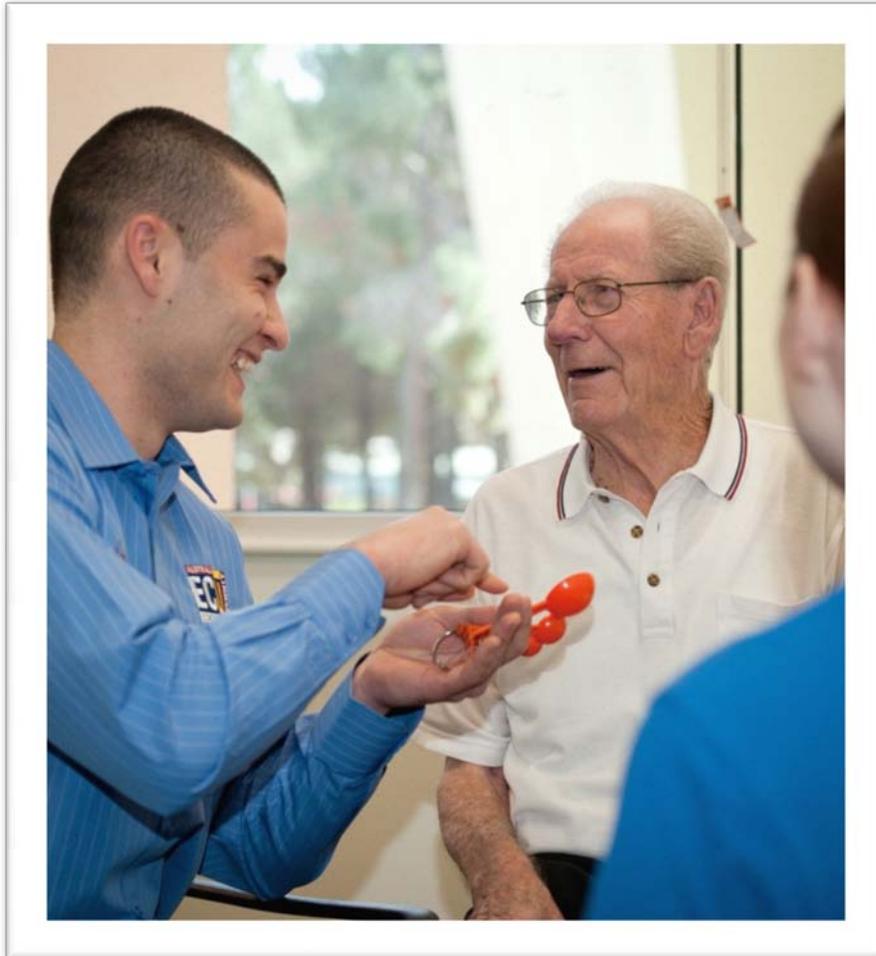


DEMENTIA

An interprofessional presentation



Facilitator Manual

THIS CLINICAL TRAINING INITIATIVE IS SUPPORTED BY FUNDING FROM THE AUSTRALIAN
GOVERNMENT UNDER THE INCREASED CLINICAL TRAINING CAPACITY (ICTC)
PROGRAM

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Acknowledgement

This resource has been developed by the Interprofessional Ambulatory Care (IpAC) Program at Edith Cowan University with funding from the Australian Government under the Increased Clinical Training Capacity (ICTC) Program.

The IpAC Program

ECU's IpAC Program was established with support from the Australian Federal Government through funding from the ICTC Program. The IpAC Program aims to deliver a world-class interprofessional learning environment and community clinic that develops collaborative practice among health professionals and optimises chronic disease self-management for clients.

This is achieved through the provision of clinical placements within the multidisciplinary team at the IpAC Unit, a community clinic that develops communication and collaboration among health professionals and optimises chronic disease self-management for clients. Additionally, a range of clinical placements are offered at existing health facilities, where trained IpAC Program clinical supervisors provide clinical support and ensure the integration of interprofessional learning into each clinical placement.

