"You've got to keep account of heads all the time":

Staff perceptions of caring for people with dementia

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ABSTRACT

Research Aim: Little is known regarding the pressures of working within dementia care units as the majority of literature has focused broadly on long-term care (LTC) rather than the provision of specialised dementia care. This study aimed to explore the perceptions of staff in relation to their capacity to manage behaviour and care needs of people with dementia living within the dementia-specific environment. Individual interviews were conducted with 35 care staff from three dementia care units in Brisbane, Australia.

Major Findings: Four themes were identified: role definition, relationships, workplace environment and workforce issues. Although the findings highlight the importance of

peer support for staff when managing difficult situations, questions regarding the quality of peer support and its impact on care provision were raised.

Conclusions: Dementia units are complex systems with well-motivated and educated staff contributing to the effectiveness of the care. An understanding of care staff perceptions of their role and its effects on care practices can help to identify appropriate support structures and training strategies thereby improving job satisfaction for staff and quality of life for the residents with dementia.

Keywords: dementia, long-term care, qualitative research, workplace environment, attitudes

INTRODUCTION

People with dementia move into long-term care (LTC) when home-based care is no longer a practical or safe care option (Hancock, Woods, Challis, & Orrell, 2006). Approximately 83,000 long-term care (LTC) residents in Australia have dementia, accounting for around 49% of the resident population (Access Economics, 2010; AIHW, 2010; Productivity Commission, 2011).

Specialized dementia units emerged in the latter part of the 20th Century in response to the particular needs of people with dementia who were seen as difficult to place in mainstream nursing home accommodation (Gruneir et al., 2008; Luo et al., 2010; U.S. Congress, 1992). In Australia, dementia-specific refers to a service that encompasses a specialised program for residents with dementia, which is commonly provided within a secure environment. Some dementia units incorporate specific design principles, such as walking tracks for people with dementia and staff receive specific training on behavioural and psychological symptoms of dementia (BPSD) and person centred dementia care. Others simply provide a physical distancing or clustering of residents with dementia within a section of the facility and there is little difference between the staff working in mainstream services or the dementia unit.

The Australian Government does not specifically identify facilities that offer dementia-specific care making it difficult to estimate the percentage of residents residing in dementia-specific units. Alzheimer's Australia estimates that the majority of people with dementia in LTC requiring high (nursing home) care are in 'mainstream' areas with only 8% in dementia-specific units whilst 15% of low care (assisted care) residents with dementia reside in dementia-specific areas (Access Economics, 2003). Entry to a dementia-specific unit is on assessment and approval by the Aged Care Assessment Team (ACAT). Residents are mostly ambulant and have complex needs generally related to severe BPSD. Separation from the facilities' mainstream services and residents is required due to their special needs and/or concern about disruption to other residents.

A wide range of care philosophies exists to guide practice in dementia care, one of the most commonly referenced within the sector is Person Centred Care (PCC). The underlying principle of PCC is to preserve the quality of life for the person with dementia with the focus of care on the person's physical, emotional, social and spiritual needs (Fossey, 2008; Kitwood, 2000). However, there remains some debate about

what constitutes an optimal approach to care for people with dementia and the influence of staff on this care.

Difficulties associated with direct care staff recruitment, retention and high levels of staff turnover are familiar challenges in LTC and have become of greater concern as the population and our current workforce ages. LTC research has found staff job satisfaction and staff turnover to be strongly related to the staffs' perception of stress or overload. It has also been noted these factors may be influenced by staff relationships with co-workers and the residents they care for (Duffy et al., 2009; Vernooij-Dassen et al., 2009). Whilst it appears that such workforce and care practice challenges have the potential to be amplified when the care provision is directed toward people with dementia the majority of literature has focused more broadly on LTC rather than specialised dementia units. Relatively little is known about the pressures experienced by staff working within a dementia-specific environment and how this may impact on the quality of care provided to a high care vulnerable client population.

