



## DSHS Specialty Training

Stakeholder Outreach Report

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## 1 | Introduction

The State of Washington Department of Social and Health Services, within one of its functions, licenses and monitors the state's Assisted Living Facilities and Adult Family Homes. Within that network of care, three care specialties exist which require caregivers to receive specialty training: dementia, mental health, and developmental disabilities. These three specialties have established training curricula and requirements that are detailed in the Washington Administrative Code (WAC), Chapter 388-112—Residential Long-Term Care Services.

Beginning in January of 2014, DSHS retained the services of Coraggio Group to assist them in implementing sections of SSB 5630 that enact recommendations of the Adult Family Home Quality Assurance Panel and relate to improvement of and expansion of specialty training for Adult Family Homes and Assisted Living Facilities. As a first step, DSHS and Coraggio Group undertook a statewide Stakeholder Outreach tour to:

- Solicit feedback on the current specialty trainings and requirements,
- Identify opportunities to improve the trainings,
- Identify needs for additional specialty trainings, and
- Identify opportunities for the revision of relevant portions of the WAC.



Planning for the Stakeholder Outreach effort began with identification of target stakeholder groups, assessment of geographic distribution of homes, and development of discussion guides to ensure that the conversations generated consistent categories of feedback. Forty meetings were held, including individual interviews, focus groups, public meetings, telephone interviews, and telephone focus groups. An online survey was also employed to gather feedback. The Stakeholder Outreach effort concluded in mid-June, 2014 and ultimately included nearly 400 individuals sharing their perspectives about the specialty trainings.

This document details outreach methodology and statistics, key findings by specialty, and an appendix which compiles all of the meeting notes and survey responses.

Generally speaking, stakeholders felt that the current specialty trainings have served DSHS well, but that updates are necessary. A few of the most common opinions had to do with improving access to training, updating training curricula to reflect current thinking and methods, making training and examinations more consistent around the state, and bolstering training around behavior management and effective communication on multiple levels.

Coming phases of this project will make recommendations for improvements to the curricula and requirements, and will assist in the revision of curricula and development of new specialty curricula, if any. The project team will re-engage with stakeholders throughout the project to inform and gather feedback.



## 2 | Methodology

A key principle of the stakeholder outreach effort was inclusion of the broadest possible group of stakeholders. To support broad inclusion, we began with an identification of the types of stakeholders we wanted to reach and what kinds of stakeholder diversity would be important to measure.

The primary stakeholder groups to reach included:

- Facility owners/providers
- Facility managers/supervisors
- Caregivers
- Trainers
- Families
- Clients/Residents
- Advocacy group representatives
- DSHS staff
- Long Term Care Ombuds

We also captured data on our stakeholders to ensure diversity of viewpoints beyond capturing the categories listed above. Those diversity markers include:

- Years since specialty training
- Size of business
- Specialization of care
- Needs level of population served
- Location: urban vs. rural
- Location: DSHS region

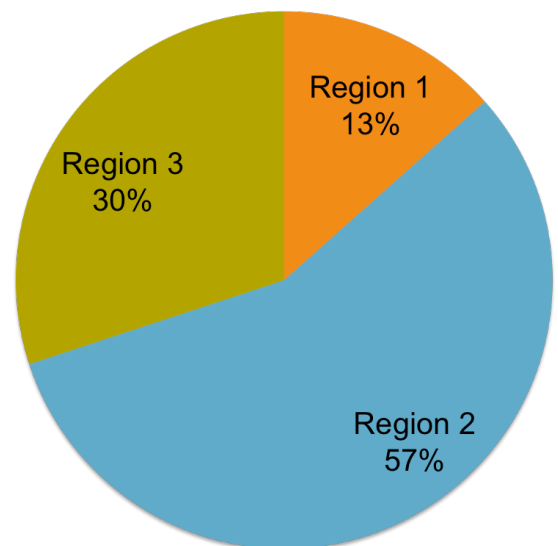
In order to identify the locations where it would be most advantageous to hold focus groups and public meetings, we used four decision criteria:

- Balance by DSHS region
- Balance of urban and rural
- Alignment to areas of greatest AFH density
- Alignment to areas of greatest ALF density

### Planning the Stakeholder Tour

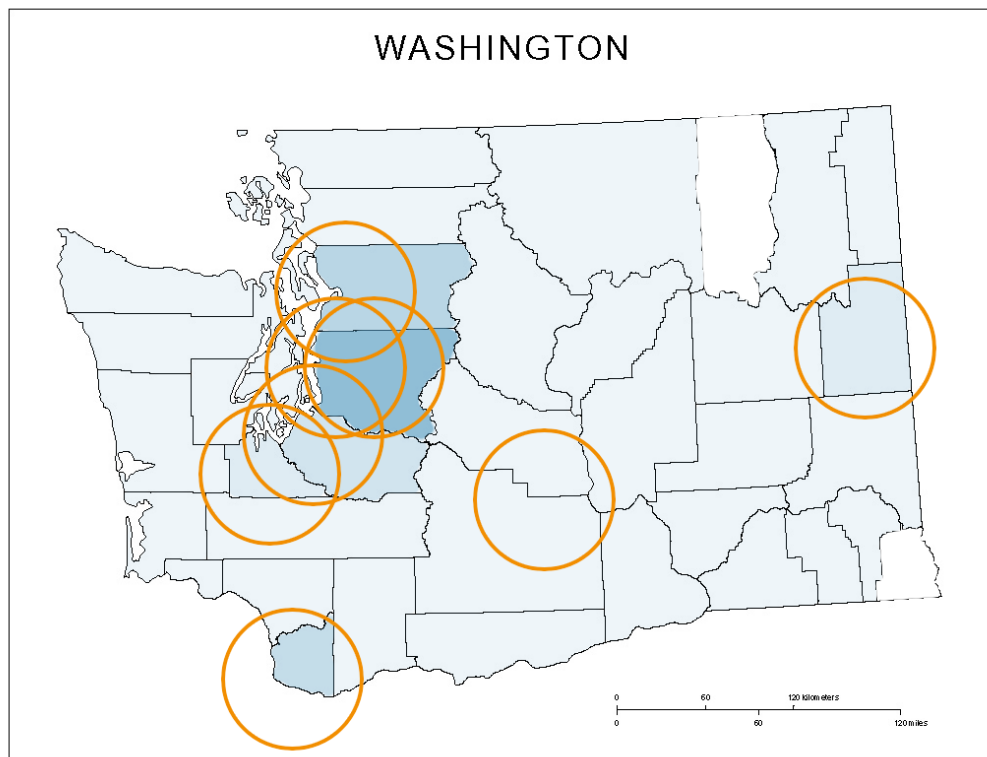
Of the long-term care facilities that host one or more of these specialties, 57% are in DSHS Region 2, 30% are in Region 3, and the remaining 13% are in Region 1. Given this uneven distribution, we recognized that we would be capturing a greater volume of participants in certain regions.

We began with an analysis of which Washington counties have the highest density of Adult Family Homes, the results of which are illustrated in the graphic on the following page, with darker shades representing higher density of homes.





Given this distribution of density, we plotted our target cities with 30-minute drive times to understand what sort of reasonable geographic reach we would have with each stop on the tour. Those primary locations and drive radii are represented as orange circles in the graphic below, and are listed by date in the table on the following page.





Tour City	County	DSHS Region	County AFH Count	Dates
Olympia (WHCA Winter Conference)	Thurston	3	122	2/24/2014
Vancouver	Clark	3	305	2/27/2014
Bellevue	King	2	1031	3/17/2014
Olympia (WSRCC Board meeting)	Thurston	3	122	3/20/2014
Everett	Snohomish	2	424	3/31 – 4/1/2014
Tacoma	Pierce	3	276	4/1 – 4/2/2014
Seattle	King	2	1031	4/14/2014
Kent	King	2	1031	4/15/2014
Spokane	Spokane	1	165	4/24 – 4/25/2014
Yakima	Yakima	1	43	5/5/2014
Seattle (Leading Age Board Meeting)	King	2	1031	5/20/2014

Each stop on the tour included some combination of individual interviews, focus group interviews, and public meetings. Participants were asked a series of questions built around capturing their perspectives of the following topics:

- Strengths of current specialty training
- Specialty training challenges or deficiencies
- Specialty training access and delivery
- Specialty training instructional methods
- Impact of language and culture on specialty training
- Specialty training testing/assessment process and effectiveness
- Specialty training requirements and oversight
- Best practices related to specialties

Notes were captured from all conversations, and are included in the appendix of this document. On our outreach tour, we heard from approximately 157 stakeholders.

### Other Stakeholder Input

In addition to our physical tour, we also employed a series of individual telephone interviews, telephone focus groups, and an online survey. The majority of this portion of the data collection took place between April 29 and June 12, 2014. The questions for telephone interviews and the online survey followed a similar format to the tour, and those notes are likewise captured in the appendix of this document. Our telephone interviews and focus groups reached approximately 20 individuals, while the online survey received 229 responses.

### Stakeholder Diversity

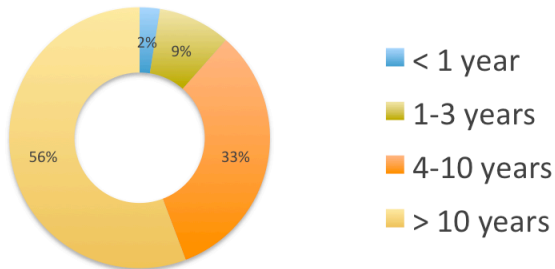
The charts on the following page represent the diversity of the total 397 stakeholders reached by all methods, with some participating in more than one method. While greater participation from caregivers and family members was identified as a goal of the outreach, this proved challenging to accomplish. The team attempted to reach additional caregivers through the providers who had attended stakeholder outreach meetings and through student rosters provided by community instructors, and attempted to reach additional family members through Ombuds

2 | Methodology

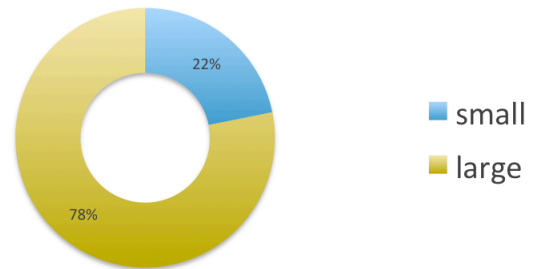
representatives and providers. These additional efforts met with only modest success, particularly for family members, where privacy concerns were cited.

*Note: because not all participants volunteered all information, the percentages for the “self-reported” categories represent the partial data that was collected.*

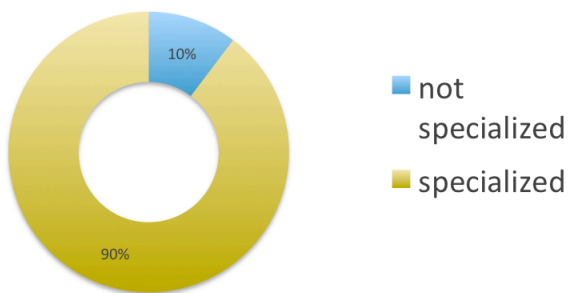
**Years Since Specialty Training**  
(self-reported)



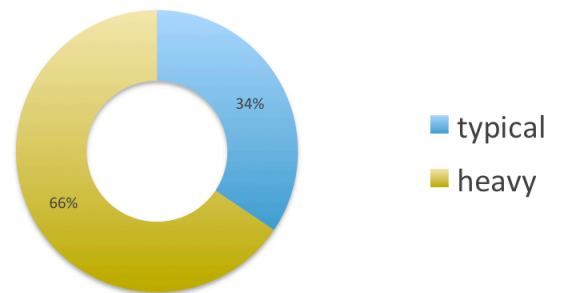
**Business Size**  
(large= more than 10 employees)



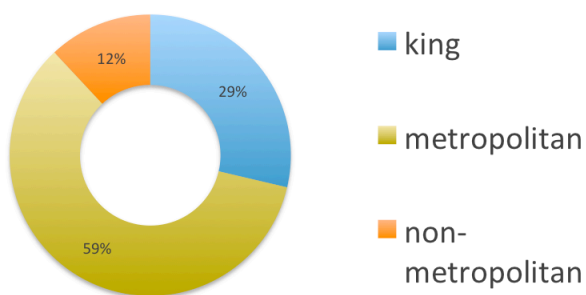
**Specialization of Care**  
(Self-Reported)



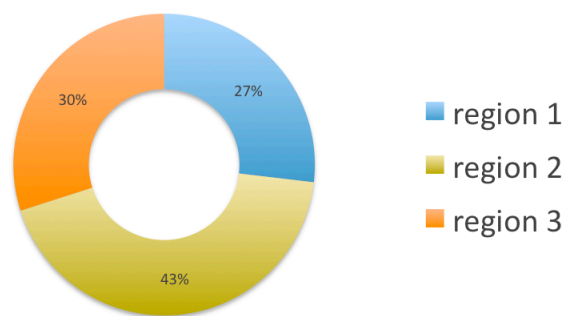
**Needs Level of Population Served**  
(self-reported)



**Location: Urban vs. Rural**  
(Based on DSHS categories)

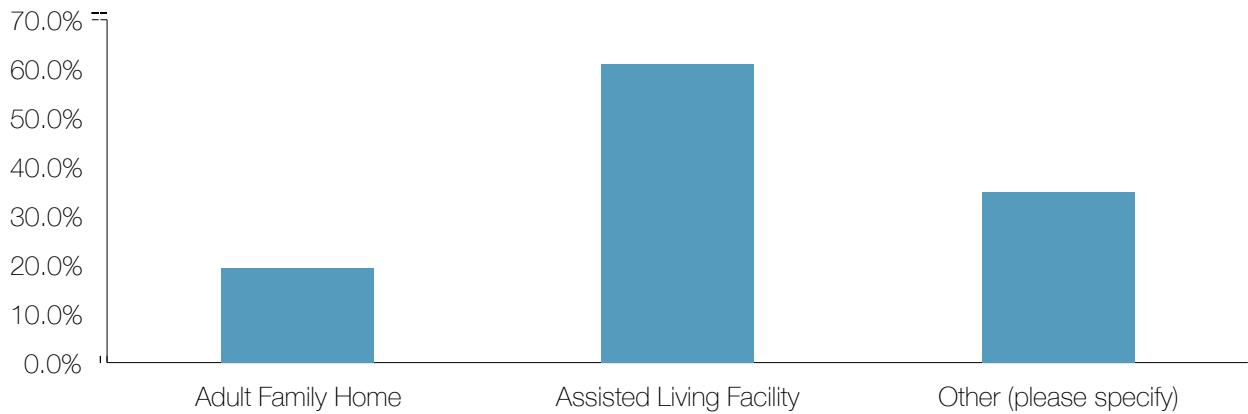


**Location: DSHS Region**



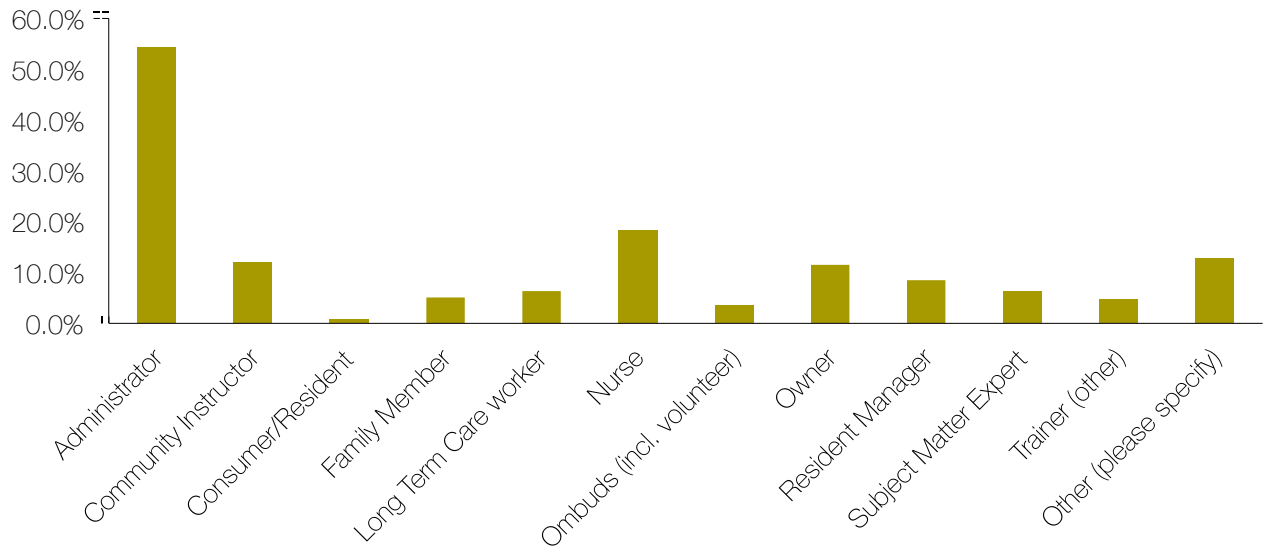
### 3 | Online Survey Respondent Demographics

What type of facility do you work in, live in or support?



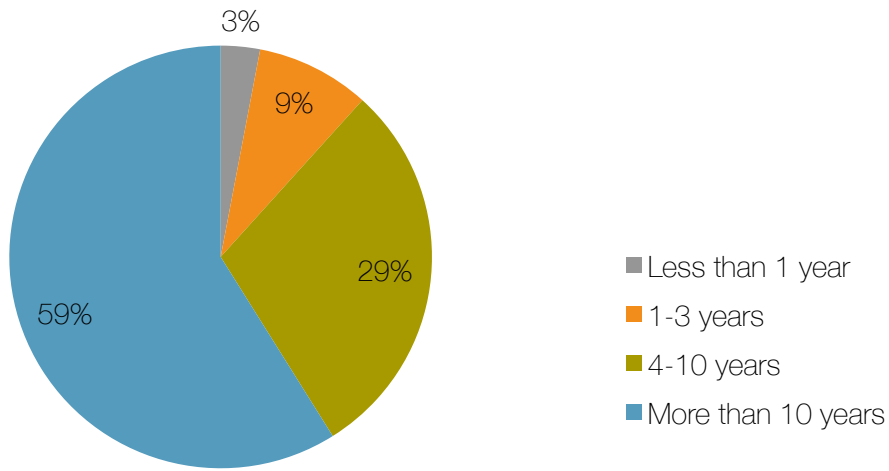
\*Other includes: advocacy groups, community college, home care, retirement facilities, skilled nursing, supportive nursing, training facilities, vocational schools, n/a - instructor, n/a - parent, and n/a - DSHS employee.

What is your role in that facility: (Select all that apply)

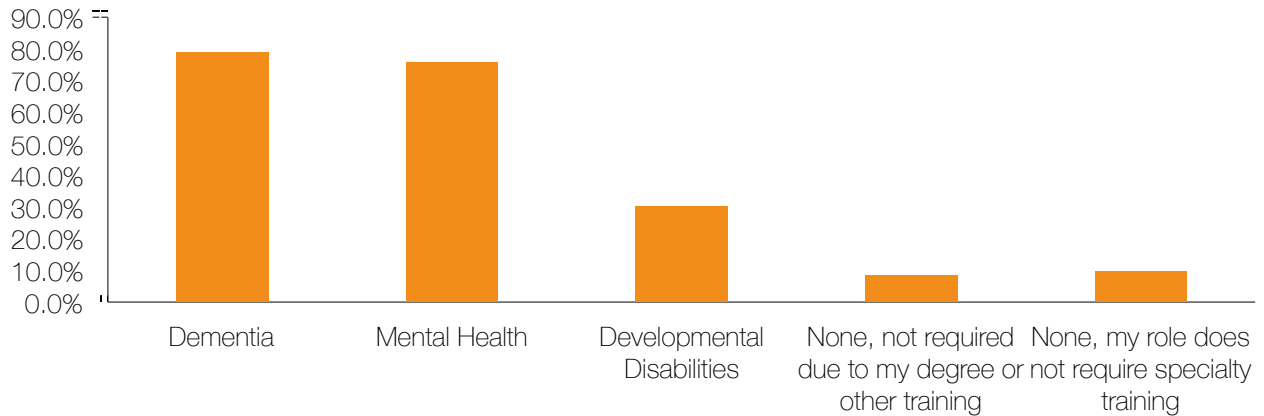


\*Other includes: activity director, assisted living manager, case resource manager, consultant, curriculum developer, employment consultant, maintenance, marketing director, nurse over-sight, office, operations, program management, quality assurance, resident advocate, retired, social worker, and staff development.

How long have you been providing, receiving or involved in specialty care?



Which specialty courses have you finished?



## 4 | Key Themes: Dementia

The pages that follow compile many of the key themes heard from stakeholders regarding the Dementia Specialty Training. While this is by no means a comprehensive list of issues identified, it does represent those themes that were most commonly discussed, and those that are most salient to the revision of the specialty training. For a full list of comments related to the Dementia Specialty Training, please see the appendix of this document.

### Key Stakeholder Comments Related to Content of Dementia Specialty Training

**One of the most important topics covered by the training is communication, and those skills and techniques cannot be emphasized enough.**

Because communication skills are so central to the interactions between caregivers and residents, stakeholders emphasized the need for the specialty training to provide caregivers with the knowledge and tools they need. This includes verbal and non-verbal communication skills, as well as skills related to approaching residents and communicating across language barriers. Caregivers need additional training in how to build understanding of where the patient is coming from.

- "Knowing special communication skills and techniques, enabling the caregiver to communicate with the resident and to help the resident communicate with others is key."
- "[On the job], I learned a lot about non-verbal communication and how it impacts the dementia clients."
- "I find caregivers often struggling in interpreting what [residents] are attempting to communicate, even if it is non-verbal. A lot of times, it is more body language."

**Many of the biggest challenges at facilities are related to an inability to mitigate behaviors. There is a training gap to prevent and deal with challenging behaviors.**

Stakeholders believe that a greater emphasis should be put on techniques for preventing and diverting disruptive behaviors, rather than on diagnoses and responses to behaviors. This includes caregivers having sensitivity to the resident's environment, and to the use of touch in communication. Caregivers need to understand how much of an influence their actions can have on preventing behaviors, and because so many caregivers are entry-level, they need the basic understanding of how to deal with the behaviors that do arise.

- "I think the concept that [resident] behavior is a form of communication is invaluable to all the specialty trainings."
- "Whenever I experience a difficult situation with a sufferer of dementia I remember what is actually happening in this person's physical body that can create this behavior and I am able to remain compassionate. I believe it lessens the frustration that can occur, as then my frustration is with the disease not the person suffering from it."
- "[Important skills include] behavior management and how to deal with people in crisis, [as well as] how to determine causes of unwanted behavior and how to deescalate a situation."
- "Spend more time instructing caregivers how to be proactive – approaching the residents better and setting up situations where problematic behaviors don't emerge, rather than so much of the curriculum being focused on responses once the behaviors have occurred."
- "The behavior module has some good ideas, but they are so far off from the real world - they are so technical that they don't do the basic problem solving that we used to do in the old days."



**Specialty training should build empathy and recognition of the individuality of residents.**

Stakeholders identified that long-term care is a person's home and should focus on maximizing independence and help people live out the end of their lives. Allowing residents to have their own voices is invaluable to this process, and caregivers need to develop empathy for clients and understand them as individuals. Understanding each resident's background may be one of the most important inputs to how they are cared for, and this may not be adequately covered in the specialty training curriculum. Stakeholders also agreed that a quality facility includes the family as part of the team, and will learn the history of the resident from their family. Understanding a resident's history and baseline are essential to the caregiver's ability to note changes when they occur.

- "[There should be more] discussion about empathy - training should 'teach' or at least 'wake them up' to understanding the other person."
- "These people are individuals and need to be treated as such."
- "Encourage a team approach in the delivery of care. Create a Person Centered Care Philosophy for your facility."
- "It's important that they know to get the resident's history from the families."

**The specialty training should build a basic understanding of physiological changes and disease progression, without dwelling on rote memorization of details such as diagnoses and medications.**

A particularly consistent theme among stakeholders was that the training spends too much time focusing students on memorizing technical facts, when it should spend more time on helping them build understanding and skills. Many stakeholders believe that caregivers can get by with a basic understanding of physiological changes and disease progression, and that an understanding of these will lead to greater empathy for the clients.

- "Add two more hours to teach the basic causes of various types of dementia along with some basic anatomy and physiology. This would allow the students to better understand why they are seeing the various symptoms and behaviors in the people they are caring for."
- "Learning the disease process, the progression and also all the symptoms that come with it has helped me immensely to appreciate [the residents] more and be able to provide respectful and compassionate care for dementia clients."
- "The photos, and [gaining] understanding of the brain changes was very important."

**Key Stakeholder Comments Related to Instruction for Dementia Specialty Training**

**Dementia specialty training is not as thorough as it once was, and is now inadequate.**

Dementia specialty training was once a much longer and more involved affair, and those stakeholders who remember that training believe that the entire system has been weakened because of the shortened training and lower requirements.

- "When I got trained, it was a week, and [even then] I didn't have a full understanding until I was out there meeting residents."
- "Training has gone downhill since what I took many years ago."

**The dementia specialty training materials need to be updated, including the video.**

Although updating the training materials is the expressed purpose of this Stakeholder Outreach Tour, stakeholders nevertheless were explicit about the need for a refresh of these materials. They believe that there is new information and knowledge about dementia that is important to include, that the materials are not as engaging as they should be, and that they could also be improved in terms of their ability to convey information.

- "Update your manuals. Update your videos. Refresher courses are needed."
- "Your videos and dementia care specialty training manuals are a little outdated."
- "One of the biggest things is to recognize that book was written a long time ago, and we have new information."

**Care for residents with Dementia is a complex subject and cannot be adequately taught in one day of training.**

Stakeholders said that the training is not long enough for a caregiver to be well-prepared or a “specialist”. More time is needed to discuss each topic, ask questions, and go back and forth to ensure learning, and optimal learning often occurs from a combination of classroom and hands-on training environments. Many stakeholders questioned whether it might be possible to assess the actual interactions with clients in care homes, in addition to the formal training. It should be noted, however, that other stakeholders were resistant to the idea of lengthening training because of the added cost burden it would impose.

- “There are a lot of topics that are covered, almost too much information in one day. Suggest the class be over a couple of days to prepare for the test.”
- “Eight hours is not sufficient to teach someone who has no experience with dementia.”
- “There is too much information to learn in only eight hours of training. More time is needed to discuss each topic, ask questions and go back and forth to ensure learning.
- “We have extended the trainings to nine hours (including the test) based on feedback from our trainers - they told us that it was too much information [for eight hours].”
- “Feels like caregivers are short-changed in the information that they need, which ultimately shortchanges the population under care.”
- “I think that (the shortening of the training) has done harm for Adult Family Homes.”

**Training is often difficult to access, and there is interest in other delivery methods including online training.**

For those who are not trained within the organization they work for, accessing training is often difficult and expensive. This includes challenges with the need for “covering” a caregiver while they are away at training, and the relative lack of trainings during evening and weekend hours. For more rural homes, traveling to training is a barrier. Many caregivers suggested that DSHS look into alternative options for the delivery of training.

- “The content is fine, but we need improved access [to the training].”
- “Online training would be helpful for rural areas.”
- “Offer online class, then go meet with real person for assessment; would allow for self-pacing and more time to digest information. (Could have a blend of both online and in-person.)”
- “I would like to see interactive ONLINE training.”

**Training is not delivered in a consistent manner.**

The skills of trainers vary greatly, from highly-experienced community trainers, to providers training their own staff. In some cases, there may even be fraudulent confirmations that training has taken place. Many stakeholders indicated a need to find ways to ensure that training happens in fact, and that there is greater consistency in the delivery of the materials.

- “The ability of the provider to delegate knowledge is not working.”
- “Taking this training a couple times by two very educated trainers was tremendous.”
- “Some instructors just play the video and don’t interact much. Consider monitoring/observing how training is delivered to ensure that trainers are competent.”
- “...The manager says they cannot afford to send folks to training so he/she became a facility instructor, and now just hands the book to the staff member, tells them to read it, and then gives them the test. The staff tell me they are supposed to take it in class, and the manager just tells them to tell the surveyors they did if they ask.”

**Learning should not end once a caregiver takes the training. Options for refreshers, resources, and reference materials should be examined.**

Many stakeholders recalled that they didn't truly begin to understand the material from their training until they were in the home providing care. Recognizing that much of the learning of skills happens on the job, questions were raised about how that ongoing learning could be supported with additional materials, ongoing access to resources, and portable "quick guide" sheets.

- "Could we develop a "student guide" that would be more useful to caregivers working in the field? Something they could have after the training that would give them quick access to the most critical information."
- "Training needs to be more 'real world' and longer. 4-6 hours is not enough. At least 2-3 times a year that they go back and get a refresher."
- "To have a resource available to call 24/7 when situations arise. This is after basic training of course. I think a 24/7 resource is important. A pocket guide would also be good."
- "We need to provide resources so caregivers know who to go to in the event of these crises."

**Key Stakeholder Comments Related to Dementia Specialty Training Requirements and Testing**

**The test is overly academic and creates anxiety without effectively validating understanding.**

Stakeholders frequently indicated that the specialty training test is overly academic and creates anxiety without effectively validating understanding. One idea that surfaced in response to the testing discussion was to consider interspersing the testing between modules, instead of all at the end.

- "[The entire training is] too much like memorizing material in high school to pass a test."
- "[The exam] feels stressful, awkward and fake."
- "[The manager test is] a terrible, awful test. It feels like a very academic exercise, and that it has not tested whether I as a manager am going to be able to lead the way in managing patients with dementia."
- "At the class, they [caregivers] get nothing – they are stressed for how to take the test."

**There are challenges related to varied levels of English proficiency.**

Because many caregivers do not speak English as a first language, there are lingual challenges related to the training and the test. Many stakeholders felt that it is essential for caregivers to have enough English proficiency to take the training and pass the test, while others argued that building an understanding of the care principles is more important, regardless of the language it is learned in or tested in. Some suggested translating training documents into 5 most common languages and offering training those languages to help caregivers that do not speak English as their first language.

- "Many of the medical terms will be difficult for those who are less fluent in English, while the concepts will not. Find ways to adapt training so that there are alternative paths to understanding, or different ways for the provider to communicate the concepts to the caregivers if they are giving the training."
- "Another training item to consider is how well [owners and managers] can relate to their [staff members who] do not speak English."
- "Right now I have a specialty training going on, and two ladies are going to fail the test, and it's because they don't speak English."

**There is interest in looking at different "levels" of training, beyond what exists now.**

Aside from specialty training improvements that stakeholders suggested for all caregivers, there was also interest expressed in making higher levels of specialization available. Many suggested that referring to the current level of training as "specialization" is misleading, but that if higher levels were added, it could become an appropriate label.

- "[We should have] multiple levels of training. I think it would help."
- "[There should be] caregiver, manager and instructor levels for the test. I would like instructors to have teaching experience, but also more intensive training."



## 5 | Key Themes: Mental Health

The pages that follow compile many of the key themes heard from stakeholders regarding the Mental Health Specialty Training. While this is by no means a comprehensive list of issues identified, it does represent those themes that were most commonly discussed, and those that are most salient to the revision of the specialty training. For a full list of comments related to the Mental Health Specialty Training, please see the appendix of this document.

### Key Stakeholder Comments Related to Content of Mental Health Specialty Training

**A key mental healthcare skill that should be better supported by the specialty training is crisis management.** Many stakeholders, including Ombuds, observed that caregivers are all too often unprepared for crises with their mental health residents. This includes behavior management skills, but also includes crisis planning—often the plans are not used properly, if they exist at all. It was suggested many times that these portions of the training should be bolstered.



- "More on crisis training - exists in curriculum, but weak. (And mental health support system is very broken, so people will need to handle crises on their own.)"
- "I don't think there is much training about de-escalating residents. It seems like what I see is that even when there is a lower-level crisis, even if that is a part of their baseline, the caregivers kind of are paralyzed and don't know, and are trying to figure it out as they go. Is there a crisis plan in place?"
- "I have observed that often the crisis plan is there, but they haven't been trained on it, and they don't access or use it."
- "Caregivers should know who to call if a situation escalates - when to call mental health crisis teams vs. 911. They should also be trained on how to react in such a situation - and how to protect themselves and other residents."

**Caregivers should be able to identify signs and symptoms of mental illnesses, and know how to track behaviors so they are aware of changes.**

With mental health clients, many caregivers don't seem to have an understanding of how to document behavior on an ongoing basis, or what behaviors they should be watching for that may indicate decompensation. This creates situations where a resident's mental health may begin to decline and—because their behavior is not being compared to an established baseline—the decline isn't noted until it has become a crisis. Stakeholders felt that instruction around documentation of behavior needs to be stronger in the training.

- "Documentation is important. The residents are in a state of change, so it needs to be written that we could see the change when they are living with us."
- "[Caregivers should understand] signs of decompensation in mental health patients."
- "Do they know the baseline and what to do when they see signs and symptoms?"
- "We don't care if somebody diagnoses mental health, because that is not their job, but they should recognize signs and symptoms. Sometimes, depression might manifest as staying in their room, and no AFH is going to report that."
- "We don't want diagnostic clarity, but we want them to share information and want them to notice these things as potential signs of mental illness."

**The training should better prepare caregivers to advocate for their clients medically and to access community mental health resources on behalf of their clients.**

It seems to be an accepted fact that there are challenges and gaps within the mental health system. However, even when services are available, many caregivers do not know they exist, or do not know how to access them. Better preparing caregivers with ways to access community mental health resources, and with an understanding of what is available and when to use it, will likely improve outcomes for clients.

- "How does a provider take notes and document changes that they see so they can advocate with medical personnel, and can communicate with the social workers and families."
- "More information on... resources available to us."
- "[Caregivers should know about] resources that are available (or not – emergency response may be limited); e.g. RSN (Regional Support Network)."
- "How do caregivers handle a situation they can't address? How do you access resources? Who do you go to?"

**Personality disorders are not covered in the training, yet are some of the most difficult to manage in a care setting.**

In the existing specialty training manual, personality disorders are noted only to mention that they are not covered by the training. Many stakeholders feel that this omission is inappropriate, because many of the most challenging mental health clients have one of the various personality disorders.

- "I don't see personality disorders [in the training] - borderline, narcissistic, dissociative. Those are the really challenging behavior components to work with as well."
- "Add personality disorders to module 1."
- "I don't see personality disorder classifications (borderline, narcissistic, etc.) in the Mental Health training outline – can be most challenging in ALF settings."
- "I think the biggest population we see out there is personality disorders, and that is not covered by the book... Those are what our main audience is, and the book does not touch on them at all."

**The cultural sensitivity module needs to be refreshed.**

We heard from stakeholders that there is a very real need to have cultural sensitivity built into the training. However, many of them feel that the current module, though well-intended, could be improved. Suggestions were made that the topic should also be intentionally included throughout the manual, and not only in the specific module.

- "The cultural sensitivity section is not very well-done at all. I see what they are trying to do, but it wasn't done very appropriately. When you are from this culture, you can write a cultural sensitivity module and miss a lot."
- "Cultural section is written by somebody who knows all the right steps from the book."
- "Cultural training is more textbook and less relevant to what is needed."

**The specialty training should provide caregivers with a better understanding of psychotropic medications.**

Because medications are so central to the care of mental health patients, and because this is an ever-changing part of the care, a great number of stakeholders felt that the training information about medications should be updated and expanded. They felt that many caregivers don't understand the importance of proper dosing, how to watch for side effects, or what other factors may influence the effectiveness of medications.

- "I would expect staff members to know more about medications related to mental health, and understand the importance of compliance with medications. [In] the community setting - clients tend to not want to take medications. I would want the staff to understand the importance of anti-psychotics and/or antidepressants."
- "I would want them to know that this person needs to be on medication to remain stable."
- "Understand medications and side effects."

**Providers should come out of the mental health specialty training with a clear understanding of the complexities of caring for mental health clients.**

Stakeholders expressed concerns that many homes begin taking in mental health clients without fully understanding how it will affect the other residents in their homes, or without being fully prepared to handle the complex nature of caring for these clients. While building this understanding is important for every caregiver, it is especially important for providers and managers to understand, pointing to a possibility that this could be somehow covered in more depth in the manager training.

- "In licensing, the homes I saw get in over their heads were the ones trying to take in this population. They didn't understand what they were getting into."
- "The desperate homes who take in a MH resident in, and then they realize that they are over their heads and that they should have done a better job assessing."

### Key Stakeholder Comments Related to Instruction for Mental Health Specialty Training

**The materials are in need of an update to incorporate the latest thinking around mental health care.**

A great many stakeholders feel that it is time to update the specialty training curriculum for mental health, especially in light of how rapidly the field is changing—new models of care and new medications being two updates recommended specifically. Additionally, many stakeholders felt that the current training is based in a "medical model" and that more current thinking would indicate a curriculum based in a "person-centered" care model.

- "Curriculum was pretty good at the time, but is not current and evidence-based."
- "There is a growing enlightenment of how to care for people. The current model is a medical model. The future model should take into account the whole person. Long-term care is a person's home and should focus on maximizing independence and help people live out their life. Training should be more trauma informed and be more experiential vs. medical."
- "The person-centered approach should be the focus of the training model, not the medical model."

**Adding video resources to the training materials would help students to understand what behaviors look like.**

Unlike the dementia specialty training, the mental health specialty training does not have a set of videos that accompany the written training manual. Stakeholders believe that the addition of a video element to this training would better prepare caregivers for behaviors they are likely to encounter in the care setting, and could demonstrate useful principles of care.

- "[The training should include] DVDs of what mental illness symptoms look like."
- "Provide video of experts interacting with mental health clients."
- "A supporting video would be nice as long as it a quality video with examples and demonstrations of various mental disorders."

**Role-playing is a strong tool for building an understanding of skills, yet some are uncomfortable with it as a training technique.**

Opinions were somewhat split on the inclusion of role-playing in the delivery of mental health specialty training. Some stakeholders felt that role-playing is a critical tool for building an understanding of how interactions with clients will go, and for practicing useful care tools. They also felt that the role-playing may help with comprehension in students who are less proficient in English. Other stakeholders felt that the role-playing is an uncomfortable part of the training, may cause students to disengage from the learning, and may cause frustration in ESL learners.

- "Do more real life scenarios and role playing."
- "The role-playing, for me, was the most effective part. It's kind of hard - for somebody who has experience in the field, that perspective is different than somebody who is fresh."
- "Struggle with role-playing exercises, particularly with ESL. Hard to explain and get through with various individuals in the class. And [the] process itself is uncomfortable."

## Key Stakeholder Comments Related to Mental Health Specialty Training Requirements and Testing

### **There is too much content to be covered in four hours of training.**

While recognizing that a longer training will put a cost burden on facilities, there was broad consensus that the current time requirement for mental health specialty training is insufficient for the amount of information that should be conveyed.

- "The timeframe is way too short. If you are just teaching the mental health book, it's four hours - that is not enough time to cover the topics in here. We originally dedicated eight hours, and got it chopped back to four."
- "Limited material or time given to the material, as I recall."
- "Need to match requirements with [the] time allowed."
- "It's a lot to take in within a short amount of time. And they have expressed that they wish there was a follow-up class."
- "[The training needs to allow for] more time to work on real life scenarios [of] hallucinations and delusions."

### **The test does not measure the desired skills, and does not measure skill application.**

Stakeholders felt that the test given with the training is too focused on testing the rote memorization of technical information from the manual, and not focused enough on assessing whether caregivers understand and are able to apply care principles and skills. Many stakeholders questioned whether a true competency assessment can be done in a written test.

- "[The test] seemed to emphasize lingo more than practical skills."
- "Need to verify skills. How do you know they can apply them?"
- "I agree we have to have an objective, concrete, written tool. In my experience the test is poorly written."
- "Where is the ongoing assessment of skill sets after the training?"

### **Having the option of adding modules that go into depth within certain mental illnesses would help caregivers zero in on the skills and understanding they need most.**

Because the mental health specialty training is—necessarily—generalized, many stakeholders indicated that it would be advantageous for caregivers to be able to add deeper training that is more specific to the population they will serve.

- "Current training is very basic preparation. Adequate starting place, but needs to continue."
- "Consider a more modular approach."
- "I think it's a good introductory to what is out there - for people who have never experienced mental health, and maybe they can use that to help a resident in a crisis situation. But it's really just an introduction."

## 6 | Key Themes: Developmental Disability

The pages that follow compile many of the key themes heard from stakeholders regarding the Developmental Disabilities Specialty Training. While this is by no means a comprehensive list of issues identified, it does represent those themes that were most commonly discussed, and those that are most salient to the revision of the specialty training. For a full list of comments related to the Developmental Disabilities Specialty Training, please see the appendix of this document.

### Key Stakeholder Comments Related to Content of Developmental Disabilities Specialty Training

**Helping residents to live full lives, and preserving those residents' rights, is at the core of what's important in this training.**

Stakeholders discussed that the caregiver mindset is very important and training should discuss the difference in supporting people who will spend the majority of their lives in a care facility. Caregivers should be trained to understand that they are there to be an assistant to the life of the disabled person, not their overseer or boss.



Photo: Wikimedia Commons user Hanoi Volunteer

- "I would like to see 'Individual Rights' up front and covered in depth during the training. Not just an afterthought in the training. For example, taking away a cell phone can really raise some ugly issues and violates individual rights."
- "One thing that could be added is conflict resolution/negotiation—that could work into what is going on. Having a daily walk through negotiating and making sure that people's rights are being protected while you are also protecting the rights of five other people."
- "Sexuality seems like it's a taboo subject, but to have a full life, you [have to] deal with that."
- "Does the place where they will be living offer the opportunity to live a full life... whatever that might be?"
- "It is important to have all of the trainings reinforce the idea that a person living with a DD is an adult who has the right to live a full life defined by the individual's dreams and aspirations."

**Staff should be better trained to be in the habit of discovering what is causing behaviors, rather than just dealing with behaviors.**

At almost every location around the state, stakeholders stressed that more training on practical skills to deal with and resolve challenging client behaviors is needed. This should also help caregivers develop the habit of discovering what is causing behaviors, rather than just trying to minimize disruptive behaviors.

- "Understating why they are doing what they do, and the steps you can take to understand and empower them overcome the behavior or challenge. More real life scenarios and examples are great to help learn these techniques."
- "Challenging behaviors are typically caused by physical pain."
- "How to address challenging behaviors. How to support the person in looking at that behavior - positive behavior support. Every behavior has a function - not necessarily a 'bad' behavior."
- "Understanding behavior, so they can understand why somebody is acting a certain way and what you can do to prevent that."

**The training could place more emphasis on the development of negotiated care plans, as well as how to include families and residents themselves in designing the plan.**

Stakeholders shared many observations about caregivers having incomplete understanding of what is involved in the development of a care plan, and in how to use a care plan once it is developed. This includes a lack of knowledge about how to include the client and their family in the development of the plan.

- "Is the family appreciated for their knowledge and part of the care plan?"
- "There has to be a connection between the family and their loved one. Training should include how to include the family in the care plan."
- "The negotiated care plan should be part of the training."
- "I see that paperwork and negotiated care plans are done but incomplete. I think there is some training that could go around that."

**The developmental disabilities specialty training should place more emphasis on recognizing and adapting care for cultural differences.**

Stakeholders felt that one of the greatest gaps in the current specialty curriculum for developmental disabilities is around cultural differences. The caregiver culture-of-origin may have an influence on how developmental disabilities are viewed, and the variety of cultures from which residents and caregivers originate indicates a need for stronger training in this area.

- "I wouldn't say that (culture) is in the curriculum - I use a couple of scenarios that we have come across that kind of help make the point. We will hit on that, but because of our experiences, not because it's in the curriculum."
- "I don't recall any cultural sensitivity... there is a part about privacy and personal space, and respect. A lot of that, but nothing on cultural differences."
- "There is a cultural thing in the DD world where cultural differences are not emphasized enough, so it doesn't come up in the DD curriculum."
- "Scenarios, videos, or practice around culture would be helpful for training."

**Communication—especially non-verbal communication—could be given more time in the training.**

Stakeholders discussed that modules on communication and behavior should perhaps be the most-emphasized parts of the training, and should specifically find opportunities in the training materials to stress the importance of non-verbal communication. Adding more real-life scenarios and examples are great ways to help caregivers learn better ways to communicate with their clients.

- "Caregiver communication can be an issue - both ESL and communicating with those who communicate minimally."
- "[Caregivers should be] learning about other ways of communication—communication boards, etc."
- "Communication frustrations can lead to a lot of other challenging behaviors."
- "Communication is more than just the words you say. Many people with DD might have difficulty processing any spoken language and might use other things than words to express themselves. Any caregiver needs to be multi-lingual in those situations and figure out how to support clients in this. Regardless of what your spoken language is, if someone is hitting their head, can you interpret it and respond to the communication appropriately (ex: I have a head ache...)?"
- "Effective communication—in the manual—I would do that one differently. It is really more about strategies that you would learn in a management class, where I would think something about non-verbal communication might be more useful."

## Key Stakeholder Comments Related to Instruction for Developmental Disabilities Specialty Training

**The curriculum for developmental disabilities specialty training is generally very strong, and is taught by excellent instructors.**

Among the three existing specialty trainings, there is clearly the most support for the current DD curriculum. Stakeholders indicated that it is thorough, relevant, and well-taught.

- "The training was pretty good... my instructor was very good. She had to retrain how everybody thought. She taught a lot about disability rights and the struggle for that that a lot of us didn't know about. And she integrated "rights" and "choices" into the curriculum. These individuals do not need protection - they need somebody to help them promote those rights. You aren't there to keep them cared for and protected, you are there to help them exercise their choices."
- "We've had positive feedback to the curriculum and the instructors - so yahoo!"
- "I thought the 18 hours of instruction, over three days, worked very well and the methodology of instruction was very good."

**Developmental disabilities training is limited, tough to schedule, and courses fill up very quickly.**

Many stakeholders raised the issue that—although the training itself is free—a three-day training that is often not local to the facility represents a significant cost to providers and caregivers. There is a desire for this training to be made more frequent and accessible, especially to rural areas.

- "The classes aren't accessible enough - it's better in frequency and range of locations, but previously we had to send folks to Seattle, and when we are up in the Everett area, that is a big deal. Considering the pay rate that these folks are on, and that they can't work until they have done that... more frequency and more locations."
- "We need to broaden the accessibility of the training so rural people don't have to pay through the nose."
- "I have a comment as a community instructor who doesn't teach DD - the calls I get from remote locations who can't get their people trained in their areas, and they need to send them to another location and put them up in a hotel. There is no training within three counties."

**There is interest in alternative methods of training and alternative ways to deliver the training.**

In conjunction with the desire to have DD training deployed more frequently and in more locations, stakeholders asked for other ways to access the training, including online training. They also brought up opportunities around skills training being a more experiential addition to the training, potentially even completed later in the care environment.

- "Make the DD training more accessible to all potential caregivers. On-line training is very helpful and [could] help us get caregivers onboard in a reasonable amount of time."
- "I don't do a lot of role playing, because I don't think it's as respectful to the population we serve. We do a lot of group work and learning about each other and who has experiences with relatives or past clients - trying to pull their experiences out."
- "Look at whether alternate forms of delivery are workable. There is research now that supports it. I'm a strong proponent of online training and I want that pursued as part of this. There was short space where we did it before it got taken back offline. And now they are handing them the book or taking their citations."
- "Can we require people to do things outside the training [within the requirements of the WAC]? If we could do it, I would [make it a] condition of passing and [require caregivers] to demonstrate it by doing something experiential. An oral or written presentation on how it was applied to make a person's life improve."
- "If you could have something where there was an AFH consult group - where they could video in to a webinar. Where they could talk out problems regularly."
- "[It would be] great to have regional mentorship team or 'hotline' accessible via app or phone, [which] would need to be very specific to specialties. (Difficult to fund and will need to have incentives built in.)"

## Key Stakeholder Comments Related to Developmental Disabilities Specialty Training Requirements and Testing

### Opinions vary about the current length of the training.

Opinions were split on whether the current 18-hour training requirement was too long to appropriately cover the necessary material, or whether it is just long enough. Very few advocated for even more time. Beyond content delivery, cost to providers and caregivers is an important factor to consider.

- "It is repetitious, [and] full of "filler" material to stretch it to 3 days, even with the multiple breaks and off-line discussions. There is really only about 8 hours of solid material."
- "The eighteen hours could be cut back to two days potentially. That is the feedback that comes back in the evaluations."
- "I had some women who didn't want to do the training. It was clear that they cared about their residents, but they had to take days off without pay to come... and that amount of money was huge to them. Three days without pay in one month."
- "The burden of cost in terms of three days out of our location, paying for housing and travel, and paying the wages... it is tough. There are no options near here for the training."
- "18 hours is about the right amount of time, with a full class, to cover all of the material and exercises to help students think it through and learn."
- "When it was expanded to the three days, I think... we were doing two days and there was typically so much discussion about behavior that we understood we needed to talk more about rights."

### Language barriers are consistently one of the biggest challenges of the specialty training.

Given the demographics of the caregiver labor pool, it is likely that debate will continue as to whether the training and exam should be provided in other languages. While some pointed out that providers and caregivers are currently required to have basic English fluency, others pointed out that failing to meet the language needs of those taking training may mean that potentially great caregivers are not able to pass the exam.

- "[It is] important to have a certain amount of English (e.g. WAC - ability to communicate in an emergency, call 911 and share information), so it may not be advisable to provide training in another language."
- "Same issue as offering drivers licenses in multiple languages and other services that provide good for the community. Shift and be more language-neutral. The language in the regulation is 'the language of the person.' Maybe we should provide language courses in the facilities?"
- "English as a second language is a problem with the training. The number one problem I receive complaints on is that we do not provide a translator for the DD specialty training."

### Stakeholders questioned the ability of the test to measure the desired outcomes of the training.

Many stakeholders had questions as to whether the test was able to measure readiness for caregivers, and whether it is aligned with the intended learning outcomes of the training. Alternative examination techniques and translation into other languages were both mentioned as potential remedies.

- "I do not know if the test is a good measure of knowledge. Based on what I remember [from] taking this class, I do not think so."
- "Passing the test does not really provide good feedback on what you have learned and how to apply it."
- "I don't know how well it measures readiness – [I'm] not in the homes to observe. The only way we know is through incident reports. [It would be] ideal to have some follow up, but [that would be] difficult to structure."
- "I think the content is right, but how do you know you are testing the right thing, or that they will do a good job if they pass? How do you test what's in peoples' hearts? I understand that there has to be some way to test it, but someone else put the test together."
- "I think the exam should be more rigorous."



## 7 | Key Themes: All Current Specialty Trainings

The pages that follow compile many of the universal themes heard from stakeholders regarding the three current specialty trainings. While this is by no means a comprehensive list of issues identified, it does represent those themes that were most commonly discussed, and those that are most salient to the revision of the specialty training. For a full list of comments related to the specialty trainings, please see the appendix of this document.

### Key Stakeholder Comments Related to Content of All Current Specialty Trainings

#### **Trainings should be updated to be more person-centered and trauma-informed.**

Many stakeholders felt that the current trainings do not adequately represent new ways of thinking about caregiving for clients with dementia, mental illness, or developmental disabilities.



- "There is a growing enlightenment of how to care for people. The current model is a medical model. The future model should take into account the whole person. Long-term care is a person's home and should focus on maximizing independence and help people live out their life. Training should be more trauma-informed and be more experiential vs. medical."
- "The shift across our industry is [towards] person-centered care. So this training is a good place to jump into that a little bit. The more you know your resident as an individual, the better you will be able to provide care to them."
- "The person-centered approach should be the focus of the training model, not the medical model."

#### **Caregivers consistently struggle with communication, and the training modules for communication should be among the most-emphasized.**

Across the state, stakeholders asserted that the communication portions of the trainings cannot be stressed heavily enough—this is central to the caregiver's ability to be successful. When stakeholders were asked to rank the modules in terms of importance, communication consistently came out on top.

- "There is not enough emphasis on training about communication differences of people with Intellectual and Developmental Disabilities (IDD). Respectful non-minimizing language is currently not the norm, nor is people-first language. The term "mentally retarded" is still in use by program staff."
- "[Trainings should emphasize] communication with older adults with limited communication skills."
- "I think the communication strategies that are presented in the specialty classes are essential in providing care to our residents in the community settings."
- "[Caregivers should be] learning various communication techniques to work with dementia and mental health clients."