The IpAC Program has developed a variety of interprofessional learning resources, including interprofessional teaching resources and interprofessional learning through simulation resources. The interprofessional teaching resources consist each of a PowerPoint presentation and a facilitator manual. Each presentation focuses on a chronic health issue, and combines general information about this health issue with a case study and guided discussion around interprofessional learning themes.

The interprofessional learning through sequential simulation resources have been developed in collaboration with the ECU Health Simulation Centre. These learning resources are packages consisting of an audiovisual resource and a facilitator's manual, and aim to facilitate interprofessional learning and to support the participants in the development of interprofessional skills.

The interprofessional learning resources developed by the IpAC Program aim to provide health students and health professionals with the opportunity to learn with, from and about one another by engaging them in interactive tutorials.

Interprofessional Learning (IPL)

Interprofessional education occurs “*when two or more professions learn with, from and about each other in order to improve collaboration and quality of care*” (Centre for the Advancement of Interprofessional Education, 2002).

Interprofessional learning is “*the learning arising from interaction between students or members of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings*” (Freeth, Hammick, Reeves, Barr, & Koppel, 2005). It has been found that interprofessional education can improve collaborative practice, enhance delivery of services and have a positive impact on patient care (Canadian Interprofessional Health Collaborative (CIHC), 2008).

The World Health Organization (WHO) has recognised the importance of interprofessional education and collaborative practice in developing a health workforce that is able to meet the complex health challenges facing the world and assist in the achievement of the health-related Millennium Development Goals (World Health Organization, 2010). In developing its framework for action, the WHO have recognised that models of interprofessional collaboration are most effective when they consider the regional issues and priority areas (including areas of unmet need) in the local population (World Health Organization, 2010). In doing so, interprofessional education and collaborative practice can best maximise local health resources, reduce service duplication, advance coordinated and integrated patient care, ensure patient safety and increase health professional’s job satisfaction (World Health Organization, 2010).

The end goal of interprofessional education is to create a health workforce with improved levels of teamwork, collaboration, knowledge-sharing and problem-solving, eventually leading to better patient and client outcomes in health settings (Braithwaite et al., 2007).

How to use this resource

This is a teaching and learning resource designed to support tutors in the delivery of educational tutorial sessions to health students to enhance skills and knowledge of interprofessional care for clients with a chronic disease, which in this resource is dementia. The resource consists of two components: a PowerPoint presentation and a supporting manual.

The power point resource consists of three components:

1. Presentation which includes clinical information about dementia, the types of dementia, symptoms, risk factors and prevention.
2. Two case studies, Tom & Diana, and Shelia with questions that can be explored through the use of butcher’s paper and marker pens.
3. Exploration of the interprofessional learning objectives specific to this case study.

4. The presentation can be used independently, though this manual has been developed to support the delivery of the presentation in a tutorial. The tutorial includes both clinical and interprofessional learning objectives. The clinical information contained in the presentation is general information, not specifically related to the one profession, and would ensure a general basic knowledge of dementia across the disciplines represented in the student group.

Interprofessional learning objectives

The IpAC Unit has developed five key interprofessional learning objectives. The interprofessional case studies have been developed to support development in these five areas:

1. Role clarification
2. Team functioning and collaboration
3. Interprofessional communication
4. Client centred care
5. Reflective practice

Each learning objective consists of a set of skills, the development of which can be supported when using the interprofessional case studies.