METHODOLOGY

Aim

The aim of this study was to explore the perceptions of staff in relation to their capacity to manage behaviour and care needs of people with dementia living within the dementia-specific environment in LTC.

Design

A pragmatic, exploratory qualitative approach, situated in the interpretive paradigm (Neuman, 2000) was used to answer the research question: "How do staff manage behaviour and care needs within the dementia-specific unit environment".

Settings

Three secure dementia care units in Brisbane, Australia, owned and operated by a not for profit operator were involved in this study (refer to Table 1).

Participants

Convenience sampling was used. Care staff, working a minimum of two shifts per week, in the three secure dementia care units were invited to participate in the study.

To ensure a variety of views and opinions were obtained, all levels of care staff were recruited across all work shifts (refer to Table 2). Thirty-five staff consented and participated in individual interviews that lasted between six and thirty-five minutes.

Data Collection

Data collection involved individual, semi-structured, face-to-face audio-taped interviews. Two experienced interviewers used an interview guide to explore the perceptions of staff in relation to their capacity to manage residents' behaviour and care needs within the dementia-specific environment. Questions were grouped into three subsections: role definition, interaction with co-workers/residents and career development/expectations. As an introductory 'ice breaker', participants were invited to describe a regular workday in the dementia unit. Subsequent questions asked them to: (a) comment on the level of support provided by the local leadership team, (b) identify the highlights and challenges associated with their role; and (c) consider the physical environment of the dementia unit. Finally, the participants were invited to consider if their current role was a long term or short-term career option.

Ethical Considerations

Approval of the study was gained from the relevant ethics committees in the University and participating organisation. Participants were provided with informed consent materials and were assured that confidentiality would be maintained at all times.

Data Analysis

An interpretive approach was taken to the analysis of data. Following verbatim transcription of the interviews, each transcript was read by the research team members to determine the meanings, values and intentions that were coming through and any competing or alternative perspectives (Struebert Speziale & Carpenter, 2003). Each interview transcript was read several times to identify areas of interest. During these readings distinct incidents, anecdotes, or stated opinions about discrete topics were highlighted using the interview subsections as initial content categories. The researchers aimed to not just link the categories to the data but to also question the data about new ideas developing. Emerging issues were discussed and following consensus the data was classified into themes. Analysis of the data revealed four themes: role definition, relationships, environment and workforce issues.

RESULTS

Role Definition

Participants defined their role by the tasks they completed and defined success in their role as completing their allocated tasks within a specified timeframe. Interaction with residents whilst seen to be enjoyable appeared peripheral to task completion. The majority of participants described their daily role as a sequence of tasks. The tasks were relayed in detail and frequently included specific information on the timeframes during which the tasks were to be completed. Following are examples of this theme: *'You've got a time slot where you've got to get everyone up, dressed and toileted and out to breakfast by a certain time' [PCW#23]. 'it's very rush, rush, rushed to get those people up and into breakfast and it becomes a production line'* [DT#2].

The residents and their needs were strangely peripheral in this commentary and were only occasionally acknowledged to have any involvement in the tasks staff completed and rarely identified as having a significant presence. When participants did identify the residents or allow them to emerge, it was as reluctant recipients of care or in explanations of their difficult behaviours to emphasise the challenges staff experienced in providing care for residents with dementia. At times, residents were portrayed, either individually or collectively, as a hindrance. Only one participant expressed her frustration regarding the dominant task orientated practice *'I hate working with task orientated staff, I find it so difficult working with them'* [PCW#19].

