Open Access

OBM Geriatrics

LIDSEN Publishing Inc.

Original Research

Improving Confidence in Dementia Care by Helping Care Staff Articulate Skills They Already Possess: The Value of the Communication and Interaction Training (CAIT) Programme

Katharina Reichelt [1, *], Ewan James [2], Daniel Thompson [1], Shaun Tanney [3]

1. CNTW NHS Trust, Newcastle upon Tyne, UK; E-Mails: Katharina.reichelt@cntw.nhs.uk; Daniel.thompson@cntw.nhs.uk
2. Post-graduate Psychology Student, University of Nottingham, UK; E-Mail: ewanjames101@gmail.com
3. CNTW NHS Trust, Carlisle, UK; E-Mail: shaun.tanney@cntw.nhs.uk

* **Correspondence:** Katharina Reichelt; E-Mail: Katharina.reichelt@cntw.nhs.uk

Academic Editor: James S. Powers

OBM Geriatrics
2023, volume 7, issue 1
doi:10.21926/obm.geriatr.2301222

Received: August 14, 2022
Accepted: January 09, 2023
Published: January 18, 2023

Abstract

This article discusses the findings from a training programme called 'Communication and Interaction Training' (CAIT). CAIT was designed to improve the confidence of carers in their use of communication skills with people living with dementia, particularly when managing behavioural agitation. This pre/post assessment study employed a mixed design, and showed positive effects in terms of quantitative and qualitative features. The participants were mainly from a specialist team who were experienced in managing episodes of agitation in care home settings. Twenty-three staff were assessed on the Confidence in Dementia Scale (CODE), which is a measure for assessing carers' confidence in communicating with people living with dementia. The findings showed increased levels of confidence in communicating and interacting with people with dementia following the training. The qualitative findings showed improvements in participants' abilities to articulate their communication strategies (i.e. higher degrees of specificity in their communication skills), indicative of improved dementia 'literacy' regarding their interventions. As a consequence of such improvements, it is suggested that greater confidence and literacy would lead to the delivery of better care due

to enhanced self-awareness of good practices, and enhanced communication skills both within the staff group and between staff and residents.

Keywords
Dementia; agitation, caregivers, e-learning, training

1. Introduction

People living with dementia experience a number of changes and challenges as a result of both dementia, and the way they are treated by others [1]. Changes in behaviour and mood are common and can be very distressing for the person with dementia and those around them [2]. Typical behaviours include: physical aggression, verbal aggression, self-harm, shouting, restlessness, lack of self-care, etc. [3]. Terms used to describe the behaviours can be disrespectful, offensive and stigmatising [4]. Language has a powerful role in perpetuating stigma in the context of dementia [5]. People with dementia have raised particular concerns about terms such as 'behavioural and psychological symptoms of dementia', and 'challenging behaviour' [6]. Hence for the purposes of this article we will refer to such behaviours as 'Behavioural and Emotional Expressions of Need' (BEEN), an emerging term that is being viewed positively by people living with dementia, carers and clinicians [6].

The national guidelines in many countries promote the use of non-pharmacological interventions as first line interventions for BEEN, but then fail to provide guidance to carry out non-drug approaches [7]. The current NICE [8] guidelines are a good example of this shortcoming, and have been criticised in a recent survey for failing to give sufficient information concerning non-drug approaches [7]. It is our contention that non-drug interventions should be seen as both primary and essential in the management of agitation. In most circumstances they should be first line interventions, and they should always be used even when one's main intervention is psychotropic medication. Indeed, whether or not a person living with dementia is receiving a high dose of antipsychotic medication or being treated for delirium, the caregivers will be interacting with the person on a frequent basis. In some cases the interpersonal contact will be highly personal, involving help with intimate care activities. If such care is not delivered in a 'therapeutic' manner, the actions of the carers may lead to agitation.