1. Role clarification

Key phrases (skills which address this learning objective):

- Describes own discipline
- Describes other disciplines
- Verbalises skills, knowledge and competencies
- Understands responsibilities
- Identifies overlap between disciplines
- Values diversity between disciplines
- Works within scope of practice

2. Team functioning and collaboration

Key phrases (skills which address this learning objective):

- Participates in team activities
- Fosters positive relationships
- Appreciates differing personalities within teams
- Demonstrates respect and professional behaviour for different disciplines
- Awareness of role within the team

3. Client centred care

Key phrases (skills which address this learning objective):

- Provides appropriate evidence based information
- Establishes client centred goals
- Facilitates decision making with client/family
- Recognises and responds to the client's changing needs

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4. Interprofessional communication

Key phrases (skills which address this learning objective):

- Maintains client confidentiality
- Provides and delivers feedback
- Promotes the role of other disciplines to client/family
- Communicates in a clear and concise manner
- Validates the knowledge of other disciplines
- Uses and explains discipline specific terminology.

5. Reflective practice

Key phrases (skills which address this learning objective):

- Identifies how IPL impacts upon client outcomes
- Reflects on how IPL impacts own practice
- Identifies knowledge deficits and seeks clarification
- Reflects on feedback and integrates changes into practice
- Reflects on own attitudes and beliefs impacting upon practice.

Presentation

Dementia is defined as 'a physical illness that causes problems with memory, thinking, speaking and doing' (Alzheimer's Society, 2011). Alzheimer's Australia defines dementia as 'a term used to describe the symptoms of a large group of conditions that result in a progressive decline in cognition caused by brain cell death. Dementia is a broad term used to describe a loss of memory, intellect, rationality, social skills and what would be considered normal emotional reactions. At some stage of the illness, some individuals may develop behavioural and psychological symptoms including psychotic symptoms' (Lyketsos, 2009).

The presentation explores the different types of dementia, the areas of the brain affected, symptoms, risk factors and prevention. There is also a link to an online video titled 'Going Home'. The question whether diet can help prevent dementia is also discussed.

The presenter will need access to the internet to retrieve the online video. This video will take 9 minutes to play and shows a dramatised example of some of the problems associated with the disease. The video clip has been developed in a foreign language and has subtitles.

Presentation slides

The presentation consists of 44 slides in total, below is a description of each slide.

1. Dementia - an interprofessional case study

2. Dementia Objectives:

- Define dementia
- Discuss different types of dementia
- Identify areas of the brain affected by dementia
- Describe signs and symptoms of dementia
- Explain risk factors and prevention
- Develop an interprofessional care plan for a dementia sufferer

3. & 4. What is dementia?

Ask the students to list terms and definitions for dementia. Check this against the definition on the next slide.

4. & 5. What is dementia?

Alzheimer's Australia defines dementia as 'a term used to describe the symptoms of a large group of conditions that result in a progressive decline in cognition caused by brain cell death. Dementia is a broad term used to describe a loss of memory, intellect, rationality, social skills and what would be considered normal emotional reactions. At some stage of the illness, some individuals may develop behavioural and psychological symptoms including psychotic symptoms'

In more plain language (Alzheimer's Society, UK): 'Dementia is a physical illness that causes problems with memory, thinking, speaking and doing. Physical changes in the structure of the brain cause dementia. These changes can be seen on brain scans which can help in diagnosing dementia'. Dementia is an umbrella term that refers to symptoms caused by changes in the functioning of the brain. These can include alterations in memory, personality and behaviour. A person with dementia may find it hard to do previously familiar tasks, such as writing, reading, showering and using numbers (Department of Health and Ageing, 2011).

To access a short online video showing the impact of dementia, access the link on the slide:

http://www.youtube.com/watch?v=9iXPHfk_7E .

This video will take 9 minutes to play. The video clip has been developed in a foreign language, but has subtitles.

6. Impact of dementia

The Australian Institute of Health and Welfare classifies dementia as the greatest single contributor to the burden of disability at older ages.

An estimated 269,000 Australians currently live with dementia (Alzheimer's Australia, 2011).