Long-term Care (LTC) in Australia is a heavily scrutinised and regulated industry monitored by the Aged Care Standards and Accreditation Agency (ACSAA). All LTC facilities must demonstrate how they comply with the Accreditation Standards (as set out in Schedule 2 of the Quality of Care Principles) through the process of assessment conducted by the accreditation body. Staff are very aware of the impact that non-compliance or failure to meet the required standard will have on the facilities funding and reputation and the indirect effect this may have on their own employment options. Participants therefore took a custodial approach to care and were very conscious of their responsibilities in relation to the safety of the residents in their care. A number emphasised the restrictive/supervisory nature of their role. One participant considered a key component of their role to revolve around *'monitoring residents' behaviour'* and *'keeping them away from danger'* [PCW#14]. Staff on a male only unit stated that they

needed to observe residents at all times as *'they are quite aggressive between each other, they can't walk past each other without bam [striking the other]'* [WPHSO#1].

Participants valued the locked environment as they considered it a tangible way of ensuring the safety of the residents. Preference for and use of physical and chemical restraint was directly mentioned or implied by more than one participant. The importance of monitoring residents and keeping them in view at all times was not only from the perspective of observing and reducing the incidence of challenging behaviour but also in relation to reducing the risk of residents' falling. For example, *'team members have been telling them for weeks that they should have a posey [restraint] vest to restrain him when he's sitting in a chair, they [management] said no, no, can't do it, won't do it, can't be done…sure enough he's got the posey vest, it took one big fall where he had to go to hospital and you find that's all it takes'* [PCW#6], Staff members at two of the units were critical of the sight lines within the facility. For example *'You can't work in the office [nurses' station] at night because you can't see or hear anybody'* [RN#1]. Others considered that the amount of 'clutter' or personal items in the resident's rooms made them overcrowded and a hazard for both residents and staff.

Relationships

Staff-Staff Relationships

Most participants clarified their own position within the unit. They used it to explain individual role responsibilities and/or to express concern or frustration with the poor practice or limited abilities of a particular discipline or staff group within the broader hierarchy.

When participants discussed interaction with their co-workers it was in the context of a unit or staff hierarchy. The majority of participants were confident of their own abilities and of the ability of those higher in the hierarchy to assist them if required. For example, *'everybody is in their own particular role but [the facility manager] is the boss…she is in charge and she is good'* [PCW#12], *'if I can't solve a problem I always go to the manager and [this] always helps'* [PCW#3].

From an information-sharing/support perspective the majority of the Personal Care Worker (PCW) participants considered that they gained most support to assist them in their role or to manage challenging situations from their peers or team members. Participants emphasised the value of positive staff interactions in increasing job

satisfaction and the importance of good teamwork to enable them to *'get the tasks done'*.

Although support from colleagues was considered to be important several participants expressed dissatisfaction with their interactions with other staff. Negative comments included; *'some people just can't sort of understand and you have to constantly go over and over and over'* [PCW#14], *'There are some shockers here who shouldn't be here, they should get rid of them'* [PCW#6], One staff member expressed frustration regarding the rate of staff turnover, *'you've just got them trained up and they beg off and you start all over again'* [PCW#12].

Staff-Resident Relationships

Participants considered the interaction they had with residents to be the most enjoyable aspect of their job. They particularly valued interactions that represented tangible evidence of resident satisfaction or improvement in health, for example, *'it's the sensitive and the caring side that really appeals to me'* [PCW#14], *'To know that you've helped them in some way'* [PCW#18], *'it's always lovely to see you've done something and someone is really grateful for it because it's not always the case is it?'* [PCW#20]

Whilst resident interactions were valued the examples of personal and peer practice that participants' provided bore little resemblance to the Person Centred Care (PCC) philosophy advocated by management. It became clear that PCC was not a term the participant staff were familiar with or, from their conversations, a philosophy they applied in their care practices. The depersonalising terms that they used in their conversation and care descriptions were more aligned with the Malignant Social Psychology (MSP) terminology as defined by Tom Kitwood (2000).

