ *Direct the participants to the DBMAS website to access the Behaviour Management. A Guide to Good practice. Managing behavioural and psychological symptoms of dementia by Burns et al, 2012. <http://dbmas.org.au/want-to-know-more/resources>*

❖ *Direct the participants to this website [www.dementia-assessment.com.au](http://www.dementia-assessment.com.au) to access assessment tools to measure BPSD*

*Slides 71-73* Whilst pharmacological management of BPSD is indicated for behaviours that cause severe distress or harm, it should be noted that only certain symptoms or behaviours will respond to medication. These are described.



*Pharmacological management of BPSD is recommended as a second line approach and indicated when behaviours are causing severe distress or harm.*

*Slides 74-79* The following slides provide a brief overview of the way dementia impacts on the following clinical care issues; falls, pain, nutrition, continence, personal care and sleep.

*❖ A small number of interventions are suggested for each clinical issue. These could be discussed further with the participants*

*Slide 80* This slide reinforces the need to address the palliative care needs of people with dementia.



*Dementia is now recognised as a terminal disease*

## Session 5: Philosophy of care



Slides  
80-100

Learning outcomes:



90  
minutes

Module 6

- ▶ Understand the importance of a shared vision and values for person-centred care and its link to the delivery of a quality service to people living with dementia
- ▶ Empathise with the persons experience of dementia
- ▶ Increase your awareness of how care practices impact on those you support
- ▶ Discuss what is meant by person-centred care
- ▶ Measure person-centred care

**Slides 81-82** In Australia, an evidence based and person-centered approach is regarded as fundamental to provision of quality care. When viewed as a philosophy of care, it will become established in the fabric of the organisation through its values and culture.

**Slides 83-88** These slides explore and draw together our understanding of person centered care.

Slide 83



**Activity: What person-centred care means to you:** Ask the participants to form into small groups and discuss the questions displayed. Give the discussion around 5-10 minutes then invite them to share some of their conclusions with the whole group. These responses can then be applied to the rest of this session, especially the common themes by Julian Hughes listed on slide 83.



*Person centered care is about the person, not the disease.*

❖ *Provide a brief overview of the history and core principles of PCC. Then introduce the notions of sense of self, self-identity and personhood and how PCC is instrumental in supporting these.*

**Slide 89** PCC and quality care are synonymous. Next time you are looking at the quality (or accreditation) standards that your workplace are answerable to, see how the principles of PCC resonate in them.

**Slides 90-93** The following slides recognise that as we strive to be person-centered, it is important that we take time to empathize with the person's experience of dementia and of being a recipient of the care we provide. In addition to this, we will describe the elements that support a person-centered organisation and workplace for staff.



*Ask the group to identify what supports and hinders a person-centered approach to care.*

*Slides 94-97* The previous slides have explained the theory but it is important to know how to be person-centred in your day to day practice. Knowing the person is an important activity within a person-centered approach. Gathering a life history is useful in areas where the person with dementia will reside for long periods (i.e. home or residential aged care). Even in places where the stay will be transient (i.e hospital) the use of a simple template such as the 'Forget me not' as displayed in slide 96 can help improve the knowledge of the person.

❖ *What strategies does your team use to hear the person's life history and how do you make sure this information is used in the day to day care provision?*



*Remember that family have a lot of knowledge and information about their loved ones. The 'Top 5 Questions' on slide 97 will help reveal useful information that will support person-centered care.*

*Slide 98* This slide guides the participants to a number of person-centred frameworks or models that are context or population specific. They are useful resources to help guide the development of a person-centred workplace.

❖ *Which ones are the group familiar with?*

*Slides 99-100* Then of course it is helpful to have tools that can measure, audit or evaluate person-centred practice. These two slides provide information about tools that are available.





## Session 6: Therapeutic communication and dementia friendly environments



Slides 101-113 **Therapeutic communication**

Learning outcomes:



30 Minutes  
Module 7

- ▶ Discuss therapeutic techniques in communication with the person with dementia
- ▶ Reflect on your own communication style and its impact on the person with dementia
- ▶ Assess the patterns of information flow between the health professional and client
- ▶ Begin to understand the journey of dementia for the clients
- ▶ Apply your knowledge of dementia to an education plan for your clients
- ▶ Analyse your own reactions to the observed behaviour of your clients
- ▶ Assess the need for referral for support networks and facilitate client contact with these networks
- ▶ Plan for ongoing assessments and client support for decision-making

Slides 102-104 *In this activity, ask the group to describe their understanding of what communication means, why and how we communicate.*



- ▶ *Click to reveal the definition on slide 102*
- ▶ *Click to reveal why we communicate on slide 103*
- ▶ *Click to reveal how we communicate on slide 104*

*Discuss in relation to the participants responses.*



*Communication is a dynamic, ongoing process with varying levels of complexity.*

Slides 105-106 The next three slides concentrate on the changes in communication that can occur as part of the dementia process.