#### **Training modules related to challenging behaviors should likewise be among the most-emphasized.**

Similarly to communication, stakeholders felt that a solid foundation in dealing with challenging behaviors—and in understanding the communicative aspects of certain behaviors—is essential to preparing a caregiver to work with clients.

- "[A critical skill is] understanding behaviors for both dementia and mental health, and becoming creative in addressing needs."
- "[Caregivers should learn to understand] what behaviors and moods are not baseline and not to assume that moods and behaviors that are ongoing are not considered 'normal for that person'."

## 7 | Key Themes: All Current Specialty Trainings

- "I would like to see more training on how to deal with DD behaviors, what to expect when living with them, how to understand them better, how to set realistic goals and how to handle behavior problems such as hygiene, temper tantrums, fighting or not getting along with other residents, etc."
- "Understanding of the disease processes, learning how to interpret behaviors to find [the] root cause, not just putting them on meds."
- "[Caregivers] really want practical applications to the challenging behaviors."
- "Caregivers are not prepared to deal with these behaviors. Some caregivers, with experience, are better at working with people and these behaviors."

**The current specialty trainings shy away from the subject of sexuality, yet this represents a very real set of issues for caregivers.**

Stakeholders felt that sexuality is given short shrift in the trainings. Improving those parts of the training that address client sexuality, and building new sections, is especially important in light of the growing understanding of the responsibility to protect the rights of residents.

- "Some of the issues with dementia and sexual health have helped me to train staff how to appropriately address sexual expression and a safe environment for sexual expression."
- "[The] video is awful regarding sexuality – because it comes from a 'shame on you' perspective."
- "[Caregivers need] real-life management of sexual issues. The course poses situations with many perspectives, but never says, 'this is what you do.' Caregivers want and need concrete answers."
- "[The trainings should include] more on sexuality, including residents' rights and how to handle behaviors."

### Key Stakeholder Comments Related to Instruction for All Current Specialty Trainings

**Many stakeholders questioned whether manager training shouldn't be given a greater differentiation from the standard caregiver training.**

The current training practice is that managers receive the same training as the caregivers, but receive a short additional segment of training, and are also given a separate exam. Stakeholders wished for more clarity around the differentiation, and possibly a complete separation.

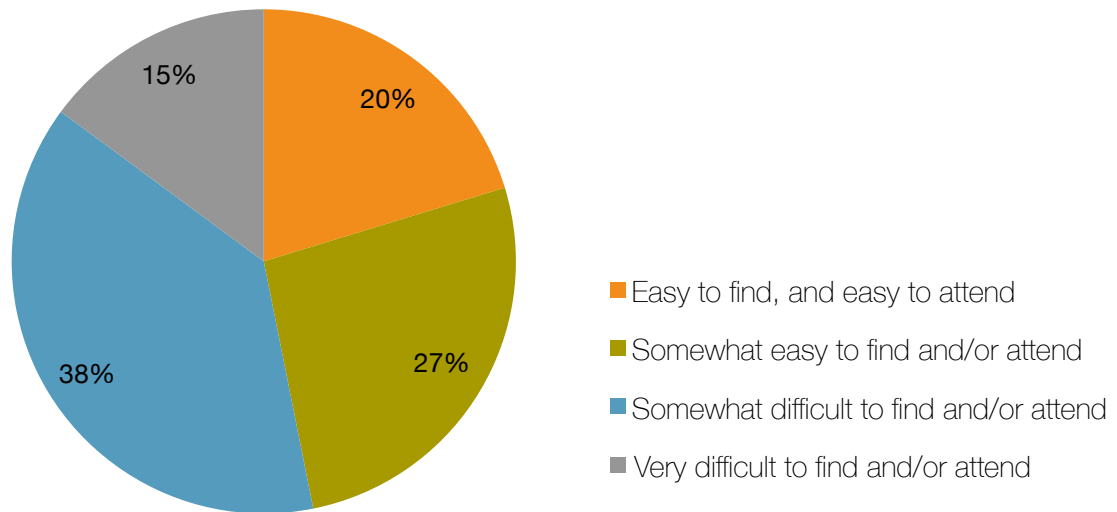
- "I have heard that we should break out the manager training... a lot of what is in the training for the caregivers..."
- "What skills should managers have? Should there be different training? It seems to me that maybe something around leadership and quality - how to evaluate and how to be a good manager. How to follow through. Seems like those would be good manager training. A lot of time people get hired, but they don't get the training that goes with the title."
- "It is also difficult to train managers in the same class as others. I think they should be offered as different classes. Everyone else had to stay an extra hour and a half while the managers were going through the extra training and skills testing."
- "[DSHS needs to] clarify [the] intended difference between manager and caregiver skills and training."

**There is a desire for the specialty trainings to be more accessible in terms of frequency, location, and audience.**

Stakeholders are eager to have greater access to trainings. The need is especially acute in rural areas, where traveling to trainings adds additional cost burdens for caregivers and providers. A desire for family members to have access to these trainings was also noted.

- "Improved access. Content is fine."
- "The classes aren't accessible enough."
- "Classes need to be more frequent and more local – staff cannot work in an AFH unsupervised until they have completed this class and sometimes staff need to wait anywhere between 4-8 weeks to get [into] a class."
- "DD training not in the private sector is a problem and not accessible."
- "Some of my AFH providers say there used to be online training that was accessible."
- "I think specialty training should be opened up to family members."

The following chart represents how survey respondents answered a question about how easy to find and/or attend specialty training is:



### Key Stakeholder Comments Related to Requirements and Testing of All Current Specialty Trainings

**DSHS should look at ensuring consistent delivery of trainings and examinations across the state.** While recognizing that the specialty trainings will likely never be perfectly consistent, stakeholders believe that there is room for improvement, and that new delivery methods or requirements may ensure a greater consistency in the delivery of training.

- “[It would be] helpful if training were more consistent - so that home owners or administrators can rely on what people have learned, regardless of where they were trained.”
- “The level of training is not consistent across the state of Washington.”
- “Training is not consistent. Trainers are human [and they have] different approaches, expertise, [and] knowledge. Sometimes managers teaching the classes don't really grasp the material themselves, [and] may just be reading/following [the] structure or showing video, vs. adding own experience, real-life scenarios.”
- “Consider a better 'train-the-trainer' model that ensures more consistent delivery and skills.”

**DSHS should carefully consider how to address language differences, and their effects on training and care.**

It is likely that there will continue to be a significant number of caregivers for whom English is not their first language. There are trade-offs to be identified and discussed between current requirements for a basic level of English to be spoken and the desire to create opportunities for highly-skilled and empathetic caregivers to succeed—regardless of their English proficiency. As specialty trainings and WAC requirements are reviewed or updated, this is a topic that a great many caregivers identified as a critical one to address, although there was a plurality of opinions as to how these trade-offs should be handled.

- “Currently, training is one-size-fits-all. If we are moving into the 21 century, we could look at translating training documents into the 5 main core languages and offer training done in English and translated into the 5 core languages.”
- “Maybe even provide a test on communication as a prerequisite before taking the class. If students do not pass, then they must take a class until they pass the examination on communication. It is not about their deficiency in the English language but they must be able to communicate clearly to a population who are already vulnerable due to their cognitive impairments.”

## 7 | Key Themes: All Current Specialty Trainings

- “Many of the medical terms will be difficult for those who are less fluent in English, while the concepts will not. Find ways to adapt training so that there are alternative paths to understanding, or different ways for the provider to communicate the concepts to the caregivers if they are giving the training.”
- “Language in the test makes it unnecessarily difficult for people who are not native English speakers. Uses words like 'may' 'inheritance' 'heredity' 'strengths' 'meaningful' that are not clear and/or familiar. Test-takers don't want to speak up.”
- “We need to have greater access to teaching English as a second language to help empower our staffs.”
- “If I have dementia and English is a second language for the caregiver, it is hard to have good communication.”
- “Caregivers who are not clear in English have more difficulty communicating with residents, receiving training, and comprehending the test. [They were] able to demonstrate that they understood in person, but couldn't pass the test.”
- “[It] could be helpful to translate the materials. The Home Care Aid exam is translated into 12 languages [but these specialty trainings are] only in English. [This] may eliminate people who could be very effective.”

### **Stakeholders felt that the system would benefit if the Ombuds and DSHS staff were required to take the specialty trainings, so that they have the same understanding as caregivers.**

Many stakeholders observed that their interactions with DSHS staff members and Ombuds are sometimes challenged because these individuals don't always have a full understanding of how caregivers are trained and what best practices for care may be.

- “Training for Ombudsman – [they] may come in to interview/assess dementia residents, but the ombudsman doesn't have appropriate skills for working with a person with dementia, and causes new problems.”
- “I think bringing the ombudsmen into the training would be very helpful and valuable.”
- “We would like it if the licensors had to take the training. They would better understand what we are doing and why. Case managers too—so they understand how much time it takes to deliver this care.”
- “Ombudsman should be trained also—they need to know how to interact with the residents.”
- “The licensors should also be trained or informed of the training requirements.”

## 8 | Possible New Specialty Trainings

Stakeholders were asked what other conditions might be candidates for new specialty trainings. The pages that follow summarize those conditions that were most frequently cited as possibilities for new specialty trainings. These requests for new specialty trainings have been grouped into three tiers, based on the number of requests that were heard. It is worth noting that there are many factors that DSHS must consider when choosing to require training for any additional specialties. Therefore, this listing is not a set of recommendations, but rather a reporting of what stakeholders had to say on the topic. For a full list of comments related to possible new specialty trainings, please see the appendix of this document.

### Tier One

#### Traumatic Brain Injury

Far and away, the most common request for new specialty training was for Traumatic Brain Injury, or TBI. Stakeholders cited an increase in the number of clients living with the effects of TBI, and the uniqueness and complexity of care for TBI clients.

- “TBI has its own set of challenges. Where my daughter resides, most of them have a very hard time communicating, but it has nothing to do with their intelligence, and that is tremendously frustrating. It brings up their social needs. It contributes to depression, anxiety—those kinds of things. And it’s highly individualized. I would hope that DSHS has some sort of criteria set for people with TBI. While each case is different, I think you can bring attention to some of the needs. Folks with TBI have pretty high expectations. Their energy levels and their abilities are such a roller coaster that it’s very hard for them to maintain what they expect of themselves. It’s a separate issue from their mobility, and their ability to speak and communicate. They still have that whole set of where they would like to be in their expectations and where they would like to be in the world.”



### Tier Two

#### Substance Abuse

Substance abuse is often comorbid with other conditions, and presents particular challenges for caregivers who must balance patient rights and the safety of the client and the other residents.

- “Possible specialty is dual diagnosis of mental health and substance abuse. We often have clients that are also substance abusers—whether that is medications or illicit drugs. They may [also] be abusing their regular medications.”

#### Bariatric Care

Many stakeholders cited the need for specialty training to address Bariatric Care, which like substance abuse, is often comorbid with other conditions. In the case of long-term care, this refers to the specialized treatment and care of obese and morbidly obese clients with coexisting medical diagnosis. Obesity is defined as a BMI of 30 or greater and morbid obesity is defined as a BMI of 39 or greater. Care challenges specific to Bariatric residents, which may indicate needed training topics, include: mobility, positioning, skin integrity, nutrition, behavioral support, trauma-informed care, promotion of dignity, and environmental modifications for timely evacuations and client accessibility.

- "Another big growth is with bariatric clients. We have very few places where we can get the clients placed because the homes aren't built to handle them. They are also needing to add staff in order to meet the care needs."

### Tier Three

#### Post-Traumatic Stress Syndrome

While PTSD is most commonly associated with returning veterans, it is increasingly recognized among survivors of other traumatic events. Stakeholders felt that meeting the specific needs of those suffering from PTSD might indicate the need for specialty training.

- "There is a lot more PTSD going on out there. And the students are saying that too. The component in the book is small."

#### Diabetes

Diabetic patients have particular needs related to nutrition, medications, skin care, and circulation. Stakeholders believed that the complexity of caring for a diabetic client, especially one who may also have dementia or mental illness—as well as the growing incidence of the disease—might mean that it should be considered for new specialty training.

- "From a nurse perspective, I think that when providers take a patient with diabetes, they should have so many hours of diabetes training."

#### Medically Fragile Individuals

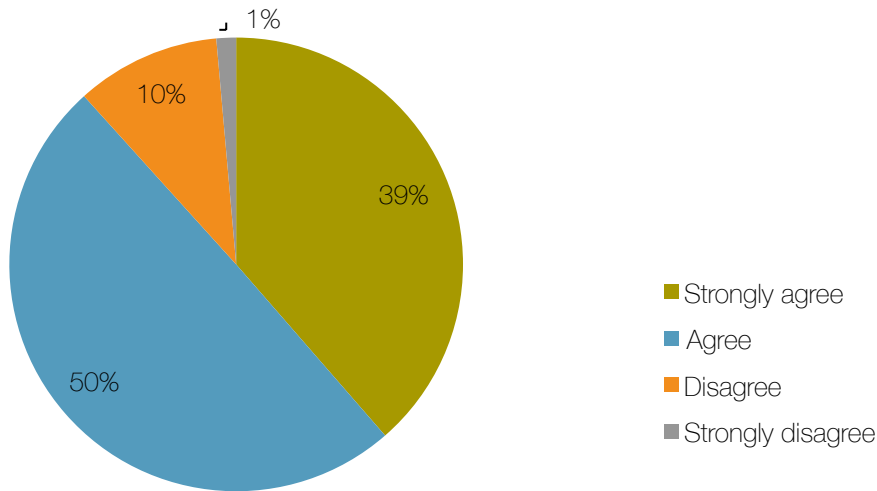
Many stakeholders also noted that caring for medically fragile individuals requires a deeper understanding of many medical aspects, as well as training to be very sensitive to changes in the client's condition.

## 9 | Appendix: Full Text of Stakeholder Comments

*Note: Because many of our stakeholder outreach events covered Dementia and Mental Health in the same session, and because some of the events asked about all three specialty trainings, there is some material in this appendix that is repeated between the specialties. Where a comment was clearly about one specialty, we have removed the reference from the other specialty sections. When sessions were specific to one specialty, those comments are represented in that section only.*

### Dementia

**Survey result: After my dementia training, I felt better prepared in my role working with this client population:**



### Strengths of current specialty training

- Dementia patients are people. Working with dementia patients requires skills to learn how to handle the various dementia behavior without restraints and anger.
- What I learned was not new to me. It is a lot like the training from National Council of Certified Dementia Practitioners.
- Learned basics about effects of dementia and how to approach and interact with people with dementia. Have had several refresher in-services that have been helpful in understanding the causal factors and how to engage with dementia residents.
- Depression, Delirium and Dementia format is very good.
- What goes on in the brain in dementia patients. How to communicate with patients on different stages. What to expect, considering each patient is different.
- We trained for our son but also for our mother who had dementia. Nikkei Manor in Japanese nursing home had very valuable training classes that for us were free.
- One class I took shared something very significant with me and I use it when I tour family members around our municipality run senior center. The quote was, "It is easier for you to get in their world than it is for them to get into your world."
- A greater understanding for the disease
- Communication, challenging behaviors, sexuality and dementia, what is dementia
- Learning the disease process, the progression and also all the symptoms that comes with it has helped me immensely to appreciate them more and be able to provide respectful and compassionate care for dementia clients. The dementia class gave me the tool to help me work well with the dementia clients.
- How to deal with difficult behaviors
- The training was a beginning. I have learned so much just by being present a good deal of the time for the residents that reside in my Memory Care Neighborhood. I am totally into searching out on the internet new ways of communicating with people with dementia. Your video's and Dementia Care Specialty Training

manuals are a little outdated. Check out The Alzheimer's Reading Room and the book by Tom & Karen Brenner "The Montessori Method for Positive Dementia Care!

- The different stages of dementia
- Communication and approach from the front. Redirecting and being proactive to prevent behaviors & falls.
- That dementia is only a symptom of a disease and not a disease in and of itself. Understanding the differences between delirium, dementia, and depression.
- Understanding the umbrella concept.
- How to ask questions or make statements to the residents.
- I've been a nurse 35 years and so most of the training was a refresher. But behavioral interventions are a must in any training of dementia
- That we have to join their world, that they cannot join ours. Not to argue with someone with dementia, it is an exercise in frustration for all involved. Have realistic expectations of their abilities.
- How to interact with those with dementia
- It is a privilege to assist a resident on his/her journey to death by adding to his/her quality of life. You cannot do this if you do not know what type of dementia her/she experiences or what type of symptoms and behaviors are unique to that dementia.
- Patience, re: approach
- Don't argue with a demented resident, it only increases the agitation. Live in their world they live in now and support the goals and focus they have now.
- Too variable to list
- Behaviors
- Gentle deception, helping family's understand what dementia encompasses.
- Everybody is so different. Could have some same diagnosis, but be so completely different in their abilities.
- There are so many levels and types of dementia, not everyone who has the disease acts the same. The caregiver's roles are many. Knowing special communication skills and techniques enabling the caregiver to communicate with the resident and to help the resident communicate with others is key.
- I loved that it taught trainees to stop repeating I'm reminding them of things they will not remember. I thought it was a fantastic idea to remember those stories and repeat it back to them because it is a comforting memory. I feel it's very important to focus on the positives.
- I was part of the original 6-week training of the original Moyra Jones. Learning the physical changes was an important part of that training. The photos and understanding of the brain changes was very important.
- To be respectful and not to hurry or rush with the resident when communicating with them. People with dementia are people like us, they just have challenges and needs that we are there to assist them with.
- The manager dementia training was very helpful in my job as a consulting nurse. I think the information is useful for all people working with the geriatric population.
- Anatomy of brain, disease process
- Dementia techniques/approaches
- So many things!
- Many take aways from my classroom experience I apply daily in my role.
- Meeting the resident where they are at to affect a change in direction or behavior.
- The various approaches and steps to take to meet a resident.
- There is a continual learning curve to take care of these residents
- How it progresses and how it affects family.
- The class was alright, I did learn some things, but actually working in a specialty has helped more, having those experiences has helped more.
- To enter a resident's "bubble," but not endorse a lie.
- Managing behaviors
- The video-I was able to observe real life scenarios. The training was not dry and hard to follow.
- Mostly review as I have been working with the geriatric population for more than 15 years as a registered nurse.
- I took the Manager testing for Dementia /Mental health and it was a nice refresher.
- I have a strong background in dementia training and working with dementia, I felt I understood prior to the training.
- How to provide care and positive approaches to people with differing kinds of dementia
- Identification of various types of dementia and predictable behaviors
- Remembering that when dealing with a behavior you have to consider if it is a problem, and for whom



- How to listen to the resident, be non judgmental and let them do as much as they possibly can for themselves.
- Skill sets, but times are changing
- Teaching methods. I loved learning the various methods and have incorporated them into my training in not just the dementia subject, but others.
- The organic effects of dementia. The actual loss of tissue that happens. Whenever I experience a difficult situation with a sufferer of dementia I remember what is actually happening in this person's physical body that can create this behavior and I am able to remain compassionate. I believe it lessens the frustration that can occur as then my frustration is with the disease not the person suffering from it.
- I already had a good understanding of Dementia as I have been a nurse for a long time and I have always worked in the LTC setting.
- The role playing and the different types of dementia
- Learning the basics of dementia was incredibly helpful to me. When I came into the industry I didn't know anything about dementia, so it made my days challenging and caused extra stress for myself and for the residents that I didn't know how to communicate with. Just knowing the basics changed my world completely.
- It reinforced the information that I've gleaned over the course of my career. Appreciated knowing more about the several different types of dementias.
- That even though a lot of residents have this diagnosis they do not all have the same experience in their journey. You must be able to see those differences and respond to each individuals needs.
- How to deal with non-verbal issues. The different types of dementia were extremely informative.
- Strategies of communication and figuring out what behaviors may be telling you
- I learned some things about the different kinds of dementia, but honestly most of my training has come from Teepa Snow videos and live classes. Her classes are expensive, but worth it!
- Play in their world and do not argue.
- That there are different kinds of dementia but really almost all types have the same type of results and behaviors
- To listen and be very patient.
- How to redirect a resident away from stressful and/or disruptive behavior.
- Understanding the stages of dementia
- Symptoms to look for. However, may not be specific to DD residents.
- Some of the issues with dementia and sexual health have helped me to train staff how to appropriately address sexual expression and a safe environment for sexual expression
- The many different types of dementia, comparing and contrasting differences and similarities.
- Care planning strategies.
- The importance of joining the resident in the moment, even if it's an alternate reality, and to talk to fears and emotions so they can feel loved and safe.
- Patience
- I knew the information already. I have done this work for over 30 years.
- Robin VanHying was my instructor and somehow, she helped me see dementia from the inside looking out. It created a great empathy and understanding within me. As a nurse, I thought I knew dementia, but I really only saw it as a diagnosis. She made it real and ignited a creativity for working with these clients within me.
- It was so long ago that I can't express any thoughts. Sorry
- Except for the typos, the book was OK
- Patience and to agree with the resident. Climb in their bubble
- How to communicate with dementia residents
- I don't remember learning anything new.
- ABC. Role playing
- I think that the concept that behavior is a form of communication is invaluable to all the specialty training.
- The different stages of Alzheimer's, the behaviors associated with each, and why those behaviors make sense -- leading to good interventions.
- To be with the person who has dementia in their reality. To engage them where they are.
- Able to understand what is Dementia, how to deal and what to expect from the person who suffered from it,
- Situations that can cause fear with clients - especially environmentally

- I took it so long ago that I do not remember. I learned more about how to care and work with them when I started to care for them
- That a sense of humor helps!
- Advising staff on keeping a routine for the client. Making adjustments for clients' new life with sun-downers & meals at different times than the other household members.
- Procedures of interaction with persons with dementia.
- Probably the tool of listening close and spending time. Giving them your full focused attention.
- Behavior management and how to deal with people in crisis. How to determine causes of unwanted behavior and how to deescalate a situation.
- To focus on providing moments of joy—then you will never do the wrong thing
- I watch the staff when teaching the class, the questions they ask give me insight into what problems I will run into later. Listening to the questions helps me know what additional training or operational changes may need to take place to give better care.
- Skills to communicate and deescalate – role-playing was most helpful.
- What I learned most was OTJ by helping nursing assistance manage residents with dementia. Getting my own hands on and personal experience. The class can give you ideas and suggestions but the hands on experience and working with experienced staff that really increased my own knowledge.
- Strategies for communication, nature of the disease, understanding what it does to the body
- I think students really enjoy the theory and science, but get the most out of gentle care and validation therapies
- Effective communication, ideas for re-direction. Disease process
- Ongoing reminders/discussions/training.
- Learning how to redirect and when to step back when needed.
- Redirection instead of overmedicating. (Frankly I really don't remember if I learned that from the dementia class, or just experience.)
- Role playing was very helpful
- Understanding the behaviors and progression. What to expect. How to care for a person with dementia.
- The training could have had more information in regards to people with developmental disabilities, especially since this is a growing area and new to many caregivers.
- I have most recently attended a conference on the "Namaste" approach to care of dementia residents which I am encouraging in my consultant visits/reports to facilities. Human touch and one on one care in an environment that supports touch, sensory, relaxation & quiet time have been found to be successful in supporting both resident and family.
- The different types of dementia, and how to respond to questions and behaviors.
- Basic differences in various kinds of dementia
- Basic understanding of how the resident thinks and feels.
- That people with dementia do not see things as others do and that how you approach residents is very important to being able to help them.
- Understanding the journey our residents are taking, the characteristics of a mental health resident, how to "enter" their world, how to redirect and how dementia affects the brain.
- Learning the different types of dementia was helpful. But, it is very hard to get a physician to get past just giving the diagnosis of dementia or Alzheimer's Disease. If I ask a doctor what kind of dementia a resident has either I 1. Don't get a response, no matter how many times I ask. Or I get 2. Why?. Then repeat at 1.
- How to manage behaviors and effective interventions for behaviors related to dementia
- We have the lengthy 4-day curriculum, but need up to date information on the shorter version of this training that can be offered to employees.
- One thing that I learned from the training is that one size does not fit all.
- Understanding of dementia, how to care for individuals with dementia
- How important it is to use distraction when dealing with different behaviors. How important positive body language is.
- How to talk to those residents and to help manage their days
- The different types and behaviors that go along with each type.
- Diverse ways dementia can affect cognition, rather than just the "short term memory loss" that is so well known.
- I learned a lot about non-verbal communication and how it impacts the dementia clients.

- I am not exactly an instructor, I have the manager specialty training certificate but because I work for a training facility I cannot teach the class as anything other than population specific. I learned a lot in his course, the causes for dementia, the differences in symptoms and approach and stages of dementia were all useful.
- Most all of it.
- It didn't impact my role as an Administrator, but in guiding my staff it became apparent that working with dementia care was / is vastly different from working with mental health issues. Obviously sometimes there are co-morbidities that make it even more interesting. Just enabling the staff to understand what the individual(s) may be perceiving, and how to actually communicate the intended message was a huge help to my staff.
- Person-centered care; validation techniques; empowerment.
- How to approach residents with dementia, dealing with a resident with dementia who is angry or confused and resisting cares. Helping the families understand the disease process and coping skills.
- How to deal with behaviors
- Working with difficult behaviors
- I will be teaching it and the instructor was very helpful to point out the difficulties in the training manual.
- Reiterated what I have learned and know from 20 years of dementia work.
- To know what do for the person with dementia also how to help the family through this area of live.
- Last 28 hours it was awesome
- To be patient and that every client is different and not all the same
- Learning about ins and outs of dementia and learning how to deal with patients' assets.
- Goes to school for RN program, how to speak and understand the people that were suffering for dementia.
- All of it
- She had stuff out of book, some slides, Lorri when she lectures - it's a favorite part and gives her insight - stories of past experiences
- Lorri was engaging and a good instructor.
- The best thing in the book is the umbrella. (page 2)
- I think it's good now. I would require all staff that interact with dementia residents to take this training (i.e. Maintenance staff, dietary workers, house keepers, etc.).
- It's fine now.
- Nothing, actually! My trainer was D'Sandra Simmons at WHCA and she was incredibly thorough.
- I think the training was comprehensive.

### Specialty training challenges or deficiencies

- Not ready when they leave the class - not truly 'specialists'
- It hasn't been very beneficial. I have a degree in psychology and experience with long term care.
- I have done significant independent research and study for the last 10 years. I can't honestly say that I got a lot out of the manager's specialty training in 2002.
- I didn't learn much. I took a CNA class a few years ago, and it didn't teach me anything I hadn't learned there. I felt like it left out a lot of helpful information.
- Very little. It is a requirement from a funder.
- Honestly I think the Teepa Snow trainings are what stick with me more than the state mandated trainings because they are so experiential and creative and she has so many engaging examples---the instructor needs to be dynamic
- I did not think that the particular training offered was very good. However, I have attended several other dementia trainings, conferences and workshops.
- Simpler information - what are symptoms and what to do about them; not so much technical detail, definitions etc.
- No everything well covered
- She does a good job to prepare, but there is more to learn on the job but can't really teach it in the classroom
- Hasn't been working in the field. In the future maybe. Currently working for tips.
- Bring real life examples into the class. One benefit of facility-based instructors is that they can see how learning is getting applied and refresh learning as needed.

- Key to focus on behaviors - Who is it bothering? Is it a problem for the resident or others, or is it just bugging you?
- Really struggle with 'gentle perception'. Get hung up on people "lying".
- We find ourselves teaching common courtesy when we should be teaching about schizophrenia and manic depression.
- Fundamentals of caregiving - there was a precursor to that when it was established at first.
- In terms of clients that have schizophrenia or bipolar, remembering that they don't have dementia - there is some difference. Reporting any changes in behavior to the charge nurse or their supervisor.
- Video is awful regarding sexuality - because it comes from a "shame on you" perspective
- Consider a more modular approach
- Also needs to include licensure requirements. Need managers, in particular, to understand how actions may impact facility/job.
- The majority of the behaviors come from us - we create the behaviors. Acting that out isn't going to get you down at eye level. You need to understand why you need to do that.
- The course has good content.
- Coming from a more practical aspect - whatever you do, please do not make it longer or more expensive. They [providers] can't afford the time away from their jobs and the added tuition. They really need the hands-on more than the differentiation.
- Some providers would like to be able to focus their staff's training on the particular forms of dementia that they have in their facility, rather than having the training survey all of them.
- For dementia units, really focus on things related to dementia.
- If you take these diagnoses, and make them specialties... and homes could focus on one specific kind of diagnosis. The caregivers are so overwhelmed that they aren't going to remember [otherwise].
- When I am teaching, I find out what is in that home, and focus on those areas so they can relate to what this is. It's great that you have it all in there, but I agree that it's long, and especially when you get in certain areas I see them nodding off.
- Some have found that the stories, scenarios and role-playing work well, including the use of actual scenarios that have happened.
- It would be helpful to have standardized tools that would help caregivers understand which tool to use with a particular kind of behavior, regardless of the diagnosis causing the behavior.
- Spend more time instructing caregivers how to be proactive - approaching the residents better and setting up situations where problematic behaviors don't emerge, rather than so much of the curriculum being focused on responses once the behaviors have occurred.
- How are we going to respond should [come into play] after we work to prevent behaviors.
- I think we would like strategies, techniques, and hands-on approaches to be addressed more in the training. I have never had a caregiver be excited to learn the names of the diagnoses; they are excited about practical things they have learned."
- The curriculum should openly state that the caregiver should "demonstrate love and care.
- Curriculum could discuss how to choose whether to use language or non-verbal communication.
- Environment isn't really listed in the curriculum. But there are a lot of sensory and environmental considerations like mirrors or how dinners are arranged.
- I think the training tries to put too much content into too little time. What you leave with is limited.
- I think you need to broaden the concepts. There are so many different ways to do the same thing. The state teaches one way. Training does not focus on the fact that you can have three types of dementia in the same person. Teepa Snow is a great trainer and recently she has focused her training on the part of the brain that is not working. It is s a more logical training.
- Dementia training may not be introduced to caregivers soon enough. Real-time feedback is needed to help caregivers improve care.
- Training is mandatory. We do much more training in our home then the dementia class. Training needs to be on the behavior not the disease. We do OJT and 4 days of orientation.
- We have to do the mandatory training. We supplement with additional training throughout the year and focus on different aspects of dementia and care at all levels.
- It is not economically feasible for all caregivers to have the training time needed. The current training is not sufficient.
- What does it mean when you say we have dementia experts on staff?
- Continuing education on Dementia is expensive.

- I am a trainer and we get young people who do not know anything about dementia. 8 hours is not sufficient to teach someone who has no experience with dementia.
- Dementia training does not address earlier onset dementia at all.
- Dementia previously 40 hours - test was 4 hours. Each type of training lasted a week. (Interest in extended training. If training isn't adequate, requires more OJT.)
- Feels like caregivers are short-changed in the information that they need, which ultimately shortchanges the population under care.
- Need to match requirements with time allowed.
- Interest in moving toward online option.
- One trainer stopped using manager material altogether. Or - another trainer teaches manager material to everyone. (Heads nodding for both pathways.)
- Need training to be more focused on real skills, knowledge and understanding of what they need to do to deliver good care.
- Managers need help in managing and supervising caregivers. E.g., What do you do when caregiver is taking wrong approach with a client?
- Need to clarify intended difference between manager and caregiver skills and training
- Change content of core training, then offer more detail in specific types as CE. Everyone can use refreshers. E.g., California requires specific numbers of hours to maintain 'specialty' designation.
- Key points from Teepa Snow - 'space matters' and 'how to approach'. Also use her material on amygdala, fear and anxiety - and how to help residents deal with it.
- Need to cover hallucinations and delusions more - trainers add own content and scenarios. Challenge in both dementia and mental health residents, but recommended approach may be different - gentle deception vs. Reality based.
- Curriculum was pretty good at the time, but is not current and evidence-based.
- Helpful if training were more consistent - so that home owners or administrators can rely on what people have learned, regardless of where they were trained (many examples of customizing the training by instructors)
- I think it's important for them to understand the diagnoses so they can understand why they may act a certain way.
- I find caregivers often struggling in interpreting what they are attempting to communicate, even if it is non-verbal. A lot of times, it is more body language.
- With non-verbal clients -- I don't know if its in the training or not, but they need to understand what the cues are - they are the same as a baby. They cry when they are wet, they cry when they are uncomfortable, they cry when they are hungry, they cry when they are thirsty.
- The current training is quite complicated for entry level workers... it gives them a whole lot of ways to look at challenging behaviors. A lot of it will be over their heads.
- I agree that having a good fit between the caregiver and the resident, but you need to pull the family in. So we are all a team. The training covers it a little bit, but not much.
- The shift across our industry is person-centered care. So this training is a good place to jump into that a little bit. The more you know your resident as an individual, the better you will be able to provide care to them.
- The person-centered care approach, and how do we do a personalized care plan?
- How to deal with conflict between residents.
- An issue that comes up a lot is assault. Often it's my feeling that we have clients who aren't really capable of doing harm - knowing what is dangerous, vs. Expected behaviors.
- Caregivers need to understand that reactions are not about us, and what is an appropriate reaction and what is not.
- Dealing with the risk of violence - I wish I could see something that defines violence vs. Behavior.
- More of this: Module 4 -- Creative approaches to challenging behavior
- Caregivers need to learn to document their work. There are different requirements depending on what setting you are in.
- Documentation is important. The residents are in a state of change, so it needs to be written that we could see the change when they are living with us.
- Complicated feelings based on transitions can make behaviors seem more pronounced, especially when they are new to the facility.
- Overall knowledge of the particular condition. Many people who work in the system do not have a fundamental understating of the illness.

- To have a resource available to call 24/7 when situations arise. This is after basic training of course. I think a 24/7 resource is important. A pocket guide would also be good.
- Providers want to do the training themselves, I do not agree with this. Another training item to consider is how well providers can relate to their staffs that do not speak English.
- Training does not address an understating of the complexity of the individual we are talking about. The basic motivation for an individual to take on this task (type of work) is an important place to start.
- Language proficiency and cultural competency.
- I think initial baseline training is helpful. But sometimes you do not know what you do not know until you are in your home applying the skills you have learned. As people gain experience and knowledge I think we need a different tier or training to build on the base.
- Technical assistance after the training when you are in the setting is very important. On site consultation and training needs to take place at the facility.
- Caregivers at a memory care facility, in my experience, receive more training. For example, we do refresher training annually.
- I am hearing a lot of siloed views. We act as if the people we are providing care for are not part of the training.
- Twice a year we do refresher training for dementia care. We cannot break up the specialty curriculum training for CE. The WAC is written and says we cannot break the training up.
- It starts with listening to and attending to the person. Specialty training needs to include how to actively listen.
- Approach is everything. The approach is based on the assessment driving the behavior. Not just the formula. The supervisor or the lead has the knowledge and can coach the caregivers on what to do if they do not have patient knowledge.
- AFH employees do have a requirement for continuing education. I do not think it is the state's job to verify individual training. I do think it is the state's job to verify each AFH facility. In an AFH, I think most of the training should take place outside of the home.
- We should not have a cookie cutter approach to training. AFH should be different. There should be checks and balances. I think they should check training annually.
- Both approaches of training are needed. In-home and external training is important with the team that is going to work together.
- We should include that the person can recover in the training. Currently, no one imagines they can get better.
- I have been a volunteer in AFH for almost 50 years. What I see is people do not understand or are impatient with people who have dementia.
- Facilities are promoted as having specialty training, yet people with dementia are asked to leave.
- As a staff ombudsman, most complaints are behavior related or discharge related because inability to mitigate behaviors. There is a training gap to deal with behavior. The rule is broad when it comes to discharge (a danger to self and others). There is a lack of knowledge of continuing education to improve the quality of patient care.
- There needs to be a higher-level requirement for training. The minimum is not working.
- I think the caregiver needs to go beyond the 8 hours of training to improve quality of care. The ability of the provider to delegate knowledge is not working.
- When I go to a home the owner is not on the premises.
- Currently, I think owners and care mangers struggle with the person. They need more assistance.
- Yesterday, I went to an AFH and AMR was trying to get these women onto the gurney. The provider asked me for help. She said I do not know what to do. This is an example of a provider who did not know what to do next.
- My mother is in an AFH and I have received calls reference to my mother asking me what we should do to control her behavior.
- There is a growing enlightenment of how to care for people. The current model is a medical model. The future model should take into account the whole person. Long-term care is a person's home and should focus on maximizing independence and help people live out their life. Training should be more trauma informed and be more experiential vs. Medical.
- Training could be enhanced by including how to be a care partner and help people live out their lives in long-term care. Design services based on the people in the care taking their life experiences into account.
- Caregivers need more continuing education updates and training in the caregiver's specialty.

- My mother was attacked in 1944 by a black person and now that she has dementia she is deathly afraid of black men. The AFH said we see no color here. It is very hard for my mother to live in this environment.
- Just saying 'I have a certification in dementia and I can handle it' is not enough. The environment is constantly changing and very challenging for caregivers.
- In AFH, patients can be discharged in less than 30 days in the home. We need to provide resources so caregivers know who to go to in the event of these crises. We need to increase the level of financial support for Medicaid residence.
- Training should include how and when to recognize that you will not be able to care for a person.
- From a family member's perspective, the AFH is not notifying us about charge increases, etc... I would like to see training that includes rules and regulations about interacting with family members.
- Specialty certification is misleading residences and families.
- I think specialty training should be opened up to family members.
- The person-centered approach should be the focus of the training model, not the medical model.
- Provide resources to families looking for placement of a loved one. If you have money you can use a placement agency. If not, there are no resources to help families.
- My mother was diagnosed with dementia and it turned out that she was dehydrated. Understanding the signs and symptoms of dementia and dehydration are important.
- There is too much information to learn in only 8 hours of training. More time is needed to discuss each topic, ask questions and go back and forth to ensure learning.
- Is it unreasonable to have field training in addition to the classroom training? How can we put what is learned by caregivers into practice?
- Asked for feedback from owners - would like evening and weekend classes, or to have trainers come to their homes
- Others noted they do offer evening and weekend classes
- Offer online class, then go meet with real person for assessment; would allow for self-pacing and more time to digest information (could have a blend of both online and in-person)
- Some people prefer a live instructor so they can ask questions
- Can't think of any part of the curriculum that is not essential, but key is in how they apply the knowledge and really interact with people. Hard to find/identify people who care.
- Big difference between head knowledge and heart knowledge.
- Need to connect to real life experience; like videos that present scenarios and how to handle them
- What gets in the way?
- Cost
- Time required
- Don't really address exceptions ... not everyone starts from the same place
- More difficult for AFH to cover staffing; may not be computer-savvy
- Helping caregivers manage their own lives - help them set boundaries around the job; how to deal with death and dying
- Care Plan and Assessment (of residents) is not part of the training. Need to learn how to connect the dots and think critically about what is happening, what needs to happen next.
- Help in managing your own behavior when residents going out of control
- Make sure scenarios reflect real life. E.g., "take her for a walk" may not be possible because 1 caregiver is responsible for 5 others.
- May need to help managers/owners be better equipped to evaluate who/what they can handle in their home.
- Understanding baseline (e.g. Schizophrenia). What is typical for this individual? What behaviors to expect or look for?
- Same curriculum for ALF and AFH - very different models and needs
- More coverage/better understanding of behavioral manifestations - linked to care plan
- Communication training really lacking - with residents, family members, resources, etc.
- List of different disease types very confusing and not practically useful - covers too much territory; focus on most common processes and issues that come up
- People need to go beyond basic preparation, regardless of training, to take on people with dementia or mental health issues.
- Practicum is important. Learning from books or lecture doesn't translate into real life practice. Must be usable information.

- Gerontology - needs of elder adults are specialized. Many have multiple chronic illnesses. Adding dementia on top of that requires specialized training/skills.
- Beyond basic levels of care (ADLs), not sufficient for helping those with dementia or mental illness.
- Nursing home administrator asked for more dementia training for nacs. Went beyond dementia specialty training - really lacking.
- Finds Teepa Snow material very useful. Takes 8 hours to see all of her dvds. Attitude changed based on her techniques - provides visual and verbal guidance. Helps them in solving real life problems. Helps them understand where the patient is coming from.
- Works locally with a Geriatric Interest group. Get together once a month to discuss issues with our industry = grassroots. Spokane Regional Health is a great resource. WHCA. Leading Age.
- Content does a pretty good job. Touches important factors
- Doesn't use DVD much.
- Corporation has a lot of its own training - have memory care facilities. High value in training, may use some of that training.
- Like person-centered care, communication, understanding disease.
- Training on interacting with family members and their needs for emotional support around end of life
- Per trainer - the training is boring! Outdated. Too much medical/intellectual material. People do it because they have to - not because it is useful.
- Needs to be more practical
- More to the point and hands on - was a lot of paperwork and reading
- Need to be able to hire the right people, right personality
- Training doesn't help caregivers understand what is happening with the people they are caring for
- Discussion about empathy - training should 'teach' or at least 'wake them up' to understanding the other person
- Need to blend both sides - understanding the person as well as giving caregivers technical skills to handle situations as they come up
- Mental Health and Dementia courses too similar/redundant.
- Too much like memorizing material in high school to pass a test.
- Training for Ombudsman - may come in to interview/assess dementia residents, but the ombudsman doesn't have appropriate skill for working with person with dementia and causes new problems
- Understanding how diagnoses manifest - what comes up?
- Understanding paranoia, delusions, appeasatory behavior, refusal/isolation
- How to handle physical aggression, prevent falls - issues that tend to keep people out of homes
- Acquire Training has good programs, anyone can use (CES)
- One of the biggest things is to recognize that book was written a long time ago, and we have new information. Frontal lobe dementia is not even covered. We talk about all of the dementias in just one module. Once I get that good foundation, then I can breeze through the rest of the course.
- Update and expand on Module 1.
- Gong forward, the behavior module has some good ideas, but they are so far off from the real world - they are so technical that they don't do the basic problem solving that we used to do in the old days. We need to do it in a much simpler form than it is now.
- The communication module - has good ideas, but I don't like the layout - it's a little cheesy.
- The rest of the book is OK, not so bad.
- As long as you highlight some of the good things as an instructor, you can use those modules
- I would add pieces to "check what you have learned so far" because we have eight hours with them, and then we need to take the final - to make sure they are grasping the content as we go.
- There is a whole segment on skills and it is set up so awkwardly, and we have so little time, that we end up jumping over them.
- They have a general overview, but where the rubber meets the road on how you meet these behaviors daily. It needs to be more specific.
- Also redirection - to keep them from abusing each other. That should be covered more explicitly. Keeping them involved can work both ways - it can keep them involved, but also keep them from having that extra time to hurt each other.
- If somebody has hitting behaviors, you need to protect other residents, but you also can't isolate them.
- If you are only going to have dementia patients, you are going to need more staff.
- Behaviors.



- I would agree on that - there are a lot of caregivers are requesting dementia training - I was referring to additional training, because behaviors are the issues.
- In our area, it seems like the more training they get, the more they want. And the variety of behaviors, it seems it can never be addressed enough.
- Hospitals want to know why a resident comes to the ER and the home won't take them back... Preventing that is a total work in progress.
- How to relate to people with dementia in our population - whether the behavior is based on dementia or their developmental disability, it causes confusion.
- There is a disconnect between going to the training and providing the care where the behaviors occur. Once they start applying it to the actual need of the resident, there is more to be done.
- For us, we come across decision-making a lot. What happens... and that leads into "there is no power of attorney", so we do guardianship trainings, and it comes up. Those things that come up because they aren't adjudicated... they can "make an x" on a form, but what does that mean?
- When they get to the level of frustration, it only irritates the client. Deescalating in response to the behaviors.
- Some could benefit from "Dementia Training II." I can't imagine that all the stages are touched on in our fairly quick specialty training.
- A lot of issues are caused by lack of knowledge.
- We see often that the ISP has been reviewed by managers or owners, but the staff has not.
- We work with a few that have a lot of staff turnover, and people don't all seem to be on the same page in that home. And there is no chance to develop a relationship.
- A lot of our individuals need consistent, stable environments - an understanding about routine. Routine change can cause big behavior issues.
- There is still a tendency to line those clients up by the nurse's station to keep an eye on them, and I think the activity department is stretched to provide the constant stimulation that those residents need.
- For those facilities that don't have a designated dementia program, if the residents are up at night, the staff aren't really equipped to be giving one-to-one care to the residents.
- Behavior interventions by staff... they need to remember to approach the clients calmly and speak slowly. Sometimes staff give a bunch of statements and direction to a resident who isn't able to process that information... they need to remember not to rush them because that can be frightening.
- Staff rushing clients through Activities of Daily Living like bathing.
- Staff becoming frustrated with clients who are frequently calling out, or maybe have repetitive statements, or constantly using their call light even though the staff member was just in there trying to meet their needs.
- Sometimes during meals if staff don't continue to encourage a client to take food, they are less likely to eat as much as usual.
- I don't think they have a full understanding of what dementia, mental health, or developmental disabilities are. When I got trained, it was a week, and I didn't have a full understanding until I was out there meeting residents.
- I am almost in shock with the limited information that is known about general care of dementia patients.
- Then if you add TBI, we have no resources in our area, and folks feel like they can treat them like a dementia patient, and that's a huge miss.
- I think the primary thing is that they are not allowed to have a locked facility so they either need to have the one-on-one situation that takes away from the other residents. If they have all dementia residents... it can become too much. Some providers don't want to take those clients, because they can't afford the staffing to give that one-on-one care.
- We have homes that have huge waiting lists because they cater to those clients, but a lot of times these clients are not able to access the services they need.
- Our specialty doesn't deal with high acuity... once they have higher medical needs, we don't have a good program to transition them into.
- There is some basic overall knowledge with AFHs that do try to fill those gaps. They have the specialty training, but they may not have served those clients for some time, and they may not have basic processes in place.
- Speaking English so they can even learn what we are talking about that.
- Right now I have a specialty training going on, and two ladies are going to fail the test, and it's because they don't speak English.

- With elderly dementia population, I have been in homes where the clients have significant difficulty understanding folks with accents. And the resident can't then relate to the caregiver, and become self-isolated.
- I think that these specialties require 12 hours of CE a year. You have to take continuing education in those areas of specialty in order to maintain that specialty and keep up with the changes in the specialties.
- Sometimes the training they take is related to the specialty designation, and maybe there should be something that requires them to have a designated number of hours for the specialty training they have. Per year out of that twelve hours.
- Most adult family homes do not really have a clear understanding of dementia - the symptoms, or even the basics. Thus, they don't really contribute much to the resident's quality of life
- There aren't many activities, even though those residents could participate.
- Caregivers and providers need to have an expanded knowledge of dementia, the different forms, the aggressive and/or placid behaviors.
- They need to have a fuller education.
- With the added knowledge, they need to know how to communicate with medical people - doctors, etc. Describe the symptoms and prevention. The (lack of) advocacy with doctors is a problem.
- Wandering behaviors - I think there's a lack of knowledge... but we do find locked doors
- If the staffing levels aren't high enough... providers need to understand that, depending on the dementia behaviors, a one-staff-run home isn't appropriate. They need to know how to scrutinize referrals better, or assert that they can't manage the care when the symptoms increase. That may mean a negotiation with state social workers on rates.
- The risk of the resident is much higher when they elope, and sometimes the calls are not made soon enough. They don't seem to understand that the resident can't function as well as they can in the controlled setting. You see this with DD and MH too.
- Those folks with mental illness and DD also develop dementia.
- Anything to do with understanding what behaviors are. They don't have knowledge of how to deal with things that are disruptive to the pattern of the home.
- They can't recognize that what they are doing affects client behaviors. They may be causing behaviors, and because they don't have a good understanding, they don't recognize that they are doing that.
- Even when they have been informed by the resident's loved one how to respond, sometimes that information is ignored. They tend to think that they have the knowledge. They think that they know how to do it better than somebody giving them the advice.
- If we did some really good training with modeling, and then follow-up with those caregivers. The provider could have a chance to model some behaviors, take it back to the home and test it, then teach it. And then come back to be assessed to see how they are doing it.
- A follow-up training or follow up visit - that would be excellent if they could incorporate that in all three areas.
- Also: more specifics about some of the specific diagnoses, along with typical behaviors to give them a better education about the differences.
- Also: some detail about what is more effective than other approaches. Sometimes people are doing the things that don't work for a person and they might be causing the problem.
- The other thing... I have run into people who took the training years ago and they need a refresher training.
- Something that would be really interesting is... if some AFH owners had an opportunity to enhance their learning style and become trainers themselves, then they could become a resource for a catchment area or a zip code... (they could) build a support system between AFH providers that wouldn't cost any money.
- If there was a mentoring kind of thing, that would be really good. And it wouldn't cost more.
- It's like anything... they need some resources that they can call on that they feel comfortable with. Peers would be good.
- I would say that I have witnessed them struggling to come up with activities for persons with the illness.
- I have seen them struggle also with customizing activities for different levels of the disease that affect a person.
- The biggest thing is dealing with some of the behaviors and not being able to address them.
- I think one of the struggles we see specifically is the lack of skillset to deal with wandering behaviors
- A lack of skills to deal with clients calling out or screaming at night during normal sleeping hours.
- The area differentiating Dementia, Delirium and Depression can be confusing
- The trainer must be effective as a teacher, experienced, passionate.

- There is a lot of topics that are covered, almost too much information in one day. Suggest the class be over a couple of days to prepare for the test.
- In the case of my mother who has lived in the same senior residence for about 10 years receiving increasing services for her dementia-related difficulties and problems associated with osteoporosis her personal and cultural history often offers a good deal of insight on her choices and behavior with respect to her fellow residents.
- I feel it is always changing and one should update every year. There are classes available for free as I said that are incredible. They are also offered at both Northwest hospital and Stevens hospital.
- No one wants to admit that we are getting older, but we do. Perhaps a feature film presentation about dementia would help.
- I don't feel that the skills portion is effective - I feel it is more important to dedicate time to the disease so that staff have the tools to formulate approaches to situations.
- Include: Different stages, mental health issues related to Dementia, Sexuality related to Dementia, family support
- The manager's test is awful!
- To continue to encourage people to register and study the book before class time.
- All of the above mentioned
- Update your manuals. Update your videos. Refresher courses are needed. How about a quick reference guide for staff to carry around in their pockets for communication techniques
- I feel that dementia training would be better served to be DVD verses books. Staff would better be served to see and understand the way dementia can look
- I like to make it facility specific. I believe I believe caregivers have a better understanding when they see real life situations and individuals.
- Add two more hours to teach the basic causes of various types of dementia along with some basic anatomy and physiology. This would allow the students to better understand why they are seeing the various symptoms and behaviors in the people they are caring for.
- Give more real life examples of how the teacher handled difficult situations.
- The training could be up-to-date
- Touch more on family denial of dementia and how to deal with the families of those with dementia, as for the most part families are lost and do not understand basic dementia physiology. Famous words of the family "Don't you remember?"
- I would like to see interactive ONLINE training. Please, please get rid of the role playing - the students hate it, and therefore get absolutely nothing out of it. Their time would be MUCH better spent watching high quality video of someone who actually knows what they are doing.
- The use of medication is sometimes necessary for their quality of life when they are in the later stages of dementia. It is important to give them quality of life, keep them safe and those around them.
- Make sure all the educators have same knowledge based information. If teaching specialty the educator must be passionate about his/her work.
- Online courses
- Have a better way of skills testing
- I would open it to all levels of participation & employment.
- Place focus of training on how the caregiver can place themselves "in the shoes" of the resident. Change the perspective on the care that they are providing.
- I want my mother's caregivers to be able to take this training online. They live in a remote location and are single parents working multiple jobs. They can't take time off work or afford the expense of travel to go get this training so they put it off or change employers so they don't have to do it. This is not okay. They need to have a distance learning option. Because they can't afford to pay themselves, and the owner won't pay, if they stay long enough the owner "trains" them. I did not say who my mother is or what AFH home she is with because I want to say that the manager says they cannot afford to send folks to training so he/she became a facility instructor and now just hands the book to the staff member, tells them to read it and then gives them the test. The staff tell me they are supposed to take it in class and the manager just tells them to tell the surveyors they did if they ask. I don't think their training is adequate in that format. I want them to have interaction and discussion. I have finished two professional degrees online and know that online training can be interactive and has actually been found to be better than classroom training. They have found that learners are more engaged because they are in the classroom when they want to be there. They can choose times when they are more rested, focused and ready to learn. They can also repeat and review

areas that they might miss in a one time verbal presentation. This is a particular benefit to caregivers who have English as a second language. To confirm for you that I am truly a family member, my mother has resided in this northwest WA AFH since 4/18/13. There are a total of five ladies in the home and it is licensed for six. The home has been in business since 2008.