Some participants referred to the resident with dementia as if they were a child (infantilising), *'Once he's up and in his fall-out chair, he's a little lamb'* [DT#2]. A number of participants spoke of the residents as though they were objects *'the non-mobile, the wheelchairs'* [PCW#25] or *'the feeds'* [PCW#23], *'you've got to keep account of heads all the time'* [PCW#18]. One participant considered their role to be predominantly to, *'make sure the heads are here'* [EN#1]. For some participants the resident's disease status or 'dementia' state was their defining feature, not as people with individual needs, *'I love working with the dementia people'* [PCW#22], *'I think dementia is very interesting to watch'* [PCW#29] Several participants referred to the residents solely in

the context of their challenging behaviours' or physical disabilities, *'they just don't sit still, so they want to get up and wander around and stuff like that, so that's a challenge'* [*PCW#20*], *'This one is jumping up and down and that one is sitting in someone else's spot and that one is fighting with this one'* [*PCW#12*].

Resident physical and verbal aggression was considered by some participants to be an occupational hazard but less than half the participants cited resident aggression as being the most challenging or unpleasant aspect of their job. Those participants who did gave examples of aggressive outbursts they had experienced. Most occurred whilst the staff member was providing intimate care for a resident, assisting with dressing, showering or in the toilet, for example, *'especially if you're showering them, sometimes they don't seem to like their clothes being removed, that makes some residents more aggressive'* [*PCW#13*], *'a male resident here who swears a lot, is quite abusive when you are trying to handle him'* [*DT#2*]. During the descriptions few participants acknowledged that the incidents may have been related to the context in which they were providing care or their approach. Staff working in the male facility more commonly reported physical aggression and sexually inappropriate behaviour. Other participants considered that resident falls that resulted in significant injuries were the most difficult incidents they had experienced.

Although staff did not appear to use a defined philosophy to guide their practice they did refer to strategies to manage challenging resident interactions. When residents with dementia were uncooperative or their behaviour inappropriate, a common strategy was to put that aspect of their care on hold and come back later. For example participants stated: *'I can usually calm them down [aggressive residents] but if not I just walk away'* [*PCW#1*]. Another strategy was to try a different approach, *'It can make a big difference how you talk to the ladies…very firm, very, I know what you need, you need this'* [*PCW#20*].

Workplace environment

Participants considered that size and access, atmosphere and lack of stimuli were issues of concern within the dementia environment. Most considered the units to be too small and lacking in outside space. Some staff viewed the environment more broadly than just the physical infrastructure and introduced the concept of atmosphere as an influencing factor. These staff did so by emphasising the role staff play in creating and influencing the atmosphere. Others commented on the positive and negative

changes they had perceived amongst the residents due to the wall colours, floor covering, accessibility and lighting. Some considered the environment to be unappealing, whilst others stated that recent changes in wall colouring in two of the units had a positive effect on resident behaviour.

The majority of participants considered that there were insufficient activities to engage and entertain the residents and those that did take place were not sufficiently stimulating, *'if you stay here for a long time it's quite boring...every week you have the same meals'* [*PCW#7*], *'we need to do more to occupy the residents…they should have more activities'* [*PCW#15*]. Some did mention every day activities in which residents engaged but it did not appear to be common across the facilities *'We give them a broom and they can sweep or wipe tables…she can be active in doing something constructive'* [*PCW#20*]. One facility had a multi-sensory room but this was not viewed as beneficial.

Workforce issues

Whilst a number of participants expressed frustration or dissatisfaction with elements of their role, workplace and colleagues the majority considered that they would remain in their current position for more than 12 months. For some their desire to remain was influenced by financial concerns or by their ability to obtain another job due to their age. Those who were planning to leave within six months were mainly leaving to advance their career by completing additional training with a minority considering a move to an acute care setting.

Participants provided information on workplace improvements throughout their interviews but all were specifically invited to consider things that would help them to 'do their job better'. Opinions regarding the education and training opportunities available to them were divided. Some participants were critical of the type and frequency of education and training available to them 'I *think they have done a lot of training on dementia and a lot of it was inappropriate to us…it was all about the how the brain functions and all that stuff, I mean it's all good information but what are we going to do with that stuff?'* [*PCW#20*]. The value of ongoing dementia-specific training as a way of improving knowledge and practice was mentioned in relation to the management of challenging behaviours. Others considered the focus of dementia education should be only on new staff.