Dementia is not a natural part of ageing and there are many different types of diseases and conditions that cause dementia-like symptoms. After the age of 65, however, the likelihood of being diagnosed with dementia doubles every five years. People over the age of 85 years of age currently have a one in four chance of developing dementia

7. Types of Dementia

The most common causes of the symptoms of dementia are (Alzheimer's Disease International (2011):

- Alzheimer's disease
- Vascular dementia
- Dementia with Lewy bodies
- Fronto-temporal dementia (including Pick's disease)

The following slides discuss these four (groups of) diseases in more detail.

8. Alzheimer's disease

Alzheimer's disease is a physical disease which attacks the brain resulting in impaired memory, thinking and behaviour, accounting for over half of all cases of dementia. Difficulty remembering names and recent events is often an early clinical symptom; apathy and depression are also often early symptoms. Later symptoms include impaired judgment, disorientation, confusion, behaviour changes and difficulty speaking, swallowing and walking.

As brain cells die, the substance of the brain shrinks. Abnormal material builds up as "tangles" in the centre of the brain cells and "plaques" outside the brain cells, disrupting messages within the brain and damaging connections between brain cells. This leads to the eventual death of the brain cells and prevents the recall of information.

Memory of recent events is the first to be affected, but as the disease progresses, long term memory is also lost. The disease also affects many of the brain's other functions and consequently, many other aspects of behaviour are disturbed.

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9. The Alzheimer's brain

This slide demonstrates the long-term effect Alzheimer's disease has on the human brain. The exact cause of dementia can only be determined for certain after the patient has passed away, by examining the brain tissue.

10. Vascular Dementia

Vascular dementia is the second most common cause of dementia and is caused by damage to blood vessels in the brain, which leads to the death of brain cells. Several conditions can cause this – high blood pressure, strokes, heart problems, diabetes and high cholesterol.

11. Multi-infarct dementia

The most common form of Vascular dementia. Multi-infarct dementia is caused by a number of small strokes, called mini-strokes or Transient Ischaemic Attacks (TIA). The strokes cause damage to the cortex of the brain, the area associated with learning, memory and language. Occurs because of brain injuries such as microscopic bleeding and blockage, the location of the brain injury determines how the individual's thinking and physical functioning are affected.

A person with multi-infarct dementia is likely to have better insight in the early stages than people with Alzheimer's disease, and parts of their personality may remain relatively intact for longer. Symptoms may include severe depression, mood swings and epilepsy. Impaired judgment or ability to plan steps needed to complete a task is more likely to be the initial symptom, as opposed to the memory loss often associated with the initial symptoms of Alzheimer's.

12. Lewy Bodies Dementia

Dementia with Lewy bodies is a preferred term which describes several common disorders causing dementia. In many hospitals this is the second commonest cause of dementia after Alzheimer's disease. The name for the disease comes from the presence of abnormal lumps which develop inside nerve cells called Lewy bodies. Following increasing pathological recognition, core clinical diagnostic features have been identified to allow diagnosis in life. People with dementia with Lewy bodies often have memory loss and thinking problems common in Alzheimer's, but are more likely than people with Alzheimer's to have initial or early symptoms such as sleep disturbances, well-formed visual hallucinations, and muscle rigidity or other parkinsonian movement features. Small protein bodies (Lewy bodies) develop in the brain, and cause the death of brain cells.

The main features of these conditions are: The development of dementia with features overlapping with those of Alzheimer's disease, the development of features of Parkinson's disease and fluctuation in severity of condition on a day-to-day basis. Symptoms may include tremors and stiffness similar to that seen in Parkinson's disease, difficulty with concentration and attention, extreme confusion and difficulties judging distances, often resulting in falls and early development of hallucinations

PATHOLOGICAL FEATURES

Several key areas of the brain undergo degeneration in this form of disease. There is degeneration of an area in the brain stem called the substantia nigra as would be seen in Parkinson's disease.