- Nothing
- My training was very thorough. Because of the many stages of this disease it is beneficial to be educated in sections. Do not move on until you feel you have gained the knowledge from the previous section.
- I thought the training program was efficient. Maybe they could give several examples on how to positively redirect clients.
- Incorporate more video studies of the changes that residents with dementia face.
- Have the ability to include people with dementia at the time of training.
- More training is needed on understanding behaviors and aggression and how to manage them.
- The importance of care staff knowing the personal history of each resident.
- I would allow more community educators so we could actually do the class in person with the caregivers and act out the scenarios etc. The interaction and stories between the caregivers was so helpful. This on-line and self-study prevents any of that.
- Rewrite the tests
- Frequency and locations of training.
- Spending time in a care community of different behaviors and coming back to class setting two discuss
- Have more examples of actual people.
- Adding the virtual dementia is what we will be adding, we already go over the history of some of our residents, building a care plan is something we are looking into and the mock discharge plans so we can talk about why we would accept this person or not and how we determine during the assessment process of how we can make their move in and stay successful, while also taking care of the family members, how to support them.
- Improved access. Content is fine.
- More focus on resident rights despite what family demands, the difficulty of moving a resident out of long term care, interventions list, Guardianship versus Power of Attorney
- Required material taken more seriously to be completely covered, not skimmed over and signed to appease the state requirement
- Focusing a bit more on what options are available for end of life grief counseling for staff and clients housemates.
- More role play scenarios
- Mental health issues vs. Memory care the challenge of serving a resident with both
- Probably wouldn't hurt to allow more time. People tend to do worse in the dementia test compared to the mental health specialty test.
- Population is aging beyond most folks expectations, Additional training taking into account the effect of Dementia on even an older senior.
- Realistic demonstrations of the various behaviors caregivers can expect to see and how to respond to those behaviors.
- Continuing education and "road shows"
- More time spent with the different types and the effects. Family dynamics perhaps. Techniques on coping with the frustration
- Not so long and the test needs have clearer questions especially most of the caregivers are not use to T and F questions they almost always do better on the multiple choice.
- More frequent classes offered in our area. The cost of private training is challenging for caregivers
- I think it should be a higher priority for ALL the staff, not just key positions.
- It was long enough in the past that I don't have enough recollection to be able to answer this question.
- Have what they need before they need it ! So much is done reactive
- Have more examples of different dementias.
- See above question 14 add a real life scenario and they need to fill out a bio on the resident.
- The class is well organized and has excellent information. Would love to almost make it a 12 hour course
- Would recommend Teepa Snow videos for the lessons.
- I think it is fine, But this training must be an ongoing training to get the most knowledge.
- Teach caregivers how to diffuse situations that might arise with a person with dementia.
- Incorporate interactive training

- Any new info concerning DD people with dementia
- I feel that Teepa Snow and her approach should be added to this training. She has true insight and an invaluable approach to training about this population
- More time for scenarios, avoid using the DVD and have a meaningful interaction & lecture process.
- Nothing!
- Focus on having caregivers observe and report symptoms and behaviors, not diagnose. Caregivers do not need to know the difference between dementia, delirium, and depression, for example. Their job is to observe and report what they see to professionals. Provide real-life situations and helpful strategies for difficult situations.
- If it could be online, I would expand it to two days and provide more time working on creative solutions to challenging behaviors. If it cannot be online then I wouldn't change it.
- Examples of situations and how to handle them.
- Add more life enrichment or activities, show more videos less lecture
- I think we should use Teepa Snow's "Accepting the Challenge" training DVD as our core curriculum.
- Understanding fear that causes client to strike out during toileting and shower.
- Dementia can cause swearing and diatribes the client would otherwise never do.
- Clients' needs for human touch and affection.
- Give real-life examples, not just textbook one with simplified answers. Many of the staff taking this course are already working with residents and need some real, translatable interventions not just good, intellectual ones.
- The manager test is poorly written and scored. Needs immediate rewrite. Use Teepa Snow videos instead of the current videos.
- To improve the future caregiver on how they can take care of the resident that is on their younger age and their ways of living.
- Less focus on memorizing diagnoses and more on client care
- Let the people you are training work in a home for a while so they can have hands on experience. They will learn far more that way then any book can teach them.
- Concentrate less on types and medications and put more emphasis on how to create less stressful situations with more examples of what might work.
- Separate training for those that work in DD group homes. Emphasize the types of dementia commonly associated with people who have other developmental disabilities such as Downs Syndrome & Parkinson's disease. Our clients have developmental disabilities as the primary diagnosis.
- Explain the necessity of learning the resident's past, both likes and dislikes, mode of operation, etc. These people are individuals and need to be treated as such.
- I can't think of anything
- Require it for all direct care staff including RN & LPN's
- I would increase the "hands-on" related to specific resident examples. It is one thing to be talking about a resident situation from the book, it's even better when I can say, You know when Mr. X does this...what have we done? What should we do now that we understand what's going on?
- Spend time on the importance of communication - maybe even provide a test on communication as a prerequisite before taking the class. If students do not pass, then they must take a class until they pass the examination on communication. It is not about their deficiency in the English language but they must be able to communicate clearly to a population who are already vulnerable due to their cognitive impairments.
- Cultural education, de-escalating techniques
- Include current videos and topics done very well by HBO and the Alzheimer Association.  
[Http://www.hbo.com/alzheimers/the-supplementary-series.html](http://www.hbo.com/alzheimers/the-supplementary-series.html)
- Also include the 12 minutes of dementia demonstration. [Http://www.youtube.com/watch?V=LL\\_Gq7Shc-Y](http://www.youtube.com/watch?V=LL_Gq7Shc-Y)
- Make it more interactive with real situations experienced by staff.
- How key confidence is. The only way we get better and more confident in dealing with cognitive impaired individuals is repeated opportunities to work with them and build a strong skill set.
- I would like to see some videos added, for example, "Bathing without a Battle."
- I would make it more relatable. Every resident with Alzheimer's or Dementia are unique. You cant possible understand all types of dementia in just one class. There are so man techniques that can be brought to the table.
- Needs to be in Pacific County
- Encourage a team approach in the delivery of care. Create a Person Centered Care Philosophy for your facility.

- Make sure staff have a role in improving delivery of care by sharing "what works" with each resident in their care with all team members, this consistency truly supports quality of life for the residents.
- As much as I enjoyed the video, I would have also liked some discussion.
- I think hands on practice with residents or those playing parts of residents to really get some experience. Not just lecture/book work.
- Online training would be helpful for rural areas
- More time working with a lead before being put on your own.
- Have more discussion and maybe try some exercises.
- I believe that there should be communities (that receive compensation) that these types of classes can be held in. I believe that, just like with clinicals, you learn so much better, when you can actually see it first hand and have the resident's be the teachers for an hour of class, maybe during lunch. Have the student(s) pick a table and visit with a resident at lunch. Not feed or work, just visit. And watch the caregivers interact. Then you could take the class back to the room you are occupying for class and discuss challenges, observations, if they think there is a difference with the types of dementia and answer questions.
- Add the different types of dementias, causes and expected prognosis
- There are several errors in the video that raises concern such as talking about clients in front of other clients, uses phrases that can be misleading to the client, etc. I think the video needs some review.
- Less video time.
- More active participation in class.
- Use more real world examples and scenarios. Videos and YouTube. Book learning only goes so far.
- Offer a self study option with a test
- Those who have completed the Dementia / Mental Health Manger Specialty training and have other courses should be able to teach the class as community instructors not just in facilities.
- Implement some of Teepa Snow's techniques into the training.
- Offer it to more staff at more convenient times.
- Make it more readily available for all caregivers since we all manage to be in the position of working with both demented folks and mentally ill folks.
- This is topic that requires hands on training. That will come with the job!
- Eliminate the section on the differences in all the dementias. It doesn't matter to CNA's. They just need to know the basics of dementia and how to treat the patient with respect.
- Greater feedback from those doing the work.
- 2 day class and more emphasis on stages and periods of time to help families deal with this horrible
- Disease
- End of life issues
- Nothing comes to mind. From the training it is just gaining the experience of observing and interacting with folks with dementia.
- Each person his different and it helps if someone who has worked with the person can leave either a record log or video of how it is done, or personally train the new worker
- On the job I watched how cruel the disease is. On the job I learned that what I did wrong with my own father was not him, but the disease. He suffered from Parkinson's related Dementia.
- Different stages, mental health issues related to Dementia, Sexuality related to Dementia, family support
- Can't think of anything else.
- Learn music therapy, memory boxes. How to communicate in their "age level" accordingly to their stage of dementia
- Communicating and approach. Techniques for preventing challenging behaviors. So many new ideas out there on the internet.
- That dementia can progress quickly and then stall after hitting a certain point
- Can't really remember.
- More information about baseline care plans. The class should be longer so there is enough time to cover all of the information. More information about the disease process itself rather than just signs and symptoms. More on observation of symptoms, what to look for and what the signs and symptoms are for the various types of dementia.
- The background of the client, the medications that the client is taking, (or look up to see why the client is taking it), how to deal if a situation comes about. That dementia is a disease and they are not doing things on purpose (most of the time).
- How to help people that are behaving inappropriately.

- I had worked in health care 25 years before taking this class, so it is hard to answer this question.
- Different approaches and how to make them work. Sexuality of the residents. This is a huge lack of understanding and things need to change regarding this arena.
- How to deal with behavioral issues
- Not to be offended by actions or remarks made by residents that have dementia.
- Residents with Alzheimer's disease do not process the color white. Shadows can trigger a hallucination.
- Caution: people can do harmful things
- How to relay this information to the care givers and create a culture
- Specific interventions for difficult behaviors and refusals of care in dementia, tips on how to "redirect" and distract. Give them a bag of tricks to try various approaches to behaviors and care. Also, nurses need a higher level of training for NSP and behavior plans for those with dementia. Teaching the nurses how to make a behavior plan, how to interview caregivers and work collaboratively for creating specific resident interventions
- Taking this training a couple times by two very educated trainers was tremendous. Surely not everything can be covered in class but with great trainers and willing students what was taught was real world.
- Everything. You can't really compare the two. Basic knowledge is just that: basic.
- Some dementia residents are combative and some are very pleasant and happy.
- I can't think of anything off hand...it seemed very comprehensive
- I believe hands-on experience is the best teacher. Classroom training is great, but you have to be able to apply your learning to a real life scenario. This is difficult for caregivers at times.
- I don't remember. But I remember being more confident to deal with issues as they came up.
- Nothing that I can think of. One simply has to experience the difficulties of each individual and respond accordingly.
- I think the virtual dementia would have been great to add, anything like that is great and helps. Maybe, adding a mock history or a few histories of some mock resident would be great so we could build a care plan, and what activities would we have for these people. Maybe a mock discharge summary from like a hospital or SNF that we get where it states the residents behaviors, so we can go through how we would make a decision on if we could take care of that person in our setting or not and why. These are all things we experience in a real setting.
- How to handle two residents that might be responding to each other in verbally aggressive manners.
- Everything. Application is most important.
- That resources are not always available. Families still struggle with understanding Dementia even with material and resources available. Most the time you are providing more support to the family.
- Would be more beneficial to those inexperienced to be instructed by managers that work in the same environment that the caregiver is working to give examples pertinent to the course material.
- Nice refresher course... we have annual training in this area already.
- I felt that nothing was left on the table one has to review the informational because it is difficult to gather and put into practice three days training without constant review to training materials
- How to teach it to others better...
- More examples of what kinds of experiences happen in AFH's with residents who are experiencing dementia
- Our care staff need more exposure, often to underlying disease processes. We (Emeritus) created games that teach, to give our nurses and executive directors more material to use post dementia specific training was initially taught.
- That there's more to it then we train people for
- The devastation in the family. The denial.
- Simple is best
- Need more focus to patience, loving, not to correct them ever. Staff needs to know they are not doing this intentional. More play time, keep them active. Give them things to hold. More practical things to do with activities, not theory. Not the list of the different dementias as they are not diagnosticians.
- I would want them to take the class so that they can have a pre knowledge of the disease and all the tools they need to take care of a dementia client.
- It's a disease that affects everyone so individually, I was just glad to know what I got from the training and I was able to apply it in different situations.
- The same as stated above, it is not a one thing works for all, you have to be perceptive not everyone in LTC is equipped to work with Dementia residents.
- More non-verbal cues, how to deal with argumentative residents

- Reality of the body changes—put Depends on, walk with walker, marbles in gloves, smeared glasses and rice in shoes. Let them walk like that for a 10-15 minute time frame. Ask them to fold clothes and read.
- Not all behaviors can be figured out
- I do not really remember.
- All of the above information. I'd look for caring people who understood the disease process, what to watch for, and how to care for someone in that particular stage of dementia. Is the environment safe? I'd want my loved one's rights to be respected despite their dementia. No restraints. Are they aware of the impact of both physical and chemical restraints?
- What the person likes and dislikes, share medical history, and what was the person's baseline.
- How to respond to their personality.
- How to find triggers and how to calm resident by redirection and involvement in their space in time. Good toileting and hygiene, safety.
- How to speak to a person with dementia, how to LISTEN to a person with dementia, an understanding of agitation, how to distract and redirect, how to relax around them, to go with the flow, so to speak. Getting the tasks done is not the main objective - the objective is for the person to have a successful day.
- That each individual is different and that a plan of care needs to be developed with the involvement of the family and those who know them best. Need to know their background, hobbies, likes, dislikes, interests, etc.
- Be patient, understanding, loving
- Everyone who comes in contact with the residents at all levels are team members and must be educated about the specialty that they serve.
- Speak calm, use the re approach method
- Who my loved one was prior to dementia and that we as a family still see the person we love and hope they will too.
- How to maintain dignity and hygiene for a resident that refuses care. Ability of caregiver to communicate about dementia care they provided to family members.
- Behaviors that can be helped
- Managing ADLs for all residents with Dementia.
- Who they were before the disease took them. How hard it is to see them how they are now and how hard it can be to visit. My uncle has dementia and I know the devastation in my own family. Family wants caregivers to respect their loved ones and be patient with them
- Approach is everything
- I would want them to know what dementia is, so that they don't challenge and correct rather they would insist that my loved one is handled gently and lovingly and know that they are dealing with a person with feelings and fears, not a "problem resident"
- How to work with and approach residents with dementia, how redirect so as to de-escalate potential problems.
- Understanding
- Take one day at a time, patience is key. Do not take reactions and negative behaviors/attitudes personally.
- I would tell them absolutely every habit, routine, likes, dislikes, etc. that I could remember. The more you know about a person, the better you can make their life more comfortable and happy.
- I would want staff to educate themselves on my loved one. Understand what type of dementia, what type of schooling, job, culture, how to redirect most effectively etc.
- Ways to calm a resident down.
- Real-life management of sexual issues. The course poses situations with many perspectives, but never says, "this is what you do." Caregivers want and need concrete answers.
- Can't think of anything she didn't cover.
- Every situation is different, but the skills I gained have been invaluable.
- Music therapy
- Hallucinations: possible causes, acceptance-never argue. Funniest was R who often saw men in her closet. Caregiver approached the closet and ordered the man out Right Now. R, from her place on the bed, pointed, "He's not in the closet. He's over there." Expostulated in disgust and went to sleep.
- A lot of the "why this behavior makes sense", especially the paranoia of mid-dementia, and how to address it appropriately.
- My class was 40 hour long. I felt well prepared. Thus said when I had an AFH I noticed that I needed to model for my employees how to care for the resident within their reality.



- How to deal with combative and difficult demented resident,
- More interventions and effective communication methods
- I do not think you can teach what I learned in a class. You can have six people with dementia in your home and you will deal with each one differently. They all have their own personalities and you have to work with that.
- That a sense of humor doesn't always help! (-;
- The interaction of the resident and their previous caregiver (spouse/family member) how that plays a role in the new interaction with the staff.
- I had already worked in skilled nursing for over 10 years. I learned that as an Adult Family Home Provider, I was more trained than any other staff in the Skilled Nursing Homes. When it came to dealing with residents with dementia I could provide care where others couldn't.
- How to teach e-caregivers with ESL.
- I had more hands on experience with difficult/aggressive residents. You can only teach so much. Personal experience with someone who is angry or frustrated is the best way.
- Talking to families about dementia care, finding the right doctor for diagnosing,
- Real life scenarios.
- As much as there are similarities in how dementia can present itself in individuals, there are various...
- Again, more information about DD with dementia. I believe dementia has a different effect on people with DD because their brains and history is just so different from people who are not dd.
- The different stages of dementia.
- I would like more help learning re-direction. I still struggle with that.
- Book learning and lecture is so not the way to learn about dementia. A person needs to experience real folks with dementia and learn what motivates them. See it first hand.
- Make sure that the student understands that reality orientation does not work in Dementia and not to confuse their roles
- Training didn't address the different types of dementia such as early onset Pick's Disease, alcoholic dementia, etc.
- How to help families understand what their loved ones are going thru.
- I was trained through DSHS with a video and discussion (train the trainer), thought the training was good, don't really remember enough about the specifics to answer this question.
- How often residents who seem "with it" will display signs and symptoms of dementia.
- More and different ways to step into the person's dementia rather than attempting to redirect them back to our reality
- Bathing techniques for the dementia client.
- How to speak with aggressive residents.
- I learn something every time I teach the course!
- There's more difficult behaviors out there than you can imagine you would ever deal with and how time consuming it can be to work with multiple people with dementia.
- In the moment approaches that work. Such as Teepa Snow trainings...
- Mostly it is an everyday different day for them.
- Have been doing caregiving over 30 years
- You are only as good as your understanding. Good to understand there are differences in types of dementia.

### Specialty training access and delivery

- Deliver the same content in their own words.
- Some instructors just play the video and don't interact much. Consider monitoring/observing how training is delivered to ensure that trainers are competent.
- Video on 12 minutes of dementia... they are in tears at the end of that.
- They need to see it in action. See other caregivers interact with residents. Take them into a memory care unit.
- Helpful to practice skills in the class.
- The trainings should have more dialogue rather than being about the book and these different scenarios.
- Place more emphasis on how residents behavior is 'not personal' - residents don't mean to be difficult. In curriculum, but trainers may emphasize differently.

- At ALF: Classes scheduled as needed. Lots of on-the-job training + refresher courses. Important to model appropriate care. Observing on the floor and reinforcing. Getting more than required hours of training.
- May be very different at AFH; may not be anyone there to observe or coach
- Harder to teach small groups. In small community with low turnover, may be hard to schedule.
- Challenging if people are not paying attention to what you are trying to teach them. Participants don't remember training a month or two later. They have difficulty applying concepts to real life events, e.g. Resident screaming. We end up sending people back through training. Some find it hard to get concept of dementia as something other than residents being difficult.
- Some people get it. Some just do not. In a small community, owners do not have a lot of options for staffing. Will keep working with people who aren't getting it.
- It isn't all on the trainer. It's not the trainer's fault that they are not learning.
- The role-play isn't realistic to what happens.
- The book is well-written, and does a good job of helping the students differentiate between the different diagnoses that comprise the dementia specialty.
- I don't use the video because the book is so good. The video is redundant.
- Other participants indicated that their trainers use the video.
- Some trainers break the content into two half-days.
- Some question how much content is retained for use in caregiving.
- I find myself tailoring the material. I would like to see it have more practical strategies for caregivers dealing with difficult behaviors. There is a little too much emphasis on differentiating between the types of dementia. I would shorten that and spend more on the day-to-day techniques they will need.
- Could we reduce some requirements so we could expand time for the "practical use" parts of the curriculum?
- The needed material is present in the book. But you cannot just go through the training, take the test, and you're done. The training gives an overview and expects the trainer or care manager to go into more details. We just do not have enough time.
- People do have to understand dementia and how it progresses.
- The required content is present in the training. We do not have enough time to dive into questions and fully understand because there is just not enough time to go over the material as needed.
- Trainers that bring examples of training into the classroom have the greatest positive impact on training.
- The content covers what is needed and to me this is at least three days' worth of training.
- The level of training is not consistent across the state of Washington. Consistency is a problem.
- What do I have to do to prove to the state that I am qualified to teach the class?
- As an instructor, I add real world experiences and make the class as real as I can. I do an exercise at the beginning of class and ask who has experience with dementia clients. We fill up the board with examples and share experiences throughout the training. After we take the test I discuss each question with my students. This discussion provides a greater understanding of the material and why it is important.
- There must be interaction and discussion. That is what makes the training work well. Just watching the video does not work.
- We use a dementia kit which students don and get a taste of what it feels like to have dementia.
- The most useful part of the training for me is hearing about life experiences. I think OJT is great but that falls on the care managers for continuing education.
- Module 3 - Creative Approaches to Challenging Behaviors - too complex and confusing. Really need simple approach to problem-solving, not multiple formulas. Combine 6-steps and ABC. Most don't know what 'antecedent' means. Also talks about what they are getting out of the behavior - may not be relevant with dementia and distract from addressing behavior effectively.
- Part of problem is people getting core training online (due to 1163).
- Trainer acts like someone with dementia - as real life scenarios.
- Struggle with role-playing exercises, particularly with ESL. Hard to explain and get through with various individuals in the class. And process itself is uncomfortable.
- Class size ?? One trainer noted she doesn't have more than about 10.
- Can be too much lecture format. Need to mix up the styles.
- A lot of my training we were working out of the workbook, and I would have preferred to do a hands-on practice session. My staff retains the information better, and they can see how they will apply it with their clients.
- The video is helpful, but some hands-on skills are what makes it sink in.

- As opposed to the role playing, letting them work in groups to solve example problems.
- In the videos, they often turn to the managers, but you may not have a manager handy if you are a caregiver in an AFH.
- It's pretty hard to get all the scenarios into a video.
- That's the kind of training I had - we all had scenarios and somebody was acting like the client. That was very useful.
- Some of my caregivers who have been to the training, they have gone from being a layman to having medical terminology - it is very technical.
- Suggest more time, but broken into smaller chunks.
- It's a lot to take in within a short amount of time. And they have expressed that they wish there was a follow up class.
- We have extended the trainings to nine hours (including the test) based on feedback from our trainers - they told us that it was too much information.
- We use short video clips to demonstrate what we have just spoken about. That helps keep their attention, as they can actually see it in action.
- I find the information about medications to be overwhelming for the caregivers.
- We need to figure out some way to train in-house to really receive the training that is most useful to the people who are living there. I think the advanced specialized training should be internal.
- I recommend designing training for the AFH or ALF specific to the residents.
- We use the huddle. This just happened. How will we do it next time? We need the basic training and then ongoing training and coaching. I expect the care manger to have a toolbox of experience and options. Training needs to evolve with the person.
- What is the lowest common denominator? For AFH one person does not have the years of experience. We need to have a system to bring in the expertise or tap into the community knowledge.
- Building a therapeutic alliance with the caregiver.
- I am thinking about my staff. They need the basic what is expected of them. What I really need for dementia and mental health, and what I spend time talking about, is what does it look like? When I get a person who is bipolar at Park Place, what does it look like? I spend a lot of time teaching my staff what it looks and feels like to have dementia. I do not use the CDs. I use a course from the University of Georgia.
- I think having people with these illnesses tell their story during training is very powerful. Allowing patients to have their own voices would be great. That authentic voice is invaluable. Ombudsmen can be good partners in helping bring patient voices into the training conversation.
- I think bringing the ombudsmen into the training would be very helpful and valuable.
- Multiple levels of training. I think it would help.
- Big difference between content and delivery. Getting theory does not translate into real life interactions.
- We use practice in the class through role-playing. Some people are 'blown away' by the kinds of interactions that can come up - and learn a lot more from the practice vs. Theory.
- Class delivery depends a lot on the instructor. E.g. Some just hand out a book, some use a lot more scenarios and interaction.
- Take concrete events (resisting showers, specific behaviors) and offer concrete tips
- Training is barely different for caregivers and managers - may be a need for more differentiation
- Brain pictures work really well. Helps people understand impact of what is going on inside the person's head that is affecting behavior.
- Naomi File is a great film (but 20 years old and \$400). Also Bathing Without a Battle. Living with Grace. Kennedy/Shriver's Alzheimer's Project.
- Set up DVDs for ease of use. Easily able to stop, start etc.
- May be helpful to have tiers that allow for more specialization and refreshing knowledge
- Need to look at new data and techniques in training - Teepa Snow, etc.
- Six hours on any topic is very minimal. Not sure how much more is needed, but not enough to be considered a 'specialist'. Might suggest 2x.
- Financial barriers - need to cover care while people are in training.
- Students may not be enthusiastic about the training.
- Need to understand diversity of students in the class. May have variety of backgrounds and personalities, but instructor needs to bring all of them along.
- Some overlap/duplication - but good to have reminders. Important material that applies to both.
- Would be helpful to have better tools for instructors - guidance, video, appropriate test answers.

- DSHS video puts me to sleep.
- Very happy when we got workbooks.
- Going through the book can get a bit boring. Tries to include scenarios and keep it lively.
- Facility does a lot of ongoing training. Employees often already have some skills and experience. Productive to have students' own scenarios to discuss. Usually wait 30 - 60 days before employees take this training (making sure they will last and also so they have had orientation and some experience)
- Last summer went through Best Friends training with David Troxel
- Hiring online provider for CEUs
- 12 years ago training lasted 4 days - big difference from content now
- Training has gone downhill since what I took many years ago
- What I 'have to teach' is very different from what I do teach - have to include 'extras'
- Caregivers in the video look terrible - would never hire them
- We used to do a lot more role-playing. It made me uncomfortable, but we needed it.
- Do more OJT training - by pairing new caregivers with a mentor for week(s).
- Would like to see more orientation/foundational training.
- What to take out? Technical names for stuff.
- Have to keep trainees engaged and entertained.
- More of a roundtable. Acting out can be embarrassing. But inviting people to compare ideas, what they would do.
- Suggested curriculum: Day One: Videos and material; Day Two: Virtual Dementia Tour (makes it real) + Group discussion of scenarios (what to do)
- Good book: Moments of Joy
- First of all, I would like to see it in a three-tier system - we have a testing process for people who will be caregivers, and another one for managers. I have a really hard time with that test for managers - it is so English-intensive that many of them have a hard time getting through it. It's ridiculous. It's a great test if you are going to be an instructor, but the reality of it is, many of these people are only going to manage their own business. I would like it to be more like DD where you have more time, but take the test in smaller pieces as you do every two or three modules.
- Caregiver, manager and instructor levels for test. I would like them to have teaching experience, but also more intensive training.

### Impact of language and culture on specialty training

- I work with a group of people who have language differences, education differences. If I let them discuss with one another about what is right or wrong, they get more out of it.
- Different words in one culture may mean something else in another culture... also, understanding what is culturally acceptable. For instance, taboos about dementia and mental health.
- The generation that is my building grew up respecting elders, respecting themselves, and their work. The generation that is taking care of them is completely different and doesn't understand how things they say may be interpreted.
- There is no filter when they (younger caregivers) are talking to residents.
- Many of the medical terms will be difficult for those who are less fluent in English, while the concepts will not. Find ways to adapt training so that there are alternative paths to understanding, or different ways for the provider to communicate the concepts to the caregivers if they are giving the training.
- I think what has been said about scenario-based teaching can help cut through the cultural and language barriers. And the videos, if they are role-playing, can help cut through those barriers.
- I think in one home you have multiple levels of culture. I encourage my staff to create the culture that fits the residents. There is a different dementia culture for elders who just need assistance. For example, we will sit around the table and do an activity called time slips (e.g. 1940s dance hall). We go around the table and each person tells the story of the scene they see on the time slip. The conversation goes from being tired, to cooking chicken, to chicken recipes. The more in the moment happy moments you have the better. Build on the positives.
- In Vietnam there is no such word as dementia. How do you explain it to a caregiver? I have to give concepts and how to respond to that. I think people respond to hands-on training better.
- If I have dementia and English is a second language for the caregiver it is hard to have good communication.

### Specialty training testing/assessment process and effectiveness

- Need to verify skills. How do you know they can apply them? If training own staff, can follow up on real life experience. Could build skills scenarios into video - discuss what happened. Some discussion occurs.
- Exam includes both written and skills portion. Skills exam is a made-up scenario that participants act out. Many caregivers just finished high school or didn't finish. Feels stressful, awkward and fake.
- Two instructors blend skills exam into curriculum, but don't call it out as a separate exam. Or instructor acts out like a dementia patient within the class.
- The manager test is like re-writing the whole book.
- "[The manager test is] a terrible, awful test. It feels like a very academic exercise, and that it has not tested whether I as a manager am going to be able to lead the way in managing patients with dementia."
- At the class, they [caregivers] get nothing - they are stressed for how to take the test.
- What we call specialty training is really basic competency training that allows you to work.
- I do not think the assessment is effective because some people can take a class and ace the test. Those same people may freak out and be afraid when they work with a person who has dementia. The real assessment happens when caregivers interact with clients.
- Some questions on manager test require memorization of specific types of dementia, which is not practical in delivering care.
- Don't give managers dementia test on the same day as the class. Too stuffed with information and hard to pass.
- Dementia exam - matching questions unfair
- Dementia test: half the questions aren't even in the material. Get challenged by students because it wasn't covered in the class. Has tried to fill in the gaps.
- They teach the module about distinguishing depression and dementia - and then they have a matrix where you have choices, and they put in one sample answer. The way it is set up is a 50/50 guess - that isn't really testing on knowledge

### Specialty training requirements and oversight

- I think that (the shortening of the training) has done harm for Adult Family Homes.
- I don't see how any one-day training can be effective. That's crazy.
- That doesn't even scratch the surface. (Even three days for DD... it's more thorough, but training should be ongoing all the time.)
- Align what the surveyors look for with the training. It is not always clear that they match up.
- We would like it if the licensors had to take the training. They would better understand what we are doing and why. Case managers too - so they understand how much time it takes to deliver this care.
- Right now we have a WAC. I can't send my caregivers to another facility who has a great trainer. Rules based on things other than outcomes of the training... these get in the way.
- Training needs to be more 'real world' and longer. 4-6 hours is not enough. At least 2-3 times a year that they go back and get a refresher.
- The deadline makes me squish some things together.
- [Could we] take the deadline away? They need to see [resident care] in action— see other caregivers interact with residents. Take them into a memory care unit [before they go through training].
- I have always felt that [the dementia training] covers a lot of material, but calling it specialty training is misleading - it doesn't make people specialists. It is a mile wide and a couple of inches deep. There is a lot more material needed to supplement it. If it isn't going to be much deeper, then maybe we should talk about a license endorsement. It's a misnomer when we say a home is now a specialized provider [when their caregivers have taken this training].
- I wish I had gotten to know our residents a bit first, then gone to the training. I would have been able to associate my training with my actual residents.
- There is a disconnect between the business decisions we have had to make and the whole architecture of the training and testing.
- From an industry point of view, we are subject to the initiative that passed, but we are never going to get to a position where we are asking the state to let us out of training. Making it better, more applicable and leading to better outcomes - that is what we are talking about."
- There might be a disconnect between the WAC and what the owners understand

- I would like to see what it means if someone says they specialize in Dementia. Is there a standard?
- In 2002, Dementia Specialty Training was 48 hours at Spokane Community College. (Original training was much more involved.)

### Best practices related to specialty

- Kindness, patience
- Competence - knows basic dementia communication skills, how to help perform ADLs.
- Compassion and understanding to not take things personally (verbal or physical attacks)
- This is their home - you don't just walk in a demand and command.
- The majority of the behaviors come from us - we create the behaviors. Acting that out isn't going to get you down at eye level. You need to understand why you need to do that.
- Able to recognize and respond to changes, basic critical thinking
- Can you problem-solve what is going on with a resident? Acting out a scenario doesn't tell me what I need to know. When you aren't able to problem solve, what is your next step? Do they have systems in place then?
- Knowledgeable about conditions and diseases; caregivers may be interacting with physicians without complete training/assessment/understanding
- Family members have different expectations - Training covers how to work with family members, but only for managers. (Some trainers share with caregivers also.)
- Caregivers may know what to do, but get burned out. Need to ensure appropriate breaks.
- I would want them to know what calms my mother down when she is upset - what things in her background might she be worrying about. What are some triggers?
- Have the caregivers understand how important it is to have an understanding of the "mental age" or last traumatic event that the resident might be "living in" - are they re-living earlier parts of their lives, or their past occupations, or specific traumatic events?
- Understanding dementia, delirium, depression - change of baseline. (Covered in basic and dementia, but could use more reinforcement.)
- How to better deal with families of people with dementia. They do not have any training and it can cause misunderstanding
- How best to communicate with people with dementia. Not to argue with people with dementia. Awareness of safety needs i.e. Wandering, getting up by themselves when they should have assistance. Understanding of types of dementia and working with behavioral issues with people with dementia.
- All the information in "bathing without a battle" and Teepa Snow's caregiver training for dementia clients.
- Getting them to contribute to their own treatment plan is essential - in early stages of dementia, but even in end stage they can probably even tell the difference between cocoa and coffee...
- Virtual Dementia Tour - sensitivity training
- Dementia is a disease process similar to other disease processes. The resident and the family need support. Keeping families informed as to why different behaviors are happening and what they can do to help their loved one.
- It's important that they know to get the resident's history from the families.
- Persons with dementia still want to feel competent - emphasize to the residents that they are "doing a good job" or to provide them with simple responsibilities.
- Touch - it's calming and important for residents to be touched by caregivers, whether hugs or gentle hand contact.
- Vital signs are important, but are not taught as part of the curriculum. Vitals could influence behaviors.
- Who is or was my loved one before dementia
- A smile can get you through a lot of tough situations. Dementia residents respond better to people they feel like them. When you listen to a person, they feel valued. Help people keep as much power of choice as possible, no one likes to feel pushed or bullied. A conversation doesn't have to make sense. Help your resident feel right whenever possible. Remember that when the resident tells you their "story" to them it's the very first time they've told it to anyone. Respect that. Not taking a bath isn't the end of the world.
- That people with Dementia are always doing the best that they can. They are technically "Brain Injured" (I also worked in Traumatic Brain Injury for over 3 years) the part of the brain that affects reasoning and memory is now broken; they can't help their behavior. Caregivers must have patience and compassion!

- How it felt to live with dementia. That was one of the special gifts Robin has to offer as she has been caring for her Mom who has dementia for the past 15 years and uses real life examples in video for training. Her mom makes a great camera personality and you love her by the time the training is done.
- Behavior needs to be emphasized in the training, over diagnoses.
- Fall prevention and medication assistance. Our family had an incident where no enforcement letters went out to our facility, and by the end of 6 months they just had one registered nurse remaining. My family member had a medication problem and other patients were injured by falling. This might be a staffing problem and /or may demonstrate a lack of understating of dementia.
- I think communication is very important to caring for a client with dementia. Each client is different. A caregiver needs to have good interpersonal communication skills.
- The main type of communication is nonverbal communication.
- Different cultures have different nonverbal communication.
- The stage of dementia that a client is in is often overlooked.
- I expect the caregiver to look and talk to the person, and learn the history of an individual before they bring them into the home.
- Caregivers need to know how to approach a person, communication skills, emotional skills, and know validation theory. Distraction does not work. Validation theory is when a behavior happens you try to validate the emotions of the behavior. Why are they angry? Why are they crying? Validate before distract.
- I use to have a resident who did not like certain words. We had to educate the staff about the person and the words. You have to know your residents.
- I like the potential clients to visit the house and spend some time with the residents. That is how you see how well they interact with other residents. It would be great to get the life story before the person comes to the facility.
- Communication is key. Especially in emergency situations.
- Young caregivers, in my experience, struggle with Activities of Daily Living (ADL). I had to show young caregivers what to do when I visited my mother and the caregivers were very appreciative.
- Turnover is a challenge to both training and delivery of care. You never get beyond the task. That is a staffing problem.
- The environment is important. Your staff can observe if patients are reacting to light, darkness, and noise and let you know if they see any client behavior changes.
- I think it is important for family members of patients to become part of the team.
- Families sometimes make the patient more agitated and upset.
- A quality facility includes the family as part of the team.
- Good material in communication module. Needs to have more focus. How to handle people's challenging behaviors with compassion.
- Highest priority = compassion. Putting yourself in their shoes. Have respect for them.
- Communication
- Someone who understands dementia, e.g. Not telling mom to use her fork when she doesn't know what a fork is. Need to understand how dementia is different from expected behavior.
- Customer service to residents and families. How to handle complaints.
- Establishing relationship with individual. If we had 8 hours communication training, wouldn't need as much detail about specific disabilities.
- May have fear around bathing and hygiene - need to recognize fear and how it drives behavior. How to communicate with the spouse or family members about ADLs - may be taking over for an exhausted and worried caregiver.
- Thought I was an expert until my mom lived with me for a year. Don't know how to build it in, but the real life experience is very different.
- Need to understand what has happened to the brain - that brain has been damaged, to dispel mythology and reaction to behaviors.
- How to establish baseline and understand concept, recognize changes and what to do. E.g. Delirium or sudden changes can signal underlying medical problems.
- Helpful to understand how to enter into the resident's world and understand it from their perspective.
- After training, assign new staff to mentor caregivers.
- Experiential approach to building empathy. Building understanding of what various techniques feel like.
- Several months OJT before caregiver working alone. Ask other staff for input.
- Don't take state pay - can't afford to deliver desired levels of care and training within state rates.

- Building intellectual curiosity - encouraging ongoing learning. Value of learning; pride in a career path.
- Use You Tube video by Naomi Feil about Gladys or real life videos (with video stars' permission) - e.g. High impact real life scenarios
- They should know what resources are available for those people
- Dynamics in the home and how that impacts residents
- Intervention strategies
- How their behaviors affect the clients
- The importance of communicating with family members... the first two homes my wife was in... I had to pull information out of them.
- The client is always the center of the care. Even though the family is part of the picture
- We know something about the person and what he is doing, we could give more attention to what we need to give to the client.
- When I think about outcomes, I wish there was a better understanding of transitions. When a placement fails, and they have to go into another placement... Make a clear point in the training that when you take a client, stick it out. To a certain extent, it's not going to be peaceful for a while. They are going to act out, and the behavior you see is part of that adjustment - but it will get better.
- The transition period is difficult, but the thing is you need resources, but how can a provider provide people when we are working with a limited budget.
- It's not only the transition part of it - it is the owner knowing that the caregivers are able to take care of the person with the condition. Don't say you can if you can't.
- It depends on the caregiver... some are quick to pick up. Others are there just for the compensation. It varies. I would give a month for them to be where I would be comfortable leaving them alone with residents.
- We need to know the person really well. Understanding both the caregiver and the resident. There are personalities that don't click no matter what you do.
- One thing I would like to see included in the training is that caregivers understand how their behavior impacts the resident's behavior. More often than not we don't recognize that what we are doing is creating that behavior.
- How do caregivers handle a situation they can't address? How do you access resources? Who do you go to?
- Giving up on a client should be a last resort - institutionalization is not pretty.
- In my experience, it takes time and concentration on the client if they are demented. You need time to be able to understand what their needs are. Knowing her characteristics and her actions.
- A caregiver who has been there for a while can give you a wealth of information about patients.
- Should it be part of the training that you need to reach out to the family and get that background? It's not covered heavily.
- I ask new caregivers to imagine that if they were 90 and couldn't speak their needs, what would they want their caregivers to know to understand their unmet needs.
- Even before I accept a resident, I meet with the family, look through the care assessment, go see them at the hospital, call their doctor. I also have them 24 hours in the home to observe. I give the caregivers very detailed instructions.
- Doing a self-reflection on your culture, your language, your background... put yourself in the position of the client and what you would need.
- It's up to the provider to have ongoing discussion and focus so that is reinforced and carried through every day. What are you going to do when you go back to your home to focus on the culture of those who you are serving?
- With dementia, simple things like a UTI can cause great changes in behavior.
- We see a lot of patients who have been labeled as predators or violent and can't be placed anywhere. In our environment, with a little problem-solving, we can find the underlying cause, and can find them to be easy to work with.
- I don't think providers should be able to say they are specialized because they took the class, they should have to demonstrate that they can handle those clients.
- We should connect good homes so they can work with one another within a network. Better networking.
- When a home brings in somebody they aren't capable of caring for, that's when the problems arise. You need to understand the condition, or you can't do it.
- As a provider, there are times that the care assessment is not sufficient. It doesn't tell you what you need to know.



- But there are times when the care assessment tells you everything, but they took the client because they looked at the rate and not the client. What does that do to the client? Look at the care assessment. Go out and meet the client. And meet the family. Because when you take the client, you take the family.
- The case managers and of course DSHS know the history of homes that have a good record. It concerns a lot of things - the rate, the assessment, and how you are going to pay for the clients. But partly, this is the caregiver that has more experience in a year - dealing physically, actually on a daily basis, and have become experts on this by experience and continuing education. If the case managers know a home is good, and what they are capable of.
- I had to place my dad last year. I would ask how much hands-on work they had. I talked about physical health, and emergency situations. What if my Dad wandered off? If my dad had dementia, I would ask what kind of training do you have, and what would you do?
- I would ask about behaviors. Do you know anything about Alzheimer or bipolar, and what will you do given certain behaviors? Do you know the disease process? Do they know the care plan? Do they know the baseline and what to do when they see signs and symptoms?
- First, I would ask what do you want to know about my dad. Then, I would ask how will they take care of him? We need to know the person first.
- I would sit down with them and say here are my mother's needs. And then see if they are empathic. I assume they are trained.
- What I would want know is how comfortable are you with learning about them. In my experience, it is easier for me to know that Mrs. Jones worked the night shift then it is to deal with the caregiver who we have to talk with Mrs. Jones about why she will not sleep at night. Do you know this person, and are you comfortable knowing this person?
- Why are you working here? Why have you chosen this job?
- I want to know how this person deals with stress and conflict. How do you respond to difficult situations? How do you solve problems? How much compassion and capacity do you have in problem solving?
- How well is the caregiver supported to do their job? Training, funding, etc....
- I want to talk to the cook. I know of a resident that is Jewish and was continually served bacon. I think cultural awareness needs to be added to the training.
- Dementia. I have seen too many family members that do not read the contract.
- The caregiver's capacity and compassion are important. How do you assess that?
- Dementia. Are caregivers trained and skilled enough to know and see residents for who they are as a person, and do they know their story. E.g. Who they are, their history, and their relationships. Mental illness relapse prevention. Know the signs before a patient moves into a relapse. Caregivers need to know systematically what their likes and dislikes are and know what changes I need to look for. E.g. Eating, sleeping. And notify the supervisors if they see changes. You only have a 72 hour window to prevent a relapse. Action should be in the care plan.
- Care plan written in the languages of the caregivers.
- Ask how work assignments are arranged days, nights, and weekends.
- The approach and compassion about basic everyday care activities. It is a struggle for a provider to thoughtfully provide care day in and day out. Approach is everything to enable the residence to have as much autonomy in their life. Basic human kindness.
- Treat patients with respect. Do not talk down to them.
- I have attended training where people with disabilities were presenters. This was a very powerful. I recommend we infuse people with these illnesses into the training to make it the better. We should adopt the saying 'they should not do or say anything about us without us'.
- 'In Their Own Voice' is a national program which can be a source for presenters.
- Wendy Lustbater from the University of Washington has video in kindness. She is fantastic.
- How to deal with challenging behaviors - many people are at an entry level
- Resources - how to access next step
- Be careful in understanding caregiver exam vs. Manager exam - not the same expectations
- How to care for specialty needs
- Questions we would ask: What training have people had? When did they take courses? What is staffing ratio? What are meals? What are activities?
- Teaching people how I would want them to take care of my parent
- Would want to observe staff interacting with residents
- Basic medications

- Basic human rights, dignity
- HIPAA laws
- What to notify nurses about - change of conditions
- Documentation
- Dealing with challenging behaviors
- Able to understand and evaluate baseline - what questions to ask
- We spend a lot of time training on the job to help people better understand
- Developing empathy - helping caregivers to understand it's not about them, but meeting needs of the residents (belongs in basic training, perhaps reinforced in specialty training)
- Successful facilities have robust activity programs. People are busy and engaged. (Activities are covered in the training.)
- Linking negotiated care plans, training and assessments
- Train every staff member to understand dementia and mental health - even maintenance, dining room staff, etc.
- Staff talking with each other about what is going on and what is successful with each resident
- Communicating with families - involving them in the process
- Invite families to come to training for free
- Entry-level folks coming in as NACs or NARs, have no 'bag of tricks' for dealing with people much older than them, with these challenges.
- Communication skills very important.
- Need to know something about pathology of the illness to understand what is going on.
- Caregivers and managers need different information, but must be coordinated.
- Choosing appropriate caregivers could be part of managers' training.
- What is preparation? Life experience? What is motivation? What compels someone to seek this kind of occupation?
- Would look at everything - would want to observe, see how things are done.
- Building and environment can be very telling - housekeeping, services, staff.
- Must go beyond basic ADL components. Must have very patient personalities. Would look at affect and how environment feels. "Gut" is usually accurate - are people happy, engaged, well kept, etc.
- Current training is very basic preparation. Adequate starting place, but needs to continue.
- Even without mental health diagnosis, people may be on mental health medication.
- Understanding importance of patience.
- How to redirect
- Where to get additional help
- Understanding depression and delirium
- If touring memory care, would look for interaction between residents and staff. Are they engaged?
- Appearance - well groomed, clean
- Respect for resident's home.
- Not just assisting with ADLs, engaging with residents throughout the day. Life enrichment activities.
- What is your ratio of residents to caregivers?
- What type of training do caregivers have?
- How do they handle challenging behaviors?
- More skill-based for caregivers. More clinical/theoretical for managers.
- As homeowner, would like caregivers to have least amount of time in classroom. Turnover is 35%. I will have to teach them on the job anyway.
- How to deal with angry behaviors, depressed and withdrawn behaviors.
- The process of the condition

### Rank of modules from the training manual

- 1
- 2\*\*\*\*\*
- 3\*\*\*\*\*
- 4\*\*\*\*
- 5\*
- 6\*\*\*

- 7\*\*
- 8\*\*\*\*\*
- 1-Intro (but would rework) \*
- 2-Communicating \*
- 3-Challenging behaviors \*\*\*
- 4-Helping with ADLs \*
- 5-Hallucinations & Delusions (mentioned once)
- Others still valuable, but setting priorities.
- Sex a big topic.
- 8 is worthless and boring.
- Incorporate a baseline for dementia residents - how to know if something is typical or changing
- Potential for tiers - focus first on 1-4, then come back for more detailed information. (But admin nightmare. Owners and managers will push back - too much time/cost.)

### Additional comments and opportunities

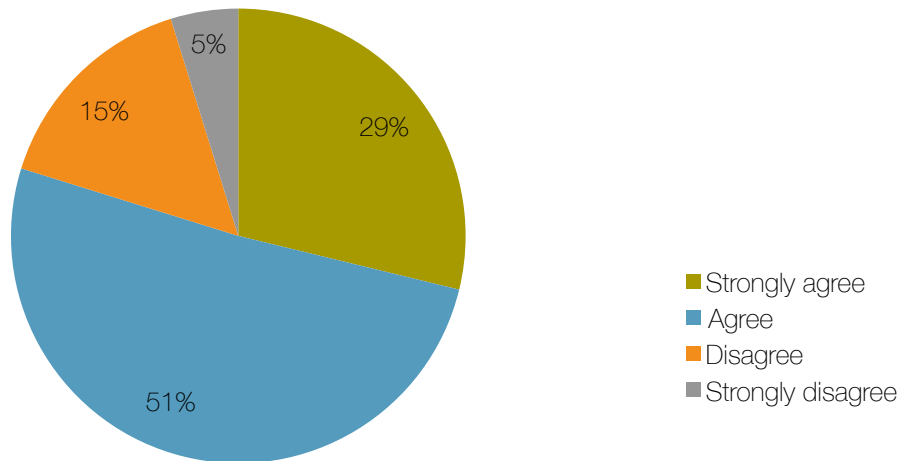
- Aging: Issues that are part of the aging population separately, talk about some of the challenges - some of the caregivers are teenagers. They don't have a clue - maybe a five-hour course.
- Developmental disability - I think everybody needs that training
- Physical disabilities - we have veterans and stuff like that when they have paralysis or other physical disabilities
- Continuing education for specific kinds of dementia that builds on the standard training
- Traumatic brain injury
- PTSD
- More on drugs and what happens, especially when combined with mental illness
- Geriatric care
- Generational differences
- More on sexuality, including residents' rights and how to handle behaviors.
- Could we develop a "student guide" that would be more useful to caregivers working in the field? Something they could have after the training that would give them quick access to the most critical information.
- I take some of the key points and have it on a sheet of paper. There are some key points that always need to be kept in people's minds.
- It would be wonderful to have resources for trainers around principles of adult education, and around ESL training.
- I would like to see some training into the new provider - train the trainer - the 48-hour course. The AFH training. Teach the new providers how to be mentors to their new staff.
- I think everyone wants more training. It is a matter of economics.
- I would consider a class for each stage of dementia.
- Quality facilities do ongoing training whether it is mandatory or not.
- The 12 hours of training is supposed be on the types of residence you have in either AL or AFH. I do not want to see more training legislated.
- I think different associations could come and talk with caregivers. Maybe a focus group on a specialty area.
- As a care manager, tell me what to teach and I will teach it. My preference is to have more continuing education options.
- I think we should have less time in the classroom and more experience with patients. Putting people in the field to practice would be very valuable.
- Some considerations for additional training are substance abuse, and mandated reporting.
- Training and mentoring for home health workers.
- Concerned about impact on licensing, ability to operate a home, rates, etc.
- Traumatic Brain Injury (there is a TBI state curriculum = CE)
- Medically fragile individuals
- Add personality disorders to module 1.
- A menu of classes that go beyond the basic training... behaviors, medications, would be useful.
- I don't think you have to go create something, but delving into specialty training for people with various disorders... additional deeper dives based on the individuals you are caring for.
- TBI or acquired brain injury

## 9 | Appendix: Full Text of Stakeholder Comments

- Schizophrenia
- Bariatric
- Homeless with chemical dependency
- Medically fragile
- MS
- Parkinson's patients
- MS (Multiple Sclerosis) patients
- Bariatric patients
- Quadriplegia
- Tracheotomies
- LGBT community
- Clients who are younger but not DD
- Substance issues, self-medication, marijuana
- Behavioral management - how to approach challenging behavioral problems; how to not get defensive
- Substance abuse
- Parkinson's - uses resource from OHSU for CEU's (approved by DSHS)
- Medications - especially at AFH
- Bariatric care
- More training on physical handling - transfers, etc. (part of core basic)
- Teepa Snow does a good job.
- Mandy teaches "Virtual Dementia Tour". 20 minutes for tour plus debriefing - total about an hour. Teases out emotion - deeper empathy. Hands on, sensitivity training. Put on glasses, gloves, inserts in shoes, headsets. Then ask them to do 5 simple tasks. With over 700 people, not one has completed all 5 tasks.
- Music - that part of the brain may not have damage. With some dementias, singing to them can make a better connection than speaking.
- Would like NAC program to include DSHS specialty training. Then they would be ready to work in many settings.

## Mental Health

Survey result: After my mental health training, I felt better prepared in my role working with this client population:



### Strengths of current specialty training

- Gained understanding of the effects from mental health issues. Learned how to interact in many instances with residents so affected.
- My background before retiring was social service with seniors living in subsidized housing. Previously working with homeless families. We had ongoing training.
- What I learned is how to recognize mental health issues and where to go with them.
- It has been years ago
- I had college courses regarding mental health so I had a pretty good understanding of it prior to the training
- Good broad overview of the most prevalent types of mental illness
- Different ways to help process the information that was needing to be provided, and a understanding when the language or environment could be a trigger for the PTSD.
- I learned a lot about different forms of mental health diagnosis, how to respond and work well with the mental health issues.
- The different types of mental health and how common they are for not only residents, but family members and how to deal with them.
- I learned about the different types of mental illness, when they manifest and how to work with them
- Can't really remember. I think it would be better to really focus on the mental health issues we have with people with dementia. Talk more about anxiety, paranoia, and depression and how to manage these.
- A better understanding of the various mental illnesses being taught about. How important medication is for people with mental illnesses. That the medication has to be taken on time and consistently. The signs, symptoms, and behaviors connected to the mental illnesses. And to take those signs and symptoms seriously. People can develop a tolerance to their medication so the client needs to be re-evaluated periodically to see if their medication is still appropriate.
- It has been too long since I took the training to give any input.
- The different types of MH conditions and how to differentiate between them to provide the best solution for their wellbeing
- Relapse prevention plans
- Mental health is a part of the resident's daily life just as a medical conditions. It is important to control your symptoms and not your symptoms to control you.
- I learned about a variety of different mental health issues.