There are a number of non-pharmacological frameworks and models developed to assist with the delivery of non-drug interventions: WHELD, DICE, DCM [9-11]. WHELD (Improving Well-being and Health for People with Dementia) and Dementia Care Mapping (DCM) are appropriate for institutional settings, while DICE (Decide, Investigate, Create, Evaluate) was developed for family settings. The current authors, however, were keen to help create a framework that could be used across all settings, helping families and staff to become aware of their existing skills in the management of agitation. With this aim in mind, the 'Communication and Interaction Training' (CAIT) programme was developed [5, 12]. CAIT is an online person-centred training programme designed to help carers and clinical staff acquire greater 'dementia care literacy'. It provides a common language within a family or service in order to promote consistent care for people living with dementia. CAIT highlights and teaches the micro-skills necessary for providing good dementia care

and managing BEEN [13]. The programme recognises carers' existing skills and builds on these, aiding and refining where necessary. A major premise of CAIT is that carers are the 'experts by experience' in managing agitation on a daily basis, and so trainers need to make them aware of their 'unconscious competence' and bring their competencies into conscious awareness. CAIT takes a magpie approach, borrowing from evidence-based practices from the clinical and retail sectors, as well as the police and armed forces [5].

While the early trials of the programme were conducted in care homes, it has also been used successfully by staff working in dementia wards, acute hospitals, and community settings [14, 15]. It is currently being rolled out across the UK within Cumbria Northumberland Tyne and Wear NHS Trust, Birmingham City Hospital Trust, Sussex Care Partnership, and Pennine Care Trust.

The CAIT programme is composed of six sections: Description of Dementia; Description of Behaviours that Challenge and the CAIT programme; Core Communication Skills (Module 1); Adaptations for Communicating with People Living with Dementia (Module 2); Communicating Around Intimate Care Tasks (Module 3); Use of Care Plans and Delivery of Complex Care (Module 4). Each section contains a series of video clips and nineteen animations to help illustrate some of the key issues. A case study, featuring a man with dementia called Karim, is also used to help guide trainees of CAIT through the programme. Participants of the programme are shown how Karim's needs change as his dementia progresses, and are able to discuss how best to meet his needs in each of the modules. It is acknowledged that there is a potential limitation of having an example patient who may not be representative of diverse patient populations. A table providing a detailed description of the content of CAIT is provided in Table 1.

Table 1 Description of content of CAIT-online programme.

Section 1 topics: Introduction	**Section 2 topics: Introduction to Behaviours that Challenge & CAIT**
Introduction to the brain	Introduction to Behaviours that Challenge
Types of dementia	Terminology to use for episodes of agitation
Parts of the brain	Notion of needs
Memory deficits & strengths in dementia	Equality and diversity issues
Time Shifting	Identifying emotions
Thoughts and problem-solving deficits	Introduction to the CAIT programme
Language difficulties	Building on carers' existing skills
Sensory Changes	Features of good carers
Module 1 topics: Core Communication Skills	**Module 2 topics: Communication in Dementia Care**
Core communication skills of carers	Communication skills in dementia care
Introduction to three communication approaches	Touch typology
CARES 'Customer care skills' guide	Gaining consent to touch
RAM (individual & family)	Approaches
Verbal judo and other approaches used by law enforcement and the military to de-escalate emotional encounters	Teepa Snow's PAC training
	Therapeutic lies
	American Veteran's Association
	BANGS

Module 3 topics: ADL	Module 4 topics: Care Planned Approaches
Activities of daily living	Care planned approaches
Approaches to care that avoid restraint	Columbo/detective approach
Avoiding confusion	Role of medication
Avoiding pain	NICE guidelines
Avoiding negative emotions	Assessment
Building on a person's strengths	Features to assessment
Pool Activity Level of activities of daily living	PBS Arousal graph
PAL QUIZ for activities of daily living	Looking for patterns – ABC/time series charts
Case studies	Formulation and care plans
Namaste approaches for end of life care	Psychological therapies
End of life management	Person-centred control and restraint