- ❖ *Provide explanations of each and check for participant understanding.*

Slides 107-110 The following slides present a number of communication strategies and skills that support therapeutic and effective communication with people who have dementia.

- Slide 110 ❖ *As you run through these strategies, ask the participants to reflect on their own communication practices and identify those they use well and those they could improve upon. Ask the participants to suggest any other communication strategies that they have found helpful.*



*Staff with good communication skills will enable the person with dementia to communicate.*



## Slides 111-117 Dementia friendly environments

111-117

Learning outcomes:



30 Minutes

Module 8

Case study:  
Genevieve's  
experience

- ▶ Understand what is meant by a dementia friendly environment
- ▶ Understand how the experience of dementia relates to design
- ▶ Understand the principles of good design for dementia care
- ▶ Understand how to apply the principles of good design
- ▶ Highlight the current controversies and issues in environments and design relating to the care of people with dementia
- ▶ Access relevant and evidence-based resources
- ▶ Debate the current controversies surrounding creating friendly environments.

Slide 112 This slide provides the definition of a dementia friendly environment.

❖ *Ask the participants what level of familiarity they have with the concept of dementia friendly environments.*



*We all have a relationship with the environment around us. The environment can either make everyday life easier for us or it can restrict our ability to function.*

Slides 113-114 Design principles



*There is no 'one size fits all' environment. These design principles can inform the creation of a dementia friendly environment that suits your facility/ward/centre/home.*

Elements that compensate for the experience of dementia

❖ *Work through each element with the participants, and gauge their level of understanding about how the changes associated with dementia would impact on their relationship with the environment.*



**Colour:** *Using colour and effective colour contrast in the environment will allow the person with dementia to 'see' their environment more clearly. Or it can be used to 'camouflage' institutional features.*

**Light:** *Good lighting and access to natural light can reduce sundowning, falls and improve self-care and wellbeing.*

**Surfaces:** *Surface finishes can be used strategically to minimize noise level and glare; aid orientation and way-finding; create warmth and ambiance as well as support functional abilities of the person with dementia.*

**Fixtures and fittings:** *Appropriate fixtures and fittings can be used to optimize the person's ability to undertake everyday activities.*





**Furniture and Furnishings:** Furniture and furnishings can be used to promote independence and mobility; support way-finding and orientation; improve visibility within the environment.

**Gardens:** Access to gardens and outside spaces are numerous, ranging from reduction in agitation and aggression; remain connected to nature; support identity and promote independence and autonomy.

*Virtual dementia experience at the Perc Walkley Dementia Learning Centre, Alzheimer's Australia, Victoria.*

#### Slide 115 Assessing the Environment

❖ *Are the participants aware of the Environmental Audit Tool? Do they know where to access this and other resources that can help inform the development of a dementia friendly environment?*

*Dementia Friendly Environments. A guide for residential care <http://www.health.vic.gov.au/dementia>*

*Dementia Enabling Environments website <http://www.enablingenvironments.com.au>*

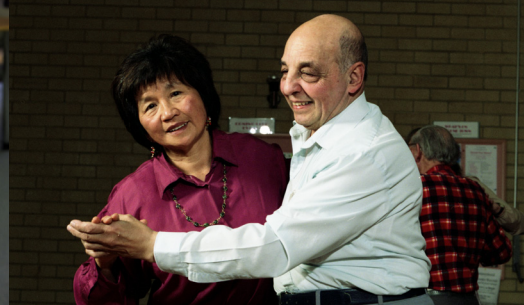
*Designing for people with dementia <http://www.dtsc.com.au/designing-for-people-with-dementia>*

#### Slide 116 **Case study: Genevieve's experience**



*Ask the participants to read the case study handout (print from slide 117) 'Genevieve's story'. Encourage the group to discuss the questions on slide 116.*





# DEMENTIA TRAINING STUDY CENTRES



The Dementia Training Study Centres are funded by the Australian Government Department of Social Services. Visit [www.dss.gov.au](http://www.dss.gov.au) for more information.