Normally the substantia nigra is populated by nerve cells which contain a dark-brown pigment called

neuromelanin. The cells of the substantia nigra are responsible for making the neurotransmitter dopamine. In both Parkinson's disease and Lewy body dementia these cells die and so the substantia nigra appears abnormally pale in comparison to normal. Remaining nerve cells contain abnormal structures called Lewy bodies, which are a pathological hallmark of the disease process.

13. Fronto Temporal Lobar Degeneration:

(Explanation below of the groups of dementia named on this slide)

This group of dementias covers a range of conditions, including Pick's disease, progressive non-fluent aphasia, semantic dementia and fronto temporal dementia. All are caused by damage to the frontal lobe or the temporal parts of the brain. These areas are responsible for behaviour, emotional responses and language skills. Nerve cells in the front and side regions of the brain are especially affected

Pick's disease: Pick's disease affects the frontal lobes, but in some cases can affect the temporal lobe of the brain. If the temporal lobe is damaged, memory is more likely to be affected. The disease gets worse slowly. Tissues in the temporal and frontal lobes of the brain start to shrink over time. Symptoms such as behaviour changes, speech difficulty, and impaired thinking occur slowly, but continue to get worse. Early personality changes can help doctors diagnose Pick's disease with memory loss often the main, and earliest, symptom. People with Pick's disease tend to behave the wrong way in different social settings. The changes in behaviour continue to get worse and are often one of the most disturbing symptoms of the disease. Some patients will have more prominent difficulty with decision making, complex tasks, or language such as trouble finding or understanding words or writing.

Progressive non-fluent aphasia: This was formerly known as Primary Progressive Aphasia (PPA). People with PA may lose the ability to speak or may begin to speak gibberish.

Semantic dementia: (Progressive Fluent Aphasia) is also known as the Temporal Variant. People with semantic dementia may lose the meaning of words and also may become preoccupied with a single activity.

Fronto temporal dementia(FTLD): This is the most common subtype and is also called the Frontal Variant. It is mainly a disorder of behaviour. People with FTD may be disinhibited or apathetic. Early symptoms can affect behaviour, and sometimes language. People may show a change in their character and in their social behaviour. A person with FTLD may become obsessive and repeat the same action over and over again. Language problems often occur early in the disease and may range from limited speech to total loss of speech. Repeating phrases over and over, or echoing what others have said are also common symptoms. Instead of being able to find the right word to describe an object, a person with FTLD may give a description of it instead. About 50% of people with FTLD have a family history of the disease.

14. Areas of the brain affected by Dementia

This slide contains an image of the areas of the brain affected by dementia

15. Symptoms of Dementia

All classifications of dementia are neurodegenerative diseases, the progressive loss of structure or function of neurons. This means that the symptoms will get worse over time.

The speed of change varies between people and also between different diseases, but in most dementias symptoms progress slowly over several years. Everybody is affected in their own way.

16. Symptoms of Dementia

Symptoms of dementia may include the following:

- Decreasing ability to remember, think and make decisions
- Communication and language often become more difficult
- Behaviour may change and some people can become sad or demoralised
- Anxieties or phobias are quite common
- Problems with time perception may cause problems with sleeping and restlessness at night
- Anger or agitation is common in the later stages of dementia
- It is common for people to be unsteady on their feet and fall more often
- Gradually people require more help with daily activities like dressing, toileting and eating.

One can imagine the impact these changes have on the carer of the person who has dementia.

17. Risk factors-see chart

- The risk of developing most dementias increases with age. As we get older, we are more likely to develop dementia. Dementia is not a normal part of getting older or an acceleration of ageing. Dementia is caused by different diseases – for instance and most commonly by Alzheimer's. About one in 20 people over the age of 60 have dementia. This rises to about one in five people over the age of 80.
- Dementia is often negatively perceived as an inevitable, untreatable and unpreventable symptom of old age. This perception, however, is false. While dementia remains incurable, there is a growing body of evidence that suggests there may be some simple things we can all do that might help lower our risk.