For some participants an increase in status and pay were factors, which would improve their working life. One participant expressed frustration regarding disparity in pay but

not in responsibility amongst the disciplines, *'I'm doing the same job as the EN's and RN's, exactly but I'm only a PC, I'm doing the medications, patching skin tears and I'm not getting extra money for it'* [*PCW#6*]. Furthermore, care of people with dementia was seen by participants as being an area that needed further compensation *'to deal with dementia is a skill; it should be rewarded* [financially]' [*RN#1*].

Surprisingly few staff stated that additional staff would improve their work life. The majority of those who commented on staffing levels did so reluctantly and only when prompted *'We manage alright, probably an increase in staff just a bit in the mornings because you get real busy in the mornings'* [*PCW#4*]. The value of staff consistency was considered primarily from the perspective of timely completion of tasks with the residents views secondary, *'working with agency staff it's quite hard because they don't know the place at all…you have to supervise them all the time, regular staff they know the person well…so we can do it quickly and do it appropriate'* [PCW#7].

DISCUSSION

Our aim in this research was to establish staff members' perceptions of their ability to manage the challenging situations they experienced in a secure dementia-specific environment. Those working in dementia care have been found to experience higher levels of stress and staff turnover which has been attributed to the population being cared for having more complex needs and being more likely to exhibit extreme behaviours (Zimmerman et al., 2005). This study was initiated by facility managers' concerns that the high stress environment was having an effect on staff recruitment and retention and this was felt to impact on the residents in secure dementia-specific care. As facility staff commonly work throughout the whole facility, it was difficult to directly attribute staff turnover to negative experiences in the dementia unit but anecdotal evidence from staff indicated this may have been the case. Staff turnover rates within the LTC facilities were 10% higher than the national benchmark, concerning in a sector that routinely experiences high turnover rates (Ball et al., 2009).

Staff Relationships

In addition to responding to the emotional needs or frustrations of residents the stressors the participants related included dealing with inexperienced and/or un-cooperative co-workers. The effect of staff relationships on staff retention and quality of care is well documented. Negative staff interactions are a commonly reported issue in the aged care workforce literature with concerns expressed regarding the impact of

such negative relationships on staff retention, care practices and interaction with family members (Vernooij-Dassen et al., 2009). A large survey of staff working in LTC conducted by the National Institute of Labour Studies found that a number of staff considered one of the 'worst things about work' was problematic relationships with their co-workers (Moskos & Martin, 2005). Two earlier studies conducted in Australia found similar issues (Moskos & Martin, 2005; Moyle, Skinner, Rowe, & Gork, 2003). The effect of workplace stress on staff turnover in LTC has been discussed previously. This studies findings suggest that participants working in specialised dementia care are challenged by their ability to respond to resident needs in a person centred manner and this is also compromised by a combination of high workloads, variable proficiency in dementia specific care and the physical environment.

Workloads

The demanding workloads of staff caring for people with dementia are commonly viewed as leading to higher levels of strain and lower levels of satisfaction than staff in mainstream LTC settings (Brodaty et al., 2003). Work pressures have also been shown to result in a more detached way of working whereby the psychological needs of residents are not recognised or permitted to impede staff members' ability to complete their allocated tasks (Sormunen et al., 2007). Within the three units it was evident that routine practice dominated and residents were afforded few opportunities to influence the routine. It is not uncommon for institutional care practices to dominate in LTC settings and advocates of a holistic approach to care are critical of care environments in which 'ritual and practice prioritise the systems rather than the individuals within it' (Heath & Phair, 2009, p. 143). To some extent the heavy workloads within the three units were self-enforced. Staff who participated in this study gave similar descriptions of their daily routine in which it was apparent that their desire to complete their allocated tasks took precedence over the individual needs of residents in the dementia facility or their desire to spend time in conversation with residents. Standardised care practices are known to have a negative impact on quality of care delivery (Cohen-Mansfield & Parpura-Gill, 2008; Heath & Phair, 2009; Murphy, 2007; Zimmerman et al., 2005) and on resident and staff wellbeing (Ryvicker, 2009). The conflict experienced by some staff in resolving the dilemma of task completion versus responding to resident needs appears to have been strongly influenced by the work practices within the dementia-specific environments.