The content of CAIT was developed from an international review of best practices from both within and out-with the area of dementia [16]. Hence, CAIT is sometimes referred to as a 'compendium of best practices'. The authors of CAIT had an additional advantage in terms of their development of CAIT, because from 2018 onwards they were involved in producing the new British Psychological Society national guidelines for the management of agitation. These guidelines were deemed necessary because of the aforementioned problems with the NICE guidelines [7]. Therefore, as the authors have been involved in producing a new set of psychological guidelines, they were able to incorporate the key recommendations from these guidelines into CAIT [16]. Consequently, the work of Kitwood, Cohen-Mansfield, Teepa Snow and WHELD [9] are all present as part of the compendium of tools. It is relevant to note that information from the new set of guidelines [16] was used in the present study during the assessment of the qualitative responses of the participants.

2. Method

2.1 Participants

Participants were all clinical staff of CNTW NHS Foundation Trust (18 female; 3 male); their profiles are outlined in Table 2. While information about the range of clinical experiences was collected, details regarding actual ages were not. CNTW is the second largest mental health NHS organisation in England. The recruits were self-selecting and came from the western region of CNTW, responding to invitations from managers and email advertisements on CNTW's websites in January 2022. All participants worked in older people's services, which meant they had regular weekly-daily contact with people with dementia. Clinicians working in other specialties were excluded. In order to participate in the training, the participants needed to agree to undertake supervision in the CAIT programme following the initial training, and also be willing to train other CNTW staff to employ CAIT (ie. a 'train the trainers' dissemination methodology). As noted from the table, the majority of the staff were working in a specialist team for the management of agitation called the 'Care Home Education and Support Service' (CHESS). CHESS provides expert advice and support to local care homes regarding the management of agitation; the staff are experts in non-drug interventions and use of formulations. As such, the participants who took part were expected

to have a high degree of expertise in the area of communication prior to the study. The staff were not charged for attending the training, which took place in March 2022.

Table 2 Profile of the participants.

Professional role	Team membership	Range-years of experience
Community Psychiatric Nurse (n = 5)	Care Home Education & Support Service (CHESS)	3-40 yrs
Support Worker (n = 5)	CHESS	> 1-15 yrs
Occupational Therapist (n = 3)	CHESS	> 1-13 yrs
Clinical Psychologist (n = 3)	Older Adult Service	3-14 yrs
Registered General Nurse (n = 2)	CHESS	2-6 yrs
Nurse Associate (n = 1)	CHESS	4 yrs
Assistant Psychologist (n = 1)	Older Adult Service	2 yrs
Assistant Nurse Practitioner (n = 1)	CHESS	25 yrs

2.2 Materials

The CAIT online programme is a comprehensive module-based training package, designed to support and improve the communication skills of people living with dementia. It was originally developed as a face-to-face teaching package [12]. The programme is supported by a manual and a text book [5]. The CAIT teaching was delivered in March 2022 by one of the authors of the programme in a 'face-to-face' two-day workshop, which made use of the online materials.

Confidence in Dementia Scale: CODE is a nine-item self-report questionnaire used to measure confidence in working with people with dementia, particularly focusing on issues of communication. The questionnaire is scored on a five point Likert scale with anchored ratings of 'not confident', 'somewhat confident', and 'very confident'. This means that it is possible to gain a total score between 9 and 45, with a higher score representing greater confidence in working with people with dementia. This questionnaire has been used previously in studies on communication [17], and appeared to be a sensitive scale for examining the impact of CAIT in studies of front-line staff. Table 3 presents the questions asked of the participants.

Qualitative assessment: Following the completion of each of the CODE scales (pre and post), qualitative information was obtained from the participants, using a pencil and paper format. The participants were asked to respond to the following question both pre and post the CAIT workshop: "If a new clinical student/trainee asked you to give them guidance on five important communication strategies required to work well with people living with dementia who are distressed, name your five strategies?" The qualitative assessment had a dual function, (i) to generate data for the project, comparing the themes of responses pre and post workshop, and (ii) to act as a process tool within the CAIT workshop to get the participants to start to reflect on their understanding of their skills. For example, to get the participants to start to articulate their skills in relation to dementia care (ie. developing better 'dementia care literacy').