- I already had a strong background in MH before the class.
- It helped me to know what classes of mental illness there were and specific tools I could use in caring for clients with those diagnosis.
- Topics concerning depression, isolation, etc.
- Vital
- Very little. Don't work with mental health population. Used the dementia pieces the most.
- That suicide comes up a lot!
- I am a MHP and facility approved instructor. The comments from recent training evaluations include:
- I am a more capable caregiver, less stereotypical attitude. The approaches taught in the training are better than dementia.
- The interventions and skill practice has helped me in real situations.
- Helpful strategies to empower residents and redirect during problem behaviors.
- I'm more patient, I am more capable.
- Realized symptoms are actual occurrence for client. I have more confidence. I learned new skills. Role-play while difficult was helpful.
- "To be more aware of my body language and how it affects others. Don't give advice, unless asked. Ask the client what they can do differently. How to deal with disruptive behaviors effectively. Yes, I feel more capable."
- "How to de-escalate effectively. Clearer understanding of mental illnesses, not judging, patience, the art of being firm and showing respect."
- Limited material or time given to the material as I recall
- Approaches to someone who is suicidal or delusional
- Types of emotional and mental health diagnosis and behavioral issues associated with each
- Information about schizophrenia in general
- Different types of mental health
- Same as dementia training, I especially liked learning about teaching methods.
- I really do not particularly find it useful except for depression
- Always look for a physical cause first when there is an extreme change/increase in negative behavior.
- Look for triggers if there is some and communicate it with your staff and co workers
- What some mental health diagnosis symptoms are presented in residents
- How different an individual with MH is versus dementia
- I think the amount of mental health issues with the residents I have served is limited. However as a community RN and working with multiple homes and facilities I am finding out why this class is important. Mental health interventions are so different from dementia. Redirection is not appropriate in mental health but validation is.
- That it is not the same as a dementia diagnosis.
- Not much other than my educational training
- How to speak with people with mental health issues
- Population specific information for the 3 types of mental health disorders
- The various faces of depression - if there's a mental health issue in AL's, it's depression, and often overlooked because it can be silent.
- I learned that depression is common and under-treated in our society, especially in the elderly. I learned that the state is biased against gero-psyc medications, even when used to treat disease.
- I really did not know much at all about mental health so I learned quite a lot. I felt like the class was a very basic course and realized how much more I probably needed to know. Robin taught this class as well and encouraged us as professionals to be life-long learners and take advantage of all the internet resources available to us now. She gave us a list of resources that was much more current than the workbook.
- The book was ok.
- Again, patience
- Talking about depression/suicide and challenging behaviors
- Again having been a nurse for 16 years at the time of my training and working in 2 different mental health units I did not learn anything new.
- We explore people the students have known with mental health challenges and what the community's reaction was to them. Stigma. How they feel about themselves when they fail.
- Common occurrence of anxiety.
- How to listen for thoughts of suicide in friends and clients.

- Listening in all situations is more important than what we say.
- Dealing with residents who have depression
- How much I didn't know at the time. I learned that giving care for someone with MH issues was similar to caregiving for a person with other issues. It is all in respect and kindness.
- Understanding different types of mental problems.
- I think the diagnoses were well explained.
- I took my training so long ago that I do not remember.
- There are a lot of crazy people in this world.
- I need to provide leadership for the staff & provide living examples.
- Understanding that there are many different causes/diagnosis, all of which cause different outcomes.
- It's really different from dementia. You don't treat a demented resident like a resident with mental health issues.
- Various mental health diseases and their impact on the residents.
- That you must focus on keeping folks calm and safe. That you do not lie to them, if asked what is true. That you validate their feelings and thoughts.
- I think the process of learning and developing decompensation and relapse planning is the best part about mental health. That whole process can be applied to many issues related to dementia and mental health. It is a wonderful multidisciplinary process, which really facilitates staff working together on a plan that can be very beneficial to the client.
- The communication techniques and role-playing.
- Students seem to respond best to communication techniques
- Dual diagnosis
- This class helped me to recognize signs of mental illness and the differences they have one everyone.
- Dealing with psychiatric patients
- Understand behaviors, diagnosis, needs, recourses
- Various disease processes
- It really mirrors dementia and can be learned better interacting with that population. Dementia training is harder than mental health. In my neck of the woods, I really only see it help people whose first language is not their first.
- Different mental health diagnosis
- The differences between different mental illnesses / conditions and how to identify symptoms and warning signs
- Mostly that you have to choose your words
- Hard to remember. This was all included in nurses training courses.
- Meds are still the number one 'PRN'.
- Dealing with difficult behaviors
- I will be a trainer so I learned techniques from the instructor.
- It is okay.
- Not much; used depression
- The lab / spent an hour every day hands on practicing on each other and dummies.
- How to physically handle patients/clients
- Nothing different, everything was very fun and everything was understood.

### Specialty training challenges or deficiencies

- Not make it so repetitive of the Dementia training
- A little more details about medications
- The class could have been longer. Maybe with more material. One week longer.
- Simpler information - what are symptoms and what to do about them; not so much technical detail, definitions etc.
- Bring real life examples into the class. One benefit of facility-based instructors is that they can see how learning is getting applied and refresh learning as needed.
- Key to focus on behaviors - who is it bothering? Is it a problem for the resident or others, or is it just bugging you?
- Difficult teaching MH in memory care facility. Content confuses care givers. We don't use 'reality orientation'.
- Really struggle with 'gentle perception'. Get hung up on people "lying".

- We find ourselves teaching common courtesy when we should be teaching about schizophrenia and manic depression.
- Fundamentals of caregiving - there was a precursor to that when it was established at first.
- Consider a more modular approach
- Also needs to include licensure requirements. Need managers, in particular, to understand how actions may impact facility/job.
- The majority of the behaviors come from us - we create the behaviors. Acting that out isn't going to get you down at eye level. You need to understand why you need to do that.
- Feels miles wide and very shallow
- Helpful to have deeper focus on specific diagnosis - perhaps modular; available when it comes up (e.g. New resident with that diagnosis)
- MH conditions have more variety than types of dementia - different behaviors, courses of action, treatment, etc.
- Don't see personality disorder classifications (borderline, narcissistic, etc.) in MH training outline - can be most challenging in ALF settings
- Need practical tools and approaches
- May need to keep more 'academic' discussion of different types (as compared to dementia, which results in more common behaviors)
- May be helpful to talk through each type from diagnosis through behaviors and strategies vs. Skipping around - better connection to practical day-to-day actions
- Need more understanding of family dynamics
- Some concepts and skills cross over all diagnoses: communication, compassion, how not be reactive, creating calm environment
- Doesn't cover substance abuse (?)
- Need for education of administrators on what types of issues they are prepared to handle ... substance abuse, cutting, impact on other residents, etc.
- Stigma associated with MH diagnoses.
- Can be harder for caregivers because it looks more willful
- If you are thinking about bipolar disorder, or schizophrenia - how will it progress? Not just the whole package of mental health - specific populations, and related behaviors.
- For mental health to be so broadly covered in one class is kind of damaging. There is so much depth to each one of these things.
- DSHS has put out a training - "difficult and challenging behaviors". That is a really good training that we use in conjunction with others. It is specifically about responding to behaviors. It's part of the trainings on the DSHS website, and became part of the core curriculum.
- There is a training out there called "mental health first aid" helps them recognize behaviors, how to respond, what are the recourses, where should they go for help. Could be added to the mental health component to enhance the specialty training.
- I think it's a good introductory to what is out there - for people who have never experienced mental health, and maybe they can use that to help a resident in a crisis situation. But it's really just an introduction.
- Regarding dual diagnosis: "with mental illness - especially with somebody who has Down's - we get pushback from the family that there may be a mental illness developing. Knowing how to approach the family members. We are not trying to label them as crazy, but helping them get the resources they need."
- Feels like caregivers are short-changed in the information that they need, which ultimately shortchanges the population under care.
- Need to match requirements with time allowed.
- Interest in moving toward online option.
- One trainer stopped using manager material altogether. Or - another trainer teaches manager material to everyone. (heads nodding for both pathways.)
- Need training to be more focused on real skills, knowledge and understanding of what they need to do to deliver good care.
- Managers need help in managing and supervising caregivers. E.g., what do you do when caregiver is taking wrong approach with a client?
- Need to clarify intended difference between manager and caregiver skills and training
- Change content of core training, then offer more detail in specific types as CE. Everyone can use refreshers. E.g., California requires specific numbers of hours to maintain 'specialty' designation.



- Key points from Teepa snow - 'space matters' and 'how to approach'. Also use her material on amygdala, fear and anxiety - and how to help residents deal with it.
- Need to cover hallucinations and delusions more - trainers add own content and scenarios. Challenge in both dementia and mental health residents, but recommended approach may be different - gentle deception vs. Reality based.
- Curriculum was pretty good at the time, but is not current and evidence-based.
- Helpful if training were more consistent - so that home owners or administrators can rely on what people have learned, regardless of where they were trained (many examples of customizing the training by instructors)
- I think it's important for them to understand the diagnoses so they can understand why they may act a certain way.
- I find caregivers often struggling in interpreting what they are attempting to communicate, even if it is non-verbal. A lot of times, it is more body language.
- With non-verbal clients—I don't know if its in the training or not, but they need to understand what the cues are - they are the same as a baby. They cry when they are wet, they cry when they are uncomfortable, they cry when they are hungry, they cry when they are thirsty.
- The current training is quite complicated for entry level workers... it gives them a whole lot of ways to look at challenging behaviors. A lot of it will be over their heads.
- I agree that having a good fit between the caregiver and the resident, but you need to pull the family in. So we are all a team. The training covers it a little bit, but not much.
- The shift across our industry is person-centered care. So this training is a good place to jump into that a little bit. The more you know your resident as an individual, the better you will be able to provide care to them.
- The person-centered care approach, and how do we do a personalized care plan?
- How to deal with conflict between residents.
- An issue that comes up a lot is assault. Often it's my feeling that we have clients who aren't really capable of doing harm - knowing what is dangerous, vs. expected behaviors.
- Caregivers need to understand that reactions are not about us, and what is an appropriate reaction and what is not.
- Dealing with the risk of violence - I wish I could see something that defines violence vs. behavior.
- More of this: Module 4 -- creative approaches to challenging behavior
- Caregivers need to learn to document their work. There are different requirements depending on what setting you are in.
- Documentation is important. The residents are in a state of change, so it needs to be written that we could see the change when they are living with us.
- Complicated feelings based on transitions can make behaviors seem more pronounced, especially when they are new to the facility.
- Overall knowledge of the particular condition. Many people who work in the system do not have a fundamental understating of the illness.
- To have a resource available to call 24/7 when situations arise. This is after basic training of course. I think a 24/7 resource is important. A pocket guide would also be good.
- Providers want to do the training themselves, I do not agree with this. Another training item to consider is how well providers can relate to their staffs that do not speak English.
- Training does not address an understating of the complexity of the individual we are talking about. The basic motivation for an individual to take on this task (type of work) is an important place to start.
- Language proficiency and cultural competency.
- I think initial baseline training is helpful. But sometimes you do not know what you do not know until you are in your home applying the skills you have learned. As people gain experience and knowledge I think we need a different tier or training to build on the base.
- Technical assistance after the training when you are in the setting is very important. On-site consultation and training needs to take place at the facility.
- Caregivers at a memory care facility, in my experience, receive more training. For example, we do refresher training annually.
- There has to always be an annual review and a refresher for mental health training.
- I am hearing a lot of siloed views. We act as if the people we are providing care for are not part of the training.

- It starts with listening to and attending to the person. Specialty training needs to include how to actively listen.
- Approach is everything. The approach is based on the assessment driving the behavior. Not just the formula. The supervisor or the lead has the knowledge and can coach the caregivers on what to do if they do not have patient knowledge.
- AFH employees do have a requirement for continuing education. I do not think it is the state's job to verify individual training. I do think it is the state's job to verify each AFH facility. In an AFH, I think most of the training should take place outside of the home.
- We should not have a cookie cutter approach to training. AFH should be different. There should be checks and balances. I think they should check training annually.
- Both approaches of training are needed. In-home and external training is important with the team that is going to work together.
- We should include that the person can recover in the training. Currently, no one imagines they can get better.
- As a staff ombudsman, most complaints are behavior related or discharge related because inability to mitigate behaviors. There is a training gap to deal with behavior. The rule is broad when it comes to discharge (a danger to self and others). There is a lack of knowledge of continuing education to improve the quality of patient care.
- There needs to be a higher-level requirement for training. The minimum is not working.
- I think the caregiver needs to go beyond the 8 hours of training to improve quality of care. The ability of the provider to delegate knowledge is not working.
- When I go to a home the owner is not on the premises.
- Currently, I think owners and care managers struggle with the person. They need more assistance.
- Yesterday, I went to an AFH and AMR was trying to get these women onto the gurney. The provider asked me for help. She said I do not know what to do. This is an example of a provider who did not know what to do next.
- My mother is in an AFH and I have received calls reference to my mother asking me what we should do to control her behavior.
- There is a growing enlightenment of how to care for people. The current model is a medical model. The future model should take into account the whole person. Long-term care is a person's home and should focus on maximizing independence and help people live out their life. Training should be more trauma informed and be more experiential vs. Medical.
- Training could be enhanced by including how to be a care partner and help people live out their lives in long-term care. Design services based on the people in the care taking their life experiences into account.
- Caregivers need more continuing education updates and training in the caregiver's specialty.
- In AFH, patients can be discharged in less than 30 days in the home. We need to provide resources so caregivers know who to go to in the event of these crises. We need to increase the level of financial support for Medicaid residence.
- Training should include how and when to recognize that you will not be able to care for a person.
- MH training should also include depression and how to deal with people with depression.
- From a family member's perspective, the AFH is not notifying us about charge increases, etc... I would like to see training that includes rules and regulations about interacting with family members.
- Specialty certification is misleading residences and families.
- I think specialty training should be opened up to family members.
- The person-centered approach should be the focus of the training model, not the medical model.
- Provide resources to families looking for placement of a loved one. If you have money you can use a placement agency. If not, there are no resources to help families.
- There is too much information to learn in only 8 hours of training. More time is needed to discuss each topic, ask questions and go back and forth to ensure learning.
- Is it unreasonable to have field training in addition to the classroom training? How can we put what is learned by caregivers into practice?
- Asked for feedback from owners - would like evening and weekend classes, or to have trainers come to their homes
- Others noted they do offer evening and weekend classes
- Offer online class, then go meet with real person for assessment; would allow for self-pacing and more time to digest information (could have a blend of both online and in-person)

- Some people prefer a live instructor so they can ask questions
- Can't think of any part of the curriculum that is not essential, but key is in how they apply the knowledge and really interact with people. Hard to find/identify people who care.
- Big difference between head knowledge and heart knowledge.
- Need to connect to real life experience; like videos that present scenarios and how to handle them
- What gets in the way?
- Cost
- Time required
- Don't really address exceptions ... not everyone starts from the same place
- More difficult for AFH to cover staffing; may not be computer-savvy
- Helping caregivers manage their own lives - help them set boundaries around the job; how to deal with death and dying
- Mental health directive in the book is not helpful - don't ever see them in practice
- Care plan and assessment (of residents) is not part of the training. Need to learn how to connect the dots and think critically about what is happening, what needs to happen next.
- Help in managing your own behavior when residents going out of control
- More on crisis training - exists in curriculum, but weak. (and mental health support system is very broken, so people will need to handle crises on their own.)
- Make sure scenarios reflect real life. E.g., "take her for a walk" may not be possible because 1 caregiver is responsible for 5 others.
- May need to help managers/owners be better equipped to evaluate who/what they can handle in their home.
- Understanding baseline (e.g. Schizophrenia). What is typical for this individual? What behaviors to expect or look for?
- Same curriculum for ALF and AFH - very different models and needs
- More coverage/better understanding of behavioral manifestations - linked to care plan
- Communication training really lacking - with residents, family members, resources, etc.
- List of different disease types very confusing and not practically useful - covers too much territory; focus on most common processes and issues that come up
- Material is hugely outdated. Many changes happening now in mental health field.
- People need to go beyond basic preparation, regardless of training, to take on people with dementia or mental health issues.
- Practicum is important. Learning from books or lecture doesn't translate into real life practice. Must be usable information.
- Beyond basic levels of care (ADLs), not sufficient for helping those with dementia or mental illness.
- Is there a Teepa snow for mental health? Don't know of anything.
- New data - medical journals and literature - gerontology, mental health etc. Tons of literature, lots of research going on. Consortiums working on specific aspects, e.g., qualis health.
- Works locally with a geriatric interest group. Get together once a month to discuss issues with our industry = grassroots. Spokane regional health is a great resource. WHCA. Leading age.
- Content does a pretty good job. Touches important factors
- Corporation has a lot of its own training - have memory care facilities. High value in training, may use some of that training.
- I don't think the providers have an understanding of what the stages are, and they tend to lump all behavioral problems as mental health and they can't distinguish between them.
- Like person-centered care, communication, understanding disease.
- For MH - more coverage of dual diagnosis - depression, bi-polar, anxiety
- Training on interacting with family members and their needs for emotional support around end of life
- Per trainer - the training is boring! Outdated. Too much medical/intellectual material. People do it because they have to - not because it is useful.
- Needs to be more practical
- More to the point and hands on - was a lot of paperwork and reading
- Need to be able to hire the right people, right personality
- Training doesn't help caregivers understand what is happening with the people they are caring for
- Discussion about empathy - training should 'teach' or at least 'wake them up' to understanding the other person

- Need to blend both sides - understanding the person as well as giving caregivers technical skills to handle situations as they come up
- Mental health and dementia courses too similar/redundant.
- Too much like memorizing material in high school to pass a test.
- Understanding how diagnoses manifest - what comes up?
- Understanding paranoia, delusions, appeasatory behavior, refusal/isolation
- How to handle physical aggression, prevent falls - issues that tend to keep people out of homes
- Acquire training has good programs, anyone can use (CES)
- I think the biggest population we see out there is personality disorders, and that is not covered by the book - those are what we see. Those are what our main audience is, and the book does not touch on them at all.
- It does a fair job with anxiety. I would add more on comprehension and understanding of some of those aspects.
- The cultural sensitivity section is not very well done at all. I see what they are trying to do, but it wasn't done very appropriately. When you are from this culture, you can write a cultural sensitivity module and miss a lot.
- When you are talking about cultural sensitivity, we need to have an awareness that the melting pot doesn't always happen. And different people will pick different things that they will incorporate and others will incorporate other things.
- I tell this story about when I was an administrator, and this cute Japanese lady moved in to my facility. In my enthusiasm, I got in contact with a dear Japanese friend who was retired, I asked her to come over a couple of days a week, speak Japanese, and bring Japanese food over. We did all of this extensive process, and it turned out that my little Japanese lady didn't speak one word of Japanese. I was trying to create community, but with all the best intentions I got it completely wrong.
- Cultural section is written by somebody who knows all the right steps from the book.
- We need to talk more about the different levels of care - it's not a group kind of thing. We need to give them some hands-on skills. Much more talking about behaviors and labeling those behaviors - those need to be identified and explained to them.
- If they are a DD provider, they have no clue sometimes - it's that understanding behavior piece. Most people think that the client is being demanding and irritating. What does that look like? Some people are good natural supports... there are things you can do to support mental health. Remove stressors, etc. You aren't giving in... you are assisting them in managing their mental health.
- We don't care if somebody diagnoses mental health, because that is not their job, but they should recognize signs and symptoms. Sometimes, depression might manifest as staying in their room, and no AFH is going to report that.
- We don't want diagnostic clarity, but we want them to share information and want them to notice these things as potential signs of mental illness.
- We ask for the same things from the folks at the job sites - watch for behaviors that might be symptoms.
- Incorporate mental health basics into the DD specialty training. Incorporating that one of the reasons for behavior might be mental health issues.
- I see that a lot of new providers want to take mental health residents. In some ways they are easier - they can do a lot on their own... But those are the folks who have the behaviors. In licensing, the homes I saw get in over their heads were the ones trying to take in this population. They didn't understand what they were getting into.
- What to look for—how to identify that a resident's condition is going downhill.
- To know enough about mental health to be able to assess whether a potential resident will trigger a current resident.
- An understanding of the medication. Even doctors don't necessarily understand how all of these things will work together, so how can we expect homeowners to get it?
- Behavioral challenges.
- Accessing mental health services in the community.
- Undiagnosed personality disorder.
- The more services you give some of the providers, the more they want.
- How does an AFH take the time to address that need and move on, because some of those mental health needs you don't move on from.
- They need to understand that there are other resources out there rather than the HCS.
- Sometimes they need somebody to come out and do one-on-one training.

- They need to know how to go about asking for and getting the services from the mental health agencies. Sometimes they won't follow through or demand the rights of the individuals to get those services.
- Sometimes they have respite facilities - to be able to get somebody into a respite facility so they can deescalate.
- Sometimes they think their only support is 911 and the ER. To have those caregivers know what to do on a weekend when the social workers are not available.
- Accessing crisis services in particular are challenging.
- I think mental health is such its own field that people don't know where to go and when to go for it. So some of the things you see with people escalating with hallucinations or delusions - you need to notify a provider early.
- Or when they stop taking their meds... give it a week, and they will probably be in a whole different state. What do they do when this starts, and who do they contact? They also need to know how to document these changes.
- Looking for signs of suicidal ideation - is this person actually just trying to manipulate the situation? You need to contact their MH provider to make an assessment.
- The desperate homes who take in a MH resident in, and then they realize that they are over their heads and that they should have done a better job assessing.
- With mental health there is a broad spectrum of diagnoses and situations. I see a lot of clients with personality disorders and that goes along with a med-seeking behavior, manipulation of staff, wanting to change the rules of the facilities. And I think staff needs to be direct and clear in the direction they give those clients so they are less likely to be manipulated.
- Sometimes staff become tolerant of inappropriate behavior and it is better if it is resolved in a timely way.
- We had a borderline personality disorder in one of our homes, and they were telling this client that she wasn't allowed to do certain things like leave the residence, even though it was an open facility. So of course the resident tested them, they started to get into "you can't do this, and you are going to get this taken away" vs. Having a behavior contract in place with her. They didn't have a plan as to how they were going to deal when this client started testing things. We had to send a social worker out to build a basic plan with the caregivers. Even with that, they didn't follow through with what the contract said, and when you do that, it just exacerbated the problem.
- I think there is a bigger systems problem - there are limited restrictions on how they serve our clients
- If a resident is decompensating, the community resources are not able to support the home, so the home ends up on its own. We don't have a place to stabilize them before we bring them back into the AFH.
- I don't think there is much training about de-escalating residents. It seems like what I see is that even where there is a lower-level crisis, even if that is a part of their baseline, the caregivers kind of are paralyzed and don't know, and are trying to figure it out as they go. Is there a crisis plan in place?
- I have observed that often the crisis plan is there, but they haven't been trained on it, and they don't access or use it.
- I don't know if they know much about the different diagnoses.
- Sometimes splitting of providers, or triangulation, (manipulating caregivers) that if there were more basic training they would have an awareness of that.
- It would be helpful if they had a refresher every couple of years. I know that's hard. Could that be done with the technical assistance that we have available? We don't have the providers available here. It would be nice if we could utilize those kinds of funds.
- Same thing... crosses all three specialties
- How does a provider take notes and document changes that they see so they can advocate with medical personnel, and can communicate with the social workers and families.
- I think that the beginning care level for a new caregiver is completely inadequate. The people who are coming in are far heavier care needs and require more care than when I started in 2000—for dementia and mental health. They are heavier care and require more knowledge. The caregivers took the training years ago, and that does not prepare them for the clients they are getting today. They are getting the highest risk of anything.
- The training is inadequate to manage people who have mental illness or dementia.
- Crisis, crisis, crisis. They do not understand the complexity of the mental health diagnosis.
- You look in there and you see a borderline personality or bipolar, and they read the words, but they don't understand what it means in terms of behaviors. They don't understand until there is a crisis.

- Too many homes that take MH clients are too eager to take them right out of western state. And there's not a whole lot of support there.
- Navigating crisis response is ridiculous. There is not much crisis support, other than calling 911.
- They have to be real experts in mental health if they want to serve folks.
- Coming out of western state, the money is pretty attractive to an AFH, but I have seen homes who have kept people who have lit the couch on fire and stuff like that. They don't understand that by retaining that person, they are jeopardizing everybody else in the home.
- The providers do not have a handle on medications. They do not understand how missing a couple of pills can seriously affect behaviors.
- They also don't understand when there is a side effect to medications.
- In addition to that, a lot of MH clients I see in AFHS, they leave, go into the community, get into drugs and alcohol, mixed with medication, and it becomes a real issue.
- And sometimes it takes months to see if a medication will work. There is nothing instant, and there is a lot of belief out there that there is a magic pill.
- Recognizing symptoms of over-medication.
- Again, it goes back to education, but the providers don't have a real understanding of how sleep, food, fluids, will impact how the medication affects the client.
- That's a good point for all training for all - overall general health and wellness... Proper nutrition, hydration... diabetes, there is so much that could proactively be done.
- A lot of behavior is blood sugar... and it gets attributed to the mental health (issue). It could exacerbate the MH condition.
- You have people sitting all day, not moving or walking. Decent nutrition, getting enough sleep
- Everything we are saying applies to all three populations of clients.
- Maybe the providers do not want to accept the rate that the state is offering for a mental health client.
- I think with the MH clients, it is going back to understand how to address behaviors. Being consistent with a behavioral plan. Taking the client's behaviors personally and not responding to them appropriately.
- I have just seen them struggle with what a family's expectation of care is vs. What a facility owner thinks they need to provide.
- Positive behavior support
- Always work hard at looking for strategies that will effectively deal with issues as they arise.
- Approaches
- There is a very wide variety of issues for people experiencing mental illness
- That often navigating the systems is more frustrating for the individual than the mental health its self.
- Most of my evaluations state that learning about the various disorders was paramount
- I think the mental health is well covered.
- More practical ways to defuse a negative situation by redirecting.
- That mental health can be more than one diagnosis
- Be sure to re-evaluate a client in case they built a tolerance to the medication and are at risk of decompensating despite taking their medication. That it takes time for new medications or for medication changes to have an effect on the client's behavior. The managers need to learn more about medications, their effectiveness, that there is a lag in the medications having an effect on the client, and which medications shouldn't be stopped suddenly.
- Have a better understanding that the residents hear voices, they talk to their voices, they act on their voices, and they believe in their voices. Accept the residents in their reality and guide them that it is not our reality but it is theirs. Listen to their opinion, do not tell them "no you don't have voices". Listen to the residents and let them speak their mind.
- That with MH it's not all black and white it is a lot of grey areas, and sometimes you need to just provide safety, and space
- Respect and trust are huge values to work with mental health.
- Strategic communication for the caregiver to talk to a resident with depression and suicide prevention
- Identification for reasons for delirium and how to report suspicion of a possible delirium
- PTSD
- That the police will not do anything, our mental health system will not detain anyone and the mental health assisted living in Moses lake-city view does not treat dual diagnosed residents. They do not accept residents who have dementia. Mental health does not easily work with assisted livings to coordinate a plan of care.

- Comments from recent evaluations:
- Would have liked to learn about medications.
- Would have liked more time in the training.
- More specific examples of behaviors and training on appropriate redirection.
- Nothing comes to mind
- I thought the training touch base with everything that would be observed in our setting
- What do you really say when the resident still is worried about the voices in the closet....
- Dealing with mental health folks is challenging.
- Having been a psychiatric nurse in my past, I found that having real stories to share with the staff members helped them to understand. Having good role-play scenarios ready to go, helped me to give them practice before trying an intervention with a resident.
- Clinicians will lower the levels on mental health drugs periodically to make sure they are on the lowest dose needed and behaviors can escalate rapidly.
- Spotting triggers and communicating them to your staff
- Dealing with residents that are having hallucinations and delusions should be covered more extensively.
- Nothing I can think of
- You always learn so much on the job. That is a tough question.
- I learned a lot about treatments for mental health residents.
- Nothing, actually! D'Sandra Simmons at WHCA was my trainer, and she was incredibly thorough.
- More in-depth information about the various disorders.
- Examples of how to diffuse situations.
- Again, that it is the illness talking, not the resident.
- How often mental health issues are not diagnosed, and many are family-related. The client's issues have been with them for a lifetime and the family has developed challenging behaviors to cope. Caring for a client may also involve a family member whose visits cause outbursts and trouble.
- Deeper info on suicidal ideation and how to work with a resident who is despondent
- That there more type of mental illness.
- Personality disorders are not included in the training and often represent one of the larger challenges for caregivers.
- You cannot teach what I have learned in a book. Hands on is the only way to learn how to work with mental health. There are so many kinds of mental problems that you have to deal with that you have to work with them one at a time and learn what works with the person you are dealing with at the time.
- We should have spent more time on the specific mental health issues that a care giver would come into contact with at our community - instead of the ones in the book.
- How to discharge a client who is not fitting in with the homes other clients.
- I think there should be more examples and personal experiences of individuals who have worked with those with suicidal ideation, panic disorders, anxiety, schizophrenia (movie "a beautiful mind"), talk about behaviors that happen to individuals who are mentally ill.
- Cultural awareness
- I work specifically with dementia. The dementia out weighs the mental health. I think I am better prepared at recognizing depression vs. dementia and ways to treat
- I wish there had been more information on the DD population who also have MH problems.
- I think it is easy to mix up how you interact with residents with dementia and /or mental health and your approach needs to be very different.
- Took more classes on bi-polar, depression, schizophrenia, and suicide and learned more. I am a visual learner so video's and demonstrations help me learn better than reading and talking about something.
- How to navigate a broken system.
- How to identify and modify my reactions depending on what kind of mental health diagnosis I was dealing with and not to take things personally
- Don't remember.
- Approach, approach, approach.
- You have to be creative
- Mental health is different for each person
- Continually work on helping students of the training to recognize mental health issues and how to interact with the residents
- Focus on approaches

- I felt it was a good broad overview. It is not enough training if a facility has many people with mental health diagnosis
- It really could be about a 2 hour class considering how much of the material is given to MH advance directives, and cultural stuff
- Longer, more frequent, on going training.
- Ideas in how to redirect.
- DVDs of what mental illness symptoms look like.
- More information about medications and their side effects. More information about decompensation and what to watch for.
- Teach the above statement.
- It is a lot of information to cram in 1 day of training. For both the mental health and dementia.
- Get rid of role - playing - provide video of experts interacting with mental health clients - show interviews of experts discussing the various illnesses - show clips of movies like a beautiful mind - make the course interesting.
- Higher knowledge base educators. Share experiences with students.
- Have a better method for skills testing
- Remove the parts of schizophrenia, bipolar and mania and add it to a specialty addition- similar to the nurse delegation and diabetes designation.
- I personally add to the training some personal experiences that I have had, and tell of outcomes.
- It could not hurt to have different examples and scenarios of different mental health problems.
- Add PTSD information
- Rewrite the tests
- More information on cutting, manipulation, lack of mental health services, drug seeking residents, resources available to us, the effects of smoking when taking certain meds they are less effective
- Allow providers to enter the actual length of the training on the certificate of completion. Include schizoaffective disorder, personality disorders, and psychotropic medications in the curriculum. The following are comments from recent training evaluations:
- More time
- More time for skill practice
- The experiences of the trainer were helpful, more time for that.
- I would love more time. Kay has great stories and tons of experience to share. More time for real life situations and how to react.
- More time, diagrams, maybe a video
- I really don't know. I don't think so.
- Provide closer to date of hire.
- Do more real life scenarios and role playing
- Obviously more help with trained mental health workers to help our case management
- More time to work on real life scenarios in hallucinations and delusions
- Deeper skills with dealing with folks with mental health issues.
- A supporting video would be nice as long as it a quality video with examples and demonstrations of various mental disorders.
- More on coping with behaviors
- Have more of it in continued education, never enough
- Non verbal cueing, make sure staff are more aware of the differences with hallucinations and delusions
- What happens when there is a dual diagnosis. Anger management, caregiver care self care
- Investigate what the mental health relapse plans that are being used, I have never seen the one in the book in the community, nor have I seen the advanced directive for mental health. Not real useful if not used in community.
- Include better examples of how a person may act or react during care or in a community care setting.
- I would shorten the sections on schizophrenia, and bipolar disease. We don't see that much of those diseases. I would focus the caregiver training on observing, reporting, and following the service plan. Caregivers do not decide how to intervene with a schizophrenic's hallucinations or delusions; that should be part of that resident's plan. I would also eliminate the section on relapse plans. After 34 years in nursing homes and assisted living in Washington, I never received a relapse plan from eastern (when it was open) or western state with an admission, nor from a hospital unit like St. Peter's psych unit, auburn gero-psyc, etc.



- Again, if it could be online, I would expand it an extra day to go more in-depth in the disorders, but I could not afford that as an employer if it were not online.
- Make it 4 hours.
- Videos of the anxiety, bipolar, schizophrenia and depression like the dementia class and how to deal with challenging behaviors
- The training is good I just don't care for the scenarios though I am sure they may be helpful to some people.
- I have brought in outside illustrations. For example, a picture of a smiling woman looking into a mirror, but she sees herself with her tongue sticking out in derision.
- Bi-polar: the importance of the health care team, baseline and lifetime therapy.
- Discuss the interplay of mental illness with other illnesses (i.e., dementia) & how to determine what kind of intervention is needed (i.e., reality orientation for the mental illness or validation for the dementia)
- More skills and less written
- Topics can be broadened in terms of type of mental health and how to deal with it.
- Add personality disorders to the training with interventions and effective communication tactics
- I would have my trainees work in a home that has mental health for part of there training.
- Give more examples and ways to work with the different mental illnesses.
- Talk less about diagnosis and more about what to do when confronted with different kinds of behaviors. For example, much time is spent (and tested on) diagnosis and how a physician determines for example who has depression. What I think is needed is when you find that a person isn't doing things they liked to do before, what do you do now.
- Add the discharging a client part.
- I think seeing examples of mental illness and discussing it with your peers or a professional who can talk with some background and knowledge of mental illness. What is covered is a beginning but just a drop in the bucket for actual hands on experience.
- Communication test prior to eligibility to take the test.
- Include cultural education.
- Increase hours to include more disorders. Include self-care into LTC curriculum including resources to go to get help - mostly for addiction as needed: WHPS
- Again, just the tip of the iceberg!! So much to cover and so little time!
- Make it available in Pacific County
- I think really look at how to communicate, respond to various outbursts, paranoia, delusions, etc. How to assist residents through the mental healthcare maze.
- Incorporate it in the dementia and call it good.
- Add videos, visuals, graphs, more in-depth information on medications, side effects, and hospitalizations.
- Although I enjoy providing this training it lacks in a number of areas. I was once adding videos and audio to my trainings, but was informed that I was not allowed to as it was not approved. Sad, staff have no idea what we are actually teaching...needs more!
- If you can teach it in a facility or adult family home why cant you teach it as a community instructor? The requirements should be the same.
- Add video to the program
- If you offered this as self study with a test I think it would be more available to caregivers
- Add a wallet size reference card for caregivers to have handy with resource links/phone numbers.
- You need to teach caregivers that their reactions can either escalate or deescalate a situation and to choose their actions and words carefully
- Provide information about dually diagnosed people and the issues involved in caring for them.
- Offer more classes at better times and places.
- Good overview.
- It's fine
- I thought the mental health training was much more realistic than the dementia training. I feel fine about it. Though the skills exercises are a bit overwhelming.
- How to cope

### Specialty training access and delivery

- To say that you can learn what you know to take care of mental health clients in six hours is not realistic.
- Helpful to practice skills in the class.

- The trainings should have more dialogue rather than being about the book and these different scenarios.
- Place more emphasis on how residents behavior is 'not personal' – residents don't mean to be difficult. In curriculum, but trainers may emphasize differently.
- At ALF: classes scheduled as needed. Lots of on-the-job training + refresher courses. Important to model appropriate care. Observing on the floor and reinforcing. Getting more than required hours of training.
- May be very different at AFH; may not be anyone there to observe or coach
- Harder to teach small groups. In small community with low turnover, may be hard to schedule.
- Some people get it. Some just do not. In a small community, owners do not have a lot of options for staffing. Will keep working with people who aren't getting it.
- It isn't all on the trainer. It's not the trainer's fault that they are not learning.
- The role play isn't realistic to what happens.
- Homes should have more expertise before caring for residents needing specialized care
- Spend a lot of time dealing with anxiety and depression – very common for anyone coming to ALF or AFH
- MH often involves multiple conditions
- Believe RCS looks at primary diagnosis when verifying qualifications (which training is required)
- Typically MH not primary diagnosis, but common for many residents to have issues
- If multiple conditions, provider can decide which training is most applicable for caregivers
- Need for clarification with licensers
- May have been living with MH conditions all their life, now exacerbated by aging, dementia, etc.
- The needed material is present in the book. But you cannot just go through the training, take the test, and you're done. The training gives an overview and expects the trainer or care manager to go into more details. We just do not have enough time.
- The required content is present in the training. We do not have enough time to dive into questions and fully understand because there is just not enough time to go over the material as needed.
- Trainers that bring examples of training into the classroom have the greatest positive impact on training.
- The content covers what is needed and to me this is at least three days' worth of training.
- The level of training is not consistent across the state of Washington. Consistency is a problem.
- What do I have to do to prove to the state that I am qualified to teach the class?
- There must be interaction and discussion. That is what makes the training work well. Just watching the video does not work.
- The most useful part of the training for me is hearing about life experiences. I think OJT is great but that falls on the care managers for continuing education.
- The timeframe is way too short. If you are just teaching the mental health book, it's four hours - that is not enough time to cover the topics in here. We originally dedicated eight hours, and got it chopped back to four.
- When we asked to use this and give the full six to eight hours for this training, they said (DSHS) that we had to only allot four hours to this. And only four can be related to this topic. And the specialty component is where you can go longer.
- You get in there where students are talking about this stuff - and you can bring out more when they are talking about their life experiences.
- The role-playing, for me, was the most effective part. It's kind of hard - for somebody who has experience in the field, that perspective is different than somebody who is fresh.
- [We should have] somebody training the class who has had some of the experiences themselves. Allowing more time for education [based on personal experience]. I think this is what resonates. They will have tools and things that are useful, outside of the material.
- The dementia curriculum does a lot more in how to approach - the role-plays, whereas the mental health is pretty much devoid of that component.
- Part of problem is people getting core training online (due to 1163).
- Struggle with role-playing exercises, particularly with ESL. Hard to explain and get through with various individuals in the class. And process itself is uncomfortable.
- Class size?? One trainer noted she doesn't have more than about 10.
- Can be too much lecture format. Need to mix up the styles.
- A lot of my training we were working out of the workbook, and I would have preferred to do a hands-on practice session. My staff retains the information better, and they can see how they will apply it with their clients.
- As opposed to the role-playing, letting them work in groups to solve example problems.

- In the videos, they often turn to the managers, but you may not have a manager handy if you are a caregiver in an AFH.
- It's pretty hard to get all the scenarios into a video.
- That's the kind of training I had - we all had scenarios and somebody was acting like the client. That was very useful.
- Some of my caregivers who have been to the training, they have gone from being a layman to having medical terminology - it is very technical.
- Suggest more time, but broken into smaller chunks.
- It's a lot to take in within a short amount of time. And they have expressed that they wish there was a follow up class.
- We have extended the trainings to nine hours (including the test) based on feedback from our trainers - they told us that it was too much information.
- I find the information about medications to be overwhelming for the caregivers.
- To say that you can learn what you know to take care of mental health clients in six hours is not realistic.
- We need to figure out some way to train in-house to really receive the training that is most useful to the people who are living there. I think the advanced specialized training should be internal.
- I recommend designing training for the AFH or ALF specific to the residents.
- We use the huddle. This just happened. How will we do it next time? We need the basic training and then ongoing training and coaching. I expect the care manger to have a toolbox of experience and options. Training needs to evolve with the person.
- What is the lowest common denominator? For AFH one person does not have the years of experience. We need to have a system to bring in the expertise or tap into the community knowledge.
- Building a therapeutic alliance with the caregiver.
- I am thinking about my staff. They need the basic what is expected of them. What I really need for dementia and mental health, and what I spend time talking about, is what does it look like? When I get a person who is bipolar at park place, what does it look like? I spend a lot of time teaching my staff what it looks and feels like to have dementia. I do not use the cd's. I use a course from the university of Georgia.
- I think the training was comprehensive.
- I think having people with these illnesses tell their story during training is very powerful. Allowing patients to have their own voices would be great. That authentic voice is invaluable. Ombudsmen can be good partners in helping bring patient voices into the training conversation.
- I think bringing the ombudsmen into the training would be very helpful and valuable.
- Multiple levels of training. I think it would help.
- Big difference between content and delivery. Getting theory does not translate into real life interactions.
- We use practice in the class through role-playing. Some people are 'blown away' by the kinds of interactions that can come up - and learn a lot more from the practice vs. Theory.
- Class delivery depends a lot on the instructor. E.g. Some just hand out a book, some use a lot more scenarios and interaction.
- Take concrete events (resisting showers, specific behaviors) and offer concrete tips
- Training is barely different for caregivers and managers - may be a need for more differentiation
- Brain pictures work really well. Helps people understand impact of what is going on inside the person's head that is affecting behavior.
- Time is tight to deliver required material. Mistake to try to cover MH in 4 hours - used to teach for 8 hours. Some teach for 6 hours, but owners don't want to pay for more than required time (4 hours).
- May be helpful to have tiers that allow for more specialization and refreshing knowledge
- Six hours on any topic is very minimal. Not sure how much more is needed, but not enough to be considered a 'specialist'. Might suggest 2x.
- Financial barriers - need to cover care while people are in training.
- Students may not be enthusiastic about the training.
- Need to understand diversity of students in the class. May have variety of backgrounds and personalities, but instructor needs to bring all of them along.
- Some overlap/duplication - but good to have reminders. Important material that applies to both.
- Would be helpful to have better tools for instructors - guidance, video, appropriate test answers.
- Very happy when we got workbooks.
- Going through the book can get a bit boring. Tries to include scenarios and keep it lively.

- Facility does a lot of ongoing training. Employees often already have some skills and experience. Productive to have students' own scenarios to discuss. Usually wait 30 - 60 days before employees take this training (making sure they will last and also so they have had orientation and some experience)
- Last summer went through best friends training with David Troxel
- Hiring online provider for CEUS
- 12 years ago training lasted 4 days - big difference from content now
- Training has gone downhill since what I took many years ago
- What I 'have to teach' is very different from what I do teach - have to include 'extras'
- We used to do a lot more role-playing. It made me uncomfortable, but we needed it.
- Do more OJT training - by pairing new caregivers with a mentor for week(s).
- Would like to see more orientation/foundational training.
- What to take out? Technical names for stuff.
- Have to keep trainees engaged and entertained.
- More of a roundtable. Acting out can be embarrassing. But inviting people to compare ideas, what they would do.
- First of all, I would like to see it in a three-tier system - we have a testing process for people who will be caregivers, and another one for managers. I have a really hard time with that test for managers - it is so English-intensive that many of them have a hard time getting through it. It's ridiculous. It's a great test if you are going to be an instructor, but the reality of it is, many of these people are only going to manage their own business. I would like it to be more like DD where you have more time, but take the test in smaller pieces as you do every two or three modules.
- Caregiver, manager and instructor levels for test. I would like them to have teaching experience, but also more intensive training.
- What I have always found is that it is hard to get people to trainings. So the owner goes... but I'm not sure tall the caregivers get the training. The sense I get is that the owner stops by once or twice a week, so I am not sure that the people who need that training get it.
- An online webinar would be really cool. I'm not sure if that would be a barrier. I think it would stop our access issue of getting the right people to hear it to get it.
- We used to go into each AFH, and that was great, but it's pretty cost-ineffective.
- If you could have something where there was an AFH consult group - where they could video in to a webinar. Where they could talk out problems regularly.
- Any time you are talking about the spectrum of mental health and developmental disabilities... I am less interested in them getting 18 hours at the beginning, and more interested that they get something every three months.
- I think it's very tough to get a lot of skills out of a one day training, or even a three day training. And these people who are providing care are in a setting where they have a very tough schedule.

### Impact of language and culture on specialty training

- I work with a group of people who have language differences, education differences. If I let them discuss with one another about what is right or wrong, they get more out of it.
- Different words in one culture may mean something else in another culture... also, understanding what is culturally acceptable. For instance, taboos about dementia and mental health.
- Important to address intergenerational culture differences. The younger staff is willing to talk about it without a problem. The younger generation is much more open to talking about mental health, but may not understand how older residents may feel about it.
- The generation that is my building grew up respecting elders, respecting themselves, and their work. The generation that is taking care of them is completely different and doesn't understand how things they say may be interpreted.
- Similar to dementia – training needs to be practical for the caregiver
- Cultures view mental illness differently
- Us culture around MH can be very elaborate, clinical
- Can be issue of education as much as culture
- MH residents may be younger – resulting in different issues
- I provide different cultural training specifically for the Jewish community.
- Cultural training is more textbook and less relevant to what is needed.

- The history of the person is just as important as culture.
- Language in the test makes it unnecessarily difficult for people who are not native English speakers. Uses words like 'may' 'inheritance' 'heredity' 'strengths' 'meaningful' that are not clear and/or familiar. Test-takers don't want to speak up.
- Culture section a favorite module to teach - really gets participants talking, comparing experiences, etc.
- Trainers need to do their own self-training in cultural sensitivity. Some groups may never question an instructor, even if they don't understand.
- Touching is a big cultural issue - norms and preferences vary widely.
- Helpful to have options in different languages. Sometimes training participants will bring someone to translate. (But still need to have enough communication skills to handle emergencies, call 911 etc.)
- Need to increase understanding of different preferences, foods
- May have gaps in generational understanding - need to cover ways of approaching people
- Cell phone use
- The homes themselves have cultures. I don't know how you would possibly put that into training... but there is a difference.
- I think it's important just to open the topic of culture difference. We talk a little bit about it, but not enough.
- Clients are emotionally driven, so if you have a caregiver from a culture that is task-oriented, it may create friction.
- They need to know what is expected and what to do in specific situations. I have to take the patient's culture and put it into the caregiver's culture.
- I put cultural stuff at the very beginning. I want to know the culture of staff members to help them be better caregivers, understanding the culture of the patients.
- I like the part of the training that talks about communion. What if someone says I just came from out back and ate someone's arm? Crazy or catholic? Also, burnt offerings within the Native American culture.
- Mental health and dementia. Go back and ask this question and tell me the answer. Teach caregivers interviewing techniques
- I like to ask questions that inform me about your culture. Does your culture have this type of facility? Behavior comes from their understanding of the world. How do I get someone to relate first hand to my experience of culture? I use Santa Claus as an example.
- I think cultural training needs to cover cultural biases? I think it is hard for people to share their cultural biases.
- To me the biggest factor is the trainer themselves. Especially with language and cultural. The trainer is important and they need to know their audience.
- Teach how you as a caregiver get to know your patients. The trainer is a role model.
- Training aids need to be translated into the cultural and language of the caregiver. Make it easier to understand in their language.
- We ask everyone the question what do you do in your family to celebrate Christmas. This conversation helps us share and understand we are a community yet we are all different.
- Yakima has 60% Latinos. I firmly believe things have to be translated appropriately.
- My facility is predominately Japanese. Using their primarily language will help learning tremendously.
- Training needs to be taught in the language of the caregiver. We must start with one group at a time and make it happen.
- If we are interested in ensuring people know how to take care of a behavior. Training in their own language will facilitate learning and address cultural differences along the way.
- We need to have greater access to teaching English as a second language to help empower our staffs.
- Respect. I want the caregiver to know that I respect them and their culture as well as want to educate them on the culture of others so that they can provide better care for our patients.
- We teach cultural differences in our CNE and community home programs. What we need to know is the disease process in other languages.
- Currently, training is one size fits all. If we are moving into the 21 century. We could look at translating training documents into the 5 main core languages and offer training done in English and translated into the 5 core languages.
- I think training should adapt to what every language is needed to improve learning.
- In my experience, my mother did not understand the caregivers and she just said yes to everything. She then developed a new personality and the response was to drug her and address the communication problem.

- I think we need to broaden the diversity of the trainers.
- A lot of people from other cultures have a greater respect for the aged.
- Touch, approach, nonverbal communication is critical.
- I had a Spanish-speaking woman who was blind. The caregiver was Filipino. They had a great relationship based on how she spoke to her, approached her, and touched her. It was amazing.
- Life stories and behavior challenges are noted on the care plan. If caregivers cannot read the care plan, how can they be expected to help their patients?
- When elderly people age they start to go back to their first language.
- We need resources that help identify facilities by cultural competency.
- In previous training, had to sit down with each other and gather background information.
- Important to find out about caregiver's culture
- Some don't comprehend the material - may be language issues or level of education - e.g. Words we use to describe mental illness
- High percentage of ESL ~35-45%
- Age may also be a cultural issue - very young caregivers don't have life experience or context
- How to deal with racial language and responses - varies greatly across generations
- Can be introduced as a potential challenge, include some examples
- Caregivers who are not clear in English have more difficulty communicating with residents, receiving training and comprehending test. Able to demonstrate that they understood in person, but couldn't pass the test.
- Diversity is a strength in our team. Some from other cultures have more affinity for caring for elders.
- Generational differences can be very challenging.
- Practical aspect of training needs to increase awareness of differences and how to approach people differently. But hard to teach people to be respectful, caring or patient.
- Could be helpful to translate materials. Residents are allowed to have a translator in their own language, but caregivers cannot. Home care aid exam translated into xx languages - but not NAC, only in English. May eliminate people who could be very effective.
- Can impact ability to pass test. People with different language can communicate as needed, but struggle with written test. Tries to help them with different wording or scenarios.
- E.g., someone was struggling with understanding the questions. Instructor read questions, which was easier to understand vs. Reading the words.
- Most caregivers are high school graduates. Material may not be appropriate or relevant to them - seems like PhDs wrote material.
- Huge impact.
- E.g. Very task-driven Asian caregiver. Good nurse but rubs people wrong.
- Highly Hispanic population in Yakima. Many caregivers but very few residents.
- We don't hire people who are not very fluent in English - because residents don't understand them. Even housekeepers and dietary workers.
- Less complex than in urban areas where there are many languages.
- Have residents who are very prejudiced, or treat caregivers with no respect.
- When I took the specialty training myself, I noticed that there were a lot of issues with language barriers.
- They pigeon-hole clients, but we know that is not true. Our clients are not 86-year-old grandmas anymore. They are getting younger and younger, and it can't just be confined to the elderly.
- They should pay attention to young generations. I always have to qualify the material. The material is written for facilities with an elder population.
- There is not a training aimed at the younger population.
- The recognition needs to be there that this younger population is going to age.
- If you aren't part of their language set, that might trigger something—if you can't understand what they are trying to tell you. The family member observations might be different—the treatment might be affected by their culture, but overall the symptoms might not be.

### Specialty training testing/assessment process and effectiveness

- Need to verify skills. How do you know they can apply them? If training own staff, can follow up on real life experience. Could build skills scenarios into video – discuss what happened. Some discussion occurs.
- Exam includes both written and skills portion. Skills exam is a made-up scenario that participants act out. Many caregivers just finished high school or didn't finish. Feels stressful, awkward and fake.