18. Risk factors and prevention

The same risk factors for cardiovascular disease (such as heart disease and stroke) are risk factors for all types of dementia. There are some simple things we can all do that might help lower our risk:

- exercising regularly
- not smoking
- achieving and maintaining a healthy weight
- controlling high blood pressure
- reducing your cholesterol level
- controlling your blood glucose if you have diabetes
- eating a healthy, balanced diet with lots of fruit and vegetables and low amounts of saturated fat.

Some studies suggest that enjoying an active life, with lots of interests and hobbies might be beneficial. Other research has found that spending more time in education is associated with a lower risk.

19. Is diet the answer?

Some research:

- Mediterranean diet may be related to lower Alzheimer's disease risk
- Modest to moderate alcohol intake, particularly wine
some research has shown there may be a lower risk of Alzheimer's disease
- Supplements of vitamins E, B6, B12 and folate Oily fish or taking B vitamins studies so far have had mixed results. Randomised trials for other nutrients or diets and Alzheimer's disease are not available
- Summarised: Existing evidence does not support the recommendation of specific supplements, foods, or diets for the prevention of Alzheimer's disease (Luchsinger et al. 2007).

20. Medications:

Dementia is the term used to describe the symptoms of a large group of illnesses that cause a progressive decline in a person's functioning. It is a broad term to describe a loss of memory, intellect, rationality, social skills and what would be considered normal emotional reactions. Dementia causes significant impairment in a person's day to day functioning. People with dementia may at some point in their illness develop symptoms such as depression, anxiety, agitation, sleep disturbance, aggressive behaviour and psychosis inclusive of delusions and hallucinations. While it is important to try to understand and address the underlying reasons for these problems, it may be necessary at times to prescribe medication if the symptoms are distressing, persistent and have not responded to psychological treatments.

A number of drugs are currently available in Australia for use by people with dementia. These drugs fall into two categories, cholinergic treatments and Memantine. As Alzheimer's progresses, brain cells die and connections among cells are lost, causing cognitive symptoms to worsen. While current medications cannot stop the damage Alzheimer's causes to brain cells, they may help lessen or stabilize symptoms for a limited time by affecting certain chemicals involved in carrying messages among the brain's nerve cells. Doctors sometimes prescribe both types of medications together. Some doctors also prescribe high doses of vitamin E for cognitive changes of Alzheimer's disease. (Alzheimers Association.org)

Cholinergic treatments

Cholinergic treatments offer some relief from the symptoms of Alzheimer's disease for some people for a limited time. Drugs known as acetylcholinesterase inhibitors work by blocking the actions of an enzyme called acetylcholinesterase which destroys an important neurotransmitter for memory called acetylcholine. Current cholinergic treatments are approved for use for people with mild to moderate Alzheimer's disease. Believed to delay worsening of symptoms for 6 to 12 months, on average, for about half the people who take them. They are generally well tolerated, however if side effects occur, they commonly include nausea, vomiting, loss of appetite and increased frequency of bowel movements. (Alzheimers Association.org)

Memantine treatments

Memantine targets a neurotransmitter called glutamate that is present in high levels when someone has Alzheimer's disease. Memantine blocks glutamate and prevents too much calcium moving into the brain cells causing damage. Memantine is currently approved for use for people with moderately-severe to severe Alzheimer's disease. Memantine is prescribed to improve memory, attention, reason, language and the ability to perform simple tasks. It can be used alone or with other Alzheimer's disease treatments. There is some evidence that individuals with moderate to severe Alzheimer's who are taking a cholinesterase inhibitor might benefit by also taking memantine. It is also believed to regulate the activity of glutamate, a different messenger chemical involved in learning and memory, whilst it also delays worsening of symptoms for some people temporarily. Many experts consider its benefits similar to those of cholinesterase inhibitors. However, it can cause side effects, including headache, constipation, confusion and dizziness. (Alzheimers Association.org)

Medications for Vascular Dementia

There is no standard drug treatment for vascular dementia, although some of the symptoms, such as depression, can be treated. Most other treatments aim to reduce the risk factors for further brain damage. However, some studies have found that cholinesterase inhibitors, such as galantamine (Razadyne) and other Alzheimer's disease drugs, can improve cognitive function and behavioural symptoms in patients with early vascular dementia.