2.3 Data Analysis

All numerical data was entered into Microsoft Excel. An analysis of the CODE scores showed they were not normally distributed and thus the more conservative non-parametric Wilcoxon signed rank tests were used to analyse the pre and post CODE median scores. Mean and standard deviation values are also presented in the results table to provide further descriptive information. The qualitative data was analysed using a standard thematic analysis [18]. This involved initially reading the written material, identifying and grouping similar concepts, refinement and use of sorting methods via a number of iterative checks, joint researcher checks, and then labelling of themes. The themes obtained were then compared to strategies from a review paper of non-pharmacological strategies used in the management of agitation [16], which is the precursor document to the new national British Psychological Society guidance on the management of episodes of agitation in dementia.

This study was part of a collaboration between CNTW NHS Foundation Trust and the University of Northumbria. It was run as an in-house 'service development project' and sanctioned by the Trust's Ethics committee. As a consequence of this project, which was developed as a pilot, a larger collaborative project has received ethical approval from the University of Northumbria ethics committee. All participants of this study consented to their responses to be analysed and used towards a publication.

3. Results

Table 3 presents the findings in terms of total median scores of the participants and single item scores on the questionnaire.

Table 3 Median (Md), Means and standard deviation scores for the Confidence in Dementia Scale.

Questions: As a result of attending the CAIT programme:		Pre (Md)	Post (Md)	Post Mean (sd)	Post Mean (sd)	$p < 0.05$
1	I feel better able to understand the needs of a person with dementia when they cannot communicate well verbally	3	4	3.07 (0.86)	3.99 (0.61)	*
2	I feel better able to interact with a person with dementia when they cannot communicate well verbally	4	4	3.50 (0.75)	4.09 (0.60)	*
3	I feel better able to manage situations when a person with dementia becomes agitated	4	4	3.04 (0.78)	3.85 (0.46)	*
4	I feel better able to identify when a person may have a dementia	4	4	3.52 (0.85)	4.00 (0.80)	*

5	I feel better able to gather relevant information to understand the needs of a person with dementia	4	5	3.87 (0.63)	4.35 (0.76)	*
6	I feel better able to help a person with dementia feel safe in the setting they're currently living	3	4	3.00 (0.69)	3.70 (0.69)	*
7	I feel better able to work with people who have a diagnosis of dementia	4	5	4.30 (0.63)	4.63 (0.61)	*
8	I feel better able to understand the needs of a person with dementia when they can communicate well verbally	4	5	4.22 (0.52)	4.61 (0.52)	*
9	I feel better able to interact with a person with dementia when they can communicate well verbally	4	5	4.33 (0.51)	4.70 (0.47)	*
Total median, Mean (sd) CODE scores pre-workshop			33	32.80 (3.92)		*(for median comparison)
Total median, Mean (sd) CODE scores post workshop			39	37.90 (3.78)		

The Wilcoxon signed rank test (W) revealed that total CODE scores were significantly higher after the CAIT workshop (Total Md = 39, n = 23) compared to pre-workshop (Total Md = 33, n = 23; z = -3.96, p = 0.00008), with a large effect size (r = 0.58). Six out of the nine scores showed higher median scores post training. It is also worth noting that there were increased mean values on all items of the CODE questionnaire post training. Thus, it can be concluded that the CAIT programme led to increased confidence in all areas of communication and interaction.

In relation to the qualitative data, the participants' responses were reviewed by two authors to identify and agree themes, and then the number of items corresponding to each theme was counted providing a frequency rating (see Table 4).

Table 4 Qualitative data of themes pre and post training in CAIT.