- Perceived very hard, even for someone with RN and interest in psychiatric nursing
- Seemed to emphasize lingo more than practical skills
- I agree we have to have an objective, concrete, written tool. In my experience the test is poorly written.
- Biggest challenge = accurately and fairly judging manager test.
- Manager test includes material that is not in the book.
- Hard for ESL participants to understand questions to pass the test.
- Nothing in the book that we buy that managers need to pass the test. Stopped using the book. Can't finish in two hours, even with open book.
- Content of the test needs to more accurately fit/reflect the desired skills.
- Focus on the test takes attention away from building skills that are more important.
- Some trainers give verbal test, to further assist those with difficulty understanding the language.
- Skills testing is most important, but has written own scenarios because standard questions don't fit.
- I don't know how great a measure it is, simply because we are dealing with people across cultures who may have language barriers. I also don't know if you take the video and the workbook, I don't know how well that is aligned to the questions on the test. And while they spend some good time on communication, the test is weighted very heavily on communication questions.
- Everything on the test is learned there in the class, but it may not be retained.
- Where is the ongoing assessment of skill sets after the training?
- In the mental health system, most people know what to do. I think they either do not do it or the system does not allow them to do it. Training is only a piece of it. We do not have a way to check whether the training is learned. We need a systematic way to check training.
- Is there assessment and care planning in the training? If it is a Medicaid client a team of people (mostly social workers) complete a care plan.
- The step that is missing is I have to take the CA and then write my staff a recipe card. The flow sheet is what we need to training on for caregivers.
- How do we take these very technical things and make it real for the caregiver. E.g. "here are some things to make this work."
- The AFH provider can do their own assessments, but in most cases they hire private people to do the assessment.
- Most assessments do not include the personal story.
- I think multiple levels of training would just become another layer of bureaucracy. I think we would be better served by rating our facilities by the people whom they serve.
- I would like to see a guide that describes what facilities can do what to help place my loved one. Maybe a checklist would help as a guide for families placing a loved one in a facility.
- Exam relates to a previous course - they need to match up
- Tests 'partly' get at skills caregivers need. But very basic. "if you don't sleep through the class, you can probably pass the caregiver test."
- Not all using same tests.
- For those licensed or experienced, should be able to challenge the test. (others noted it can be challenged.)
- But some still don't get the special needs of people with dementia or mental health issues. Even nurses may not understand the brain processes in play.
- Words appear in tests that are not in book - 'programming' 'value' 'caregiver affect' - too conceptual, not concrete
- "Managers' exams are just awful!"
- Mental health test for managers: never got one. Said they were redoing it. Used a different test for LTC.
- Finds it hard to grade the answers. Manager test is mostly fill-in the blanks.
- Written test may not be a good measure of how well the person has truly understood and can apply the concepts in real life situations.
- Hard to say. Depends on audience. Have had training where (trainer) felt really good, but results on test were not good.
- May need to be updated.
- Challenges with test can be due to language differences (ESL).
- There are two tests. If first one not passed, can take second test.
- Harder to pass the test if not native English-speaking.
- Test available in various languages. In individual provider world, may only be caring for a family member in a different language. For AFH and ALF, must be proficient enough to respond in an emergency.

- Test is administered in different ways.
- I think the test measures your ability to do a test. It tricks people - it isn't designed to see if you really know something, but it's specifically designed to make you fail - playing the game with the language.
- I really think when you finish the first module, that if there would be a testing at the end of that, and then you could go through the next couple of modules and test at the end of that. That would be better, and you would test on the material. In the meantime, you could have some concrete testing that covered specifics.
- On delusions, so much learning happens when we go over those questions because people engage.
- When it came to the test, some people took it in five minutes, others took the full three hours.
- Assessment - we think the test is awful. I walked out of there saying "what?!?" It just didn't pertain back to the material that is in the course. Luckily, the instructor recognized that the material from the test did not match the curriculum in the book. It's a mismatch.
- As a provider, I am not going to go off of the test. It would be a disservice to the residents. There should be a standard of understanding, but some people do tests better. As a state, you need to have a bar. Maybe there should be a portion of the test that doesn't end in the classroom, maybe there should be a follow-through. I find my caregivers, and I know their experience. For those using an agency, or somebody answering an ad... that may not be something that the state needs to do, but there needs to be that portion.
- It's more of a generalist type of testing, I think it's helpful to make it a little more difference for future testing. There are different levels - we have people with schizophrenia, bipolar... more specialized type of testing.

### Specialty training requirements and oversight

- Align what the surveyors look for with the training. It is not always clear that they match up.
- We would like it if the licensors had to take the training. They would better understand what we are doing and why. Case managers too – so they understand how much time it takes to deliver this care.
- Right now we have a WAC. I can't send my caregivers to another facility who has a great trainer. Rules based on things other than outcomes of the training... these get in the way.
- Training needs to be more 'real world' and longer. 4-6 hours is not enough. At least 2-3 times a year that they go back and get a refresher.
- The deadline makes me squish some things together.
- [Could we] take the deadline away? They need to see [resident care] in action -- see other caregivers interact with residents. Take them into a memory care unit [before they go through training].
- Seems 4 hours is not enough given breadth/variety of conditions
- Why different length from dementia?
- Not truly a 'specialist' after any of the classes
- How are homes designated? When is training required? May be unclear.
- Community support for MH issues very light.
- Who is going to be responsible to follow-up if we do different training levels?
- Can be hard to match up black and white rules from the state with realities of what happens.
- Hard to keep up with regulations and to pay good caregivers within required rates. Rates may go down if resident no longer considered having 'mental health' specialty requirements.
- Training relates to citations - lack of knowledge may lead to safety issues. May also be cited for not having required training.
- State's goal is for all to be successful. If home shut down, residents will need new placements.
- WAC restricts CE - can't be same subject as previous year. May get in the way of refreshing or increasing training in specific areas.
- Hear about situations where managers deliver caregiver training by handing people the book and give them the test.
- I have heard that we should break out the manager training... a lot of what is in the training for the caregivers...
- In my opinion, I would say it is too little in terms of time. It is a lot of content, and I don't think they retain a lot of it - even for an experienced caregiver. Even after a few weeks, if they aren't reviewing, they are losing that information. I try to do shorter trainings over a couple of days. Especially for a caregiver who has had no exposure, it will take a few months to get them comfortable and competent.
- Caregivers can create a bigger problem, and the blame for that problem will land on the patient.



- We have to meet the CE as an AFH. The licenser looks for it in every caregiver, so we attend the continuing educations. But some do it for the sake of meeting requirements, but the heart is not there.
- Hopefully any additional requirements for structural changes would be somewhat optional. We get into a place where the options are out there for this additional training. If that's necessary for what they need to excel in their business. I hope we don't have more regulations.
- CE requirements - would like to see refresher requirements. (possibly as an online option.)
- Operators may object to having to pay for more training.
- Lorrie noted: no current requirement to attend a specific CE subject. But looking at offering CE that builds specific skills.
- Need the basic training first.
- Also good to have some real life experience before coming to training (but can't work in a house alone until trained.)
- Training is not consistent. Trainers are human - different approaches, expertise, knowledge. Sometimes managers teaching the classes don't really grasp the material themselves - may just be reading/following structure or showing video vs. Adding own experience, real-life scenarios.
- Glad specialty training exists. Helping people to be more prepared.
- Caregivers move from job to job. Would be beneficial to have consistent training, so that you know what you are getting.
- Would it be helpful to include specialty subjects in NAC training? Yes, content helpful, but participants very sensitive to time requirements.
- More homes hiring NACS, then need specialty training within a certain number of days. Creates hardship for AFH because they can't staff NACS on their own if they haven't had specialty training.
- Not doing as much training for facility. More employees come already having required training.
- Knowing they had specialty training would give some peace of mind, but would want to know what ongoing training occurs.
- Would like caregivers to have more skills, but it's a risk to send them to more training then have them leave the job. Prefer to hire people who already have certifications.
- Time and cost get in the way.
- Retention is a huge issue. Don't want to invest in educating people that will leave quickly.
- Need to clarify direct/indirect supervision requirements.
- Is becoming a CNA too easy - resulting in poorly qualified workers? (mixed opinions)
- May be a need for 'recertification' training
- Disconnect - some instructors - residential settings - 'attest' while others - community trainers - are approved/verified
- Trainer quality is very uneven. Some trainers 'horrible' - others quite good.
- Some trainers allowing smartphones - participants not engaged.
- Would like to see CE requirements of teachers—must be continuing training in designated specialties.
- Consider a better 'train-the-trainer' model, that ensures more consistent delivery and skills.
- There is a broad range of experience among the students for these classes—there are some people who had been in the field for ten years, and some who were completely new to it.
- Regarding care assessments: “The guy comes to the house, provides training, hands-on experience, is in the house with the caregivers - he is a clinician from sound mental health. This particular individual does this training, and sound mental health pays for it. He brings paperwork, stays for a while. Observes how things are with this - Patrick Russell is his name. I have heard that other clinicians don't provide the depth of explanation that Patrick Russell does.”
- Also regarding care assessments: “At my home, they come and only interface with the resident. So it differs with the individual.”
- Can be hard to match up black and white rules from the state with realities of what happens.
- Hard to keep up with regulations and to pay good caregivers within required rates. Rates may go down if resident no longer considered having 'mental health' specialty requirements.
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- Caregivers can create a bigger problem, and the blame for that problem will land on the patient.
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### Best practices related to specialty

- Kindness, patience
- Compassion and understanding to not take things personally (verbal or physical attacks)
- The majority of the behaviors come from us – we create the behaviors. Acting that out isn't going to get you down at eye level. You need to understand why you need to do that.
- Able to recognize and respond to changes, basic critical thinking
- Can you problem-solve what is going on with a resident? Acting out a scenario doesn't tell me what I need to know. When you aren't able to problem solve, what is your next step? Do they have systems in place then?
- Knowledgeable about conditions and diseases; caregivers may be interacting with physicians without complete training/assessment/understanding
- Family members have different expectations – training covers how to work with family members, but only for managers. (some trainers share with caregivers also.)
- This is their home – you don't just walk in a demand and command.
- Caregivers may know what to do, but get burned out. Need to ensure appropriate breaks.
- Understand illness
- An understanding of the importance of structure when dealing with mental health clients. And an understanding of the difference between baseline and changing behaviors
- Medications
- How to interact
- How to de-escalate
- Not sure I would pick ALF or AFH unless it was truly a specialty for that facility
- Appropriate environment for the behaviors that might occur
- Resources that are available (or not – emergency response may be limited); e.g. RSN (regional support network)

- Would look for ECS contract, which provides additional resources
- How to address and problem solve behaviors.
- The reasons behind different behaviors. I think all family members and home caregivers need to have access to group education.
- When dealing with patients and family from communities of color and non-western European ethnic communities respect and/or familiarity with the differences with regard to cultural nuances can be make or break the overall connection between patient, family and facility.
- I would provide a detailed narrative with information and require they read about our son
- The staff would need to know who I was and what I did. The staff would need to know how active I have been in the community and the volunteer work I did. I did not ask for this disease but it opened up its arms and embraced me.
- The disease process
- My loved one's life story.
- What works for my loved one, why they are resistant to care at times, how to involve me in the process of their care
- Infection control, peri care, dignity and respect.
- I would want them to understand and respect that every individual is different. It is important to know that not everything will work the same for everyone.
- I would want everyone to know that my loved one is an individual and that even though I know there are similarities in the disease progression some things are defined by my loved one's ethnic background, religious preference and life experiences. That I as a family member am an excellent resource and that although I am no longer this person's primary care giver please don't ignore me when I try to share information with you.
- The habits and routines of my loved one. Any key triggers and methods for defusing behaviors that you have used with your loved one in the past.
- Training is an integral part of caring for someone with specific needs. We just throw caregivers out there and expect them to know what to say and do in difficult situations and with difficult clients and then wonder why they quit so quickly or the outcome is bad.
- That they are special and loved and not the same person they once were but are still a person that needs patience, understanding, acceptance, love, support, and care.
- More tools in the tool belt to overcome refusals of care and creative approaches/interventions.
- More background information about the resident. Making it easier to understand the residents frame of mind,
- About my loved ones past and present; fears, likes and dislikes.
- Oh my goodness, I am already starting on my own personal care plan and putting in the behaviors that I might have if they lift me by pulling up under my arm and giving me a wedgie..:) I would definitely give them the history of my loved one, what their dislikes and likes are, I would probably be even more specific because of my experience, but the history and how I would like my loved one to be approached in certain instances etc... I would also want them to keep in good contact with the doctor, wouldn't wan them to use any psychotropic meds if at all possible, use appropriate approaches. I would want to know that the staff were involving my loved one in personal and group activities, brushing their teeth....oh my gosh the list goes on.
- How to be loving and respectful but that's difficult to teach.
- Interventions, what resources are available for the person as far as crisis line services, medications.
- I would want them treated with dignity and respect, and to have any change of condition reported to me. I would want the staff to know about my love ones life's' journey.
- All of the required training
- To be kind, be patient and to listen to the resident's wants/needs/desires without bias.
- Everything learned in the classes to provide a loving, supportive environment for my loved one
- Identification observation good case management flexibility in aging in place patience serving residents in a dignified manner through knowledge of resident rights and solid clinical skills
- What their strengths are
- How to interact and accept behavior that might seem abnormal. I would want care staff to not see "behavior" as a bad thing, but as communication. I would also want the staff to know some of my family members history, so that they could build on old memories as they assist with my family member.

- The importance of patience, consistency, the ability to redirect behaviors, understanding the appropriateness of 'living in the residents' world as long as it is done with respect and dignity. Understanding the importance of finding activities that are meaningful for each resident.
- How to effectively help them maintain dignity and self respect
- The things in your loved ones past (good and bad) need to be addressed because they seem to always come out sometime in the journey and it helps staff to respond and communicate with my loved one.
- To be open and friendly, not to be afraid of a situation that makes it worse. To be calm and confident in how the care was being provided
- How my "Mom" lived her life; her likes and dislikes; what calms her; what upsets her; favorite colors; favorite foods - then I would give them a mini-bio with a picture album for their reference.
- I would want the staff to remember that even though my loved one is confused and may not be able to care for herself anymore, she is still a person who needs love, respect and personal interaction.
- Love my parent as if they are your grandparents and listen.
- Bio-psychosocial history, patterns, habits, relationships, hobbies
- I would want them to know more interventions and redirection techniques, which would allow for more patients and understanding...and not only have frustration due to lack of ways to help.
- Better understanding of "difficult behaviors", communication skills with "non-verbal" clients, redirection examples
- My loved one's life history and background, and anything that makes my loved one feel special or loved. I would ask for that to be charted and care planned to meet my loved one's emotional needs.
- How to handle the day-to-day issues that may arise
- How to redirect my family member and how to diffuse situations.
- How to calm and redirect the resident.
- How to communicate, how to deal with challenging behaviors
- Who the loved one was, what accomplishments, work, empathy they did during their lifetime.
- What to expect, how to deal with it, how to maintain quality of life, how to deal with the family
- How wonderful my loved one was and still is. To follow the golden rule. To look at her as a person not a job.
- To take care of my beloved as a person on how she was before and how she is now. Not on how she is suffering from this disease.
- How to provide the best quality of life for them and how to keep them safe
- Kindness, understanding, patience and hopefully some experience.
- What my loved one was like when he/she was healthy. What he/she liked to do, what music he/she liked to listen to, what stories, etc. I would also make sure they were truly caring and compassionate people that knew how to give baths, laugh at jokes, and love my person as they are.
- 1. Reword a request 2. wait a few minutes & ask again 3. Ask with different words & switch the yes/no answer
- I would want them to know that I would expect them to have a lot of patience.
- How to approach the resident and how to interact with them in order to provide needed care.
- All about what my loved one loved when they were well. Their habits. What worked at home to redirect them. What triggered episodes of agitation. Their entire history of how, what, when, where, they grew up.
- How to communicate to my love ones clearly. My love ones will not be able to adjust to the language barrier, but caregivers should be able to do this.
- I would want the staff to know the history of my loved one. What they loved, hated, foods they liked, what was important to them, did they have a faith base? Who was important to them. Did they like to travel? Where did they grow up? Did they have a special friend(s), pet(s), grandchildren, where did they meet their spouse? What was their focus most of the time now. Not to reality orient people. Go with the era their mind is in at the time. Allow them to ramble, wander, play in the dirt, never argue with them
- More of what the resident experiences are. What they see, hear, smell, taste and feel
- To give them the time that they need and deserve to be able to process.
- I would want them to treat my loved one as a very special individual with unique needs.
- Patients, and redirection. I would not want staff who automatically went for the medications just because there is a behavior. I want them to know how to help non medicinally.
- Behaviors to expect and how to deal with them. Knowledge on progression of the disease. Healthy nutrition and exercise. How to handle emergencies
- The residents true life history!

- That quality of life is a crucial part of care in any facility. I would want my loved one's life to remain as close to their normal routine as possible.
- I would like to watch their interaction - how they respond to behaviors, how they redirect, do they have patience, respect in their communication.
- I don't understand the question. What staff? Staff where I currently work or staff at the care facility I am researching? I work in a memory care facility so I would not mind if the staff knew. If it was the other facility, I would want them to know as well so I could get a better overview if they could take care of my loved one to my satisfaction.
- A lot more than they know now.
- No matter how long they have taken care of my loved one or been a caregiver, or worked in the geriatric field, I expect the staff to always be professional, kind, and as attentive, as when they first met them.
- I would definitely want them to take the courses offered and have multiple, common sense interventions for behaviors and safety.
- Treat people like people, listen to them, spend time with them, show that you care.
- Likes and dislikes and triggers that cause behaviors.
- The loved one's history, so they could gain insight into how best to communicate and where he/she might "be" in his/her mind.
- Patience, empathy and how to be understanding
- While the state program is adequate it is to some extent not applicable in the normal care setting.
- How to relate to the residents.
- How organized is the community?
- Be patient and kind and patient...
- Not to be frightened of the odd behavior and how to deal with it.
- Who the person is and was. What is meaningful to them. How to communicate effectively to meet the needs.
- To step into their world where they are right at the moment. Not try and keep them in today's world.
- Small environments the residents thrive in them
- An understanding that many mental illnesses are progressive, just like dementia is.
- I would expect them to understand behaviors. We have clients who are physically challenging, so having staff know what to do. They can be physical as well as verbal. The first reaction would be to harm them back or fight back. Patience is the main thing here.
- In my situation, I have individuals who have developmental disabilities as a whole what happens is that mental illness starts to happen - in their thirties, for instance. My goal with my caregivers is for them to be able to see the signs so we don't miss something. Whether it is depression or something else. You can't teach the signs of that developing within that timeframe (of the class).
- I would expect staff members to know more about medications related to mental health, and understand the importance of compliance with medications. Rather than in the community setting - clients tend to not want to take medications. I would want the staff to understand the importance of anti-psychotics and/or antidepressants.
- Caregivers should know who to call if a situation escalates—when to call mental health crisis teams vs. 911. They should also be trained on how to react in such a situation—and how to protect themselves and other residents.
- The other services that a mental health patient would also receive. That isn't defined in the training. I don't think that they really understand that there are ways to use other resources.
- You have to look for these other resources - this would be very county-specific. Who do you call?
- I think the caregiver also needs to understand their responsibility to keep the other residents in the home safe as well. What situations warrant a crisis team to be brought out? We are also responsible for the other five residents. We need to know where to get that help from.
- I guess [we need more training around] resources - as far as homelessness or sound mental health - we have to have a case manager or social worker. We have clinicians who come on a quarterly basis for an overview of behaviors for the three months. It's pretty much like a doctor's visit kind of thing.
- Not too long ago, some students expressed concern about physical aggression. I showed them a few simple techniques I learned working at western state. Our populations are getting younger, and it might be that we need to add information about keeping yourself safe.

- To some extent those approach best practices are covered in the training - how do you approach this person. Is this the kind of statement you would want to use with this individual. I think it is addressed, but I don't know how effective it is.
- They have rights as a resident, but when does it infringe on others' rights? It's a very shaky bridge to be on when it comes to mental illness. Your responsibility to ensure their quality of life - a lot of times, with mental illness they tend to isolate, don't eat well... those types of things are client-specific, and when does the responsibility fall back on the provider. When is getting up at four in the afternoon for breakfast a problem?
- Training for helping people with mental illness, they usually do some counseling. Topics they discuss with the counselor - can be carried out to give better care for that individual. The continuation from the counselor's office into the AFH. To address behaviors - let it be consistent.
- In Idaho, there are trainings for physical restraints. It did prevent you from getting bit or hit very hard. Those aren't allowed in Washington State - we were told to run and lock ourselves in a room and call 911. Try to get them in their own space, but protect yourself and the other residents. That is not really the best option.
- An annual assessment that every resident has from DSHS- should be more detailed. This could benefit providers - we could get supplemental funding.
- I try to spend a lot of time on depression. Any good assessment we have - at least 75% of them are depressed. So we spend quite a bit of time on just depression alone. This would fare well to be segmented or broadened - we look at each type individually.
- I don't know how this connects to the case workers—when I, as a DD provider, have issues with a resident connected to mental health issues. If that person leaves my home, that diagnosis of mental illness may prevent them from being taken by another home. We don't need to be convincing the care provider that they aren't seeing signs of mental illness. I am not getting the support to diagnose.
- How to care for the person.
- Most people come to facility when they are very frustrated.
- All the certifications make no difference - want to see that person is cared for, looked after, place doesn't smell. Want to know that staff cares.
- Want nurses to have knowledge. Want caregivers to be caring.
- Would ask what they know about specific diagnosis of my family member.
- Would ask about specific behaviors. If loved one does \_\_\_\_\_, what will you do?
- Coping skills for caregivers - how to deal with frustration, anger; taking care of yourself; when to ask for help
- On the job training - working side-by-side with a skilled mentor
- I would expect them to understand things like that depression is a mood disorder, but has a broad spectrum
- Do-s and don't-s for specific disease situations - for example a schizophrenia patient might do better in a small group situation with other residents of similar age.
- Families want to know that you are going to love their family member and do what you can to take care of them the best you can.
- When I have an AFH who doesn't know what to do, I wonder where they got trained... I have often felt that when we have these specialty populations... we insist on annual fire drills, but we don't have an annual resident rights drill. A certain portion of the CE should be reinforcing those specialty skills.
- I come from a skilled nursing setting, where we have four hours every year on fire, resident rights, infection control and another. I would like to see some of that for homes that are saying they are specialty. So they stay fresh by taking those CE courses.
- I think for me personally, aside from all the credentialing questions... lack of structured activities. Do they offer group things? The good ones have something like a Friday movie night - not required, but come if you want. So it ends up being more of a family structure.
- There is another one where all of the individuals eat dinner together. Less like an institution, and more of a family home kind of feel.
- Does it feel clinical, or does it feel like a home?
- To me, the really good AFHS have a very welcoming feel
- Certainly, I would want them to learn about what resources exist in the community that they can use - what is the protocol, who do they notify, etc.
- That empathetic caring that comes through - even in the setup of the house, how do you create empathy?
- We have done talks with residential providers about empathy -- how do you use praise, empathy, make them feel like a human being?
- Tell stories, anecdotal situations. If they understand the history of the client... a lot of times, they get a packet and decide whether they can manage the individual. Understanding how they got where they are.

- You can learn more in an hour of play than in an hour of conversation. Have fun and do things that are positive psychology stuff. Weaving that into everything we do.
- Something about that empathy and why are you in this business?
- It's obvious to us that they care for the clients... that they aren't just interested in providing jobs for their family and paying off the house.
- That they care for these residents as individuals. Some of them do special Olympics with their clients, but some don't
- Good communication with case managers, etc.
- Some understanding of why behaviors occur.
- Those that work at it and go the extra mile to understand what is going on with a client.
- I see that in all three cases, where you have the table of contents, you have some basic topics that are covered. Communication strategies, behaviors, working with the family. I think what they should come away with is a concept that the fact, in the simplest terms, they need to understand that the folks they are assisting have highly individualized problems. You can't lump them all together. I think throwing a lot of information at people - even if they have CMA training or experience, is very different than how they need to focus and react.
- In our brains, we try to be logical and make sense of things, but that is not at all really helpful for the individual. What is helpful is to understand what the treatment plan is, reference it quickly if there is an issue, and to understand the importance of looking for change. It's a clue that something is going on and maybe needs to be investigated. Could be an allergy or a problem with their medication - whatever it might be... very often things are "slid over" in the care setting... it was ok yesterday, so let's see what happens. For family members and friends this is very difficult when they have the history.
- Even when someone is accompanying the patient to the emergency or a new physician, practical things don't happen like a simple history of where this person is at... and being able to hand it off to somebody. It seems to me that often the care providers don't have this information.
- I would expect them to know how to access vital information, take notes.
- The greatest help is to learn how to be inclusive with whomever you are working with. Make that individual feel as if their concerns are being considered. They may not make sense - they may be frustrated, angry, or suicidal... But you aren't going to gain calm or a place to communicate if it doesn't start with inclusion. I believe these folks are in a place where there is some sort of trauma-perceived or real - their best protection is to escalate. That may be the best mechanism they have. And that gets them in trouble, and excluded.
- That business about having a little summary is really important for somebody involved in treating these individuals.
- I think it's very important for these caregivers to be following an appropriate policy. Delivery of services is an important part of the training. What do you do when you have a full slate of responsibilities and a situation comes up. What do you do?
- Pocket guide to the training... needs to be on file and they need to be able to access that. I do skilled nursing situations where care providers seem very impersonal. And it's hard enough to be isolated in any kind of facility setting without some sort of personal interaction.
- The demands on the staff are a big problem - no question about it.
- Do they meet state requirements? When my daughter moved, the AFH was not in operation - it was new.
- If you work with these communities, you have a sense about things. The director and supervisor was clearly very experienced to me, and very sensitive. It was somebody who got information, and I guess I relied a lot on that and intuition because I think that having people who are care providers and open to family and friends is critical.
- They knew they were going to meet licensing requirements?
- How they manage their day?
- How many people are going to be there per resident?
- Who will be there at night, how many hours are covered?
- Where do you go for emergency care?
- Are you familiar with my daughter's health providers? ...pretty practical questions.
- Understanding and valuing routine is, I think, of greatest benefit to folks with these kinds of issues. It enables them to get through their day.
- They are more likely to get out and have time for getting outside the facility
- Regular meals, and even personal care - grooming and brushing your teeth.
- Having that routine, daily and weekly, is very helpful.

- Treatment plans don't always get developed or applied, and skilled nursing was horrible [in that regard]. Mobility problems... those residents might be very frustrated and blaming themselves. They might be unsure what they can ask for in way of assistance.
- One of the things I would like to see in the training is how to encourage people that they are in a trusting relationship and what they care about/prefer is important to those who provide for them.
- A care provider who is rushing though their day may not let the person know that they will get their shower, or whatever happens to be going on, and that kind of comes back to inclusion.
- I hope a large part of these trainings focuses on connecting with the person. Not about medications and how they are diagnosed, and that sort of thing.
- Having some socialization is really important - it's key. To be planted someplace under a roof and go through the motions of daily living without socialization, or very little... that's what happens in skilled nursing, and in AFHS, some are better than others. There is a world outside of bingo. The psychosocial part is very important.
- Understanding of the MH challenge
- Would want a staff that is trained well enough to interact with the resident in a caring manner and working hard to preserve dignity.
- Every patient is different and what works on one patient maybe does not work on all.
- Persons from different ethnic and cultural backgrounds often manifest a different approach to mental health care which requires sensitivity and a respect for preferences to ensure access to all pertinent information - self disclosure issues can be one when relating to family. I believe ethnic cultural studies for example within the diverse Asian-American cultural communities were done as early as the seventies and eighties.
- Approaches
- The specifics of my loved ones' mental illness, signs of decompensation, effects and side effects of medication
- A understanding of his brain processing differences, how to deescalate him as he starts in to a crisis cycle, and how to manage themselves as a caregiver when he is in a full blown crisis and not add to the crisis state.
- Get educated, Take the mental health class as that will greatly help them to provide good care.
- That they are coming to a site with staff that are well trained for mental health issues. Most of assisted living are elderly and do not want to take in mental health patients.
- What the mental illness was that my loved one had, what had been tried and what did not work for them
- It would depend on if their primary diagnosis was mental illness or dementia. I believe approaches are somewhat different if the primary diagnosis is dementia.
- All of the above as well as specifics about the particular health care needs my loved one had. I would want the staff to know that schizophrenia presents differently from bipolar disease and that the behavioral symptoms of the diseases need to be treated differently.
- Listen to their problems. If they are violent, what makes them violent. Watch their body language. Know that it is normal for the residents, always respond in a positive manner. What triggers their behavior.
- Connection with psychologist or psychiatrist for intervention needs, as there are very limited availability for beds in this badly needed area.
- How to support the client through active listening.
- How to gently provide limits to behaviors and boundaries, how to assist in working the relapse prevention plan - non-pharmacological methods of soothing and calming.
- Everyone who comes in contact no matter what level are part of the care team and he/she needs to take class to obtain knowledge to add to the resident's quality of life.
- Motivation techniques for depression; identification of delirium; identification, reporting of observations and prevention of suicide
- Everything I could remember about them to make their life as good as possible.
- Most all will not accept a resident with a MH diagnosis unless the diagnosis is established and managed with current medication. A crisis or relapse plan must be in place. Knowledge of last relapse would be critical. I would want people to know that my loved one is a person who struggles with a mental illness. I would want them to know that this person needs to be on medication to remain stable.
- The caregivers need training in order to care for clients with specialty needs. I would hope they hadn't done an on-line class where they learned nothing.



- Mental health disorders affect people differently. It's important to notice subtle changes quickly and have them addressed by health provider and have family alerted to the change(s). Respect and dignity go a long way as does care, compassion, understanding, and patience.
- How to be compassionate
- Is it a voluntary requirement for them to be there, what support do they have access to? Med management and case management ? For how long?
- The alternative curriculum I am using is thorough, provides basic information and the skills are important. The staff should know all of the content covered in the mental health specialty training.
- Respect and dignity. Understand that mental health parallels with physical health in that many times it is not in the residents control to change the condition themselves and they need understanding, patience, care and support.
- How to approach my loved one in a respectful, non-judgmental way
- The community and staff are well prepared to absorb them . A community that rejects mental health needs
- What symptoms of relapse look like
- Training period
- How to reassure my family member, to know that the care staff cannot "change" or "cure", but can love and guide. I would want them to be well-versed in what to report to the nurse, especially adverse side effects of medication.
- Care for the whole person, not just the illness. That person is a part of a family and the way they are treated affects that family. Would want their loved one treated with respect they deserve.
- How to deal effectively with residents with mental health issues.
- Any triggers and coping that works, each person is unique
- How to deal with aggressive residents in a calm and confident matter.
- What triggers resident has, what interventions worked in past and who do we call when crisis r escalation occurs. Mental health support in community very poor. In book has all these resources but very hard to get mental health help in communities and AFH's. Caregivers are frustrated. Just sending to ER and refusing to take back. Not good for client.
- Just love them for who they are and have patience.
- The special needs and history of each individual and strategies for success
- My loved one's mental health history and what works to keep him/her at peak performance, whether that is a combo of taking medications appropriately to meeting social/emotional needs.
- Follow the individualized plan for each resident.
- I would want them to have learned to overcome the stigma of mental health issues and realize how many folks actually deal effectively on a daily basis with mental health issues.
- What cause my family member to get upset and how to keep them calm.
- Again, patience and understanding of the disease
- How to communicate, what some mental illnesses look like and to deal with challenging behaviors
- That mental illness is not funny or something to joke about or make fun of it is a legitimate illness. That mentally ill people are "people" and like to be treated with respect and compassion. Again you must have patience, understanding, be a great listener and know how to assure someone is not a harm to themselves or others. If in doubt regarding someone's ability to "contract" for safety place them on one to one safety watch and always report anything like "unsafe" behaviors to your supervisor.
- I would want a team approach.
- Sensitivity to mental health issues (non-judgmental attitudes), working knowledge of the mental illness my loved one has, appropriate person-centered interventions
- To care for them with respect and patience.
- Understand my beloved that she is suffering from this disease,
- How to look beyond the symptoms and see the person.
- Kindness, patience, understanding and some experience.
- The same as my answer for the dementia questions; who he had been and how to make sure he knew he was still loved.
- Mental health looks different in everyone. Behaviors are signs that something's not right, watch them — learn from them. Take time to learn about me as a person, remember that living at a new place is hard. It's all about approach.
- How to avoid crisis situations.

- All about my loved one. How to redirect them. How to validate them. How to keep them safe. What triggered decompensating, and what could help them return to baseline.
- Much the same as the dementia section I completed.
- Clear communication.
- How important care plans are and that they should be individualized
- I would want the staff to be able to step back and look at the situation before they respond. A huge factor in dealing with the consumer is being able to deal with yourself, and how you are going to respond to the situation.
- Compassion, training, staff participation and redirection.
- Understanding of behaviors, how to deal with them,, what to do or who to call in an emergency. Very important to know and understand triggers and how to defuse or calm down someone who is in a state of manic or out of control. How to avoid behavior problems. Understand medications and side effects. Know MH agencies and what is available in the community for support.
- Boundaries are set, communication is respectful,
- No matter how long they have taken care of my loved one or been a caregiver, or worked in the geriatric field, I expect the staff to always be professional, kind, and as attentive, as when they first met them.
- Better approach techniques and what resources were available locally.
- How to manage chronic MH issues, medications, side effects, life skill deficits.
- Patience and kindness
- How to communicate with an agitated mentally ill person. How to provide positive behavior support. How to know when the interaction with the person is escalating to a level of difficulty that is beyond their scope of training and what action to take.
- Understand where the residents are coming from.
- Is everyone friendly and organized.
- Be kind and patient.....very patient!
- I would want them to understand the odd behaviors of mentally ill people, not to be frightened, and to treat the patient with respect and understanding.
- The right med with the right diagnosis

### Rank of the modules from the training manual

- 1\*
- 2\*\*\*\*\*
- 3\*\*\*\*\*
- 4\*\*\*\*\*
- 5\*\*\*\*\*
- 6
- 7\*\*
- 8\*\*
- 1-intro to disorders \*\*\* (need baseline understanding)
- 3-communication
- 4-challenging behavior
- 5-decomp & relapse \*\*
- 6-suicide prevention \*\*
- 8-getting help & self care
- Chapter 7 is repeat of dementia material. Chapter 8 covered well in core basic.
- How much overlap with core basic? Minimize overlap to increase time available for specialty topics.
- What would you delete out of each section? Possible survey question ...

### Additional comments and opportunities

- Aging: issues that are part of the aging population separately, talk about some of the challenges - some of the caregivers are teenagers. They don't have a clue - maybe a five-hour course.
- Mental health
- Dementia
- Developmental disability - I think everybody needs that training

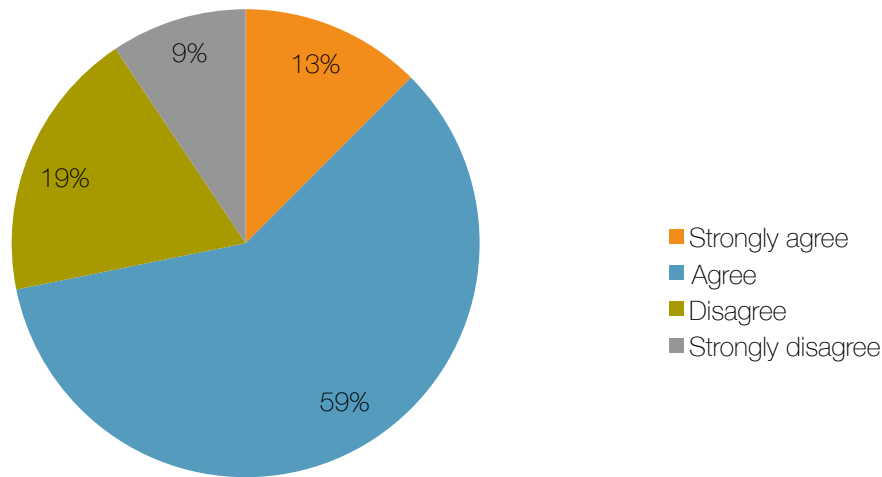
- Physical disabilities - we have veterans and stuff like that when they have paralysis or other physical disabilities
- Traumatic brain injury
- PTSD
- More on drugs and what happens, especially when combined with mental illness
- Geriatric care
- Generational differences
- More on sexuality, including residents' rights and how to handle behaviors.
- PTSD
- There is a lot more PTSD going on out there. And the students are saying that too. The component in the book is small.
- Possible specialty is dual diagnosis of mental health and substance abuse. We often have clients that are also substance abusers - whether that is medications or illicit drugs. They may be abusing their regular medications.
- There are a lot of issues with homelessness - people are coming into facilities having been homeless.
- I want to stress again - the challenging behaviors training is something that would be good to tack on to this training.
- The challenging behavior course forces students to recount challenging behaviors they have encountered.
- I think you could do topic-specific training for mental illnesses. If I had schizophrenia training and I had a caregiver assigned to that client, that would be helpful. Taking it down to the level of schizophrenia, bipolar, substance abuse and mental illness.
- The basic core curriculum would include mental health, and as the employer works through their career, we could send them to sub-topic classes for their CE.
- Substance abuse training would be really beneficial. Dual diagnosis.
- PTSD
- Might be good to have classes about how the medication works. The doctor understands, but the caregiver should have an understanding of that. [the current training] gives the basic drugs that are given, and it gives some of the basic side effects. You get about thirty minutes about the treatments. There are alternative treatments, too.
- I think one thing - if there is an aging component to this, what you are looking at when there is mental health, and then there is dementia too -as your populations are getting older.
- I don't see personality disorders - borderline, narcissistic, dissociative. Those are the really challenging behavior components to work with as well.
- There are more new medications now days that are not included in the training. I think the alternative treatments - more people are trying to do a less medicated approach. As a provider, when somebody chooses the natural path, how do we deal with that - can we support medical marijuana? I haven't come across it in an AFH, but it may be there.
- The broadness of mental health makes that challenging. Which is why putting it in more segments might make it more effective.
- You are just touching the tip of the iceberg with your 40 pages here... it should be deeper. Maybe there should be groups of three mental illnesses - there are a few disorders that should definitely be segregated [into separate trainings].
- Training and mentoring for home health workers.
- Concerned about impact on licensing, ability to operate a home, rates, etc.
- Traumatic brain injury (there is a TBI state curriculum = CE)
- Medically fragile individuals
- Add personality disorders to module 1.
- A menu of classes that go beyond the basic training... behaviors, medications, would be useful.
- I don't think you have to go create something, but delving into specialty training for people with various disorders... additional deeper dives based on the individuals you are caring for.
- TBI or acquired brain injury
- Schizophrenia
- Bariatric
- Homeless with chemical dependency
- Medically fragile
- MS

## 9 | Appendix: Full Text of Stakeholder Comments

- Parkinson's patients
- MS (multiple sclerosis) patients
- Bariatric patients
- Traumatic brain injury
- Quadriplegia
- Tracheotomies
- LGTB community
- Clients who are younger but not DD
- Substance issues, self-medication, marijuana
- Behavioral management - how to approach challenging behavioral problems; how to not get defensive
- Substance abuse
- Parkinson's - uses resource from OHSU for CEU's (approved by DSHS)
- Medications - especially at AFH
- Traumatic brain injury
- Bariatric care
- More training on physical handling - transfers, etc. (part of core basic)
- Teepa snow does a good job.
- Music - that part of the brain may not have damage. With some dementias, singing to them can make a better connection than speaking.
- Would like NAC program to include DSHS specialty training. Then they would be ready to work in many settings.
- I find it very difficult to get information as to how to connect to other resources, and from the standpoint of management - I see that good managers has to really focus on their priorities, and pray that they have time left over after that. Because of the nature of the business.
- TBI has its own set of challenges. Where my daughter resides, most of them have a very hard time communicating, but it has nothing to do with their intelligence, and that is tremendously frustrating. It brings up their social needs. It contributes to depression, anxiety - those kinds of things. And it's highly individualized. I would hope that DSHS has some sort of criteria set for people with TBI. While each case is different, I think you can bring attention to some of the needs. Folks with TBI have pretty high expectations. Their energy levels and their abilities are such a roller coaster that it's very hard for them to maintain what they expect of themselves. It's a separate issue from their mobility, and their ability to speak and communicate. They still have that whole set of where they would like to be in their expectations and where they would like to be in the world.

## Developmental Disability

Survey result: After my developmental disabilities training, I felt better prepared in my role working with this client population:



### Strengths of current specialty training

- Really having that relationship with the resident and their family - there is constant feedback, and they aren't trying to do everything themselves.
- Those homes always seem to be involved with a lot of healthcare professionals who help to develop the care plans.
- Always open to feedback and change - looking to the resident and their family, and consulting with healthcare professionals.

### Specialty training challenges or deficiencies

- Let care managers teach it themselves instead of being restricted to the DD contractors
- Online training would make it easier.
- Availability of the class is limited, tough to schedule, and courses are fill up very quickly. There are a limited number of instructors.
- Availability and access are the biggest challenge for the care manger.
- We use PTO for caregivers to attend training and if you only have one caregiver it makes it difficult to cover what needs to be done over the 3 days.
- Could there be competency based training to test out of the training requirement? I think there should be.
- Parents need to go through training.
- Maybe one-day focus on the specialty needed in your home and then the other two days could go into other areas.
- DD training is different because there is a lot of emphasis put into where we came from and where we are going. DSHS is trying to declassify DD and normalize it as much as they can and not focus so much on Autism and Down syndrome. We need to focus more on how to treat clients with DD.
- One full day is focused on the history of DD and the training does not reflect what is needed for caregivers.
- I would ask does the history help the caregiver do their job. What do we want caregivers to do?
- The training was pretty good... my instructor was very good. She had to retrain how everybody thought. She taught a lot about disability rights and the struggle for that that a lot of us didn't know about. And she integrated "rights" and "choices" into the curriculum. These individuals do not need protection - they need

- somebody to help them promote those rights. You aren't there to keep them cared for and protected, you are there to help them exercise their choices.
- There are some things in the DD training that - because it is so intricate and complicated - there are concepts that are hard to grasp. The whole ISP thing, and whether they are under 18 or over 21... we have to go over them because they are on the test, but does a caregiver in a group home really need to know that? But they should know about what are their hopes and dreams, etc....
  - Understanding baseline and what drives behavior in the first place - there is usually an underlying need that is not being met.
  - Sexuality is not covered, or it is covered very briefly. Medications are not covered. Mental health and substance abuse are not really covered. If you are taking a holistic look at a person, you got to talk about some of those issues. Sexuality seems like it's a taboo subject, but to have a full life, you got to deal with that.
  - More opportunity to practice. Do a lot of scenarios, but residents can be so diverse and caregivers may come from a different culture.
  - Guidance on non-verbal communication.
  - Useful to have pocket guides - resources, checklists, key points. Believes resource guides available - have tried different versions, formats - but hard to get people to use them.
  - Would caregivers use an app (as alternative to pocket guide?)
  - Add information about aging with DD; people are living longer
  - We try to limit the training to 25 people or under to allow for more conversation. When it gets too big it is really hard to manage and make sure you aren't compromising the quality.
  - The specialty training is in addition to the fundamentals of care training. My first thought is that the owners and managers would tell you "shorter". But in terms of quality of care... I feel like the content is probably pretty good in terms of being comprehensive. We sit down once a year with Linda and look at the training and test. We do 2-3 days once a year.
  - I think more information around the historical perspective of DD is important for caregivers and managers to know.
  - There has to be a connection between the family and their loved one. Training should include how to include the family in the care plan.
  - Training should specifically cover the developmental disabilities that a caregiver has in their homes.
  - Training should address the individual's right to choose. We must allow the person to be their own advocate and help the caregiving team respect that right
  - I think the training needs to be ongoing. Training should cover how caregivers and care manager can reach out to the services around them and determine what they need to improve the quality of care for their clients.
  - Training should include what assistance is available and how to access the resources available.
  - Ensure care managers know that technical assistance is available and free.
  - More time for training would be great. I know it is hard and time is a challenge.
  - The Negotiated Care Plan should be part of the training.
  - The DD training program and material are very good and I do not have suggestions. Something that Peggy uses in her teaching is DVD's. I went online to look for videos and could not find them. The DVD she showed were excellent, and demonstrated that people with DD have a lot of talent and can contribute in many ways.
  - Personal experience is definitely something needed to improve classroom learning outcomes.
  - I really like the residential guidelines conversations. That is the part of training that is most applicable for the DD administration. I would like to see more development and clarification of this module.
  - Power and choice is also very important with the DD population.
  - The ethics and laws part of the training could use improvement. There were no activities for that part of training that I can remember.
  - I like the behavior module of training and how it was tied into residential guidelines.
  - The overview was one of my favorite modules.
  - I do not remember the crisis prevention and intervention part of the training at all.
  - I feel like the training is a good foundation. Our newest day staff took the course a year and a half ago, and she feels that it was very helpful, and she comes from a background with a brother who has downs.
  - I felt like my class in Spokane 12-13 years ago was terrific material.
  - We've had positive feedback to the curriculum and the instructors - so yahoo!

- I think what we see the biggest thing is that afhs are not able to adequately communicate or support people individually. They have five individuals there, and one of them has a doctor's appointment, we have trouble getting them to come... because they can't leave the others, they aren't participating in the care. It should be more systemic. It makes it hard for us to gauge their training.
- You see them getting easily frustrated with anything that disrupts the system of the house. They have a lot of trouble dealing with somebody who breaks the routine.
- More individualized care.
- We want staff to chart things for us and note when certain things happen, and that seems to be a challenge for staff. What does hitting look like? What does aggressive posturing look like? It's difficult to get active reporting. Sometimes it's vague. And sometimes it's that there isn't consistent observation from the staff as to what, say, aggression looks like.
- It's hard to get them to sit down and take the time to do the notation that we want them to do.
- Effectively communicating what you are seeing.
- Understanding why behaviors might occur. Typically there is something that has happened. Getting adequate medical care - ability to self-report is different. Staff needs to be able to advocate for appropriate medical care.
- It seems like people who specialize in that seem very skilled in what they do. I always felt like I was getting an education when I did a licensing visit. A lot of them have case managers through DDA and have access to additional resources.
- I see it as a mixed bag. Many of the providers are doing an exceptional job, and we have had some folks supported for years and years.
- A lot of providers have been declining to serve clients from DDA because of lower daily rates.
- Behavioral challenges.
- What I see is that providers are trying to tell case managers what the rate should be. So we struggle with trying to let them know that they aren't going to be our \$150/ay rate. We should touch on this topic in the specialty training. I don't know how much of the training emphasizes rates, but it could be helpful.
- Highlighting the differences in care that may be needed by different individuals. For instance, social needs, or employment connections.
- Activities around the home that they can provide... that aren't provided in LTC. It is not a requirement, but it is something that families like to see. Taking care of them includes socialization.
- Caregiver communication can be an issue - both ESL and communicating with those who communicate minimally. We have quite a few people who understand English, but are non-verbal, and then the caregiver is ESL.
- Having a caregiver not being able to understand questions - that is an issue.
- There are cultural differences - the caregivers may have beliefs and attitudes that come from another culture. Sometimes they treat them like children, even though they are adults.
- Learning about other ways of communication - communication boards, etc.
- Communication frustrations can lead to a lot of other challenging behaviors.
- Knowing that they can talk to the doctor about doing an augmentative speech therapy that can assist with that.
- The gaps can be across the board.
- Communication.
- Taking them for healthcare appointments. That's kind of a WAC requirement that they need to do that if there is nobody else out there to do that. Doctor and dentist, etc. They don't always see this as their responsibility.
- Also I seem some issues with client rights, whether it's that the person wants to have raisin bran for dinner, and the provider is not allowing or wanting that. They need to learn that there is no winning and losing. It is that middle ground that is getting to the point of not escalating.
- Or the people who want to help out - and they take it too far, and all the sudden they are doing chores.
- Knowing that today is going to be very different from tomorrow.
- We have a lot of people who find out an incident occurred, and they didn't report it to the right person, or didn't report it at all. They may not have thought it was important - social worker and RCS. That has gotten providers in trouble before. They don't have the training as to what is required, and when to call. We encourage them to over-report, if anything.

- For that matter, social leave - care providers need to track that and monitor that. Eighteen days in the year is the threshold for social leave. We have some residents who are younger and are going to see their parents twice a month... people creep up on overpayment situations.
- I think what was most helpful for me was to talk to the caregiver of that person in the community - to find out what strategies worked with that client so we could mimic those interventions while the resident was in the nursing facility. Failing to do that could lead to problematic behavior.
- Prior to working with the state, I worked a long time in nursing facilities. We would occasionally accept clients with DD. It was hard for other residents to be tolerant of those clients, who had verbal outbursts - things they couldn't control or were difficult to redirect.
- I think clients with developmental disabilities have special needs that a nursing home isn't always familiar with.
- I think the staff can take care of the needs, but it's harder for them to fit into the general population of the nursing home.
- It's almost like the mental health piece - they will take a resident into their home thinking they can meet their needs, and there are behaviors that are not being addressed.
- Sometimes it's unclear on the information they get... sometimes it's vague and they don't know how to address that need.
- I see that paperwork and negotiated care plans are done but incomplete. I think there is some training that could go around that.
- Sometimes it's just not clear what they are getting themselves into. They go through an orientation, of course, but changes happen and providers don't have a complete understanding of that change. And then they are surprised when the licenser comes to their home.
- I see a disconnect with the licensing arm. Providers come here and we can't connect them to their licensors because of an attitude that it is "showing favoritism".
- Record keeping
- Note taking
- Behavior tracking is skimpy
- Actually, what we have all just said... I see all of that. I also see that people still want to talk about, treat, use language (as if) people with DD are children or something... and they aren't. They are adults. So don't call them a kid, and don't think they are going to behave like a child... maybe there is some immaturity, but that is not like a child.
- There's no way that any 40-year old, no matter what their DD, is acting like a six-year old.
- In Thurston County, there is a group of AFH providers who work exclusively with our clients, and they have done it for fifteen years plus. They have developed a lot of skills, but they have learned their limits through the school of hard knocks... they are pretty savvy. We haven't seen the new homes with novice providers.
- The other thing that happens with the DD clients is that the DD portion of our organization offers some extra training, extra education, and they are very sensitive to the needs of the providers and the residents. The training is just as much for the resident as the provider. The resident will benefit from it.
- DDA has done a really good job of identifying issues and having training in those areas.
- We have sent one-on-one technical assistance in... as long as the placement is too far down the road to disaster.
- We've streamlined the referral process. We have point staff that screen our clients for who is appropriate for this level of service, so we won't push some forward into an AFH. We have the privilege of other programs being available for the heavier care.
- We offer cost-free continuing ed. That is not available for dementia and mental health.
- Here's another huge deal - an emphasis on swallowing issues. We just had another choking death in a supported living scenario. And he was in his early 30s. You can never stop training that.
- There isn't an understanding of how dangerous hot dogs and grapes are. And gooey bread with sticky fillings.
- When we screen, if we see red flags like assaultive behavior, we find something else. We make mistakes, but we make a lot less than we did in previous years.
- Again, they don't understand the differences between the different kinds of DD, and they tend not to understand the individualizing.
- They tend to look at what they can't do, vs. What they can do.
- Lack of understanding, I think.



- I have seen them struggle with behaviors. Understanding how to deal with those behaviors. They don't have the skillset to follow a plan and understand how to use a plan
- The other thing I see is a lack of individualized planning
- Very little
- More specific training to the clients we work with
- We did not have a lot of developmental disabilities with the residents. They could have covered their body language and behavior more.
- What is considered a disability and factors
- What I have found more productive is classes or studies that specifically talk about my clients developmental disability. I have done many hours of private study and feel that is more impactful than sitting through courses that try to cover a number of different issues at a time.
- Not much
- I don't know if it needs to be in the training--but Asperger's and other autistic issues. I have had to research on my own. I have seen poor care because of lack of knowledge.
- More specific information about DD in the elderly as I only worked with seniors
- That a person with a developmental disability might also have mental health disorder.
- You cannot learn out of a book what I know how to do. The books can give you ideas and tell ways you might try in a given situation, but hands on will teach you things you will remember.
- Consistent support between residential and employment providers is necessary. Expectation for the resident with ASD should be shared with all domains of life for consistency and support management.
- All was covered.
- Nothing
- I think the DD specific training should be incorporated into the RFOC training
- Knowledge of seizures and Alzheimer's
- Problem solving and local resources.
- Make the course 6-8 hours
- It is repetitious, full of "filler" material to stretch it to 3 days even with the multiple breaks and off line discussions. There is really only about 8 hours of solid material
- Specific to the agency you work in
- Just keep it up-to-date
- Nothing I think its good
- 1. Put it on-line. Many of the respite caregivers who come into the home have day jobs or a regular 40 hour a week job, and cannot take the time off to attend a 3 day class. Our CE's can be on-line and feel that DDA could figure out how to do this, to make it easier to train new providers, caregivers, etc.
- 2. The class feels like there are so many topics trying to be covered, that it is overwhelming and students don't walk away from the class with the information that you really want them to.
- 3. Find instructors that can relate and teach with the students/potential caregivers.
- 4. Update videos to really discuss/show/really relate to what we deal with in an AFH setting.
- 5. Make the DD training more accessible to all potential caregivers. On-line training is very helpful and help us get caregivers onboard in a reasonable amount of time.
- 6. Consider having training that is more general overview and then requiring care providers to show that once they have clients: they take a class specifically on the clients primary DD diagnosis. So that they have more of a background on the disability and a general understanding of it. So depending on the number of resident's in a home, a potential caregiver could have "x" amount of hours beyond the initial DD specialty class and these hours could be required after they have taken the general class.
- More trainings in other places than Seattle area.
- They aren't children - respect and adjustment to their needs and wants.
- Train the difference between DD, Dementia and Mental Health - also what happens when DD has a dual or triple diagnosis of all three.
- Not sure
- Split it up between training for workers who have younger clients and older clients. It was not helpful for me to know all the stuff about what services the client had access to before s/he was 18 years old (for instance).
- The class I took looked at caregiving through rose colored glasses. It is not that in reality.
- I would have the trainees work at a home that has DD people as part of there training.