Proficiency and quality of care

The majority of direct care in mainstream and dementia-specific LTC is provided by unregulated or paraprofessional staff (Access Economics, 2009). Personal carers or Assistants in Nursing (AIN) make up the largest proportion of the workforce (64% compared to RN's 17%) and this is expected to increase (Access Economics, 2009). This skill mix is reflected in the facilities from which the study sample was drawn. The importance of well trained and supported LTC staff is constantly reiterated in the literature and is seen as an essential component in attaining good quality dementia specific care (Alzheimer's Australia, 2010; Lai et al., 2007; Sormunen et al., 2007). The staff rated their ability to manage their daily resident interactions highly in stark contrast to the practical examples they gave of their day-to-day work practice. These indicated that they relied on a limited range of strategies to manage the complex needs and behaviours (BPSD) of the people with dementia in their care. It has been noted that staff members belief in their abilities is not always reflected in their objective performance in a challenging situation (MacKenzie & Peragine, 2003; Moniz-Cook et al., 2000). This has been linked to staff members' limited capacity to reflect on their own practice or may be related organisational standards of care resulting in staff modifying their practice to align with that of other staff members (Moniz-Cook et al., 2000; Sormunen et al., 2007).

Participants depended on co-workers to enable them to effectively complete their task allocation during their shift and indicated that they were strongly influenced by co-workers support and knowledge in managing complex resident behaviours. Their opinion of co-workers knowledge and experience was commonly related to the length of time a staff member had worked in a dementia-specific environment as opposed to any formal education or training the individual may have benefited from. This interdependence can be viewed in a positive manner if co-workers are well educated and there is a supportive workplace culture. However, it can result in poor work practices being replicated when staff skill sets are low or attitudes entrenched and the dominant culture is task, as opposed to resident, orientated (Sormunen et al., 2007). Although assumptions that higher grades of staff routinely provide better quality care than those of lower status have been challenged (Heath & Phair, 2009).

Quality of care is commonly identified as an issue of concern in LTC and more so in discussions on dementia specific care (Alzheimer's Australia, 2010; Cohen-Mansfield &

Parpura-Gill, 2008; Heath & Phair, 2009). The impact of work practices on quality of care is becoming increasingly recognised. Staff and organisational factors are known to influence quality of care. Staff factors include understanding and knowledge, proficiency and communication skills whilst institutional factors are related to the psychological and practical support staff receive and the degree of flexibility permitted in timing of care, delegation of tasks and responsibility and in resident and family involvement in care (Cohen-Mansfield & Parpura-Gill, 2008).

Environment and activity

Whilst efforts had been made to improve the physical environment of the facilities, the reality was that the environments were stark and opportunities for meaningful activity for the residents were limited. Two of the units had only limited access to an outside area. The impact of structural elements on care delivery is increasingly being recognised (Dilley & Geboy, 2010; Murphy, 2007) and advocates of dementia-specific design have questioned the ability of staff to deliver quality outcomes for residents in low quality environments (Fleming et al., 2008). In the main the participants did not freely comment on the physical environment in which they worked viewing it predominantly in relation to their capacity to maintain resident safety through monitoring residents for altercations or falls and containing them in a secure environment.