Pre-CAIT (no. responses)	**Post-CAIT (no. responses)**
Give time for person to understand and respond/patience (16)	Understand/assess unmet needs (11)*
Express yourself via non-verbal cues/other types of communication (facial, touch) (11)	Be calm/reduce emotion (11)*
Speak clearly/slowly (10)	Body language/aware of one's self (10)*
Make eye contact (9)	Speak clearly/tone of voice (9)
Face the patient/centre yourself (9)	Consider your approach (visual, verbal, touch) (9)*
Body language (8)	Listen/validate (9)
Listen/do not talk over/validate (8)	Formulation (Newcastle/8 unmet needs) and care plan (8)*
Smile (7)	Person centred (8)

Be calm (6)	Empathy/understand person's reality with their dementia and fluctuation (7)*
Introduce yourself (4)	Look at non-verbal communication (7)
Avoid medical/jargon terms and use simple sentences (4)	Create quiet/safe space (7)
Aware of tone (4)	Preventative non-pharmacological activities/therapies/techniques fitted to individual (6)
Have a quiet area/remove distractions (3)	Speak slowly & face front of client (5)
Aware of fluctuating capacity (3)	Processes (RAM/BANGS/PAC/PALS) (5)*
Awareness of the individual (2)	Short/simple sentences (4)
Share knowledge about patient/self (2)	De-escalation techniques when required/escalation curve (3)*
Do not disagree (2)	Good eye contact (3)
Humour (1)	Aware of triggers (2)
Avoid open ended questions (1)	Introduce yourself (2)
Record every interaction for better understanding (1)	Patience (2)
Use alternative media e.g. writing post it notes (1)	Therapeutic untruths (1)*
Tactile (use of touch) (1)	Micro-skills (1)*
	Find balance in order to avoid de-skilling (1)*
	Consider physical health (1)
	Record behaviours (1)
	Ensure they have their aids (hearing/glasses) (1)
	Do not argue (1)*

Key: * features with a high degree of specificity and technicality, indicative of improved dementia care vocabulary [16]. RAM – Reduce emotion, assess need, meet need; BANGS – Breathe, agree, never argue, go with flow, say sorry; PAC-Positive approach to care [19]; PALS – Pool activity levels.

The findings presented in Table 4 show that there was an emphasis on general communication skills in both the pre and post groups. However, there was a greater variety and specificity of management strategies identified in the post group. The items identified with an asterisk (*) were assessed as demonstrating greater technical knowledge because they related to skills identified in the latest review of non-pharmacological management strategies for agitation [16].

In the pre-workshop group the most common strategies were: 'patience'; 'non-verbal communication'; 'speaking clearly and slowly'; 'good eye-contact'; and 'facing the patient'. In contrast, in the post-workshop group the most common strategies were: 'understanding and assessing the unmet need; 'being calm/ reducing emotions'; 'use of correct body language'. Other common points that arose in the post group were: considering your approach, using formulations and care plans, having a person-centred approach, displaying empathy, understanding the person's reality with their dementia, creating quiet and safe environments and awareness of preventative activities and therapies fitted to the particular individual's needs.

4. Discussion

The current study found significant improvements in confidence on all 9-items of the CODE, and also showed a significant improvement in the total score on the scale. This was an impressive finding considering the high level of competence in the participants prior to the commencement of the study. To put the total median scores into perspective, a previous study by Elvish, with a mixed group of acute hospital staff (n = 62), found a pre-intervention median score of 29 and a post-intervention increase to 35 [17].

The positive results are consistent with previous assessments of CAIT [5, 13, 14], which demonstrated significant post-training improvements. However, the previous studies used bespoke and adapted versions of communication scales [14]. The current study is the first to demonstrate benefits for CAIT using a well-validated scale. The results provide the current authors with confidence in using the CODE in a larger study examining the CAIT training. This confidence is corroborated by the qualitative findings post-training which showed participants identifying a greater range of non-drug strategies, and providing greater specificity with respect to these approaches. Many of the strategies identified in the post analysis were consistent with methods recommended in the new British Psychological Society guidance, the final version of which will be published in full in late 2022 [16].