- Training specifically on the characteristics of autism and how each person can and will be different, design strategies for communication like visual schedules, calendars, communication devices as well as understanding the significance of socialization for individuals with autism, thorough knowledge of "best-practice, evidence based" autism specific support strategies and the ongoing support of those strategies to keep the supports consistent. Changing the attitude of "care-giver" to "Autism Life Coach" to encourage life long learning and skill acquisition.
- I would have training specifically for DD people who are seniors who are moving into assisted living. And training for DD people who are young and attending job training etc.
- I took it at the DD office in Vancouver. I send all my staff there as well.
- Incorporate it into the RFOC training
- 1. Teach about nutrition and food preparation. How do you feed people who are "VERY Picky eaters" so that they will eat healthy [foods]. Eat smaller portions. Do not eat so much fast food and don't drink pop.
- 2. Teach recreation activities- or going to classes
- 3. Help with Social activities/ Special Olympics etc.
- Make it available in Pacific County
- "Offer training for community instructors so this training can be more widely offered. The classes are always full and not offered on weekends.
- An online option would be nice also.
- Reduce the time to 2 days. It's difficult for providers to be unavailable for two days.

### Specialty training access and delivery

- Caregivers and care managers should have different levels of training.
- I am glad for the DD training itself. Nothing in the 75 hours of basic training is focused on DD.
- What I thought was good was the understanding about the life change transition.
- Communication and approach is very important. An awareness of how to communicate with people with DD is important.
- It would be great if an outside party would come in assess our trainers and provide feedback to make it better and more consistent. We want caregivers to walk out of training being wowed.
- I would encourage a customized approach to working with clients with DD. Problem solving and creative thinking are very important skills for caregivers to possess.
- The classes aren't accessible enough - it's better in frequency and range of locations, but previously we had to send folks to Seattle, and when we are up in the Everett area, that is a big deal. Considering the pay rate that these folks are on, and that they can't work until they have done that... more frequency and more locations.
- She had us draw our community... and imagine what that's like for somebody living with DD - it might be limited to their doctor's office, etc. Vs. What our communities look like - what we think is typical needs to be what it looks like for them too.
- Videos are used, and role-playing. A mixture of videos of people living with intellectual disabilities and talking about how it has impacted their rights, and their ability to have self-determination. To videos that were more about seeing more similarities, not just that they are "a client". Students were impacted by people talking about that.
- I don't do a lot of role-playing, because I don't think it's as respectful to the population we serve. We do a lot of group work and learning about each other and who has experiences with relatives or past clients - trying to pull their experiences out.
- There wasn't any role-playing in the one I had.
- The class didn't do role-playing, but the trainer did. Scenarios - those are helpful for people. Describing a situation and having them answer questions in relation to that.
- The eighteen hours could be cut back to two days potentially. And that is the feedback that comes back in the evaluations.
- As an attendee, I would agree with that (that it could be shortened), but I'm not sure that the ESL students could do without that third day.
- No separate tracks for managers and caregivers...
- I think the underlying theme when I took it was empathy - putting ourselves in another person's situation. I remember another exercise. Write down what you make, and your greatest fear, etc. Now hand it to the

person next to you. That is what it feels like when your care assessment is handed out to the staff and to have this person make their judgment of you based on what is on their care plan.

- I like teaching DD specialty first, then teach mental health and dementia. I like teaching the need-based stuff, and then it makes it easier to teach the dementia and mental health. It helps. I just think that seeing people care through those eyes.
- I have a comment as a community instructor who doesn't teach DD - the calls I get from remote locations who can't get their people trained in their areas, and they need to send them to another location and put them up in a hotel. There is no training within three counties.
- It's a huge barrier to people who come... I get calls all the time. There are only five trainers.
- That is one of the hugest differences between DD specialty and the others ... it is all paid for. It's all paid for by the state.
- Look at whether alternate forms of delivery are workable. There is research now that supports it. I'm a strong proponent of online training and I want that pursued as part of this. There was short space where we did it before it got taken back offline. And now they are handing them the book or taking their citations.
- I adjust the training to the individuals I have - they introduce themselves and the experience they have. A few years ago, it was a shock to them that people with DD could live full lives... now it is not a new concept to them. It lends to be able to delve into some of these other areas.
- Better to receive training from contracted trainers. Would make life much easier for owners - as training is more consistent and complete.
- Per WAC, if setting has approved trainer who has taken manager training from contracted trainer, they can teach the 18 hours to their own staff - not outside their facility. (Changed ~ January 2012 ... not many know about the change.)
- Different process to approve trainers for DD vs. Dementia/MH Community Trainers.
- Lots of sessions. Planned by region for the year based on demand. Advertised on web. 25 spots - always full. Counts toward 75 hours. Owners of homes specializing in this population want their people to go. Will set up additional training for minimum 7-10 people.
- Some people who express interest in delivering own training decide against it. Must be in person. Pretty complex material.
- Can be difficult to schedule around staff for 3 days.
- Believes 3 days in a row is important for continuity.
- By comparison, case managers receive 1 month training, are college graduates and are mostly native English speakers. Still need learning on the job.
- 5 certified trainers have been around for a long time. Specialize in DD, Master's degrees. Independent contractors - also do other types of training.
- When it was expanded to the three days, I think the pieces... we were doing two days and there was typically so much discussion about behavior that we understood we needed to talk more about rights.
- I'm constantly trying to add in more videos, trying to get to different learning styles. The three of us on the west side of the state get together every couple of months to show each other videos that are working. Because that's what I do, I connect with other people doing other training.
- I was in the Olympia office doing a training, and they had a situation come up with one of their providers where they had a review of a program and an identification that they needed to have some supplemental training done quickly. So I designed a custom curriculum for ninety staff, pulled from the DD training. We are customizing it to the amount of time they have... I hope it has value.
- There is a budget for supplemental training. The process is that Service Alternatives holds the money, but they work with all the regions... so it is triggered in that way.
- Books, current videos, the "disabilities scoop" - a link to a current, really vital resource. The trainers share them with each other and I share them during the training.
- The manual has a lot of links to it - we have talked about that. When you are reading the manual those aren't live links, and that can be distracting. The DDA website has links to resources, and so on.
- We all started with 4-5 videos that we can all use or not use. I have supplemented that with more current. So I will go out on YouTube, especially on language and ending the "R" word. I just review them to make sure that I am OK with what they are saying. I have a library on my computer. If you can make things as timely as possible, it makes it more interesting.
- The only way it happens now... if there were unlimited resources, there could be a follow-up visit with each home. The training I am talking about - developing meaningful goals... they are going to run it as a two-day training with follow-up by request.

- Caregivers are taking CEs online.
- Training happens through SEIU and the training partnership. The care shouldn't be different between in home care and AFH and ALFs.
- Component for companion homes?
- The SEIU/Training partnership is developing an online training course for individuals in companion homes and positive behavior support. Should be available by mid summer. Consulted by DD and ARC to find out what are the best resources for positive behavior support and they are sending the curriculum for periodic checks. And they are constantly developing additional trainings.
- It is a big challenge for training to have quantifiable benefit on what the person has learned. It depends on your audience. How is the current training designed to be experiential for the benefit of the student?
- Report back - how did you use the information (after training)?
- The training is very involved and experiential (small groups and role plays). People demonstrate how they have acquired skills through the training.
- Can we require people to do things outside the training? If we can put it in WAC....? If we could do it - I would put the condition of passing and to demonstrate it by doing something experiential and bring it back. An oral or written presentation on how it was applied to make a person's life improve.
- I think there needs to be a section on human sexuality and basic understating of guardianship.
- Abuse and neglect also need to be part of the training.
- Training should include 'How to' deal with difficult issues and the tools to deal with those issues.
- How to communicate with patients with developmental disabilities. Understating why they are doing what they do, and the steps you can take to understand and empower them overcome the behavior or challenge. More real life scenarios and examples are great to help learn these techniques.
- Allowing caregivers to have experiential conversations and share ideas. Then the facilitator can guide the training to achieve each the learning outcome.
- The 'Dignity of Risk' needs to be covered in the training. This is a very important and challenging concept.
- I would like to see 'Individual Rights' up front and covered in depth during the training. Not just an afterthought in the training. For example, taking away a cell phone can really raise some ugly issues and violates individual rights.
- Training about the regulatory environment and rules they will work with would be beneficial to add to the training.
- I think different levels of training would work great. It would provide the opportunity to go deeper into specific disabilities.
- Weekend training might be an option that providers and caregivers could benefit from.
- We might consider having a conversation with the payees to help empower the person with DD and the decision they make whit their money.
- I teach the development disabilities specialty course. They used to teach it every 3 to 4 months and now, due to demand, they try to teach it once a month. It's not my favorite class to teach. 18 hours of training and one student is a challenge.
- Because the state offers the training for free I often enroll students into the state run course.
- 18 hours is about the right amount of time, with a full class, to cover all of the material and exercises to help students think it through and learn.
- I think a tiered specialty training (e.g. Refresher training) approach would be a good idea. It might also be a good idea for corrective action.
- Follow-up hands on training where caregivers learn new and advanced techniques would be very useful.
- I thought the 18 hours of instruction, over three days, worked very well and the methodology of instruction was very good.
- Those of us who have always lived in a world of full verbal language... we have no idea what it's like to be incapacitated or challenged in those areas. It would do trainees well to do some exercise where they didn't have the capacity to speak. But they couldn't respond verbally. And just to practice what that feels like. So new employees would be able to develop empathy. Patience, longer response time. These are just facts of how it is.
- Folks such as ourselves, who operate on a tight budget - we are a non-profit organization - we have community partners who contribute and make it possible. The burden of cost in terms of three days out of our location, paying for housing and travel, and paying the wages. It is tough. There are no options near here for the training.

- Somehow, another facility director got a training at her facility last year, and we were able to send two of our people to that, and it was a big help
- I'm wondering if we could come into the 21st century and move toward online training.
- I had to go to Spokane, which is four hours away. My husband joined the team later, and he went to Yakima, only to find that they had canceled the class. After the second faux pas, we signed him up for a class in downtown Seattle, and I called the day before and found out the course was moved to Kent. He challenged the class and passed with flying colors.
- I had learned not to trust the online registration. You need to call back and make sure they didn't change it or cancel it.
- We need to broaden the accessibility of the training so rural people don't have to pay through the nose.
- I think it would be really possible to do the class with one of your fine instructors being filmed, put it online, and have the test proctored.
- What I have always found is that it is hard to get people to trainings. So the owner goes... but I'm not sure all the caregivers get the training. The sense I get is that the owner stops by once or twice a week, so I am not sure that the people who need that training get it.
- An online webinar would be really cool. I'm not sure if that would be a barrier. I think it would stop our access issue of getting the right people to hear it to get it.
- We used to go into each AFH, and that was great, but it's pretty cost-ineffective.
- If you could have something where there was an AFH consult group - where they could video in to a webinar. Where they could talk out problems regularly.
- Any time you are talking about the spectrum of mental health and developmental disabilities... I am less interested in them getting 18 hours at the beginning, and more interested that they get something every three months.
- I think it's very tough to get a lot of skills out of a one day training, or even a three day training. And these people who are providing care are in a setting where they have a very tough schedule.

### Impact of language and culture on specialty training

- It is a balancing act between rules and culture.
- I do not think there is anything in the DD training as far as a culture is concerned.
- Meals are an example. You eat as a family and you have to figure out how to eat as a community while taking culture into account.
- The mandatory training for caregivers has made a big impact. Caregivers who do not speak English as their first language are challenged to make it work. I have seen people lose their job because they were not able to pass the exam.
- I wouldn't say that (culture) is in the curriculum - I use a couple of scenarios that we have come across that kind of help make the point. We will hit on that, but because of our experiences, but not because it's in the curriculum.
- Language and culture - this is a big one. We are seeing this across all areas of caregiving. There is a change in demographics. Especially in Snohomish, King and Pierce County - we are seeing different cultures coming in and English being a second language. There have been a lot of comments about the class being offered in different languages... Linda says that it is in the WAC that it has to be taught and tested in English.
- I don't recall any cultural sensitivity... there is a part about privacy and personal space, and respect. A lot of that, but nothing on cultural differences.
- There is a cultural thing in the DD world where cultural differences are not emphasized enough, so it doesn't come up in the DD curriculum.
- Important to have a certain amount of English (e.g. WAC - ability to communicate in an emergency, e.g. Call 911 and share information) - so may not be advisable to provide training in another language
- There is a manual, and we teach from that manual, but some of our biggest challenges is recognizing the audience - being that many, many people we support don't speak English as a first language. You combine that with a fair amount of content we are going through and then they need to take the test... which I am fine with being in English... but depending on the makeup of the audience, up to 75 % of the audience may not speak English as a first language, so in terms of exercises that can be difficult.
- I think, to some degree, it affects exercises and activities. From a trainer perspective you know that if people don't pass the test, they don't have a job. I worry about people who might be wonderful caregivers but may have a hard time with the test.

- TASH - national organization that looks at developmental disability across the lifespan. They do an annual conference, and for a number of years they focused on cultural differences.
- The idea of having training for English before they go to DD specialty training. They do not know what a physical therapist or occupational therapist is. The current manual goes up to grade 22?
- Same issue as offering drivers licenses in multiple languages and other services that provides good for the community. Shift and be more language neutral. The language in the reg is the language of the person. Maybe we should provide language courses in the facilities?
- Language and communication - we are not communicating well if our audience is not understanding.
- Diversify the faces in the front of the room for training. Diversify how the message is delivered. Audience vs. Messenger. Can create anxiety.
- Maybe in place there could be some kind of system for the diverse languages / caregivers to become trainers.
- Create a partnership with other languages at select trainings.
- Communication is more than just the words you say. Many people with DD might have difficulty processing any spoken language and might use other things than words to express themselves. Any caregiver needs to be multi-lingual in those situations and figure out how to support caregivers in this. Regardless of what your spoken language is - if someone is hitting their head, can you interpret it and respond to the communication appropriately (ex: I have a head ache...)
- 75% of the students are ESL (approximately)
- 95% pass rate several years ago. Current statistics are at around 50% pass rate. Reasoning: Caregivers are coming with little or no familiarity of people with DD and might not speak English.
- The temperature in the home is a cultural thing. There are different preferences for temperature
- How to deal with different cultures and meals. For example, shoes off in the home, Sunday for church, etc.....
- Understanding the meaning of rules for medications and even what is hot and cold.
- Scenarios, videos, or practice around culture would be helpful for training
- Native Americans do not have a word for disabilities. It is important to know that.
- Nothing of significance to add from our earlier conversation.
- The use of the word "retarded", as well as other derogatory words is still a problem.
- I do not see a problem with language and culture. Most populations are made up of the same or similar cultures in this area.
- English as a second language is a problem with the training. The number one problem I receive complaints on is that we do not provide a translator for the DD specialty training.

### Specialty training testing/assessment process and effectiveness

- I do not know if the test is a good measure of knowledge. Based on what I remember taking this class I do not think so.
- Passing the test does not really provide good feedback on what you have learned and how to apply it.
- People would take advantage of additional training for more pay. Those people that are dedicated will do the training anyway.
- Is there any way to validate the instructor's credentials to teach these courses?
- How might we review and revise the DD specialty training curricula as we move into the future?
- The test is administered differently. Some administer it in portions, some wait until the end of the last day.
- Passing is 70% on this test, and it's 80% on the others.
- It's also different because DD specialty training is more thorough, and it's also fill in the blank. The other training has almost all true/false and multiple choice.
- There are matching questions about basic definitions.
- There are some scenarios that they ask you about best practices related to that scenario... "which is NOT" questions really throw off the ESL students.
- We sat down as a group last August... and we looked at that. We asked what some of the problems are people having with the test, and what can we do about that? The same test has been out since 2006... which could undermine attending the course... we are training everybody to know what they need to know to pass the test...

- There are questions that are definitely difficult for ESL students. At the same time, they appreciate that the terminology used isn't simplified, because they need that to communicate with other care providers and families. We use a lot of acronyms - it's important that we spell out what those mean.
- Need to revise test for language, etc.
- Only one test, answers can be passed around. Will revise to have 3 versions.
- Believes test accurately measures content. 70% required to pass. Most people do pass. Unusual to have more than 2 fail out of a class of 25.
- Don't know how well it measures readiness - not in the homes to observe. Only way we know is through incident reports. Ideal to have some follow up, but difficult to structure.
- We spent a full day last summer with Linda to talk about the questions and the clarity of the questions. Clean up the double negatives, but in terms of written test to determine competency.... I don't know how you do that.
- I think the content is right, but how do you know you are testing the right thing, or that they will do a good job if they pass? How do you test what's in peoples' hearts? I understand that there has to be some way to test it, but someone else put the test together.
- Barriers: time and resources - freeing up caregivers from schedules to be able to go.
- Example - I had some women who didn't want to do the training. It was clear that they cared about their residents, but they had to take a day off without pay to come... and that amount of money was huge to them. Three days without pay in one month.
- We are required that 90% of participants have to complete an evaluation of the training and those get sent to Service Alternatives. It's paper, but there's an online option too. They also send that to each of the regions to the liaisons in each of the regions.
- How are the trainees tested? 61-point exam, true false, multiple choice, short answer, fill-in-the-blank type questions.
- How well it measures people to do the work: Up until a year to two years ago, the course content and test did a nice job of giving people a nice basic foundation of skills and as time went by - caregivers come in who often are ESL are not understanding many of the concepts taught in the class. They may just squeak by or take a second time. During visits - some of the participants are not applying what is being taught in the course. Biggest issue is language issues.
- I think some of the material should change on the test. I have seen and given the exam and it has to be written more simply for people to understand. The exam has been lowered as far as age wise. I think the exam should be more rigorous.
- The exam needs to be more skill analysis and less common sense.
- Remove the true and false form the exam.
- I think the DD test does a good job measuring the intended learning outcomes.
- The test has a lot of multiple-choice questions. I do not think there are enough questions and I do not know if the exam is a good measure of a student's knowledge. I think someone could pass the test without the training.
- I think the test must be appropriate - my husband who challenged the test would have said something if the test was inappropriate - he was a lifelong principal.

### Specialty training requirements and oversight

- The 120-day rule is sometimes undermined by a case manager who won't move a resident until the training is in place.
- Because there is such a tight rein on the DD part of it, we know that people who have the certificate, they probably have the same quality of training. Whereas somebody who has the dementia or mental health certificate, I will give them additional training.
- When you delve into more specialties, it means more time for the provider that they have to pay for, but as an Ombudsman... if you have an individual in your home who has a TBI, you should have the training for that, and you should have to pay for it. That's kind of black and white, but that's my take on it.
- I find that a lot of them lack the specialty training that you are supposed to have now.
- Be clear that we are not re-teaching basic skills.
- Levels of training/specialization?
- Can request special consultation. TA providers do consultations all the time = deeper dive into specific issues with residents.

- Great to have regional mentorship team or 'hotline' - accessible via app or phone. Would need to be very specific to specialties. (Difficult to fund and will need to have incentives built in.)
- What do we need to do before homes even get licensed?
- Seeing decline in applications for AFH (not a supply problem) - due to expanded requirements for training, English competency exam, etc.
- The follow up and quality assurance piece comes up - taking the training doesn't guarantee that you will do what you need to do. But you still need to cover it because if you don't, somebody will say they didn't know.
- Hopefully there is some kind of process in place so that there is some kind of oversight in place.
- As a parent - information comes from the care provider and they say they need to do ongoing training that is not usually specific to DD and is frustrated to have to do annual training that has nothing to do with DD. The caregiver gets information from the parents, but the parents do not have enough information.
- As parents there is no input to suggest / bring to someone's attention for continuing education related to the children's disability.
- People with a disability are there for a lifetime because they are young. If there is a problem, it is a measure of how we are doing our job (ombudsman).
- Knowledge of the training needs to get out there. For example, the change in payment is just not getting out there.

### Best practices related to specialty

- Respect. My child is nonverbal. I must trust caregivers to take care of my child.
- CPR, the ability to communicate, and safety.
- The transition from being at home into a caregiving environment.
- I would want them to be trained on how to be a medical advocate. Often a practitioner is not trained to advocate for a person with development disabilities.
- I would want them to have knowledge of the different disorders based on client needs.
- My role as a caregiver is a life counselor. I need to be able to support them with these new activities, for example a job. One thing we do not get is training on teaching clients life skills.
- Help clients prevent chronic disease. For example, diabetes.
- I coordinate specialty training. The focus of specialty training is the basic introduction for people that are new. It is a broad-brush stroke. The focus has been to provide people with the values caregivers uphold as guidelines. Recently, there has been a real push to put together more courses. I think specialty training has room for improvement. But I think it is important to think about what are our goals, and what we can realistically accomplish in a three day training.
- Advocate for someone who goes to the doctor. Ideas around helping teach people basic skills are great.
- Communication, patience, respect are important skills for caregivers to know.
- Patience, support, and a willingness to decipher communication through activities. Develop creative ways for people to support people.
- I wish we had a network where Adult Family Homes connect with each other, share ideas, and do activities together.
- Just because you went to the 18 hours of training does not make you a specialist. You have to have experience and a desire to take care of clients with DD.
- As a parent, caregivers need to know about my child. Is he frightened? Will he eat? Etc.....
- Individualized care for clients. Coming up with really good routines and schedules help clients with DD thrive.
- Visuals tools. For example picture calendars and schedules help clients understand their day.
- My favorite is when I see people involved in the home. For example, one person setting the table, one person making the salad, etc....
- In Michigan, they have the Person Centered Plan, which is done every year. What are your likes and dislikes? Family members can contribute to the plan, and the plan is followed throughout the year. The plan can be changed as needed throughout the year. Care is provided based on the Person Centered Plan.
- A lot of the same things - compassion, communications
- I would ask if they had people with special training in DD
- I would also look, based on the disability of the individual I was placing - does the home already have similar disabilities? The environment is really important.



- It was about how do you deal with the behavior in that situation... it's better to teach them critical thinking skills vs. Specific skills.
- Are the other residents happy, engaged with one another, not in their rooms... do they offer activities outside the home? I would not want my loved one kept in the home and not part of the community.
- For me, the priorities are really about people living full lives. Sometimes it's easy to think about DD as separate from the population at large. But the reality is that they have the same desires and wants as everybody else. Does the place where they will be living offer the opportunity to live a full life... whatever that might be?
- Talking about different life areas - they call them the values of service delivery - that is one of the biggest areas. Sometimes we focus so much on the disability, and sometimes we forget to focus on living a life that is worth living. Supporting a full life.
- I focus on planning and behavior. What are goals and dreams? How does that impact daily life, and how does that in turn affect behavior?
- I would say people don't actually really understand their jobs until they have been in it for six months - regardless of the specialty.
- The history of developmental disabilities. How did we get to where we are with our treatment of people with DD. Addresses language, letting people be as independent as possible, residents' rights.
- People have ability to make choices regardless of diagnosis.
- Challenging behaviors are typically caused by physical pain.
- How to address challenging behaviors. How to support person in looking at that behavior - positive behavior support. Every behavior has a function - not necessarily a 'bad' behavior.
- Cultural relevance is key. Most homes staffed with people from other cultures.
- I see it to be a missing piece now - especially in homes. We were forced to look at that again when we were bringing people out of sheltered workshops and into employment. It's coming up more with the federal program Employment First. That isn't always happening in homes. Everybody gets quality lives, and meaningful lives, but not the teaching aspect. What the division promotes involves integration and inclusion, so that teaching component is integral to all of that. An important piece of that is the documentation - how do you show progress and lack of progress? What does the data show in terms of best practice?
- Early on, I benefitted from all kinds of different training and conferences. I just have been really lucky to both have a lot of training and implementation to put it into practice. And I have been delivering different types of training for a long time.
- Effective communication - in the manual - I would do that one differently. It is really more about strategies that you would learn in a management class, where I would think something about non-verbal communication might be more useful.
- All of us have experience in the field of developmental disability. I believe that part of the criteria for DD contracted trainers is a certain amount of experience. The same when a facility wants to provide the training themselves.
- I would ask about all of these topics - my mother is in an adult family home, and these skills are universal.
- Quality/benefits of life are huge, so people can see the sameness.
- Understanding behavior, so they can understand why somebody is acting a certain way and what you can do to prevent that.
- Rights is huge.
- I remember going through the process and asking these questions. Respect, dignity, choice, rights, understanding behavior - that is what was important to me when I was placing my mother in an AFH.
- What have you heard caregivers asking for? I have heard some people say they would like it to be more in depth. Behavior, effective communication, crisis prevention and intervention.
- There is a project within the Division called Roads to Community Living. The focus is on moving people back from the institutions into their community. In talking with them about what's still missing, is a component of teaching new skills, teaching for independence, teaching for optimum level of performance. When we developed the teaching technology, it was meant to be a teaching strategy for people, regardless of where they were. Visual systems for independence, finding ways for people to have more independence. Historically, what has happened - there have been so many other things to pay attention to that the teaching component hasn't always been in the forefront.
- Total Living Concept in Auburn - they have been in the field forever. They do an excellent job. They hire people they know are from different backgrounds, and they do a good job of making sure it doesn't affect care.

- Trainings at DD - the values are germinated there, but add that it is important to have all of the trainings reinforce the idea that a person living with a DD is an adult who has the right to live a full life defined by the individuals dreams and aspirations. The people who love and support you are often trying to define it for you. The environment should be nurtured to promote value for the individual. The training should address if the caregiver is appropriate to care for the DD population - it is a lifetime of living in the long-term care system.
- Have they been a parent?
- Proficiency in English
- Religion?
- Have they had background checked?
- Know everything about them.
- Are they a good cook?
- What is the quality of housekeeping?
- That the person has some awareness and history of people with disabilities in this country.
- We used to warehouse and mistreat people - gives you humility and there are things you do not know and can be imparted to people coming from diverse backgrounds.
- The current training has a lot of history.
- Everyday physical care (outside this specialty)
- Behaviors - parents use some brainstorming to find out what to do and what to try. Where do caregivers go? (Resources.... In a home, they will go to an administrator for information and resources. At times they will go to the case manager or other providers. A person working in the home they should be able to go to SEIU to find resources.)
- During the training - lets talk about if this work is for you, who you are comfortable supporting, how do you spend your working time, how do you handle people who challenge you? (From a trainer perspective) Some people welcome this, others decide it is not what they want to do after all. Some people come and do not understand the concepts and not getting the message [to determine if the job is appropriate for them and their capabilities]. Sometimes they cannot visualize what the job entails.
- I would ask about what training each caregiver received.
- I would want to make sure that the home had a specialty designation in developmental disabilities.
- My list is very long. Training, safety, the quality of the home (e.g. Clean, etc.), is the family appreciated for their knowledge and part of the care plan.
- I would ask have they received and do they understand positive behavior training?
- There is a Great video out of Minnesota and it is about getting rid of the word retarded.
- The Credo for Support is another great video.
- My relative had the mentality of a 12 year old. She had Prader-Willi (Compulsive Eating). When she was put into a nursing home they had a snack table and she would gorge herself. It is good for caregivers to know the needs of each client, and have access to resources if they do not know what to do in certain situation.
- I would want to know how you deal with dietary needs of a client's given free will and the risk of not following a doctor directed diet. (e.g. Help clients make good choices for themselves).
- What we need is training on the practical skills to deal and resolve challenges with clients and their behaviors.
- I think it would be good to add more diagnosis to the training. There are a lot of other things we need to be trained on. For example, Prader-Willi Syndrome.
- I think it would be useful to have managers training, but I do not know how it would be done.
- I would want to know if caregivers were licensed, etc..... Additionally, I would also want to know what is expected of caregivers. I would like to see more activities with the DD population.
- I would want to know what training caregivers went through and have they been through refresher training recently?
- If I knew a caregiver attended the specialty training that would give me a higher level of confidence with the caregiver's ability to provide care. I went through the training and think It was well done.
- I think specifically the training needs to include that cautionary chapter - to remind folks that every situation is unique. Every single individual is a unique human being. And those people who are their supervisors are the experts. No matter what you learn in your training, the bottom line is: "how does it work in the home where you work every day."
- I would begin by asking them what influenced them to even consider to begin working in this genre - their background, their vision of who they are. Their talents. What drew them to the opportunity? Then I would just want to know them as a person. I have had feedback positively that the Dwelling Place is doing fine.

- One of the things we really focus on is that - even though the employee comes to work here - you are going into somebody's home. That is the reality. How do you value making your very presence more a part of their lifestyle, their community, their home. Rather than a boss, or a paid staff member, or all the connotations that can be perhaps a misuse of personal power.
- Absolutely, from the get-go, understand that the person you are here to serve is the director. They are really the ones - that is why you exist as an employee - it is their home, their life, and you are here as an assistant.
- We have in heart adopted the philosophy of the Larch homes - because our "core members" need assistance. We are here because of the fact that our folks need assistance. People need to come in with a very humble and teachable spirit, with a large capacity for listening and observing, not making snap judgments. Being very conscious of their own ability to communicate, vs. The residents who have challenges to communicate.
- I think for me personally, aside from all the credentialing questions... lack of structured activities. Do they offer group things? The good ones have something like a Friday movie night - not required, but come if you want. So it ends up being more of a family structure.
- There is another one where all of the individuals eat dinner together. Less like an institution, and more of a family home kind of feel.
- Does it feel clinical, or does it feel like a home?
- To me, the really good AFHs have a very welcoming feel
- Certainly, I would want them to learn about what resources exist in the community that they can use - what is the protocol, who do they notify, etc.
- That empathetic caring that comes through - even in the setup of the house, how do you create empathy?
- We have done talks with residential providers about empathy -- how do you use praise, empathy, make them feel like a human being?
- Tell stories, anecdotal situations. If they understand the history of the client... a lot of times, they get a packet and decide whether they can manage the individual. Understanding how they got where they are.
- You can learn more in an hour of play than in an hour of conversation. Have fun and do things that are positive psychology stuff. Weaving that into everything we do.
- Something about that empathy and why are you in this business?
- It's obvious to us that they care for the clients... that they aren't just interested in providing jobs for their family and paying off the house.
- That they care for these residents as individuals. Some of them do Special Olympics with their clients, but some don't
- Good communication with case managers, etc.
- Some understanding of why behaviors occur.
- Those that work at it and go the extra mile to understand what is going on with a client.
- I see that in all three cases, where you have the table of contents, you have some basic topics that are covered. Communication strategies, behaviors, working with the family. I think what they should come away with is a concept that the fact, in the simplest terms, they need to understand that the folks they are assisting have highly individualized problems. You can't lump them all together. I think throwing a lot of information at people - even if they have CMA training or experience, is very different than how they need to focus and react.
- In our brains, we try to be logical and make sense of things, but that is not at all really helpful for the individual. What is helpful is to understand what the treatment plan is, reference it quickly if there is an issue, and to understand the importance of looking for change. It's a clue that something is going on and maybe needs to be investigated. Could be an allergy or a problem with their medication - whatever it might be... very often things are "slid over" in the care setting... it was OK yesterday, so let's see what happens. For family members and friends this is very difficult when they have the history.
- Even when someone is accompanying the patient to the emergency or a new physician, practical things don't happen like a simple history of where this person is at... and being able to hand it off to somebody. It seems to me that often the care providers don't have this information.
- I would expect them to know how to access vital information, take notes.
- The greatest help is to learn how to be inclusive with whomever you are working with. Make that individual feel as if their concerns are being considered. They may not make sense - they may be frustrated, angry, or suicidal... But you aren't going to gain calm or a place to communicate if it doesn't start with inclusion. I believe these folks are in a place where there is some sort of trauma-perceived or real - their best protection is to escalate. That may be the best mechanism they have. And that gets them in trouble, and excluded.

- That business about having a little summary is really important for somebody involved in treating these individuals.
- I think it's very important for these caregivers to be following an appropriate policy. Delivery of services is an important part of the training. What do you do when you have a full slate of responsibilities and a situation comes up. What do you do?
- Pocket guide to the training... needs to be on file and they need to be able to access that. I do skilled nursing situations where care providers seem very impersonal. And it's hard enough to be isolated in any kind of facility setting without some sort of personal interaction.
- The demands on the staff are a big problem - no question about it.
- Do they meet state requirements? When my daughter moved, the AFH was not in operation - it was new.
- If you work with these communities, you have a sense about things. The director and supervisor was clearly very experienced to me, and very sensitive. It was somebody who got information, and I guess I relied a lot on that and intuition because I think that having people who are care providers and open to family and friends is critical.
- They knew they were going to meet licensing requirements?
- How they manage their day?
- How many people are going to be there per resident?
- Who will be there at night, how many hours are covered?
- Where do you go for emergency care?
- Are you familiar with my daughter's health providers? ...pretty practical questions.
- Understanding and valuing routine is, I think, of greatest benefit to folks with these kinds of issues. It enables them to get through their day.
- They are more likely to get out and have time for getting outside the facility
- Regular meals, and even personal care - grooming and brushing your teeth.
- Having that routine, daily and weekly, is very helpful.
- Treatment plans don't always get developed or applied, and skilled nursing was horrible [in that regard]. Mobility problems... those residents might be very frustrated and blaming themselves. They might be unsure what they can ask for in way of assistance.
- Getting them to contribute to their own treatment plan is essential - in early stages of dementia, but even in end stage they can probably even tell the difference between cocoa and coffee...
- One of the things I would like to see in the training is how to encourage people that they are in a trusting relationship and what they care about/prefer is important to those who provide for them.
- A care provider who is rushing though their day may not let the person know that they will get their shower, or whatever happens to be going on, and that kind of comes back to inclusion.
- I hope a large part of these trainings focuses on connecting with the person. Not about medications and how they are diagnosed, and that sort of thing.
- Having some socialization is really important - it's key. To be planted someplace under a roof and go through the motions of daily living without socialization, or very little... that's what happens in skilled nursing, and in AFHs, some are better than others. There is a world outside of bingo. The psychosocial part is very important.
- My loved one's strengths and clear guidance for when and what type of supports are needed
- I would want to develop a plan that was tailored to my love one and my family period
- What are the triggers
- How to treat my loved one like an adult and not speak down to them. How to deescalate a volatile situation
- Caregivers will fail without adequate training.
- Understanding their disability and treating each person as an individual
- I would want to make sure that the care provider understood the characteristics of my son/daughter's disability; medically could handle their needs; that they had enough staff to handle the needs of the home; behaviors of the other clients in the house; ensuring that my son/daughter could get along with the others; a good relationship with the caregiver
- How to communicate and how to meet their social needs
- Understanding of the disability, appropriate interventions, compassion
- To enjoy my loved one.
- Kindness, understanding, patience and hopefully some experience.
- The characteristics of autism, how the individual that they will be support experienced their autism based on the classic characteristics and be provided best practice implementation supports, training on best practice

- supports and a cohort of other ASD residential providers to share experiences with and be mentored, continual review of incident reports that are addressed to change the maintenance of a "said" behavior, functional communication strategies and expert consulting to make positive changes towards skill development for the resident with ASD as well as the residential care provider-ASD Life Coach.
- My son is DD - we looked for an environment that would support him to be as independent as possible, one that gave him limited "possible for him" choice options. A place where he felt respected, listened to and as happy and content as he could be.
- How to assess situations and deescalate resident's behavior before it becomes a crisis.
- Patience-treat them like you want to be treated.
- That I want my loved one to be treated as a valued person. The issue is oversight, and requiring staff to remember, and act in the best interest of the client... In time, staff become lazy and more interested in how they want to spend time - the focus needs to be the client 100% of the time
- All of the above. Plus they need to listen to the person with a disability. Do they want to live in the parent's home? Where do they want to live? And if in an apartment- how can they get a Section 8 voucher and the support they need to live a more independent life.
- Understand how they think, behave, and how to react in a kind, and patient way. Recognize the signs of illness because they can't always tell us. Be able to set goals they want and help them reach these goals. Hygiene and relationship issues. Recourses available
- Local resources for my loved one, technology and resources available to my loved one, and approaches for special situations.
- Information about resources in the community for the residents. Information about providing positive behavior support. Information about different types of developmental disabilities and resources available for seeking more information. That adults with developmental disabilities are not children. Resident rights.

### Rank of the modules from the training manual

- Introduction =
- Overview of DD = 1
- Values of Service Delivery = 3
- Effective Communication = 5
- Introduction to Interactive Planning = 1
- Understanding Behavior = 5
- Crisis Prevention and Intervention = 0
- Overview of Legal Issues and Individuals' Rights = 1
- Resources = 2
- We are frequently using other communication methods other than speech.
- With behavior there is always a meaning behind it.
- The medical model is damaging to care.
- People are more focused on personhood. We are growing and becoming more enlightened professionals.

### Additional comments and opportunities

- Training on autism is additional content that would be useful for caregivers to know.
- The Washington Care Assessment is the equivalent to the Michigan Person centered plan. The care assessment is the tool the family, case manager, and care manger have to ensure the proper care is being provided to the client with DD. Unfortunately, it is not always followed.
- Training on how the care assessment works with care plans would be very helpful.
- We should have an additional training on documentation.
- Break down the DD to topic specific modules. Autism, Down syndrome, etc..
- Basic health specialties. For example, hepatitis, HIV, etc.. It is part of the 70 hours training.
- Support the transitioning resident. The transitioning person is where we have the most issues and where we need training.
- Coping with loss would be good additional training for caregivers.
- Different levels - DDA is already set up with technical assistance to provide ongoing training, so I don't know that there needs to be different levels.. Again, this is an 18-hour training. Vs. 6 hours where that may be more justified.

- There are trainings being added all the time to make sure we can comply with 1163 - and not have the same training year after year.
- So maybe that is a follow-up question - is this being covered in the basic training? Are there redundancies in terms of all AFH and boarding homes?
- What I tell my students is get to know your clients, then take your CE aimed at those. If we do levels, we are taking away the essence of DD and getting to know them as a whole... and we are adding something that we don't want to go with.
- There is an overview, which defines developmental disabilities and the history of service. I think that's incredibly important. Even though we don't deliver service that way anymore...
- One thing that could be added is conflict resolution/negotiation - that could work into what is going on. Having a daily walk through negotiating and making sure that people's rights are being protected while you are also protecting the rights of five other people.
- Some of the CE trainings do a good job of covering basics, then delving more deeply into different topics. There are things that would be useful there, and talking to more people about what would be useful.
- What skills should managers have? Should there be different training? It seems to me that maybe something around leadership and quality - how to evaluate and how to be a good manager. How to follow through. Seems like those would be good manager training. A lot of time people get hired, but they don't get the training that goes with the title.
- Those with Down Syndrome age 15-20 years faster and there is a decline in ability and how does it get addressed in the training?
- There is good literature out there for self-determination is it incorporated into the training? [Linda Gill: this is incorporated into the training].
- Autism
- Training around anticipated life in the long-term care system. Reassess and be more supportive of these kinds of trainings. It is different than working with people who are at the end of their life. (End of life vs. Long term care of younger people with DD.)
- Certification in positive behavior support. (CE)
- Crisis management.
- Positive crisis management.
- Physical disabilities (e.g. Quadriplegic, etc....)
- Dual Diagnosis (e.g. Dementia and down syndrome)
- Health and nutrition
- Sexuality
- Self-esteem
- How to help a person with DD manage money
- I think different levels of training would be great to consider moving forward.
- DSM and Prader-Willi
- Obviously, every single situation where any of these trainees is going is an employee will be unique, with unique residents with unique needs. So the OJT becomes very important.
- Additional education would be of benefit, if it was accessible. Same challenge.
- I would say wound care/assessment - how do you treat, and how do you prevent
- Diabetes, and some of the chronic illnesses... COPD, kidney disease, MS... those seem to be big ones.
- Even nutrition - how that related to other subjects... could be included in diabetes training, for instance.
- Basic pharma class could be good
- I find it very difficult to get information as to how to connect to other resources, and from the standpoint of management - I see that good managers has to really focus on their priorities, and pray that they have time left over after that. Because of the nature of the business.
- TBI has its own set of challenges. Where my daughter resides, most of them have a very hard time communicating, but it has nothing to do with their intelligence, and that is tremendously frustrating. It brings up their social needs. It contributes to depression, anxiety - those kinds of things. And it's highly individualized. I would hope that DSHS has some sort of criteria set for people with TBI. While each case is different, I think you can bring attention to some of the needs. Folks with TBI have pretty high expectations. Their energy levels and their abilities are such a roller coaster that it's very hard for them to maintain what they expect of themselves. It's a separate issue from their mobility, and their ability to speak and communicate. They still have that whole set of where they would like to be in their expectations and where they would like to be in the world.

## All Current Specialty Trainings

### Strengths of current specialty trainings

- Really having that relationship with the resident and their family - there is constant feedback, and they aren't trying to do everything themselves.
- Those homes always seem to be involved with a lot of healthcare professionals who help to develop the care plans.
- Always open to feedback and change - looking to the resident and their family, and consulting with healthcare professionals.
- Communicating. That is just so critical.
- The operator is very hands-on, and they are there and know all the residents. They are involved daily.
- It seems like as they expand into multiple homes, we see quality decline.
- The more they do with the clients - having them interact with each other. That is very helpful.
- Personalizing it; having a well-lit, bright home.
- The providers seem to have huge knowledge of all the community resources and things that are going on, and how to connect a person with supplementary services.
- Those that are actually able to provide the staffing - some don't provide enough staffing so that all they can do is the personal care.
- There should be a TV that the clients get to watch their shows on, vs. The caregiver's shows -that goes to clients rights.
- A lot of times, they have a home that is on the shuttle or bus lines. They do better, because people can get out to community and activities.
- Those who are really good at assessing and understanding how a resident will interact with current residents.
- They are getting to know their residents as people with previous life experience and interests that they respect and honor in the nursing home.
- They are very welcoming and include them in daily life.
- Very strong emphasis on customer service - taking the time to make sure that concerns are resolved and that customers feel heard. It's easy to get distracted by all the paperwork and regulations that you are complying with.
- They are involved in their lives.
- I have specialized providers where even if a resident is not returning to their home, they visit them in the hospital. I see providers not giving up on clients, and reaching out for help when they don't know an area and want to continue working with that client.
- They are active. They are involved with resident families. They get to know everybody in that person's life. They take trips, and there are activities
- They advocate for their clients through the various systems to make sure they are getting their clients' needs met.
- I think our special dementia place in Vancouver - Stonebridge - how they treat those folks and interact. They are just amazing when I go out there. If I could replicate that program and put one in every county in the state, I would. They have the baby dolls out, they have a book section. You see that with everybody from the janitorial staff, to the clinicians, to the front desk. But I see that with some of my AFH's, too.
- Feeding people properly.
- Hydrating them properly.
- Actively involved with their medical care.
- Providing social activity, and/or they engage the residents.
- They don't just turn on the TV.
- They are not warehousing - (they are) treating the residents like human beings. They are not left in a living room with the TV on.
- For people with DD, no matter what their functional level, they want to set goals and accomplish them - a good provider will help a resident do that. I have known providers to help their residents to grow to live independently. Treat them like the person they are.
- Because you are a caregiver or a provider, doesn't mean that taking care of them is the only thing you can offer them. It's harder to talk to them and keep them focused for a few minutes.

- They are getting to know what works with their particular client, and developing their care and services around that. If you go to ALF the staff seem to have a better handle on that, and they are more willing to make adjustments when it doesn't work. I don't see that at AFH's.
- It's more client-focused in assisted living. It's more home-focused in AFH
- ALF's have a better handle on the paperwork and the documentation. AFH's have a harder time doing negotiated care plans and those kinds of things.

### Specialty training challenges or deficiencies

- "[caregivers] really want practical applications to the challenging behaviors."
- "[if I could redesign the training and remove all barriers] I would only take a couple of hours in terms of the academic content, and use the rest of the time in the home showing and demonstrating approaches to dealing with behaviors. That home will have its own environment and culture and they are going to react differently than they would in a role play."
- More discussion of the behaviors associated with the disorders is needed.
- The academic piece of the training is essential - we want caregivers to act, not react. This also involves having an understanding of potential triggers for certain behaviors
- It was easier to be able to access training online.
- DD training not in the private sector is a problem and not accessible.
- The hours are 6-8, can the information be condensed? 8 hours to dedicate to training is a lot. 4-5 hour blocks would be easier to manage.
- Dementia and mental health training do not give the caregivers takeaways that are practical for day to day working with residents. Very academic. Need "what do I need to do if...when..." What can I say or do to make the situation better? Understanding each type of dementia is nice but it comes down to techniques being more important. Solution is to spend time with caretakers and have detailed care plans.
- Documentation and use of documents are not covered in training and it should be. (ex: care plan, interventions, etc.) The department does not have this type of training. DDA has an anatomy of a meltdown. Maybe this should be addressed in the training.
- Positive behavior
- DSHS should tie the requirement in of documentation and use of documents but not own the training.
- Teepa Snow is a great resource. She talks about approach.
- Talk to Lynn Korte at DSHS about Teepa Snow video from DSHS. There are different types of dementia. Translates to mental health training.
- Talk to RCS and citations - likely to be linked to dementia or mental health and the need to provide preventative information like documentation.
- Doing a lot of talks around misuse of antipsychotic drugs with dementia residents - has spoken to family members who had no idea these drugs were being used; or may be told that if they don't put family member on drugs they will be discharged
- Key principle: atypical antipsychotics being described for people with dementia do not work except for sedation, and have other side effects (stroke, heart attack, falls, etc.)
- Look at environment and physical factors first, before going to drugs
- The biggest complaint that we deal with is involuntary discharge. So finding a way to keep that from happening would be great. Anything we could do to keep people from needing to be discharged. Can we train to help prevent that?
- It would be good to have resident rights as part of the training.
- Talking to people, and listening to their needs - that is at the core of everything. More of that is good.
- Back in the day we were all encouraged to take the training. That was over 10 years ago.
- Particularly in the area of MH, in my experience, training is not enough. In most cases people have no background in MH.
- This is too much information to train a person on in such a short period to time.
- What we hear about are behaviors. Physical aggression, not taking medicine, wandering at night to smoke a cigarette, screaming, yelling, intimidating, etc.....
- Caregivers are not prepared to deal with these behaviors. Some caregivers, with experience, are better at working with people and these behaviors.
- Our job is to help them and give them support. Our only option is advice in these difficult situations.



- The providers do not have the education or support to learn therapeutic techniques and are winging it. I also do not think they have the number of staff to deliver the care.
- In most situations in AFH there is only one person on duty at a time.
- Money talks. If you can pay caregivers more you will get better caregivers. Therefore, what we see and deal with constantly is caregivers coming and going. Money is a big one, and if they are Medicare clients the pay rate is low.
- Dementia. Most of our caregivers do really well with dementia. They are almost better able to care for people who are not mobile. Problematic clients are early into dementia and mobile. The caregiver at times gets beat up in the process and may get burnt out quickly.
- Each module of training should be a day or two with follow-up. Maybe AFH's could network together and talk about best practices and share ideas.
- Associations might provide the potential to help with the educational process. There are even some private companies sponsoring training. 'Ready meds' for example in auburn is a great example.
- The AFH community is very tight.
- Community instructors are also a way to help with continuing education.
- Home and community services staff might find it beneficial to attend the specialty training. It might facilitate identification of the gaps and weakness in the training. Great idea for those who do not have a background in the specialty area.
- Missing real life aspect; how to apply learning
- Too much rote information learning; e.g., don't need to know all details of physiological aspects of dementia
- MH and dementia too short - DD too long (lost interest/attention)
- Dealing with challenging behaviors
- Dealing with wandering - how to redirect
- Nighttime / sun downing behaviors
- Managing behaviors within milieu of residents
- Resources: where do we get additional support if faced with a situation we can't handle?
- More information on 'how'? Guidance is to redirect ... how?
- WHCA had alternative curriculum that Vicki developed.
- Mentoring - opportunity to check-in after the training.
- Online training - being able to watch a video online and take a test.
- Cost is a factor so anything that would lessen the amount of time. Focus on what really truly needs to be trained. We train them to assess what type of dementia more than training them to deal with what they see. Skills are more important than assessing a type of dementia.
- Current training is a lot of book learning. You hit the ground running and the notebook sits on the shelf. The way we learn best is to utilize the information at the moment we are offered the information.
- Some balance between classwork and hands on.
- A lot of care staff a month or two after training won't remember the definitions but they will remember experiences.
- Learned more on dementia training put on by Teepa Snow than the DSHS specialty training.
- Facilities that do both dementia and mental health could have a combined class to address overlap in the trainings so you don't have to take a separate class.
- Easier to get trainers certified. Current process is difficult. Nurses being rejected after they were already certified. Would be nice to be approved to be a trainer at any organization - not limited to one.
- Sometimes there is a waiting list to get people into training and sometimes it creates a hardship for timing and location.
- Teepa demonstrates things in ways people have a better understanding / more informative.
- Probably keeping everything straight. There are so many requirements for the day-to-day care, and the changes they need to track, but also making sure that all your staff have their qualifications and that everything is updated.
- They always struggle with staff turnover - when you are on top of it, somebody quits, and you have to start over. That can be very devastating in an AFH, and a chronic issue in assisted living.
- Probably just not having the skills as a resident changes and their care needs increase; not really knowing what to do.
- In assisted living, you always have an RN looking over those needs, and they discharge when they get to a higher level of care. But in an AFH, they can keep them through to end of life. So sometimes, not knowing

- ... it can be very subtle changes, and then all of a sudden you are in over your head. A skilled provider will bring in other resources to make sure that the resident is assessed, etc.
- Not everybody is made for this work.
  - Homes want to keep their residents, but admitting when they are in over their head is kind of a challenge.
  - If I were a provider, handling the families would be my biggest struggle. There is a difference in quality of care expectations between the caregivers and the families.
  - In the assisted living facilities, the administrators teeter on the line of meeting needs and being customer-service oriented.
  - In assisted living, residents can be assessed as being independent with their medication. They are supposed to monitor that, and when that system of delivering meds is no longer effective, then they get resistance from the family and the resident.
  - You are between a rock and a hard spot sometimes. The state may mandate something that will keep you in compliance, but the family wants something else. So you are stuck between the rules and being customer service-focused.
  - We did have complaints coming through that had to do with medications that were sent home with families, they would come back from a family visit and the medication wasn't given properly. If that is a higher need medication like insulin, it could be a really bad thing.
  - There were caregivers that didn't understand the resident needs. I think specific and general - the complaints that have come in have been a lot around diabetic care, but also others. Wound care. Dementia care.
  - Dementia "specialty", and how that name gives the wrong impression. Just because they have taken the class, that doesn't mean they are experts in dementia, or that the house is prepared to take in all the issues that come with a dementia patient.
  - Wound care is a big one... that could be its own specialty. As could a physical one: bridging, passive range of motion, and pressure sores.
  - Fractures - if somebody falls, a correct assessment is needed to determine if there was a fracture.
  - Have taken dementia and DD training. DD pretty good; dementia disappointing - not good training at all. DD more interactive, group work, hands on.
  - Very interested in mental health training - didn't know there is specialty training. See caregivers with limited understanding or training.
  - Training is just one component in overall care.
  - Fantastic video by dr. Allen powers ~ 30 minutes. Would start dementia training with that video to open up minds and thinking. Reframing - e.g. Not thinking of them as 'childlike'
  - Bringing an individual into the room, not defined by the label or viewing the person as a problem.
  - Anything similar for mental health?
  - DD training has whole section on 'person first' - building empathy for having things taken away from you.
  - Examples are very helpful.
  - How to work with people without resorting first to medication. Everyone has the right to be free of physical and chemical restraints. What other resources are available?
  - Training should be ongoing. Refresher on fundamental skills - universal precautions, ADL's, etc.