The progression of vascular dementia can often be slowed significantly or halted if the underlying vascular risk factors for the disease are treated. Doctors may prescribe medicines to control high blood pressure, high cholesterol, heart disease, and diabetes. Medications can be prescribed to relieve restlessness or depression or to help patients sleep better may also be prescribed.

21. Case study activity

To facilitate this exercise, divide the class into two groups. Using butcher's paper and marker pens, one group will consider the case study about Tom and Diana (**Slide 22, 23**), the other group will consider the case study about Shelia (**Slide 24, 25**). The case studies are formatted as handouts at the end of the Facilitators Manual.

Have each group consider the three questions on the slide:

1. How might the client and the carer be feeling?
2. What would a health professional consider when developing a care plan for this individual?
3. Consider how each discipline within the interprofessional health care team can help the individual to achieve their goals.

26-28. Question 1: How might the client and carer be feeling?

Answers: (available on the presentation slides)

Client:

Shock - leading to disbelief or denial is a very common reaction. Sometimes denial can be a good thing and can help the client cope with the reality of their disease at their own pace.

Fear - often the biggest fear is of a loss of control – over the future, and over one's own life. Not knowing what is going to happen can be very frightening indeed.

Common fears include:

- Becoming a burden to one's family.
- They may be frightened of passing the condition on to children.

- Fears of physical indignities, such as becoming incontinent and dribbling.

Guilt is a very common reaction. The patient may think that they have done something wrong, or not tried hard enough to prevent the disease. They may even feel they're to blame. This is however an organic disease, whatever the type of dementia; it is not their fault.

Sense of loss - the patient may feel sad that perhaps they will not be able to do some of the things they have planned.

Relief - This may seem strange to some, but the patient may feel relieved that they finally have a diagnosis. Now that they have a concrete diagnosis, they can do something about it.

Acceptance - They may never accept their illness. This is OK.

The patient may also want to think about driving, health, legal decisions, work, money and benefits.

Planning for the future can make things easier to manage later on so they need to take advantage of all the advice, services and support available.

Carer/Family member:

- **Angry and sad** - the person they care for will never be the same again.
- **Stress, depression or anxiety** – a lot of changes are happening, which are out of their control, and the pressures on the carer will only increase with time.
- Struggling to **combine work with care**
- Worried about **finances**
- **Lacking time** for the other interests in their life
- **Fatigue** due to long hours spent caring, lack of breaks, lack of sleep
- Difficulty maintaining **relationships** with family and friends
- **Inability to plan for the future**
- Worried about **contingency** for emergencies, such as if the carer becomes ill
- Difficulties coping with **challenging health problems** such as incontinence
- Lack of **practical skills** such as knowing how to lift the client properly

29. Question 2: What would a health professional consider when developing a care plan for this individual?

Support the students to think of not only the client/identified patient, but also about care solutions to support the carer.

Answers: (available on the presentation slide)

- Support the client and their family/carers with the diagnosis and disease process
- Encourage the client to maintain a healthy diet and exercise program
- Facilitate participation in therapy sessions to improve the clients symptoms
- Seek further help from outside agencies and support groups
- Encourage the client and their carer to continue seeing their friends and doing the things they enjoy

30-38. Question 3: Consider how each discipline within the interprofessional health care team can help the individual to achieve their goals.

Who can help? Ask the students to brainstorm what discipline could be involved and how, before showing the possible health professionals described in the following slides.