As noted in the introduction, one of the aims of CAIT is to increase the 'dementia literacy' of staff. The themes and strategies mentioned by the participants in the post-strategies suggested improved levels of articulation. Improved dementia literacy has a number of potential benefits in relation to dementia care. For example, it would enable carers to become consciously aware of their actions and strategies, giving them 'labels' to describe their actions which they may have previously carried out intuitively or unconsciously [20]. Further, greater literacy within a team would permit better informed conversations about the provision of effective care – what went well, or not so well, and how could things be improved? The current study has specifically focused on the better articulation of communication skills, which is particularly relevant to carers of people with dementia who are frequently called upon to de-escalate episodes of distress and agitation via their use of verbal and non-verbal approaches.

In many respects CAIT is a continuation of earlier work by researchers such as Kitwood [11] and Eggenberger, Heimerl and Bennet [21] regarding communication skills. Eggenberger and colleagues supported the use of person-centred forms of communication, and provided guidance in three areas: carers' verbal skills, non-verbal and emotional skills, and behavioural management techniques. As one can see from Table 1, which outlined the contents of CAIT, all of Eggenberger's three features are present in the CAIT programme. It is worth noting, however, that CAIT is more appropriately described as a 'carer-centred' approach due to the fact it emphasises the role of carers as being both the foci and agents of change [5].

Despite acknowledging the encouraging findings from this study, there are limitations. For example, it was a relatively small-scale, non-randomised project that did not conduct a follow-up. The study relied on a self-report scale, and there were no observational measures employed. This means the result were open to a social desirability bias, with the participants perhaps rating the programme highly due to them receiving the training for free. The lack of observation also means that while CAIT can claim to have produced attitudinal shifts, there is no evidence of clinically significant behavioural changes in relation to the participants.

While it is important to recognise these limitations, the mixed-design provided useful qualitative and quantitative information. Indeed, through the study the authors were able to demonstrate CODE's value, even when used with an experienced team working in the area of dementia. Such a finding is important because there continues to be a lack of consensus about what should be regarded as good outcome measures in the area [22, 23], and Schepers et al. [24] argue that there are few measures for examining positive capacities in staff that are appropriate for frontline clinical staff. As a result of the findings a new set of studies using CAIT have begun, which are employing CODE and two additional measures regarding 'staff knowledge about dementia' and 'staff self-efficacy'.

5. Conclusion

CAIT is a new carer-centred training programme designed to build on the existing skills of professionals involved in the care of people living with dementia. The current study demonstrated that even when used with a group of experienced care staff, CAIT led to significant improvements in perceived confidence. The CODE assessment tool was shown to be sensitive to the contents of CAIT and, even when used with a small number of staff, the effects of the training were measurable. The qualitative findings outlined the specific benefits of CAIT, showing a greater range and details of communication strategies post-treatment. The authors have also argued that the participants' responses post-CAIT demonstrate a great degree of articulation regarding management strategies, tentatively suggesting increased 'dementia care literacy'. It is suggested that higher degrees of literacy is a stepping-stone to the delivery of better quality of team-working and service delivery for people living with dementia.

Author Contributions

KR: original idea, intellectual contribution, writing of article, revisions. EJ: intellectual contribution, writing of article, revisions. DT: writing of article, revisions. ST: writing of article, revisions.

Competing Interests

The authors have declared that no competing interests exist.

References

1. Patterson KM, Clarke C, Wolverson EL, Moniz-Cook ED. Through the eyes of others–the social experiences of people with dementia: A systematic literature review and synthesis. Int Psychogeriatr. 2018; 30: 791-805.
2. Alzheimer's Society. Factsheet 525LP: Changes in behaviour [Interent]. Available from: https://www.alzheimers.org.uk/sites/default/files/pdf/changes_in_behaviour.pdf.
3. Moniz-Cook E, Woods R, Gardiner E, Silver M, Agar S. The Challenging Behaviour Scale (CBS): Development of a scale for staff caring for older people in residential and nursing homes. Br J Clin Psychol. 2001; 40: 309-322.
4. Cahill S. Dementia and Human Rights. Bristol: Policy Press; 2018.