### Specialty training access and delivery

- The training needs to be hands-on and practical. This will help ensure that placements "stick".
- "when I do my trainings, I open it up and let them know that they are the experts, and I am here to give them tools. Peers will learn really well from peers."
- "I would incorporate peer-to-peer training, possibly a roundtable with new AFH providers, and offer them those stories."
- It would be great if there were a library of training available to providers and caregivers - that didn't cost them anything - and that they could apply to their continuing education requirements.
- Regarding online delivery of content: "we have a northwest resource locator, so workers and families can use that locator. But to get them to actually do it, you have to sit beside them. And they are going to have to have internet access to have provider1, which is how they will get paid. That will implement soon."
- "some of my AFH providers say there used to be online training that was accessible."
- "I think, in general, we say when we are doing our assessments, [that] we write our instructions at the ninth grade level."

- Why did the training time change to the current 8 hour format? - because a large number of providers were saying the time was not practical and the WAC requirements were covered and beyond.
- "eight hours is too short."
- The added case scenarios in the old format of training made for a better caregiver.
- Online training opportunities would be helpful.
- Updating the WAC to align with the objectives
- Manager training vs. Caregiver training. There should be a difference between these two trainings. Currently there is just a test difference.
- Current trainings are set up in modules - it would be nice to pull out each module and create more in depth trainings for each.
- Divide a class up into categories or people with disabilities and have them spend time in that role. Empathy training.
- "we just want that piece of paper (the certification) and then we train them."
- "how can we bring the experience of the resident to the caregivers in the training?"
- Interactions and meeting loved one's needs over defining types of dementia.
- I would use role playing. I would show some videos of interactions. A lot of people don't have a good idea of who their clients are beforehand. Give them an idea of who their clients are going to be and have them do role playing... pretend that you are putting on the call light just to have somebody to talk to and see how that situation plays out in the role play.
- I thought the training I received 10 years ago was very minimal.
- I think different levels of specialty training would be great. It would probably be more expensive and require a specialized staff.
- Don't know that instructors all well qualified or delivering consistently
- DD used lots of videos - too many, too old, lost interest.
- Waste of time for an experienced person.
- DSHS people who do inspections etc. Should attend training to understand what is being taught.
- Would like to have more classes available. Sometimes have difficulty getting in.
- Don't think it's a good idea for AFH to deliver own training. Limits breadth of knowledge/different perspectives.
- Lots of role-playing is valuable
- Encourage self-awareness
- Helpful to have a resource caregivers/managers can go to with questions after training
- Good to explain a bit about different diseases, so that caregivers understand what is going on with each person
- Consider follow up at provider association meetings - review case studies
- Manager class and caregiver class are very similar - sees opportunity to really differentiate the material.
- There is no 'train the trainer' version. Manager can train after passing the class and attesting to 'adult learning' training.
- What is working well...
- Dementia - the video, parts of it are good but the round table at the end is usually skipped and adds time.
- Wish there was a similar curriculum for the mental health - using a self-created.
- Pocket guides would be really helpful. "I want a pocket guide!"
- Use of examples - making it real - very valuable
- I am a trainer. I need to be, as we cannot find local classes, and if we do they usually cancel due to low attendance. Therefore I provide the training on evenings and weekends or make a way to fit it in.
- Attended on my day off.
- Our company is very focused on providing a wide variety of in-service trainings to all staff through monthly meetings and monthly online courses that are monitored closely for compliance.
- I take the training on my days off. Or usually have to ask another co-worker to switch shifts with me.
- If there is enough advanced notice I can usually schedule time away. Often depends on where the training is offered. So far it has been only on the west side.
- Have to request a day off to attend to this class.
- It is a hit or miss proposition even for myself despite not being a full time worker or full time caregiver.
- The whole family helped watch our son, so I could go and train. Some programs I was able to take him with me, as I needed him to specifically be there to be shown how to train him personally. I also got valuable cooking lessons from people trained in gluten free, dairy free, and allergy cooking.

- I receive training notices on a regular basis and I write my schedule based on the offered trainings.
- I just schedule it
- Paid staff time
- I go when training is offered
- Have a very difficult time making the arrangements and at times am too weary to attend!
- You just do
- Usually online or weekends
- We make it a priority, and search for opportunities to participate.
- I teach the class once a month but it is very difficult to find people to come and attend the class sometimes.
- I am the trainer in our facility
- One has to be very organized and schedule the two day class within a time frame when I have less pressing matters.
- As a manager to be able to train or to be trained I have to work on top of my current duties verses taking the time to train or be trained within the scope of what I do
- I try to schedule the specialty training as soon as possible when someone comes to work for us but I like them to have at least two weeks under their belt as I believe it gives them a better understanding of what we are talking about. I find myself repeating the class with minimal individuals in order to be sure to fit them in.
- I am a community instructor, there shouldn't be any excuse for not providing training. Everyone one who is involved in care should take this class.
- Make adjustments.
- I schedule it. We usually use WHCA programs on Thursday morning.
- We provide training and have to pay trained staff overtime to cover shifts while our new employees attend trainings.
- Add extra hours to the labor - it is difficult - online training would be ideal.
- Training has to be offered multiple times at different times and at several locations so people can work their schedules around those dates and times.
- Work the schedule so those needing classes can get it
- I am a community educator and I try to meet the students needs. Week ends and evening classes. It is a delicate balance to keep healthy in the workplace, family and education.
- Plan
- It is easy to find training for the DNS or ED; but when we get into line staff training such as NAC's and nurses - there is not a lot.
- Schedule when optimal AMT of staff can attend
- On line trainings
- Routinely scheduled and an expectation, for which time is allocated for all staff.
- Right now, I only hire those that have taken the training and come with a certificate
- Add hours in addition to regular working hours.
- As best I can. It is required and therefore I must make the time
- Difficult to do among normal day-to-day tasks and workload.
- Make arrangements trade shift
- We have to schedule the time off for them when there is a class available.
- When I find a training class that I need or want, I schedule it around to work or try to get a coworker to switch schedules.
- Will do it on my days off.
- Provided in on the monthly schedules
- Providing there is enough lead time, I just make it happen.
- We prearrange the schedules and stress the importance of being in compliance with the company and state.
- The facilities I work with are now typically having the administrator do the training which is all self study or they are using an on-line program like comestone. Either is better than the caregivers having to drive to Spokane because we have no community educators approved to teach it in our rural area anymore.
- The training was done prior to being hired therefore time wasn't a problem, money is.
- As a provider we pay for all specialty classes. We also provide the ability for caregivers to use an ongoing computer program for continuing education. This program is at no cost to the caregiver.
- I teach and schedule in to new staff training schedule
- Make time. No other answer.

- I have a nurse staff educator that is department approved to teach dementia/mental health. She also provides regular in-services to nursing staff regarding various health conditions/best practices/etc.
- We schedule a specific time and make sure it happens.
- We make it part of our orientation/training requirements and try to complete all trainings in the first 6-8 weeks of employment.
- Schedule it in advance.
- It is very difficult as a manager with so much happening in the buildings, staying in compliance with all the other regulations, ongoing training with the state having to approve the training is difficult.
- We schedule it during a "shift change" time period.
- As needed and or required
- I make time because it is important to the betterment of my community.
- It is tough, and needs to be regularly scheduled, but is important.
- As a program director, my company paid for me to attend CNA classes shortly after being hired. They were flexible with my schedule, allowing me to attend classes while simultaneously maintaining a 32-hour work week.
- Scheduling
- Have to do its a requirement!
- Scheduling 8-10 hours of training is always challenging, however staff are very appreciative and get a lot out of the class. Training evaluation results are very positive. Frequent feedback from staff is that they'd like more time in the training.
- Staff meetings, written in-services, out agency classes, hands on
- We schedule it in on schedules for some staff to attend. It's just limited finding trainings in Spokane.
- Scheduling as needed...
- Manager, it is very difficult.
- Do the best possible to cover shifts for two days while staff are out
- Scheduled as per compliance
- We adjust our staff schedule to make sure all staff attend the training.
- Schedule
- Extra hours
- I usually rely on on-line training since I don't have full days or blocks of days to attend meetings.
- As part of a college, we offer both dementia and mental health each quarter (about every three months)
- I have to attend after hours
- Based on need and then we just schedule it and make the time
- Work overtime
- My business office director finds a class, usually in the next town 30 miles away but sometimes we have to go into Olympia or further to find one, and schedules our new employee. We try to schedule more than one so they can car pool and expenses are less. We would love to host one but there really isn't enough of a demand out here for more than one or two employees at a time.
- We work hard to get trainings done around the work schedules of our staff so that training is completed timely without creating a staff shortage at the time of the training.
- You must plan ahead and understand that continuing education is critical no matter how long you have been in long term care
- Try to locate a trainer and set a date, and coordinate with 15-20 schedules is difficult. On top of that, you then have a large number of staff unavailable to work the floor while training is taking place. Payroll also can take a hit, having to pay your staff for their training time.
- I have to give time to the caregiver to go to class. We pay for the class and their time
- Scheduled paid time off
- It should be a requirement for all
- Training is of utmost importance and sets the foundation for consistency in caring for residents and in helping to reduce staff turn over. There should be initial training before a staff member works with a resident, and then ongoing training monthly.
- I am a community instructor but the homes/ facilities love that my training schedule is 2 days a week so they can continue to work the students
- Assign internet course work to be completed off site.
- Since it is part of the job we make time for it.
- You have to put it in your schedule. Everyone needs continual training.

- We schedule training usually before or after our regular staff meeting days (once per month). We also frequently sign up for webinars and encourage staff to join. Any free training or informational programs that we come across, we try to attend. It is difficult to find low cost specialty training in the area.
- We make time monthly to provide in-service as well as offer on line classes. The challenge is complying with all states requirements along with providing pertinent training on our monthly in-services. Many times although we may have a professional come out to conduct trainings, these trainings sometimes do not meet the states requirements yet our essential in training staff on how to deal with specific dementia related situations.
- I plan ahead & usually have to get someone to cover shifts for those that are able to attend have coverage. The problem is then I have to pay overtime to those that cover shifts for someone else.
- Hire the necessary staff.
- We offer it multiple times a month
- "we do some training during meetings. Here, we maybe ""training"" everyday because I like for us to first step back and ask ""whose has the challenge...the staff or the resident"". Assessment is very important to remember to rule out medical cause for change and then tracking patterns so all our staff get involved and we like to try our direct caregivers ideas. I don't think caregivers should put pressure on themselves to ""fix it""...here we ""try"" something.
- To look at patterns overtime and so all staff contribute to information and ideas"
- Management may cover
- We have to schedule it far in advance and schedule the caregiver off of the schedule for this time frame.
- Scheduling > a month in advance allows to modify my regular work schedule
- Making time is a matter of committing to what is most important to a person. We pay normal wages for employees to attend the trainings.
- Training is super important in our company and is made a priority.
- We had to fit it in. This was difficult for employees who were not paid for class time. They either had to give up paid time or give up time off.
- Due to our remote location and small population base, it is very difficult to build a class size that makes it financially feasible for an instructor to come to us. To send our staff to training is financially not feasible for us. It is four days of travel, lodging and meals. When cornerstone healthcare training was able to offer the courses online, it was wonderful. It was economical; students could get their training right away; and robin is a phenomenal instructor. Even though it was online, she always connected with each student and was available 24/7 to answer questions or provide feedback on assignments and tests. She did the classes via video and written components so the staff felt like they knew her and had an ongoing mentor available. The staff who attended her online training are the best staff I have ever had in truly understanding dementia and being comfortable with mental health clients. I sincerely hope you will consider online options in the future because I miss the quality I was getting and the economics. Now there are times I just am not able to get my staff to training and just have to expect a citation in survey.
- Fit it in the schedule
- We try to schedule employees on a day off and pay regular wage for the class time. If unable to schedule on a day off, we provide coverage on a work day and pay regular wage. We also pay for the classes.
- You just do.
- It must be scheduled
- Had to take time off of work
- Encourage continued education, training, assignment to participate in training opportunities
- As an owner of a school I set up trainings on an as needed basis. When people from the community contact me in need of training I set up a class for them. I give discounts when a person does both dementia and mental health specialty training together. I also give a bigger discount to facilities that send 4 or more people to the same training.
- As an owner of a school I set up trainings on an as needed basis. When people from the community contact me in need of training I will set up a class for them.
- "each shift has spaces of ""down time"" that can be used for training.
- I serve as conduit of exchange of ideas so caregivers are not competing with each other but supporting."
- I was an aid to a couple of folks who needed for a few day until they hired a regular one
- As much as possible training will be arrange on day off, but can be arrange with my supervisor so we can give way to learn and update our knowledge.

- I take advantage of any relevant opportunity, but it has required finding and accessing childcare in the past (a huge obstacle for many). Currently, I and the organization I work for - northwest autism center - provides training and education in the community. What we frequently hear from caregivers is that the trainings they have been required to attend are not specific enough to the needs of the population they serve. We are also told that not enough information about hands-on strategies for addressing different challenges are provided.
- Schedule on quarterly basis
- Take it from my own schedule as a priority, schedule it as I can for staff oftentimes having to have more than one training session to accommodate everyone.
- Within the state guidelines after hire.
- I get some of my training when I go to the meeting for WSRCC. If I have to go some were else for training I have to make sure I am covered at work so I can go. I have to make sure I am covered when I go to meetings also.
- Quarterly we hold all staff meeting and whom ever attended the training present the info to the staff.
- The information is there, the understanding and support during implementation after the training is necessary for success. When the support from an autism specialist isn't there, many times the strategies are put away because it wasn't effective the first time or other staff refuse to use the strategy and it becomes overwhelming to keep consistency.
- As the administrator I must keep track of staff completing training according to their time-frame. The cost of these classes is a hardship! Especially for small businesses.
- We use on-line continued education. It works very well.
- Other than in-services for continuing education, staff are responsible to make time for training.
- It is scheduled into all other activities and tasks and provided on site whenever available for ease of access. We have program to track due dates and send reminders to staff
- I just have to do it--I am the trainer, and my facility needs to be in compliance
- We schedule on-going training based on our all-staff and department meeting schedules. We also staff around outside workshops to allow staff to attend -- hopefully avoiding OT but sometimes taking the OT if the training is valuable. For new staff who require the specialty training, it is their responsibility to obtain it on their time -- we will adjust their work schedule if necessary to make them available.
- They either take time off to attend classes or do the self study course and test when they are ready.
- Specialty training requires traveling out of the area I live so this entails having to take it on days off. It would be better to again offer online learning- sitting in a class out of town for 6-8 hours makes for a long day!
- You make a commitment make training important. You also complete training "on the fly" train what you need staff to know as it is needed.
- Training needs to be available at different times and days: weekdays, evenings, weekends to make it easier for people to attend
- Training is somewhat easy to schedule - hurdles are budget for training hours. Once its on calendar and caregivers are scheduled to attend then it's not an issue.
- I am a nurse manager and there are several of us who have taken the courses and teach the training courses here at horizon house so we do not have to find someone on the outside to teach.
- We have online trainings available for free through "in the know"
- Attend webinars and conventions when education is imperative as a manager.
- Schedule training times and dates in the community. We do our own teaching
- We have to catch people on shift - 24/7. Otherwise the cost is prohibitive.
- Try to schedule some form of training 1x per month.
- Our executive director conducts the training, so we just schedule a day with her.
- We have to base it on the staff availability. If there are not enough staff on the floor we have to postpone the training some times. Most of the time the training is required before starting the job.
- Our organization (board and staff) participate in training and conferences as it relates to ASD. We also offer training regarding ASD topics to individuals and families affected by autism. We will have trainings in September to better equip our state's first responders with the knowledge they need to respond to situations involving an individual on the autism spectrum.
- Did not see that in the adult family home I was part of. No time for them to even get a day off.
- It is part of keeping your license current
- My husband will take time off his job so I can be gone for one to three days at a time. If he goes to training I am by myself, he again needs to take time off his job. This is hardship on the whole house. We really need to have more online classes available or classes provided in pacific co. I used to have a caregiver stay while

we took a day off to go to classes in Vancouver but now with all the new regulations/caregivers trainings we cant afford to send anyone to the trainings. Thus no caregiver at this time unless I can find a CNA. All the CNA's in the area have let their licenses laps because there is not a nursing home here any longer or have moved away. The assisted living in this area do not have as many requirements/training wise for their LTC as the AFH's. Which doesn't seem reasonable at all.

- Schedule the class within the correct time frame after hire and make sure the employee understands that this is a requirement of their employment with us. We pay for the class. If the class is not completed in time the employee will be removed from the schedule.
- The facility schedules the training, and I get coverage for those times.
- We have gotten a trainer on staff and pay staff to come in as long as it isn't over time
- There are no classes regularly offered in our area. Our caregivers have to travel to Olympia on their own time. We do give them the time off to attend the classes.
- Managers must create the opportunity for all staff to be trained in an ongoing dementia training program both as part of their in-house staff development and providing opportunities for out of facility educational offerings. These educational opportunities can be offered during normal work times to avoid overtime and build education into annual budget so costs are controlled.
- We try to have training at different times so that team members on different shifts all have a chance to go to the training or to scheduled them with enough lead time so that coverage can be arranged for all who need to come.
- Just have to prioritize and make the time
- We staff accordingly
- We schedule caregivers to attend all required or beneficial trainings. We make it a priority.
- I set aside time quarterly, this enables me to have open slots for new staff as well as provide refreshers for old staff.
- The 2 state associations, leading age and Washington health care association have been providing various trainings available to members and non members and their staffs. Good recourses.
- As a company we teach specialty mental health and dementia training
- Provide funds for caregivers to hire respite care to run the home while they attend training
- I do the training here for our staff. I get many calls for people who are looking for the training, but I am only training living care staff at this time.
- We have allocated training time
- After my normal day is where I can fit it in, in the evening or weekends.
- "just have to make it a team concept the better trained the better our service delivery
- Training and improvement of caregiver skill set must be stressed and rewarded"
- Allow two full days every three months for specialized training.
- Online trainings, attend trainings through WHCA
- We offer dementia or mental health specialty training once a month (alternating classes) at another building.
- We plan it into the schedule
- Just make it a priority.
- We schedule the training times.
- Have to take time off, travel, and train staff upon my return.
- I have hired professionals to come in a train my staff - particularly when I ran a building with a locked unit.
- I am the boss so I can get away easily. My staff just has to adjust their schedules as needed.
- I look at what training opportunities will fit into my schedule, for my staff, I approve and cover time off for training.
- Yes, when available
- Hiring additional on call staff to accommodate time off for staff to complete training
- It is difficult... You have to manage your teams schedule to accommodate for their absence.
- It is necessary and part of the job of a caregiver to receive as much training as possible to provide excellent care.
- Just schedule it into the day to get the training done in a timely fashion
- Scheduled as needed and available.
- It is difficult to find a local class, give them time off to complete the class, pay for the class, and pay for their time as well as someone else filling in for them while they are absent. It would help so much to learn on the job as we do many monthly trainings that are more current and brainstorm specific behaviors we are currently dealing with.



- We use Conner Stone so it can be done on the computer most of the time.
- Assisting with scheduling adaptation, offering "in house" resources to bolster training.
- Establish it on the calendar. I am the trainer for dementia and mental health courses.
- "send employees to classes which is expensive and not enough around-- use the community colleges
- "Like the ADM course"

### Impact of language and culture on specialty training

- Language and culture [are] absolutely barriers in trainings. I think it's probably one of the reasons [some] placements aren't successful as well.
- Speed of language - even among native English speakers (e.g. Younger people talk faster - while dementia residents process more slowly)
- Most of the residents are Caucasian, but caregivers are not.
- Older generation may have preferences for who takes care of them (gender, nationality, etc.) Need to help caregivers understand this may exist - can be insulting.
- For most of our caregivers English is their second language. We are dealing with a population that has hearing problems, and if you cannot understand them, that just complicates the situation.
- Another issue is the cultures of the clients in the facilities, and the culture of the people running them. For example, spicy food with clients who do not like spicy food.
- How to deal with families culturally also presents challenges for caregivers.
- Caregivers may not be well educated - often high school only
- Not handled well in training
- If owners and caregivers can't communicate in a culturally appropriate way with residents, won't work
- Very different views of dementia, mental health, DD in other cultures
- People with accents can be more difficult for people with cognitive disability and/or hearing issues to understand.
- Talking louder doesn't help!
- Language - those who have ESL no matter the culture, the test is a challenge. Understanding the questions is difficult. Left on their own they do not pass the test and the instructor spends a lot of time intervening.
- In the delivery of care - it is always a challenge for some residents who do not understand the language (accent thick). The caregiver can walk through or be there with them but training on a topic that is something you cannot hold onto - it is hard to explain. Some of the things we say or do in the medical industry there is not a word to describe them in their language.
- Mental health and dementia is not offered in other languages. In the Seattle area it would be helpful. The languages vary from community to community. A sample list could be emailed.
- Cultural context is very important. How you present material - need for understanding the whole person. E.g. Dementia is not just 'fading away' but how to bring out dimensions of well-being. Want to change cultural paradigm.
- Labels create assumptions of how that person is viewed or approached.
- Can be barriers to residents asking for what they want - can feel guilty and/or providers believe they are doing enough and not receptive to requests
- Need to require basic competence in English to ensure effective communication can occur
- Ombuds see issues of patients' rights - may be asked to deliver additional training
- I think you are talking about two ways of it. One situation of it is the caregivers are from a diverse background and the residents are from the dominant culture. The other is when the residents are from diverse backgrounds.
- The parents are care providers. Arc of Washington used to do that training, but we have looked into giving it for parents who come from different backgrounds.
- That was the training that we did before. Even though our target population is not caregivers, but providers who are mainstream and provide services to a diverse population. You need to think about your own value system and how you think about disabilities, and you have this core service that you need to provide... do they understand why?
- If the provider does not understand why the mainstream culture sees people with disabilities one way, when where they came from people with disabilities were thought about differently... you see people leaving the position often because of that.

- Take one thing for example - when you want to provide training to somebody who comes from a different cultural background. The best way is to have somebody who is bilingual deliver the training - the best practice is not using interpreters. Quite often the interpreters themselves don't have the knowledge of the field. There will be a lot of special terminologies that you will be using. And some of the things you are talking about may not make sense to them at all, and make it harder for them to interpret.
- Our staff members are all bilingual. When you want to explain it to our clients, if we don't spend the time to understand what the terminology means, they wouldn't be able to explain it to the families. If we just used an interpreter, very often their interpretation may not be accurate.
- Currently, in Washington state, what are the most spoken languages? We do have a list of the top fifteen languages. DSHS has eight languages they have chosen to interpret. Training partnership has chosen a few languages as well.
- We need to understand that people who have limited English proficiency doesn't mean that they don't know things. Both parties will have to understand how they can work with each other better. The main thing is to teach the providers how to communicate with the providers and the families. I don't know how much more you can incorporate.
- You have to be able to embed your training with the culture and developmental issues. You want to infuse a cultural perspective in each situation - instead of using your examples which may only come from one culture... include those perspectives in your examples. It's the principle that your value system has to be infused into the practice that you are training.
- You do need to carve out time just to talk about cultural diversity as one of your themes, and then infuse into the curriculum... into the content.
- When you want to create the curriculum, you need to have somebody from the field who has the experience to give you the feedback, that can be a challenge. I think it's very important that you get the extensive cultural diversity issues and get those people.
- Limited language makes it difficult for individuals to pass the course
- Makes it more difficult
- Different cultures have different ways of dealing with channeling behaviors. The important thing is that the person with MH, dementia or DD is understood by the caregiver.
- Greatly!!!! I see too many AFH's that the workers don't speak English and the residents are get frustrated. It adds to there already tough level of communication. I could go on...it's a problem!
- The awareness for this illness is better in us than in third world countries. The Philippines use English as a second language.
- Important for staff to have fairly understandable English to be able to communicate with elderly with hearing challenges, etc. Have not noticed cultural issues arising.
- A caring culture transcends most language difficulties, especially with severe dementia where it is difficult to determine if the primary language is understood. This is not the type of care that just anyone can do.
- It affect big time. Specialty training should be translated in all language for the caregiver to easily understand and be able to impart knowledge & skills with out difficulty.
- Absolutely! My mother is a native born educated American born citizen and speaker of English. Her folks were immigrants from japan. They were all survivors of world war 2 internment camps here in the united states.
- I personally speak 4 languages so it is helpful for teaching. However if the patient is English speaking I think being able to speak his or her language is essential to someone who has difficulty with language.
- Language is critical. I am slightly bi-lingual but not enough to make a difference. I need to purchase the Rosetta stone and become more fluent.
- At this time it has not been an issue for me
- We have not had this issue yet
- Language and culture are everything. They make a world of difference. We need to remove the stigma that comes along with dual diagnosed individuals. A person who experiences the world with a disability tends to get less mental health support because people attribute everything to the fact that they have a disability.
- Many direct care workers are ESL and I am not sure they truly understand most of what is taught.
- It does not
- Many other cultures do not share in the value system of DSHS, so that needs to be the starting point of the specialty training, without that all the training will not make a difference.
- It is difficult for ESL students and they have to take the class twice and have some one on one teaching for them to understand the concept.

- None
- I think it has a huge impact. Certain cultures view people with dementia/mental issues so different.
- Language and culture are a huge barrier to what people learn or accept as ok within the training of mental health and dementia. I find that some feel that mental health is evil and dementia clients need to be in nursing home settings
- All of my staff are Caucasian or Hispanic and this has not been an issue for us. I do know that facilities that have a variety of cultural backgrounds struggle with this particularly the testing.
- When training students from other cultures they often don't understand what dementia is or what causes it. They may not view dementia, mental health, and developmental disabilities the same way they are seen in the western culture. They may regard it as punishment or possession. When working with students for whom English is a second language, they may not understand the meanings of various English terms making it more difficult for them to understand what's being taught.
- People need more interpreters.
- You have to adapt to everyone's culture and speak from the heart. Listening is a big key, that goes back to patients.
- It impacts communication with our specialty group. Most residents English is a first language and a large portion of employees it is not. For people with dementia they have difficulty at some point even with the English language and when you have an employee that English is their 2nd language it makes it even more difficult for the resident. " it's not what you say it's how you say it " might apply here.
- Language barriers cause difficulties in test taking, even when the student has understood the class orally.
- There are many different cultures providing care in facilities and in home care. Cultural differences have to be taken into consideration and taught about dementia in this culture and how it may differ from their culture and how to work in this environment.
- I feel all of those caring for my residents should be able to speak the English language well
- Huge issue. I find my students who are ESL students may speak English fairly well but understanding the concepts are challenging. I will spend time as a 1:1 to make sure the concept is understood and they can apply them in the work place.
- Very much! Especially the age gaps between the youth and the generation they take care of.
- The lack of understanding in either can thwart any and all progress. Open communication is a must.
- Culture affects by the means that people tend to be more affectionate with residents, by hugs/kiss, which can be misunderstood
- Language barrier is a problem
- Very much as each ethnicity and background might have a different approach to elder care and their acceptance of dementia and/or mental illnesses
- I taught the specialty training about 6 years ago and ESL was a giant barrier that required longer training sessions and more 1:1 time. Also took 1:1 for testing due to translation of difficult test questions.
- Makes the role-playing component very difficult. Test taking is also affected.
- Comprehension
- Significantly but manageable.
- Attendees at the Tacoma office often
- It is heavily affected. Attitude, care quality and quantity.
- Ability to understand
- Loaded question. But, it really depends on the depth of language or culture variance. And how 'teachable' a person is.
- It is huge. Caregivers need to be able to understand what they are learning if they are expected to utilize the skills.
- A lot. Several of my employees have English as a second language, and usually another employee needs to be available to translate it to Spanish.
- Long range, not sure.
- It is extremely important to recognize the diversity and culture of our residents as well as our employees. Knowing the cultures of our residents can make the difference in whether they are successful living in the environment that we create for them.
- It is not an issue in an interactive class where the instructor can accommodate. I bet the on-line and self-study versions are difficult for ESL students.
- We have a number of ESL caregivers. We partner with an outside agency for this training. It has been my experience that caregivers can be successful no matter what language or cultural background. Often we

learn more watching someone else provide care to residents with dementia or mental health issues.

Mirroring is a good form of teaching.

- It is difficult at times. Educating yourself on a person's language and culture takes very little research. Treating everyone with the same respect, dignity and compassion goes along way in breaking down any barrier.
- We don't currently have any residents or nursing staff that language/culture would be an issue for.
- So far in my area that has not been a problem
- I find the way the tests are written is very difficult due to the concepts expressed in double negatives and vague language.
- For folks that need interpreters, have test anxiety, or classroom anxiety it is difficult.
- Very much so. It becomes more difficult for both parties to communicate when there is less of a common denominator for expression and understanding
- I'm sure it affects it but on a case-by-case basis needs to be evaluated.
- It hasn't affected us too much, if there is a language barrier we end up reading the test to them, and there is usually someone who speaks the language so they can interpret.
- Different cultures respond differently in terms of language and communication. For example, many Asian cultures shutter at the thought of looking an elder directly in the eye. It is critical that caregivers are aware of these differences, although one cannot be expected to know every culture's customs and expectations.
- Past experience and learning is important.
- At times we hire people that English may not be there first language or people who have difficulty reading. The tests are very difficult for them to understand. Plus for people who suffer from test anxiety taking a long written test is difficult.
- Respectful and culturally compassionate care are very important aspects of the mental health specialty training as it's important to discuss stigma as it relates to culture and mental illness.
- Some difficulty with testing in another language if English is not their first language.
- Unsure
- I have seen no issues personally
- There is not enough emphasis on training about communication differences of people with IDD. Respectful non-minimizing language is currently not the norm, nor is people first language. The term "MR" is still in use by program staff.
- Make sit more challenging to learn, should be able to take it in their native language. Its hard to teach through a language barrier
- Language and culture are very important when it comes to providing the best possible care for residents.
- In many ways those skills need to take into account all variables
- It is an issue. There are many great caregivers who struggle with comprehending the written pieces of training.
- I am not quite sure what you are asking.
- Depending upon a care giver's mastery of English, the training can be more or less effective due to the many nuances and specific words and phrases that we use to teach basic disease process and interventions and systems. Culture is an area that we need to continue to focus, understanding the difference between cultures of care and appropriate behavior for both cultures, the care staff member and the resident is a must. Then one can add observations, interventions, etc. For the various specialties.
- Because we primarily have returning NAC students enroll in the courses, it is not a difficult transition. We teach NAC in English and we teach the dementia and mental health in English. We are available before and after class to tutor students one on one if the student desires the help. We are very clear about making ourselves available and encourage tutoring.
- Not in my facility
- Language makes training more difficult especially with mental health where the terms are hard to understand even when English is your primary language.
- Most of our caregivers have English as a second language.
- I would like to see more Spanish classes, etc. I believe our employees would take more from a class that is given in their native tongue when they don't have to translate everything. I believe every culture has an elder respect that can be useful for training in that language as well.
- Not applicable in my experience.
- It can be very difficult at times, if the person from another culture is the staff they can sometimes not understand what a resident needs so being educated to each culture is imperative.

- The face-to-face training is imperative when crossing cultural and language barriers, online training you lose the element of interpersonal communication to get certain things across. Other cultures also have different beliefs about the care of elders, and expressing expectations outside of their norm is difficult.
- Language becomes a barrier for residents and staff with accents. Not all caregivers have a full range of the English language and it can be misinterpreted.
- It's a major impact. We need more training with Chinese and Ethiopian languages
- A lot, just because every culture is different and see things different ways. So this type of training may be difficult for different cultures.
- For people affected by dementia - as they lose their ability to remember, professional caregivers may be able to understand behaviors if they know about the person's past.
- It has made it difficult at times I have found when there are language barriers when English is a second language. There is not always an understanding of the concepts of interventions and approaches when staff miss part of the message due to language barriers. Also there are some cultures that have a wonderful work ethic but they are also very task oriented (get in and get it done mentality) and this at times can be difficult when they have to care for residents that need to move at their own pace or need things explained to them in short directions and not feel rushed.
- Language has not been an issue in any of my classes. All students need to speak English to attend classes and read service plans
- Must read write and speak English to do the job
- That is one area that is a challenge when it comes to training. We try to have the courses interpreted when possible.
- Not sure
- Language barriers are certainly a challenge when it comes to proper training.
- I have been in a situation where either-or has affected my training
- Do they really understand it?
- Language can be a barrier
- Hopefully the importance of considering language and culture are explored in the specialty training as you cannot hope to understand the concerns, motivation or behavioral triggers of resident's behavior without consideration to their language and culture. I guess we may think of language and culture when we are looking at "ethnic communities" however we always need to be aware of the unique presentations that evolve from anyone's background or past lifestyle.
- In this area we do not have many culture or language variances.
- English is the primary care language. ESL and cultural varieties actually can benefit the global understanding required to provide care to all persons. Functional literacy is critical to understanding new terms and new concepts for all students
- I think the language barrier is huge. In my opinion, I think the pass/fail rate could be improved if something were done about this.
- I do not have a culturally diverse staff or population so do not feel I can answer that adequately.
- Language barriers are often an obstacle when dealing with residents with these illnesses. Staff speak in a slow calm tone, and listen with a caring heart.
- Enough. We have workers from all over the world-Philippines, Africa, India, Russian, Korea, China and other countries
- Significant.
- Language and culture can have an effect on any class you teach. The most important thing is to make sure your students are understanding what is being taught and not just being polite "bystanders". The role-playing scenarios help assure that people are getting it too. I have everyone participate in training classes.
- Many clients born before WWI are racist; if they are mentally incapable of remembering, I intervene for the caregiver and ease the relationship, deliberately set up fun exchanges until they are accepted, handle the care myself if they are not.
- I provide conversation about the world the client grew up in, the movie stars, music, cars, etc. And encourage the caregiver to remember the topics so they can participate when the subject is repeated the next day. "Come on up and see me some time."
- I make time to listen to the caregiver tell stories about their country of origin so they get to talk about themselves too. It also helps me when I need to train or correct them."
- If there is a language barrier, then the concepts (and the way that they are presented) are outside of their experience and ability to comprehend. I have proposed that those with a language barrier take a introductory

class--with an emphasis on language and concepts--not the full course. As an educator I have offered to teach these introductory classes, but because I am an RN without work experience or education in the specific areas I have been denied that opportunity. As a nurse educator (having taught nursing school at the LPN through masters level, and ABD in adult education. I feel that I can create a introductory program for all the specialty areas that will enhance those individuals ability to understand when they actually take the specialty classes.

- In every way. As a training administrator I make sure every instructor receives training on accommodating cultures and ESL students. Thus said, it always comes down to respectfulness and patience with every interaction.
- It affect a lot of ways, with now a days lots of multicultural workers where they have English is their second language, unable to convey proper communication with the resident has this diagnosis which can be interpret in different ways,
- If you are providing a training to a group, language and culture variance can create obstacles to understanding and interpreting information. There is often not enough time to ask questions and many attendees do not feel comfortable voicing questions in front of a large group.
- Communication varies from culture to culture; training for students with language barriers is extremely difficult.
- We have a lot of Spanish speaking individuals and would benefit from tests that are in Spanish
- If you have trouble communicating in language or you do not know about there culture, the people you care for are going to have trouble understanding you, they may not know what you wont from them.
- Not much but English in the second language for many of our staff
- Considering autism is a social-communication neurological disability, language and the ability to communicate is significantly compromised. That being said, visual support can be used for both the resident with autism as well as a care provider who has language barriers of their own.
- So far everyone passes their classes.
- Here, we find it does not affect it.
- Has not been an issue for us.
- ESL staff often need extended testing time or rewording of questions
- Communication style of the trainer has to be flexible, so that all cultures can learn the information
- Language differences make expressing concepts challenging when there are technical words and/or no direct translation available. Many ESL staff need to read the materials to fully understand what was said in class, and this takes extra time for them. Culture is a challenge, especially when the "norm" for the staff's home culture does not match the "norm" we are teaching. Training for the trainer on cultural norms of the populations we derive our staff from would be helpful to determine where the differences lie and how to address them so that the staff understand what we expect them to do, what to expect from the residents, and why.
- I have not had experience in this particular area?
- Caregivers need to be able to relate to the residents they care for... This means understanding the time they lived in and what matters to them.
- It is the most important part. If a caregiver does not understand the training material it doesn't do any good for the resident. Everyone, resident, caregiver and administration ends up losing.
- Workers need to be able to communicate with the population they are working with, English should be encouraged. Care plans, shift notes, Rx and medical orders must be understood to be adequately provided
- Language barrier is very difficult - most caregivers at this time are ESL students. They must overcome not only the cognitive deficit and the language barrier but also some cultural gaps.
- I think language and culture majorly impact the training especially if the person speaks English as a 2nd language. Some people have that ability to be calm, caring and communicate even if there is no common language but these people are few and far between. Providing staff experiences with dementia patients by demonstration and return demonstration.
- More than half of students are ESL and culture is a large discussion due to current stigmas to these topics
- The caregiver willingness to be assertive seems to have a cultural element.
- Not very impactful for my community as it is mainly white English speaking
- It can be very difficult. Some cultures see dementia resident's differently
- I'm sure it affects it greatly. For most of our staff it is not a primary concern. We have a number of college graduates on staff who comment that the training is "simplistic and time consuming."

- It's always a contributing factor for comprehension. We have been fortunate to not have a lot of issues with this, but it does come in to play from time to time.
- It plays a major role in assisting residents. When residents are from a different culture most often because of the dementia, (residents that I deal with) they resort back to their roots. Many times it could mean not being able to understand their wants and needs. When there are staff members from other cultures, it may be hard for the staff to understand how best to care for a particular person because they do not understand. These barriers are often overlooked.
- It seems like many of the adult family homes are being staffed by people from other cultures. Which is fabulous and they seem to be very caring wonderful people but it also means that
  - 1. Language can be an issue-difficult to understand them
  - 2. Their culture and religion can get in the way- the food they serve, the attitude of not exercising
  - 3. The judgment about how a person lives their life if not religious- not catholic- how they view death
- I am not sure. We have no problem with this
- No experience with this.
- Both of them affect learning by employees. Sometimes it is hard as their own culture may not take them down the correct road in working with residents who have dementia and mental illness. Many staff do not understand mental health and how their expectations of behavior have to change with mental health issues. Language and volume of speech are things that often need practiced on my ESL employees
- Non-applicable
- Since all healthcare staff are required to speak and understand English it would be the managers responsibility to make sure employees are able to comprehend all aspects involved in the delivery of dementia care.
- Language is important. If a resident cannot understand you they will likely be more resistant to the care you are trying to provide. But language is not the only form of communication. Your body language and facial expression communicate a lot as well.
- Trainings should be culturally sensitive to different ethnic groups based on the belief systems in that particular group.
- We have several staff that are ESL employees.
- Language and culture has a major affect - one must address both of these.
- I have not had any issues with language barriers but I have with culture. I believe providing an open table approach to people helps to move through some of the concerns that center around culture. I give everyone opportunity to ask question, speak out, and bring forward examples from their experiences.
- We do not have resources internally to teach in languages other than English. But we will refer out to other agencies.
- Trainings often revert to most basic information due to language barriers. This is discouraging for English speaking caregivers and prevents them from obtaining greater depth of knowledge.
- We are a very diverse organization assisted living community, both in our resident and staff mix.
- It affects it. Sometimes I think that it would be great to offer an interpreter, free of charge, during class time. Not because the students I work with cannot speak English but because I want to make sure that they are totally clear about what I am trying to teach them and it makes the student more apt to ask questions that they wouldn't ask because they don't know how to word it properly to gain the answer that they are looking for. Or make the study material and test in their language. The caregiver is going to speak English at work anyway, the least we can do is make it as easy as possible for them to learn so that they can completely have the tools to make them successful.
- I would say that it must be extremely difficult for those attending conversational language is challenging
- Issue to translate clinical terms is very difficult
- English as a second language can be a barrier with testing.
- While not an issue in the community I manage, I can see where English language learners would have trouble grasping some of the fundamentals of providing dementia/mental health care. Cultural awareness is also key in providing good care.
- Classes should be taught by a diverse group of instructors, and instructors should have some awareness of the cultural and language barriers to providing care.
- Our employees who speak other languages are more likely to have to retake the tests.
- We have to be very creative and explain everything. In addition we may have to read the test questions.
- My mother in law has dementia and is Japanese speaking. The staff finds it difficult to figure out what she wants when her dementia worsens. Also, due to her dementia she forgets that she can't do everything on

her own so she is a high fall risk. We finally put her bed on the ground as it would be in her culture and no more falls. I think that understanding the cultural differences can make huge differences in the way that caregivers interact with residents.

- Different cultures have different customs. Caregivers should be trained to be sensitive to these different
- People should have a good knowledge of speaking and writing English in order to communicate with residents, complete paperwork and understand medical terminology. It's also valuable to have bilingual staff if residents do not understand English. Cultural beliefs can affect caregiving also.
- I am not an expert in this, but by observation I would say that these are critical issues to address...
- ESL students need more time for the training, a self study like the nurse delegation would be better for some of those students.
- Have not seen that be an issue.
- It is very challenging.
- Many staff - English is not their primary language so it is very difficult. Out training modules can be taught in Spanish as well as English.
- Very large barriers here. Many of my students are ell students from Africa (Ethiopia mainly) and the pacific islands. They have specific cultural beliefs and histories that can impact their perceptions of MH/dementia and need specific training that addresses that at times (mainly around de-stigmatizing these issues). Also, language barriers are a huge issue in that many of the words and concepts are more complex than in other parts of their training.
- I think the information and language in the trainings is too sophisticated for people with English as their second language.
- Greatly. This is a vital piece for both the resident as well as the caregiver.
- Most CNA's pass the exam.
- Has tremendous impact if the caregivers cant communicate with the elder population

### Specialty training testing/assessment process and effectiveness

- I think it would be lovely to be able to give them a test that offers them opportunities to describe in detail how they would handle a specific situation. Those scenarios being developed... instead of regurgitating, they are giving you an applied approach.
- I think there are ways to assess practical application. So if we can get to that in some way, it would be very helpful.
- They learn what they are taught, but does not address practical application.
- Should be emphasis on the skills. More case scenario testing.
- You can answer questions on a test but that does not predict if you are really able to provide the needed care for your client.
- It might make sense to do training. Then more training. Then more training.
- Doesn't test for real life skills
- Recommend using a scenario and/or evaluation throughout the class discussions
- Provide a care plan and scenario - what are you going to do and why?
- Tests don't match learning outcomes (which are defined in WAC).
- Is training verified? (may not even be delivered as required.) Recommend not allowing owners/facilities to both deliver and verify training.
- Teepa Snow classes are not counted for CE, but she is a national expert.
- Would be ideal to require demonstration of skills with a real resident (but impractical).
- Test itself - the test does not measure what we want it to. Took the test a year ago and probably couldn't pass it again today.
- Dementia is more difficult and don't know why it is more difficult than the mental health.
- Students could make a good argument on why their answer is correct.
- Training is being done to the test.
- Test along the way might be more effective.
- A trainer should be evaluated more / quality control.
- Ombuds failed assessment. Instructor was 'crazy' and eventually left. (was several years ago.)
- Dementia = not an accurate measure. More what you remembered from the day, not what you could do.
- DD - too long, don't remember



## Specialty training requirements and oversight

- Ombudsman should also be trained also - they need to know how to interact with the residents.
- The licensors should also be trained or informed of the training requirements.
- Beyond requirements of an assessment - social history? Preferences, strengths, limitations? And frequency of assessment. How frequently am I revisiting the assessment? Dementia changes.
- Assessment form and care plan form - you have to have a really good assessor, because it does not prompt or walk them through things as far as behaviors and triggers. Some assessments are great and some are not. There are no requirements of training to write better assessments.
- Checkboxes without an explanation is bad.
- Assessors are social workers or nurses. There is a term in WAC for qualified assessors. There is no training for these.
- Lynn or Yolanda - supplemental assessment form.
- Consider initial training requirement plus additional refresh over time - initial training doesn't make them specialists; need OTJ experience
- Censure or closure of DD homes most often due to violation of resident's rights - taking over in a more parental or authoritarian role; sometimes require owner/provider to retake the training
- Other issues that come up: documentation; physical care of dementia residents
- Useful for HCS/RCS to attend training - to know the baseline, may be able to add real life examples
- What are instructor qualifications? What should they be?
- Good providers will show up for training, get the most out of it and do their best to apply it. Very difficult to engage not-so-good providers at that level.
- Levels? Useful to have deeper levels available. Would like to see career-pathing and investment by caregivers.

## Best practices related to specialty

- Activities to improve quality of life for clients.
- From a personal point of view. I want them to have the skills to meet my mother where she is. That they have skills to lessen anxiety. I want them to be fun - bring loving humor. You don't want them to plunk them in front of a TV and call that an activity.
- For activities, one of the biggest thing is how to meet the patients where they are - what mental age they are, or what they think they are still doing.
- In my own trainings, I have received in evaluations that I need to simplify what I have done [because of cultural or language differences]. So what I do in my trainings is preface them by saying that everybody comes from a different culture, and everybody learns differently, you need to feel safe enough to let me know if I need to approach it differently or more slowly.
- We have different exercises in our training - for challenging behaviors, we have an exercise we do where we offer a scenario and we have a client who is really melting down, and we ask them how they might approach that client differently. We get a lot of requests for more training around specific disorders and diagnoses. They need to understand how to help a bipolar patient, or a patient with PTSD.
- Care conferences can be very successful, when possible - bringing in Medicaid brokered mental health providers, protective services, the case manager, the provider, any information from the hospital, and add-on specialists.
- English
- Understand and get to know my family member. To really understand the limitations. How does the caregiver go around those? Does the caregiver understand behaviors? - what provokes her, what makes her happy? What time of day does she like to take a shower?
- What does my mom worry about? Kids? Money? Anxious?
- Referral sources. Is there a pharmacist available when I have a question? Who are other people that I can contact. It would be nice to have area specific resources available at each training.
- Hands on. Feedback, observation, as behaviors come up we do training.
- Person centered training. Impossible in a classroom setting.
- When the caregiver gets back - you take out care plan and assessment and explain here is what you are going to be doing now. Adding the practical application after the DSHS training.

- Getting to know our residents summary for new employees. (ex: Glenn views the home as his operations and we are his employees and he likes business meetings and when he gets upset you do xyz...) crib notes
- How do you build an escalation plan?
- When you find something that works (with certain behaviors), document it. That should be in the training.
- Question: is there a checklist developed or orientation available to share?
- Look at how caregivers interact with residents (as Ombuds will simply observe)
- Often sees facilities that are understaffed, particularly activity people (may not be training issues, per se)
- Creating appropriate activities to keep residents engaged (not just TV or bingo for Alzheimer's residents)
- Ability to work with agitated people in ways that calm them down; redirecting
- Sensitivity to people's emotions, even when words not making sense
- Helping people to feel connected and useful - e.g. Even folding laundry
- Ability to build relationships with residents, as well as camaraderie/support group among caregivers
- Adjusting ADL's to the person - such as making food accessible, opening containers, etc.
- Residents continuing to ring the call light - if they keep using it, it is because they are not getting what they need. I have seen facilities where the call lights are just going, and nobody is responding.
- Most of the time, you can spend five minutes with somebody, and really spend that time, and they will be satisfied. If you actually engage where that person is for five minutes.
- There is a tendency to make better relationships in AFH. But the problems are meals and the lack of any activities besides television.
- Meaningful activities may decrease behaviors.
- If you can build relationships between the residents, that will help a lot. Even the ladies with dementia, they will hang out together.
- Homeowners should know what they are capable of handling.
- Dealing with difficult behaviors. Some are really good at it. Some have no training. A lot of people panic when dealing with clients.
- What is lacking is evidence based clinical approach for caregivers. In practice that would look like CBT, and ADH being trained in the specific area.
- They call us to deal with difficult clients in emergency situations.
- I would ask how you deal with somebody who does not do what you need them to do. Medications, toilet, taking a bath, etc..... Those are the things I would look for in the answers I was given.
- I would ask about the staffing and what type of other residents are in the home.
- I would want to know about caregiver training and experience, and how they deal with people with Alzheimer's and dementia.
- Full life (heads up) is a full day TBI facility in Seattle.
- Ok to be in their world (dementia); don't need to argue reality but keep them safe
- Expectation that they know how to provide basic care, ADL's etc.
- Specific to specialty areas - how do they interact? How do they know what to do? What kind of support do they have (from owner, manager, nurse, etc.)
- Would assess how residents look and act
- Feeding properly - adapting to where residents are and limitations of their condition (e.g. What kind of food they can eat)
- Have skills to solve problems with residents
- Know and understand the care plan; know the individuals
- Understanding why they are there and the care they need to give is so much more important than understanding an academic description of the condition.
- Key element is understanding resources, where to go for help
- Recommend true practitioners to review material - active caregivers, attorneys, etc.
- Would like to see more application of hands-on skills
- Will depend on what family member's needs are
- Certificate doesn't tell you what they can do - would want to see them in action with someone with similar issues; how they interact with residents
- Recognizing how the caregiver's own behaviors may exacerbate or prompt the resident's behavior
- Able to differentiate approaches that work with each population and individual - homes may have more than one specialty designation and caregivers try to approach everyone the same
- How to handle resident refusals - may get frustrated, or family may have different point of view

- Families believe that specialty designation means more than it does - that caregivers are better equipped than they could be given limited amount of training
- To dig deeper to find solutions - pull out a book, access additional resources, etc.
- Benefit of activities - helping residents finding activities that interest them; can be as simple as tossing a ball back and forth
- Owners/managers: really reviewing and understanding assessment - accurate determination of ability to meet resident's needs
- Brochure on website to help families find a home
- Website provides information on which homes have which specialty designations
- There are a lot of good homes that do a lot of good stuff.
- Can be more difficult when people with different needs are mixed
- Ability to communicate with residents
- How to troubleshoot issues
- Ability to identify if resident has changed (baseline)
- Manager class and caregiver class are very similar.
- Consider when/how material is updated, as research changes.
- Nursing homes have ratings that provide more information, but not AFH/ALF.
- Placing a loved one... Have a caregiver who is proactive in recognizing signs and symptoms and how to report them. See caregivers to be more proactive in noticing. What is baseline and when it changes.
- Understand culture and desires. As a family member - they can recognize things that sometimes a caregiver doesn't understand. Mom was a drill sergeant in the army and she deals with things differently than other people. You don't know if you do not go into depth. This also spreads over into cultural differences.
- 14 languages spoken by the residents - staffing issues.
- Far more role-play and interaction than is in the outline. Interacting with each other - they get more information (during training).
- Walk into meeting and dressed into an old person...and discusses what it looks like and feels like. Could be done on video / visualization.
- Dementia training from virtual dementia tours. Two people came from Yakima and we felt there were positive outcomes and some different. Hands on with goggles that were foggy, static in ears, gloves on hands so it simulated... a list of tasks to complete with these items and simulate limitations / levels of confusion and disorientation.
- To see it and feel it.
- Gentlecare (angle has this book)
- If family members irritate the client - what do you do?
- Train the family on how to interact with the client and deal with the disease
- Resource: book: a different visit (Judy Plesha's shelf)
- Why mom doesn't recognize them?
- Get on eye level
- Psychological education of "what we do" for providers and caregivers. Dealing with the social and history of families and you need to read between the lines and keep them safe from what happened in the family and also respect peoples wishes.
- At one point someone becomes the legal representative
- Communication with residents is key.
- Very high expectations for placing a family member.
- How are they going to address the group as a whole - so behavior of one doesn't impact others.
- How will you meet individual needs ... care plans.
- How home is set up
- Staff continuity is a positive sign.
- Universal precautions - not spreading disease and infection.
- Ability to provide all kinds of assistance - feeding, bathing, transfers
- When to call nurse for more support.
- Specific to dementia:
- How to address behaviors that come up
- Able to 'roll with it' - not trying to force the person; requires a bit of improve
- Understanding of anxiety - can be friction between resident and caregiver
- Basic definition of dementias - person could have combination of several; everyone is unique

- Look at person in terms of what they can do, not just what they can't
- Bulk of training on communicating and appropriate responses to behaviors
- Treating people with respect, as an adult - don't talk down to them, no 'honey', 'baby' etc.
- Getting to know them as a person
- Specific to mental health:
- Tend to be younger people, e.g. Leaving state hospital
- Definitely different skillset
- Still need to know the individual
- Able to communicate in a way that puts the person in a less anxious state vs. More anxious
- Should include training on provider boundaries and how caregivers need to take care of themselves - can be high level of stress and burnout
- Helping providers/owners choose who is going to be successful working with their residents
- Understanding how to work with medications - e.g. What if someone refuses to take meds
- See more homes shut down with mental health residents - very complex and challenging; six may be way too many for one caregiver
- Specific to DD:
- What kind of outside activities and connections with community do you offer/support? Ways for residents to get involved.
- Usually leave DD homes feeling pretty good. Believe DD training is pretty good. Always room for more - especially 'person first'.
- Unique situation - people more likely to have outside activities in DD homes, so caregivers get a break. (not a training issue - but a factor in how DD differs.)
- Really a different world - more support systems, younger people, etc.
- Communication, behavior prevention, positive behavior support
- Dementia and Mental health
- Identifying behaviors related to different diagnoses, especially people with mental illnesses
- I believe that the required amount of training for mental health, dementia, DD and continuing education is not enough. I question also the where and who is providing the training. I thinking that a 2 year training before working in LTC should be mandatory
- All
- Understanding the particular care needs of the specialty. For example if a person has dementia, the more understanding the better of that problem.
- Knowing medications, what the side effects are, and how to be given. Understanding the disease that the resident has, and what can occur when taking care of them.
- Patience and the ability to redirect with gentleness.
- Caregivers need to take all the specialty training in order for them to understand the residents care need.
- Understanding how to communicate with person with dementia. Respect for cognitive and developmentally impaired.
- My observations: caregivers need training in dementia, these residents need to be treated individually not warehoused. Drugs need to be monitored by outside agency. At start would be a DVD by Teepa Snow, very easy to understand.
- As a family member no training is needed but in my case having taken in the past training to fill a volunteer position as a long term care ombudsman which did not eventually work out, experience as a person with a physical health and mental health issues shared with my elderly mother has been a kind of training. I also attended a conference about 11 years ago for family members of Alzheimer's patients that was helpful.
- I went all over the country and got training and now am a trained behavior therapist. I received training in dietary and behavior from various sources. UCLA and locally in Washington
- Patience is the biggest gift a caregiver can share. Knowledge about dementia and knowing what is next is critical.
- Knowledge on how to be an effective care person to those residents with various specialty needs
- It is important for staff to understand the disease and to have the tools to manage behaviors associated with it.
- Overview of traits in people with any of these disabilities. Some information about differences and dealing with issues such as poor speech, delusions, sight impairment.
- Knowing diagnosis and what to expect from that individual based on their diagnosis and past trauma or experiences.