A focused activity program is seen to be an essential component of good dementia-specific care (Alzheimer's Australia, 2010; Lai et al., 2007). Programs within the facilities mainly consisted of large group activities and there was no consideration that the activities were in anyway inspiring or if the residents had any choice in selecting activities or participating in them. Some participants considered that group activities conducted by the Diversional Therapist (DT), and by implication the role itself, were only of value because they relieve staff from the responsibility of supervising the residents for short periods, allowing them to complete their tasks.

CONCLUSION

It is evident that for good dementia care to occur in a dementia specific unit, a number of factors need to be considered. These include the selection, training and supervision of staff, resident focused activity programs, physical separation from mainstream areas and inclusion of established design principles for physical environments for people with

dementia (Fleming et al., 2008; Lai et al., 2007). The interviews provided an opportunity to identify current practice and experiences in managing residents in three secure dementia-specific units and it became apparent that the only element that consistently applied to the three units under investigation was the fact they were physically separated from the mainstream areas.

A major strength of this study was the richness of data achieved from the individual interviews. The study findings provided insight into, how the care staff identify with and define their role and the impact this has on the relationships they form with both staff and residents and consequently the type of care they provide. The interviews highlighted a limited understanding amongst direct care staff of the person centred philosophy advocated by key management staff and also their opinion of available training and educational opportunities aimed at advancing their skills and knowledge.

Gaining an understanding of direct care staff perceptions of their role and how this affects their care practices is of great importance in identifying appropriate support structures and training strategies. The findings support the development of staff training and strategies to improve the quality of care provided and in particular to address the issue of limited understanding of person centred practices. The findings also support the need for flexible delivery of training provided at times convenient to staff (Moyle et al., 2010). Some aspects of care provision whilst acknowledged may be more difficult to address due to broader structural issues. Whilst it is apparent that changes need to occur to address endemic cultural practices at present there is a lack of incentive for LTC providers to improve care practices beyond current regulatory standards and levels of financial remuneration (Alzheimer's Australia, 2010).

Word count – 4942 [without abstract]

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Table 1: Overview of the 3 Dementia-specific Units

	Unit A (n = 20)	Unit B (n = 14)	Unit C (n = 21)	Total (n = 55)
Gender:				
Female (%)	-	100.0	90.5	60.0
Male (%)	100.0	-	9.5	40.0
Age:				
(Average Years)	78.6	88.4	86.8	84.2
Length of stay in dementia facility:				
(Average Years)	3.4	3.1	3.8	3.5
Residents with a health diagnosis of:				
Alzheimer (%)	35.0	64.3	42.7	45.5
Cognitive Decline (%)*	65.0	35.7	57.3	54.5

* Vascular Dementia, Dementia with Lewy bodies, Korsakoff's syndrome, cognitive impairment and schizophrenia with memory decline.

Unit A – Males only

Unit B – Females only

Unit C – Mixed gender

Table 2: Demographic & Professional Characteristics of Participants (N = 35)

	Unit A (%)	Unit B (%)	Unit C (%)	Total (%)
Age:				
20 – 29 yrs	38.5	9.1	9.1	20.0
30 – 39 yrs	30.8	45.5	-	25.7
40 – 49 yrs	7.7	18.2	36.4	20.0
50 – 59 yrs	15.4	27.3	45.5	28.6
60 yrs & over	7.7	-	9.1	5.7
Gender				
Male	38.5	36.4	18.2	31.4
Female	61.5	63.6	81.8	68.6
Profession:				
Enrolled Nurse	-	-	9.1	2.9
Registered Nurse	-	9.1	-	2.9
Personal Care Worker	84.6	90.9	81.8	85.7
Divisional Therapist	7.7	-	9.1	5.7
Workplace Health & Safety Officer	7.7	-	-	2.9
Employment Roster:				
Weekend Shift	15.4	18.2	18.2	17.1
Day Shift	69.2	45.5	63.6	60.0
Night Shift	15.4	36.4	18.2	22.9