5. James IA, Gibbons L. Communication skills for effective dementia care care: A Practical Guide to Communication and Interaction Training (CAIT). London: Jessica Kingsley; 2019.
6. Wolverson E, Dunn R, Moniz‐Cook E, Gove D, Diaz‐Ponce A. The language of behaviour changes in dementia: A mixed methods survey exploring the perspectives of people with dementia. J Adv Nurs. 2021; 77: 1992-2001.
7. Gray KL, Moniz-Cook E, Reichelt K, Duffy F, James IA. Professional perspectives on applying the NICE and British psychological society guidelines for the management of behaviours that challenge in dementia care: An e-survey. Br J Clin Psychol. 2022; 61: 112-131. doi: 10.1111/bjc.12316.
8. NICE. Dementia: Assessment, management and support for people living with dementia and their carers [Interent]. NICE; 2019. Available from: https://www.nice.org.uk/guidance/ng97.
9. Ballard C, Orrell M, Moniz-Cook E, Woods RT, Whitaker R, Corbett A, et al. Improving mental health and reducing antipsychotic use in people with dementia in care homes: The WHELD research programme including two RCTs. Program Grants Appl Res. 2020; 8. doi: 10.3310/pgfar08060
10. Kales HC, Gitlin LN, Lyketsos CG. Assessment and management of behavioral and psychological symptoms of dementia. Br Med J. 2015; 350: h369.
11. Kitwood TM. Dementia reconsidered: The person comes first. Buckingham: Open University Press; 1997.
12. James IA. The use of CBT in dementia care: A rationale for Communication and Interaction Therapy (CAIT) and therapeutic lies. Cogn Behav Ther. 2015; 8: e10.
13. Thompson D, Shirley L, Gray, James IA. New perspectives on responding to Behavioural & Emotional Expressions of Need: The micro-skills involved in de-escalating agitation. J Dement Care. 2022; 30: 22-23.
14. James IA, Safrova M, Kamal O. Review of the CAIT online training programme for dementia and the introduction of a new tool for assessing training in communication. FPOP Bull. 2022; 158, 15-21.
15. James I, Randall C, Reichelt K. Thirty-six simple ways to de-escalate behaviours that challenge: Helping carers know what they already know by improving 'Dementia Care Literacy'. J Dement Care. 2022; 30: 29-33.
16. James IA, Moniz-Cook E. Preview of key themes in the new DCP/BPS guidelines for the management of behaviours that challenge. FPOP Bull. 2022; 160: 12-25.
17. Elvish R, Burrow S, Cawley R, Harney K, Graham P, Pilling M, et al. 'Getting to Know Me': The development and evaluation of a training programme for enhancing skills in the care of people with dementia in general hospital settings. Aging Ment Health. 2014; 18: 481-488.
18. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006; 3: 77-101.
19. Ehlman MC, Nimkar S, Nolan BA, Thomas P, Caballero CE, Snow T. Health workers' knowledge and perceptions on dementia in skilled nursing homes: A pilot implementation of teepa snow's positive approach to care certification course. J Contin Educ Health Prof. 2018; 38: 190-197.
20. Carper BA. Fundamental patterns of knowing in nursing. In: Perspectives on philosophy of science in nursing: An historical and contemporary anthology. Philadelphia: Lippincott; 1999.
21. Eggenberger E, Heimerl K, Bennett MI. Communication skills training in dementia care: A systematic review of effectiveness, training content, and didactic methods in different care settings. Int Psychogeriatr. 2013; 25: 345-358.

22. Dunn R, Moniz-Cook E. Evaluating interventions for Behaviours that Challenge (BtC) in dementia care–what instruments do specialist practitioners working in the UK use? FPOP Bull. 2019; 148: 51-61.
23. Moniz-Cook E, Vernooij-Dassen M, Woods R, Verhey F, Chattat R, Vugt MD, et al. A European consensus on outcome measures for psychosocial intervention research in dementia care. Aging Ment Health. 2008; 12: 14-29.
24. Schepers AK, Orrell M, Shanahan N, Spector A. Sense of competence in dementia care staff (SCIDS) scale: Development, reliability, and validity. Int Psychogeriatr. 2012; 24: 1153-1162.