- Behavioral interventions, medication management, family resources, copes rules
- Basic understanding of sensory processing issues and communication/behavioral/et al concerning people with ASD
- Understanding the stages of Alzheimer's and all the particular behavior and physical changes through the process of the disease. Training on activities and other stimulus for folks with dementia/Alzheimer's.
- What they receive in dementia specialty training is excellent
- Additional training being available- is the most important to being able to provide better care.
- To have a working understanding of developmental disabilities, the brain processing differences, sensory dysfunction, communication disorders, autism spectrum, anxiety management, values of inclusion and autonomy of the customer in supporting not controlling, loss and grief issues effecting the daily life of individuals with I/DD, and basic understanding of PTSD.
- Clinical knowledge/skills & resources for each diagnosis, customer service training
- Being with versus doing for
- Communication is primary
- Gentle deception and what it means - role playing with it
- They need to have knowledge about the different kind of mental health diagnosis. They also need to learn about dementia, the disease process and the different ways they can work and respond well to those client they are working with.
- Learn to care for dementia residents.
- To be able to interact with people living with memory loss, such as finding and building on the strengths of each person through favorite activities that give them purpose. To treat them with respect and compassion. Less medications and more interaction.
- I feel that those caring for residents with specialty care needs would benefit from more training specific to the needs of that client and that training should be more one on one with the client verses classroom setting
- Communication is key to being a good caregiver. Other items that are necessary are infection control, proper peri care and safe transfers.
- Caregivers need continuous support and training in individualized care as well as an understanding of the care plan and baseline of each resident. This is a critical element that the caregivers should know in their everyday job assignment. 1. Observation 2. Documentation 3. Report 4. Follow up. "
- Managers and supervisors need to provide continuous support and teaching to their caregivers about residents including any change in condition, change in medication or new medication and side effects.
- Families need to be updated regularly regarding their loved ones condition as well as provided with teaching regarding their loved ones condition and care."
- Knowing how to help people with mental health issues, resolving problems with staff and families, what to look for with non-verbal people, and having a basic knowledge of the body and medical conditions.
- Patients.
- Communication, behavioral intervention, basic care vital signs which is not taught in class
- Feeding techniques
- Ability to communicate effectively
- Understanding dementia physiology and behaviors related to different types of dementia. Not having unreasonable expectations of people with dementia. Know how to get families to have realistic expectations of those with dementia. I have been to gentlecare training and Eden associate training and feel both were very helpful in understanding people with dementia.
- General understanding, hands on experience and ability to look up info and call someone if further questions
- First of all the resident is a human being who just happens to be diagnosed with a special need. He/she is not defined by their needs. Knowledge of the diagnosis and what symptoms are unique to that person and their culture. Skills of patience and kindness.
- Good communication knowledge in the health care field
- Compassion, tolerance, behavior management, resident rights, reproaching, the importance of documentation
- Altered thought process, patience. Common sense
- Nursing knowledge
- To recognize and understand the differences between dementia and mental health; learn, practice and become proficient in various approaches to support the needs of our residents.
- For dementia: creative thinking, flexible personality, patience, knowledge of dementia care interventions, knowledge of person centered care,

- Communication skills
- I want caregivers to understand how to communicate with my mom and make each day pleasant and meaningful for her. I want them to understand they can't talk to her like the normal elderly client and expect her to do what they say or understand them.
- Mental health & dementia
- Patience and the ability to reproach
- Broad general knowledge of disabilities and medical support needs. Experience with supporting people with specialty related needs prior to becoming a licensed provider. It is helpful if providers have good organizational skills and a mind for running a small business. Most importantly, good listening skills and patience.
- Understanding of common signs, symptoms, and reactions of individuals with special needs and how to react to unusual occurrences and behaviors.
- Patience communication
- At minimum, a basic knowledge of how the brain (and other organs as appropriate) work. Understand that many of the "behaviors" that residents have is not of their choice. Always remembering that kindness and care will work the best with all tasks being performed, big or little. I think that they should always think of how they would want their most loved ones approached and cared for. They may not always remember what happens in the residents mind, but they could really remember how they, and their loved ones, want to be treated.
- I think that it is important for long term care workers to understand that everyone prefers to be cared for differently. Proper bedside manner is also very important.
- Common sense in important, also just basic care in important.
- Approach skills/techniques
- Comprehensive understanding of diminished sensory abilities
- Training in ""compassionate deception""
- Ability to work with understanding and patience. Lead with your heart and then incorporate your skills and training.
- I have been a community educator for mental health, dementia and DD training for years and feel the information in the DSHS curriculum in relevant and helpful to my students. I hate that I am not approved to teach it any longer because it was nice to be able to do a classroom setting with interaction rather than the facilities doing on-line or self-study versions now.
- Understanding the different behaviors that are associated with each diagnosis and the best ways to address issues that may arise or be prevented.
- Understanding physiology, anatomy and disease process
- Staff need to have a ongoing understanding regarding resident care needs as they relate to understanding and ability.
- On the job training is very valuable. Knowing your surroundings, your support groups, back up and proper protocol is important. Additional specialty education is key in preparing a caregiver for the multiple situations that occur in the workplace everyday.
- In addition to the basics...dementia approaches/techniques, how to diffuse/calm upset residents, how to maintain patience with challenging behaviors
- It is important to understand the limitations of someone with specialty care needs and to have some basic skills to help with providing specialty care.
- Sensitivity to their mental health is very important.
- Vital
- Understanding the disease process, knowing the residents past history, brainstorming interventions.
- Patience, compassion, education (continuing), people skills and a sense of humor.
- Learning about the functions of the brain and the different kinds of dementia and medication effects are important of course, but training on how to approach in different circumstances is key, going over the history of the resident is also key so we can watch for the different behaviors (I.e...if they are up all night, in the past did they work night shift) our staff just experienced the virtual dementia tour, and so we will be adding that to our training. We are also partnering with a CNA class so they will have more dementia training in the CNA class, as they will be experiencing dementia in any setting they work in , be it in home care, hospital, al, SNF...we would love to also get into the nursing programs and teach it also.
- It is important to have a working knowledge when dealing with individuals suffering from dementia and various mental health conditions. Dementia can progress through three stages, and it is key that employees

identify what stage a resident may be at to provide the best care possible. Additionally, it is critical that individuals who come in contact with these populations conduct themselves professionally, with patience, sympathy, and understanding.

- Understanding that accessing services may take awhile, services are not immediate. As the executive director you must reach out and try to access all services possible for the resident. Many times, I do not find Medicaid case management helpful.
- In order of importance: interventions for problem behaviors, emergency procedures, respectful communication, cultural competency, mental illness symptoms and medications.
- "specific health issues to the population
- Specific social issues
- Disease process of dementia
- Dignity
- Communication- words, tone of voice, body language"
- First aid/CPR
- HIV
- Positive behavior support training
- Reading PBSP
- Learning triggers"
- Disability specific, ADL's , medications, creating iisp, bsp, goal writing, task analysis, de-escalation skills
- Understanding the geriatric population, understanding dementia and mental health experience.
- How to use the best approach to providing care
- People providing care to individuals with intellectual and developmental disabilities need to be aware of the rate of sexual abuse of this population, be able to recognize the signs of abuse, know who and how to report and know about sexual abuse prevention.
- As more people with disabilities are seeking meaningful relationships, care providers need to know how about the elements of healthy relationships and how to support them."
- Managing behaviors, not taking it personally, how to prevent resident to resident altercations in dementia residents, meaningful activities
- Caregivers should know about their residents: their needs, preferences, how to accomplish their ADL's. They need to take the fundamental class, specialty training and any classes available for the special needs of their residents.
- Understanding and skills
- Communication with older adults with limited communication skills, coping with extreme behaviors, skills to have the caretaker take care of themselves.
- Understanding basic disease processes, understanding and exploring typical behaviors and needs and ways that needs can be expressed in the various specialty areas. Examples for appropriate investigation of unmet needs and examples of appropriate interventions. Role-playing. Information/education materials in the primary language if possible. Spending time learning about how a caregiver's own culture and behaviors that are their own culture are often different than a resident, and how to provide care in a way that may be very different culturally.
- Communication skills, professionalism, understanding of the basic pathophysiology of different diseases processes, emphasis on specialized communication strategies needed to redirect escalating behaviors. Emphasis on respect and dignity of residents should continue to be part of the program.
- Ongoing and best practices to help with mental illness and resulting behaviors
- Approach and a understanding of how the disease progress and why
- The physical effects of dementia. They need to know that it is organic, not willful behavior. I believe creating compassion for the sufferers of the disease is very important. And knowledge on the impact on the family would be helpful in dealing with family members as well. The same thing for mental health. A more in depth knowledge of the causes in the brain and the effects of medication is huge. I know this from my experience as a caregiver.
- Know the residents diagnosis and therefore have a understanding of what they are experiencing, however, knowing that each person is unique and some things will not work for all residents.
- You have to have an understanding of the issues your residents and families are dealing with in order to provide them appropriate care. Your staff need to understand too, so that the depth of their compassion can increase and create a warm safe environment.

- How to deal with argumentative situations, how to understand non verbal communication, how to recognize signs of possible of abuse and neglect
- How to redirect, handle anger, protect self and others. Understanding how the disease impacts each person individually. Caregiver care of self. Danger signs, dehydration, weight loss, increased signs. How to communicate.
- Completing the training for dementia/mental health.
- Understand the progressive nature of dementia, knowledge about the individual with dementia and education about the special issues that are part of the person's care needs. Also appreciating the role of the family and any care partners of the person with dementia.
- A baseline knowledge of the disease process, approaches staff are to use as interventions
- I think the communication strategies that are presented in the specialty classes are essential in providing care of our residents in the community settings
- CNA skills, observation, therapeutic communication, self-care skills
- In my opinion even further knowledge of specialty training is beneficial to our caregivers
- I always say treat the residents as if they are your grandparents. Love them for who they are and you will learn great things!
- I think an understanding of the different kinds of dementia and the disease processes are very important to have when working with this population. Any specialty training that works with care staff on their "approach" with dementia residents is helpful. I also think it is important to teach the difference between a mental health diagnosis and a dementia diagnosis as treatments and care plans are typically very different.
- Redirection, dementia disease process, patience
- The ability to understand the client needs and assist them with activities of daily living. Taking care of anyone with a disability, or any type of mental illness a caregiver must have patience, the ability to listen and know how to calm down a resident if a situation arise.
- I feel it is important that caregivers are able to anticipate the needs of their residents to a certain extent. Also, it is important to know that arguing with a person with dementia or mental health/developmental disabilities is not helpful. Even if you know they are confused about something doesn't mean it is ok to tell them that they are wrong or mistaken. As long as that person is not harming themselves or someone else, it is ok if they are mistaken. Know when to let it go and change the subject if possible. Being able to redirect someone from a certain behavior is important. Knowing how to direct a resident to completing a task is important.
- Their unique needs
- CNA and good listening skills
- My mental health specialty was as a geriatric mental health specialist working for Okanogan behavioral health for 17 years after working in LTC in a variety of positions for 10 years. OBHC work included going to all the facilities in the county as a consultant to help with psychosocial and behavioral challenges with the purpose of preventing hospitalizations and finding ways for staff to cope with and meet the interests of residents with challenging behaviors or mental health concerns like depression and anxiety. I am very opinionated and passionate. As I really don't know what is being taught in the present MH specialty classes, I don't want to be too critical. There is tons of literature to guide caregivers but I think the classroom is still the best mode for training as it leads to discussions that can help caregivers relate. I think that there should be more emphasis on the importance of the skill of self-awareness. Any trainings or presentations I have done start with " it is not just about what kind of dementia or and dealing with difficult behaviors" and "the degree of successful management of resident's behavioral challenges is dependent on the level of the staff's self awareness". I apply my thoughts to anyone working as or supervising caregivers, from the top down. Some past studies have demonstrated that a significant number of individuals in care giving have had codependency or dysfunctional issues before becoming caregivers. I think these past experiences may impact the way many caregivers communicate with their peers and residents they are caring for. I have invented the wheel but this is an area that I never see addressed in behavioral and dementia trainings. For example: the power of listening and not giving advice or comfort too soon, and using empathy and validation as tools. Advice and comfort can are always a given but the resident or peer may not feel "heard". Just learning about the keys to communication is not a helpful as practicing this skill in class. Self-awareness is a journey of a lifetime.
- Aging developmentally challenged population
- A basic knowledge of the disease process. Multiple appropriate interventions and tips for dealing with stations related to those dealing with dementia, mental health, and developmental disabilities.
- Basic overview of dementia disease, strategies for success when working with dementia clients, understanding the progression and appropriate care planning.



- Understanding behaviors for both dementia and mental health, and becoming creative in addressing needs.
- Practical, on-the-job skills.
- Understanding the different types of dementia and mental health disorders. Learning various communication techniques to work with dementia and mental health clients. Learning how to work with behaviors that may arise. Learning how to control the caregiver's emotional response to challenges and maintain appropriate boundaries.
- Knowledge of clients individual needs / ability to slow down to match the clients cognitive level / have a true desire to be in the field!!!!!! Helping support staff understand and allow clients to really be a part of the choice making decisions. Use self-reflection when choosing your actions when supporting a client, "would I want that done to me in that way" with dementia, don't argue or try to force one to remember. Going along with the story in their mind at that moment. (I could go on and on but these are very important skills in my book!)
- Knowledge of clients individual needs / ability to slow down to match the clients cognitive level / have a true desire to be in the field!!!!!! Helping support staff understand and allow clients to really be a part of the choice making decisions. Use self-reflection when choosing your actions when supporting a client, "would I want that done to me in that way" (I could go on and on but these are very important skills in my book!)
- Understanding what behaviors and moods are not baseline and not to assume that moods and behaviors that are ongoing are not considered "normal for that person". Learning to work successfully with those individuals who are experiencing mental health issues in a way that is therapeutic, using the care-planned information to assist with that care.
- Dealing with difficult residents.
- Patience, compassion, and understanding
- Basic knowledge how to treat and communication with others.
- Developmental stages in learning, behavioral developmental stages, language based learning disorders including an understanding of aphasia, sensory processing and sensory integration disorders, treatment, and strategies, therapeutic approaches to treatment supporting positive behavior outcomes, understanding of behavioral dialect as it relates to mental health conditions, strategies and approaches, processes in implementation of the least restrictive treatment approaches, understanding of prescribed medications as used in treatment
- When working with people that suffer from dementia, mental health issues or developmental disabilities it is very important to obtain the proper training to prepare you and to give residents/patients the best care available while meeting their individual needs. Learning how to approach a person safely and without causing them distress is among my top priorities as an instructor. Communication skills as well as being able to anticipate the patients needs are invaluable to any caregiver.
- When working with people that suffer from dementia, mental health issues or developmental disabilities it is very important to obtain the proper training to prepare you and to give the residents/patients the best care available while meeting their individual needs. Learning how to approach a person safely and without causing them distress is among my top priorities as an instructor. Communication skills as well as being able to anticipate the patients needs are invaluable to any caregiver.
- Medications, community resources, advocacy, medical needs
- Calm patience, willingness to respond to behaviors creatively, attention to mars details, transfer skills, sense of humor, willingness to learn from other caregivers and continuing education units, self care,
- I think that the information presented in the classes are pertinent and useful--but that most caregivers do not use the information. It is not the information that is flawed, it is the system in which it is presented. I think that it needs to be separate from and in addition to the core training. They do not retain the information-- especially if they are novice with not experience. Specialty training should be after they have some life experience under their belt.
- I volunteer on two boards
- Every care recipient is an individual. Caregivers need to accommodate the individual with the commonalities of respect, kindness and cheer.
- Knowledge and experience goes hand in hand, it will be perfect to have all training needed if you are caring for the elderly that is suffering from dementia. Mental health, and development disabilities, it will help you understand the feeling of the resident and you can take care of them better due to this training.
- Those caring for residents must be knowledgeable about the disorder/disability that their residents may have. They must be knowledgeable about how behavioral challenges can be a manifestation of the resident's disorder. They should learn how to evaluate behavioral challenges (and rule out any medical

issues needing attention), how to employ strategies for increasing communication, and systematically improve independent functioning. These strategies should include the use of visuals, social stories, schedules, and choice boards. Those caring for residents should be well trained in de-escalation techniques.

- Symptoms and interventions
- Empathy, compassion, willingness to do ""dirty work"", sense of humor, self-care ability
- Intelligence, knowledge of elder specialty needs, access to information on senior care
- The bare minimum of what the classes teach. We also offer more in our dementia training that involves a virtual dementia tour since we have a memory care unit in our building
- Being able to accept and get along with different personalities. Have some common sense. Learn as much as you can from experience and schooling. I have found that experience is the best way to teach a person to take care of people. You learn by doing.
- Behavioral management- tip for staff on appropriate ways to redirect
- Setting and maintain boundaries between staff and clients
- Understanding of support strategies that are specific to those who experience autism spectrum disorders, specifically communication supports, predictable schedules, opportunity for consistent choice with visual information, social stories to help the resident understand concepts, perspectives and reasons for certain situations, consistent training across all domains of the residents life, home, work, recreation.
- The ISP and IISP are much more relevant than the specialty training's. Our clients have a combination of issues from all three specialties. The service plans address the person as a whole.
- Listening skills, redirection skills.
- Values and history of the service system
- Basic understanding of the needs. If you become too specific/technical, caregivers will tend to tune out.
- Knowledge of dementia process, progression, impact on ADL's and behaviors
- Understanding of communication barriers and interventions
- Understanding of behavioral triggers, interventions, medications, community resources
- Basic care skills and support available
- Understanding of resident rights and how that translates to people with cognitive impairment
- Importance of dignity and validation, emotional support and personalized care of those your caring for
- Etc.
- For dementia: to enter their reality, even to the point of therapeutic fibs--to provide moments of joy
- For mental health: to tell the truth if asked. To focus on validation. To keep safe
- Understanding the behaviors & the "why" behind the behaviors, communication tactics & strategies, interventions, how to provide quality of life for the resident & family, how to take care of themselves so they don't become overwhelmed.
- Each individual is different in their disease process. A base knowledge of the individual as well as the disease process and a basic set of skills to use when dealing with each person as they move through the levels of their specific disease.
- Basic knowledge of the disease(s) .
- Behavior challenges related to care.
- Practical solutions to providing care.
- Knowledge for how to provide care for the specific place you are working, where and how to find out what is expected of you as a caregiver. What specific information you need to give the best care for a resident, and where you learn that information.
- Constant oversight, and the understanding and practice that each person is important, and you should spend every minute of every shift doing your best. Staff tends to get robotic when expectations of high quality are not maintained
- Communication
- Identifying triggers, signs of escalating behaviors, signs when to get help
- Responding to behaviors - de-escalating
- How and where to get help
- Patience, caring and understanding are critical. About human needs, providing a positive caring and understanding environment for residents with special needs. Doesn't always go as you planned. Need to be flexible and go with the flow.
- Management of emotional stress
- Available resources in their community

- Options for aging in place, in home care
- Medicare/Medicaid rules
- Worked at Harborview on psych floor x2 years
- DNS at dementia unit x6 years
- DNS at al that had mostly MH and dementia clients
- Sister to a brother with severe autism
- Certified hospice nurse"
- Dementia training, bariatric training, and overall geriatrics
- Effective communication and re-direction
- They need to understand that every resident will present differently. It is important that they have some guidelines, not only for what to expect, but how to respond in a helpful way.
- Training on best practices for this specific demographic
- Learning how to deal with behaviors and redirect as necessary.
- Compassion, patients, dementia training, mental health training, fundamentals of care,
- 1. Healthy eating/nutrition 2. Activity/recreation 3. Socializing 4. Non judgmental- non religious discussions
- Hands on care, behaviors and appropriate interventions, symptoms. I would like to see more trainings on how to deal with DD behaviors, what to expect when living with them, how to understand them better, how to set realistic goals and how to handle behavior problems such as hygiene, temper tantrums, fighting or not getting along with other residents, etc.
- Understanding the different types of dementia and mental health issues. Knowing how to redirect and learning some basic behavior management.
- How to work with residents who are experiencing delusions, or presenting behaviors out of the norm.
- Understanding of the disease processes, learning how to interpret behaviors to find root cause, not just putting them on meds. Lots of practice with dementia and how to interact, giving them lots of tools to use to communicate effectively.
- Caregivers do need education about mental illness and dementia to better understand those they care for.
- Assessing base line cognitive levels for each resident for use in creating a care plan & care directives that focuses on person centered care, supporting a philosophy which encourages expression of choice and practices self-determination in meaningful ways for both resident and caregivers at every level of their daily life.
- Dementia, mental health, developmental disabilities, ADL's, customer service/support
- The causes, symptoms and management of residents with dementia and/or mental health diagnosis
- Basic understanding, dignity and respect, specific disability information, caregiving information, behavioral supports, resources, refreshers or follow-up courses, comprehensive, but also easy access, shorter sessions.
- Their social needs
- Communication skills are one of the greatest keys. So often I meet staff who take on an authoritative role with the skills of telling not showing, talking not listening, doing not observing.
- Gentle care, validation
- History, philosophy of care, self care, organization skills to provide care for multiple individuals, individualizing care
- Patience, listening, gaining trust and making the resident feel safe which means to follow through with what the caregiver states they are going to do, communication is a must, setting boundaries and expectations, routines are very important lowers anxiety and makes the resident feel more independent, learning and understanding a resident's motivation for behaviors, looking beyond what is in front of you, to promote a sense of independence, how to safely and effectively resolve conflict, being nice! They are people. Not just diagnoses and behaviors. The caregiver needs to be genuine. Don't just go through the motions and think that you are fooling people. Resident's feel more than they observe or hear.. .
- Understanding the role of case management rules and regulations
- Patience enjoying what you do, leadership, staff development and retention
- Connecting your facility to the community
- How to deal with behaviors related to memory loss with regard to ADL's, understanding how important approach is, individualizing care.
- Strategies to provide care in the most respectful, least stressful manner possible.
- Hands on skills. Book knowledge does no good if they cannot put it to use.

- I think that the ability to think outside the box and be empathic is essential to being successful with this clientele.
- Compassion, patience, understanding and the ability to make the residents feel valued as individuals
- Dementia care
- Knowledge of providing positive behavior support to residents with behavioral issues. Knowledge of types of disability and challenges faced by those with disabilities.
- Training in the nuances of dementia vs. Mental health and the capabilities / progression of each. Training also in how best to approach different situations with persons afflicted with either dementia or mental illness ... There are so many variables!
- How to deal with difficult residents with dementia both in person with the resident and afterwards at home.
- Problem solving, approach, understanding, bathing/dressing techniques, med management / rights
- Nursing judgment, proactive, patience, ability to think "out of the box"
- Dementia/mental health
- Interventional strategies on dealing with confusion, providing care for someone with special needs. Stress, burnout coping mechanisms.
- The how to work with difficult behaviors.
- Core information is good for dementia behaviors and how to assist difficult dementia residents.
- Information that will be immediately used in their settings. They don't need to know the differences between all the dementias. They need to know what to do when residents act out.
- I feel that you really need to know resident care. Dementia and mental health
- Understanding the whole person (psychological, emotional, physical, spiritual). Understanding of accepting the reality that is in the moment. Knowledge of approaches to use to respond to the needs that behaviors are trying to communicate.
- Compassion and understanding of the dementia progression. Validation techniques: desire to get to know the person and their interests; caregiving skills; understanding the importance of resident rights: independence and choice.
- Dementia and how to deal with behaviors with out meds, redirection

### Is there a difference between adult family homes and assisted living facilities in terms of resident care and staff knowledge?

- Yes, and it kind of varies. There is good and bad with both.
- With AFH, you are less likely to have a caregiver that has gone to college, and has that consistency of training, but by the same token in ALF, it is less personal - you don't have the same caregiver every day having a relationship with that person.
- I don't think I see a difference in terms of readiness.
- With assisted living, you might have a higher caliber of training - more organized, but with an AFH, once you have been trained, you have somebody right there next to you who can constantly assess, remind and reinforce.
- The memory care homes I oversee are impeccable. I'm not seeing the assisted living facilities.
- That's hard to quantify. I don't get too involved with ALF. They have their own licensing requirements.
- ALF's have to do in-service trainings with their staff in dementia annually.
- The many times I have been in there with my family, and all I can think of is that some of them are really awesome, and some have issues in regards to losing client belongings in the ALF's. The AFH, being smaller, are better able to keep track of those things.
- I think AFH offer more assistance (to the clients)
- Yes - but it depends on whether you are talking about a good AFH and a good ALF.
- The assisted livings aren't dealing with high-acuity issues. I would say it just depends on the particular home.
- When the owner trains their staff, I don't believe they are getting the same information as they would get in the classroom. I don't think it's monitored as well, so we don't really know what they are teaching, and I don't think it works as well. I don't think we really know if they are getting what they need.
- The clients are different - the clients have to be able to function with assistance. They don't need to have all their care needs provided. The AFH clients can often be far heavier care than assisted living.
- In ALF's, caregivers are given ongoing training. They have to go to these trainings. That isn't the way it is in an AFH - you can pick anything you want as long as you meet the state requirements.

- The groups served within the DD assisted living are receiving a higher level of care than what we typically think of for ALF.
- The other advantage is that you do have licensed personnel in those facilities at some time. You have a person with a higher knowledge base observing that person... so you have that going on, which is nowhere in an adult family home.
- ALF staff tend to be trained better, and they have a lot more resources. You can see it in how they work with clients in the home.
- I would agree with that. When the AFH owner trains the staff, each of those providers is taking away a different understanding, and they are taking that understanding to their staff.
- And it takes a skillset to be a trainer, and I imagine some just aren't as good of trainers as somebody else.

### Additional comments and opportunities

- Skills not leaving the training with but should?...star training from university of Washington - big thing was antecedent behavior, another way for staff to approach challenging behaviors. How to break it down and what to do. (note: angle has a copy of this curriculum)
- Tiered training could work if you gave homework to the students and bring it back to the group. Sheet of paper - look for this, look for that...
- Tiered training. This might be an issue if the person moves somewhere else? Can it be transferable?
- Tiered training. If adding time - how to break down without adding?
- Tiered training. If it fell under the 12 hours of CE?
- Tiered training. If training is done in house it is easier and more applicable if the training is relevant to the organization.
- Traumatic brain injury
- Diabetes (including nutrition, skin care, etc.)
- Bariatric care
- Substance abuse
- [Providers should have] training for working with their own staff around their discomfort or bias for specific positions.
- If we did continuing education, we could get in there to do practical training... if staff were better equipped.
- With this grant program, we have been going into homes and giving them supplemental training. They try to get another placement, and they come in with a contracted provider to come in and work with the healthcare provider to train them on strategies. I would say it is a low percentage [taking advantage of these services] at this time, because we are raising awareness that it is even there. I am sure all of them could benefit from it. Even if part of their training could make them aware of the availability of this program. Note: this is a federal grant program that allows for wrapped services when a client discharges from a nursing home - allows for more successful placements.
- TBI
- More required training for admission of residents, if a provider chooses to go to a specialty training it will be recognized and placed on license but there might be concerns about making more requirements.
- Quality over quantity trainings.
- MS, Parkinson's, tube feedings
- Specialty to separate out for the consumer - on the license?
- Mental health training - break it up into smaller types of training
- Autism
- Personality disorders
- Medications? How and when to give? And when medication is not appropriate?
- Medications - why they are taking each medication and what are they for? Are there side effects? (is this a delegating nurse responsibility?) Training note: here is how to interact with the nurse to.... Maybe general information should be given.
- "I don't believe there should be more required training."
- The ability to evaluate taking on new clients before admittance. We deal with a number of people who take on clients and we get a call a day or two later to come and move the client.
- Bariatric clients
- TBI clients
- Continual education to deal with this opportunity would be very helpful.

- Alcoholism and drug abuse - when combined with dementia can create additional challenges; how to handle behaviors in group living situation
- Over past 6+ years, population in AFH changing, becoming more difficult to manage - more health care needs, more difficult behaviors
- Managing and effect of pharmaceuticals - both prescribed and self-administered
- Some trainers may be producing certificates in areas they are not approved to provide training
- Routine inspections + when complaints come in - all visits unannounced (looking more at certificates and documentation, not a skills test)
- Had job in the past to visit every AFH every year - no longer in place
- Chronic conditions
- Parkinson's
- Traumatic brain injury - different perspective, different needs
- Attended WA TBI conference - amazed at amount of information and resources available
- Possibly PTSD
- Medically fragile
- I would say wound care/assessment - how do you treat, and how do you prevent
- Diabetes, and some of the chronic illnesses... COPD, kidney disease, MS... those seem to be big ones.
- Even nutrition - how that related to other subjects... could be included in diabetes training, for instance.
- Basic pharma class could be good
- Positive behavior support
- Resident rights could be its own
- Drug and alcohol dependency: we have a high homeless population that end up being admitted to nursing homes. Some of those clients have the skills to survive on the street, but they are also often mentally ill. Being conscious of those residents who may have drug dependencies and that may tie into the mental health issues.
- I would really like to see more teamwork. I don't like to see it separated out - with RCS. Just teamwork. Listen to what other people are saying that they need, and believe them. If a licenser is going to say "go read your WACS", be prepared to answer some of the questions that leave big loopholes.
- I am almost appalled at what the AFH providers are not given. They aren't shown how to fill out a care plan... they don't even know what a good plan looks like, so they guess, and then they get dinged if it doesn't meet the expectation of the social worker.
- They have no place other than the AFH association, which is reliant on us for getting information. I think it's unfortunate. Even the seasoned providers are leaving.
- On top of that, having that basic... because things change. It would be nice if there were some kind of ongoing information given to the providers and their caregivers about the specialty and what is new. These caregivers are trying to deal with some pretty complex clients. There need to be some basics on how to spot substance abuse. We have a whole set of clients who are actively using, and caregivers don't know how to deal with those issues.
- TBI - we just don't have the resources down here. We don't have any training that helps providers prepare.
- An overall behavioral training - we have everything from people who scream, persevere... even if you don't have the special mental health training... I think AFH's, if they don't have a diagnosis, but often they are serving these patients before they are diagnosed.
- Types of communications
- Crisis management
- I want to make another plug for negotiated care plans being a serious requirement for training. These providers are getting a smattering of specialty training, and then they are accepting people without any instruction on how to write the hands-on care plan. They think filling in the blanks is more important than getting it right.
- When there are changes in symptoms, you need to revise the care plan right away. That is probably one of the biggest problems I see is a lack of understanding how it all flows. They don't understand the reasoning behind it.
- That should be incorporated in all three specialty trainings.
- I am very concerned about providers who are allowed to do the mental health and dementia training. From what I have observed, that is pretty inadequate. I would say the training should be done by a qualified trainer. The DD program has qualified trainers to do the training. Therein lies a lot of the issues.

- A lot of those DD trainers, want to have a say in whatever changes are made. We don't want the training changed by folks who aren't a part of our system. Hear that loud and clear.
- From a nurse perspective, I think that when providers take a patient with diabetes, they should have so many hours of diabetes training.
- They need to have the same kind of training when they take Parkinson's, cardiac problems... they all have symptoms that need to be recognized by the people providing care to them.
- The whole basic medical knowledge....
- Writing negotiated care plans
- PTSD
- There are any number of diagnoses that I believe should have specialized training, but now we only have three. We need to expand.
- They need to have better knowledge about a lot of them rather than just these three specialties.
- I would like to add that we are already up against providers who won't accept our clients because our rates are too low. If we ask them to do more training or do it differently, will there be a difference in the daily rate to reflect that these folks have more training?
- The complexity of the clients has just skyrocketed
- We've been talking about TBI
- Maybe an autism one
- Another big growth is with bariatric clients. We have very few places where we can get the clients placed because the homes aren't built to handle them. They are also needing to add staff in order to meet the care needs.
- The online class I took was expensive and requires a computer and purchasing of books.
- I like class rooms. However, it should be available on line for rural areas.
- Is this training just for providers or for RCS survey employees as well?
- I would like to see all persons working with these three groups have required training and updated yearly.
- See #27.
- I like that you are trying to educate others to help this population
- There should be ways to pass the test without taking the course. Personally I have worked in residential services for persons with developmental disabilities and or mental illness for over 20 years and could teach the MH and DD courses. Our facility is in a small town in the middle of the state. The poor funding rates make it very difficult to send staff to training as it is at a minimum 8 hours and requires out of town travel and expense and may include the need for overnight lodging.
- I wish, just once, that the department would listen, really listen to the people out there doing the work. We know what is needed and what isn't
- I feel these training in great enhancements, and that our caregivers are in training at a level to help keep our loved ones safe. Please feel free to contact me if you would like more feed back.
- It would be best if the MH and dementia were combined as many of the key components relate to them both, such as hallucinations/delusions and cultural aspects. Then the differences could be more easily shown by a comparison graph. Such as you would not use "gentle deception" for the person with MH issues who is cognitive.
- The specialty training was much more geared to our population than the long term health care aid training we are moving towards
- Not the specialty training, but very frustrated with the core basics HCA training process.
- Thank you for asking for our input.
- It is a good thing to have in place but it is a lot of info to absorb for the length of time, especially for those people who have never worked in the field before.
- I sincerely hope that significant changes will be made to the current courses. The video component of the dementia course is just terrible - as an instructor I cannot keep the students awake. Watching a talking head is pointless. The students want well- acted video. Please let these courses be taught online. As a manager, nothing hurts my bottom line more than to have to find coverage on the floor while I send a student to a course. If they are online, then they can do it anytime, 24/7, and it does not affect the work schedules.
- I tried to sign up for the DD class several months ago and had a very difficult time getting someone to answer questions about the class and ended up no doing it cause I couldn't reach anyone via phone
- I love the specialty areas and realize how important it is to not only to take the specialty classes but to be able to apply the knowledge in the workplace. Address all of the learning styles for all students needs.

- The tracking and reporting of trainings is cumbersome and difficult to get a replacement certificate. Is there a way to have instructors enter information into a database when trainings are completed and then print the certificates for the student? This would allow for ease in replacement of certificates and the database would be accessible to all administrators and surveyors for verification of training.
- It is very difficult to write down information. I understand it is for bettering (if that is a word) the information for future caregivers of any type. I personally use the curriculum required, and expand as I have had experience. I find that I personally enjoy when at a training, experiences that others have had, and what they did to make it better. It is not all about me (which I don't care for from others) rather the situation and what was the direction we took, then the outcome.
- Again, I think all staff that interact with dementia residents need to have dementia specialty training (i.e. Maintenance, dietary, house keeping, etc.).
- The DD is more extensive than dementia, yet we deal with dementia more on a daily basis
- Thank you
- More of us ED's should be able to do the training for our staff members.
- We continue to see budget cuts but the demands keep on increasing. The behaviors are getting more challenging and people who are younger are needing assisted living services.
- Our agency (also a licensed CMHA) has hired caregivers who had completed the 4 hour mental health specialty training at previous employers and they do not have the same skill set or knowledge of mental illness as the those who have completed the 8 (or more) hour training curriculum. My concern is that for some employers the specialty training has become just another requirement that needs to be fulfilled, therefore the quality is compromised. I have been teaching the mental health specialty training for almost 12 years and I always receive positive feedback from staff; they always want more information and more time in the training. The curriculum is very good. I suggest the department request the approved trainers submit training evaluations to the department on a regular basis for quality improvement purposes. I also suggest allowing refreshers or each of the lessons to be repeated for continuing education.
- Sad to say in my nursing career many times the mind set is that if it is documented it is done. I am a strong believer that material that is given/required to be covered say in 2 hours should be covered in 2 hours not 1 with the attitude that the instructor is doing you a favor. The information is important and is only taken to be as important to know as it is presented to be.
- I think that if these trainings are located in Spokane that myself and others would attend.
- Very helpful and well received
- Nine out of ten people with IDD experience sexual abuse yet information on identification and prevention is not mandatory for care givers of this population. The state has an opportunity to significantly improve the lives of people with IDD through mandatory training of care providers for people with IDD. When do you think this will happen and, why hasn't it happened yet?
- Refresher courses for instructors?
- Please put the training on-line so it can be more accessible to caregiver who work during the day and cannot take time off to attend this course.
- We are losing caregivers because they cannot attend this course."
- I appreciate your looking into updating these two programs.
- We need more accessible classes here in grays harbor
- The on line training for caregivers is a waste of time by the time they complete the training they are off on a different adventure or they do not feel that they have gained and more knowledge that the training that they get in the facility with a caregiver and in the facility often the caregivers do not have computers or online access this makes it ruff for new caregivers. They do not all have the money to have the access and they have to go to a public place like a library to do the training, it is a huge waste of money and time as it drives up the cost to private pay residents to pay for the training. Often facility's do not hire anyone that is not a NAC so new people do not even get the chance to see if they want to provide care.
- I'm very interested in being on advisory committee, I love to teach and help my staff grow. I have a unique ability to see someone's strengths and there weaknesses and help them understand and manage both
- Thank you for reaching out to interested members of the public.
- Our current communities do not admit residents with developmental disabilities so the staff do not take this class. The staff members who have taken the mental health and dementia classes that are currently offered seem to have a good foundation when they leave the class.
- I have given your contact info to the last classes I taught. I requested the students call in and do survey with you from the last email we received. Hopefully some have called.



- The classroom requirement is a huge burden on trying to find qualified aides to hire. The closest classroom course is a 2 1/2 hour drive. I took the training on-line and there was graded feed back by the instructor. I don't see anything in the curriculum that warrants classroom participation.
- Many caregiver's are required to take these classes for their area of employment and many times fail to understand the tools given to improve their interactions with specialty populations. "it's just a class I was required to take" is the basic comment I receive from students.
- Take out the repetition. If a student has learned cultural effects and respectful communication in one course, there is no need for a repeat in another.
- Please go back to having an online option.
- 3 days is too long
- Classes need to be more frequent and more local - staff cannot work in an AFH unsupervised until they have completed this class and sometimes staff need to wait anywhere between 4-8 weeks to get on a class.
- Staff need to complete all 3 specialty classes before they can work unsupervised - dates of classes often clash and are not frequent enough - this can cause long delays in staff being able to work unsupervised"
- Thanks for asking us for input. Good idea.
- I have a question: how do I get a copy of the dementia training DVD?
- "a review course would not be bad. Consider the modules presented in each manual and build a review course from caregiver input. A list of situations they may have encountered and they pick one or two to discuss with the ""a b c"" approach. One-hour credit.
- A lot of caregivers work two jobs and have little extra time, even less money."
- Dementia training should be longer -- it used to be 2 days, now it's only 6 hours :(
- I would like to have input on the dementia manager's test revision.
- To continue to update the information to caregiver so we can take care of the individual who suffers in this kind of disease, understand the individual,
- With the rapid growth of technology and its benefit to supporting the needs of those with disabilities, there should be technological training provided. Ipods are increasingly used to support not only communication needs, but socialization (pictures and videos for sharing are important for the nonverbal), and for independent engagement (residents can use these devices for recreation and for learning activities when not on outings or otherwise engaged).
- I feel more confident in an employee who went to a classroom setting for these courses. I had excellent instructors!
- Training is important, but oversight is the difference in long term client care and satisfaction
- We get a lot of calls for folks who need the specialty training but do not have access to a local class.
- Thank you for the opportunity to give my feed back. I hope that it helped!
- The trainings need to be made available in pacific co or online. Or at least the class part online and testing else where so we don't have to be gone several days away from our residents and business. Not to mention the expense of travel, hotels and caregivers!
- We are reimbursed on average \$20 less per day than it costs to care for the residents. The state should offer the training for free and have regularly scheduled classes. We have low turnover and it is very hard to find trainers who will train a small amount of people.
- If you feel that you would like to contact me that would be fine. If you think that I could help with this subject that would be great too. Just let me know what I can do. Geriatrics has been my life since I was 17 years old. I love to work with the folks that have dementia!!!! To me they are often the forgotten population. I love to teach. Shannond@villageconcepts.com or 360.675.2569.
- It would be helpful to have updated, current and easily accessible curriculum for approved instructors, including cd's and other audio-visual enhancements. Also, the instructor training should be offered routinely and agencies provided regular information about these options.
- Contact me if you want to discuss anything, I'd be glad to discuss,
- I've heard very good feedback from caregivers on the developmental disabilities training
- This is a very important and needed resource.
- The dementia training needs to be much less information. It is also difficult to train managers in the same class as others. I think they should be offered as different classes. Everyone else had to stay an extra hour and a half while the managers were going through the extra training and skills testing.

- I think it is ridiculous that licensed nurses are required to take this training in assisted living when it's not required in a SNF or hospital setting. The nurses get a bit indignant about testing when they are already licensed.
- Better teachers are needed---- no self course is needed the caregivers don't learn anything

### Possible New Trainings

- [Providers should have] training for working with their own staff around their discomfort or bias for specific positions.
- A menu of classes that go beyond the basic training... behaviors, medications, would be useful.
- A review course would not be bad. Consider the modules presented in each manual and build a review course from caregiver input. A list of situations they may have encountered and they pick one or two to discuss with the A B C approach. One hour credit.
- Additional education would be of benefit, if it was accessible. Same challenge.
- Again, I think all staff that interact with dementia residents need to have dementia specialty training (i.e. maintenance, dietary, house keeping, etc).
- Aging: Issues that are part of the aging population separately, talk about some of the challenges - some of the caregivers are teenagers. They don't have a clue - maybe a five-hour course.
- Alcoholism and drug abuse - when combined with dementia can create additional challenges; how to handle behaviors in group living situation
- An overall behavioral training - we have everything from people who scream, perseverate... even if you don't have the special mental health training... I think AFHs, if they don't have a diagnosis, but often they are serving these patients before they are diagnosed.
- Another big growth is with bariatric clients. We have very few places where we can get the clients placed because the homes aren't built to handle them. They are also needing to add staff in order to meet the care needs.
- Attended WA TBI Conference - amazed at amount of information and resources available
- Autism
- Autism
- Bariatric
- Bariatric
- Bariatric care
- Bariatric care
- Bariatric care
- Bariatric care
- Bariatric care
- Bariatric clients
- Bariatric patients
- Bariatric patients
- Basic health specialties. For example, hepatitis, HIV, etc.. It is part of the 70 hours training.
- Basic pharma class could be good
- Behavioral management—how to approach challenging behavioral problems; how to not get defensive
- Better teachers are needed—no self course is needed the caregivers don't learn anything
- Break down the DD to topic specific modules. Autism, Down syndrome, etc..
- Certification in positive behavior support. (CE)
- Chronic conditions
- Classes need to be more frequent and more local – staff cannot work in an AFH unsupervised until they have completed this class and sometimes staff need to wait anywhere between 4-8 weeks to get on a class.
- Clients who are younger but not DD
- Continuing education for specific kinds of dementia that builds on the standard training
- Coping with loss would be good additional training for caregivers.
- Crisis management
- Crisis management.

- Diabetes (including nutrition, skin care, etc.)
- Diabetes, and some of the chronic illnesses... COPD, kidney disease, MS... those seem to be big ones.
- Drug and alcohol dependency: We have a high homeless population that end up being admitted to nursing homes. Some of those clients have the skills to survive on the street, but they are also often mentally ill. Being conscious of those residents who may have drug dependencies and that may tie into the mental health issues.
- DSM and Prader-Willi
- Dual Diagnosis (e.g. dementia and down syndrome)
- Even nutrition - how that related to other subjects... could be included in diabetes training, for instance.
- From a nurse perspective, I think that when providers take a patient with diabetes, they should have so many hours of diabetes training.
- Generational differences
- Geriatric care
- Health and nutrition
- Homeless with chemical dependency
- How to help a person with DD manage money
- I don't believe there should be more required training.
- I don't see personality disorders - borderline, narcissistic, dissociative. Those are the really challenging behavior components to work with as well.
- I don't think you have to go create something, but delving into specialty training for people with various disorders... additional deeper dives based on the individuals you are caring for.
- I think different levels of training would be great to consider moving forward.
- I think one thing - if there is an aging component to this, what you are looking at when there is mental health, and then there is dementia too -as your populations are getting older.
- I think you could do topic-specific training for mental illnesses. If I had schizophrenia training and I had a caregiver assigned to that client, that would be helpful. Taking it down to the level of schizophrenia, bipolar, substance abuse and mental illness.
- I want to stress again - the Challenging Behaviors training is something that would be good to tack on to this training.
- I would consider a class for each stage of dementia.
- I would like to add that we are already up against providers who won't accept our clients because our rates are too low. If we ask them to do more training or do it differently, will there be a difference in the daily rate to reflect that these folks have more training?
- I would like to see all persons working with these three groups have required training and updated yearly.
- I would like to see some training into the new provider - train the trainer - the 48-hour course. The AFH training. Teach the new providers how to be mentors to their new staff.
- I would say wound care/assessment - how do you treat, and how do you prevent
- It would be best if the MH and Dementia were combined as many of the key components relate to them both, such as hallucinations/delusions and cultural aspects. Then the differences could be more easily shown by a comparison graph. Such as you would not use Gentle Deception for the person with MH issues who is cognitive.
- LGBT community
- Managing and effect of pharmaceuticals - both prescribed and self-administered
- Maybe an autism one
- Medically fragile
- Medically fragile
- Medically fragile
- Medically fragile individuals
- Medications - especially at AFH
- Medications - why they are taking each medication and what are they for? Are there side effects? (Is this a delegating nurse responsibility?) Training note: Here is how to interact with the nurse to.... Maybe general information should be given.
- Medications? How and when to give? And when medication is not appropriate?
- Might be good to have classes about how the medication works. The doctor understands, but the caregiver should have an understanding of that. [The current training] gives the basic drugs that are given, and it fives

some of the basic side effects. You get about thirty minutes about the treatments. There are alternative treatments, too.

- More on drugs and what happens, especially when combined with mental illness
- More on sexuality, including residents' rights and how to handle behaviors.
- More training on physical handling - transfers, etc. (part of core basic)
- MS
- MS
- MS (Multiple Sclerosis) patients
- MS, Parkinsons, Tube feedings
- One thing that could be added is conflict resolution/negotiation - that could work into what is going on. Having a daily walk through negotiating and making sure that people's rights are being protected while you are also protecting the rights of five other people.
- Parkinson's - uses resource from OHSU for CEU's (approved by DSHS)
- Parkinson's patients
- Parkinsons
- Personality Disorders
- Physical disabilities (e.g. quadriplegic, etc...)
- Positive behavior support
- Positive crisis management.
- Possible specialty is dual diagnosis of mental health and substance abuse. We often have clients that are also substance abusers - whether that is medications or illicit drugs. They may be abusing their regular medications.
- Possibly PTSD
- PTSD
- PTSD
- PTSD
- PTSD
- Quadriplegia
- Quadriplegia
- Resident rights could be its own
- Schizophrenia
- Schizophrenia
- Self-esteem
- Sexuality
- Some considerations for additional training are substance abuse, and mandated reporting.
- Substance abuse
- Substance abuse
- Substance abuse
- Substance abuse
- Substance abuse training would be really beneficial. Dual diagnosis.
- Substance issues, self-medication, marijuana
- TBI
- TBI
- TBI
- TBI
- TBI
- TBI - we just don't have the resources down here. We don't have any training that helps providers prepare.
- TBI clients
- TBI has its own set of challenges. Where my daughter resides, most of them have a very hard time communicating, but it has nothing to do with their intelligence, and that is tremendously frustrating. It brings up their social needs. It contributes to depression, anxiety - those kinds of things. And it's highly individualized. I would hope that DSHS has some sort of criteria set for people with TBI. While each case is different, I think you can bring attention to some of the needs. Folks with TBI have pretty high expectations. Their energy levels and their abilities are such a roller coaster that it's very hard for them to maintain what they expect of themselves. It's a separate issue from their mobility, and their ability to speak and

communicate. They still have that whole set of where they would like to be in their expectations and where they would like to be in the world.

- TBI or acquired brain injury
- The 12 hours of training is supposed be on the types of residence you have in either AL or AFH. I do not want to see more training legislated.
- The ability to evaluate taking on new clients before admittance. We deal with a number of people who take on clients and we get a call a day or two later to come and move the client.
- The challenging behavior course forces students to recount challenging behaviors they have encountered.
- The whole basic medical knowledge....
- There are a lot of issues with homelessness - people are coming into facilities having been homeless.
- There are any number of diagnoses that I believe should have specialized training, but now we only have three. We need to expand.
- There are more new medications now days that are not included in the training. I think the alternative treatments - more people are trying to do a less medicated approach. As a provider, when somebody chooses the natural path, how do we deal with that - can we support medical marijuana? I haven't come across it in an AFH, but it may be there.
- There is a lot more PTSD going on out there. And the students are saying that too. The component in the book is small.
- They need to have the same kind of training when they take Parkinson's, cardiac problems... they all have symptoms that need to be recognized by the people providing care to them.
- Tracheotomies
- Tracheotomies
- Training and mentoring for home health workers.
- Training on autism is additional content that would be useful for caregivers to know.
- Training on how the care assessment works with care plans would be very helpful.
- Traumatic brain injury
- Traumatic Brain Injury
- Traumatic Brain Injury
- Traumatic Brain Injury
- Traumatic Brain Injury
- Traumatic Brain Injury
- Traumatic brain injury - different perspective, different needs
- Traumatic Brain Injury (there is a TBI state curriculum = CE)
- Types of communications
- We have veterans and stuff like that when they have paralysis or other physical disabilities
- We should have additional training on documentation.
- We've been talking about TBI
- Writing negotiated care plans