Answers: (presentation slides available for each discipline)

- Nurse
- Medical Practitioner
- Dietitian
- Exercise Physiologist/Physiotherapist
- Occupational Therapist
- Clinical Psychologist
- Speech Pathologist
- Social worker

39. Key IPL discussion points

Returning to the larger group, discuss the following questions in relation to IPL.

39. Question 1: How can we ensure that the care is client centred?

Possible answers:

- Actively encourage client involvement in clinical decision making
- Respond to the changes in the client's needs
- Discuss with the client what care options are available
Encourage self management, health promotion and disease prevention.

Follow this with a general discussion relating these skills to the case studies:

- How can the client be involved in the decision making? What choices do the client and carer have?
- How can each discipline ensure that when changes in need occur, the care will be adjusted?
- How can the client improve their own health? And the carer?

40. Question 2: How can we demonstrate effective communication with other members of the interprofessional team?

Possible answers:

- Show respect and interest when listening to other team members' ideas and viewpoints and do not dominate discussions and activities
- Use terminology that is understood by members of the interprofessional care team and provide clarification when required.

Follow this with a general discussion relating these skills to the case studies:

- How would the range of disciplines in this case communicate with each other?
- What barriers for interprofessional communication can you identify?

41. Question 3: How does an interprofessional team differ from a multidisciplinary clinic?

Possible answers:

- Identify where other health disciplines fit within an interprofessional team, acknowledging skills and knowledge of other team members and consider where other disciplines overlap with and enhance own discipline's role in the provision of health care
- Identify misconceptions relating to own and other health professions
- Holistic client centred care
- Improved communication, both written and verbal, from all disciplines involved with the clients' specific care plan.

Follow this with a general discussion relating these skills to the case studies:

- What disciplines involved in these cases overlap in what they can offer the client?
- How would they address this?
- Were any of the discipline descriptions different from what you expected? In what way?

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Attachment1: Case Study Tom and Diana

Tom is a 79 year old athletic, active widower. Tom was as social worker and cook at his community senior centre where he met Diana, a 79 year old divorcee with two daughters, who was a professional ice dancer before retiring. Tom stated "We have been friends for 14 years and together as a couple for 8". When they first met, they worked out at the gym, swam, and took art classes together. Neither one was looking for a new relationship.

In 1994, Tom noticed a change in Diana's paintings and in her memory. In 1995, Tom and Diana came to the psychiatric clinic for a memory loss assessment. Diana was diagnosed with Alzheimer's disease. As the disease progressed, Diana was unable to continue painting, her memory continued to deteriorate, and her mobility decreased causing her to suffer a few falls. She started refusing food and experiencing difficulty with fluids and subsequently became generally weaker. She started to require 24 hour care. To provide this care, Tom gave up the activities they used to do together and, as time went on, he gave up all outside activities.

Tom contacts an outpatient interprofessional health care centre to see if they can offer any support.

Attachment 2: Case study Shelia

Shelia is a healthy and active 48 year old woman who is the social support for the rural village where she lives with her husband and youngest son. Shelia has two other daughters who both live two hours from home and whom she visits frequently. Shelia loves cooking and entertaining with her friends and swims regularly.

Shelia works as a secretary for a busy building firm in the village and often puts in long hours to ensure smooth running of the office. Shelia is renowned for putting 100% effort into all that she does and is always helping others in times of crisis. Shelia has no past medical history, other than hospital admissions for the births of her children.

Over the past 12 months, the family had been getting concerned that Shelia was having difficulty 'finding her words' and family members needed to finish her sentences more frequently. Shelia is also finding it hard to grasp new ideas and is finding the work load at the office increasingly difficult. Shelia has gone off certain foods and the family are concerned that she is losing weight. The family GP knows her well and decided to refer her to a Neurologist for further tests and assessments. Following various scans and examinations at the Neurology department, Shelia has been diagnosed with Pick's disease. Shelia and her family are desperate to find out more about the disease and what help is available for the future.