EMPOWERING CAREGIVING FOR SENIORS LIVING WITH DEMENTIA

A Field Practicum Report
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Abstract

Growing older is beautiful but also challenging because of changes to the body, difficulties in completing familiar tasks, and other indicators which are associated with becoming an older adult. This document is a reflection of my experience during a field practicum at Parkridge Centre, a long-term care home managed by the Saskatchewan Health Authority. The report provides a brief overview of the agency, its services, programs, and resources. It goes on to provide an overview of the role of the social worker in offering care to seniors who have been diagnosed with dementia in a long-term care home using cognitive behavioral therapy as a tool. The report further examines what dementia is, the use of cognitive behavioral therapy, and how systems theory frames the delivery of services and care to older adults diagnosed with dementia in a long-term care home. The document goes on to examine the role of caregivers looking after older adults with dementia. It relates some of the challenges and successes of my experience, the clinical experience I obtained during the period of my practicum, and how it translates to my work as a social worker providing care to seniors in a long-term care home.
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Introduction

This section provides a brief introduction to the process of getting a field practicum placement. As I began the process of finding a placement for my practicum, I realized it was not as easy as I had thought. During the process of obtaining my Bachelor of Social Work, we only needed to let our supervisor know what our area of interest was and they would match us with placements. However, the situation was different for a Master’s degree. The proposal writing was very intense and I began to realize how much would be expected of me as I moved into the field practicum itself. I have always wanted to work with older adults and my experience with my father, who has dementia, sparked my interest in knowing more about the disease and how care can best be provided to older adults who have been diagnosed with dementia. Older adults are considered to be 65 years and older in this document; “most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person” (World Health Organization, 2002). In this report I will be using the term older adult as it applies to the age range that I will be focusing on.

After visiting Parkridge Centre to meet with the senior social worker, I concluded that I would like to know more about the care being offered in this setting. The dementia assessment unit at Parkridge is the only one in Saskatchewan. I was, therefore, delighted to obtain this learning opportunity. I interned at my field practicum from July to October 2018 and it was one of the best learning experiences I have ever had. The process of getting a placement was quite intense, but I was able to secure one that I enjoyed and through which I was able to obtain insight into dementia and how it impacts not just the individual but caregivers as well. Working with and providing care to seniors who have been diagnosed with dementia is tough and demanding; however, I am very privileged to have had this immersive, high-impact learning opportunity.
As I started my practicum, I put a lot of pressure on myself since I was the first MSW practicum student ever at Parkridge. I felt the onus was on me to set a high standard in order to pave the way for more students desiring to work with older adults or in long-term care homes. I had the opportunity to work in a neighborhood (South One), which is the Parkridge term for locked-down units (the doors had codes to ensure the safety of residents). In Parkridge we referred to the people in the homes as residents rather than clients, as we tried as much as possible to deinstitutionalize the setting and make residents feel at home. The next section describes this setting in greater detail.
Agency Review

This section provides an overview of Parkridge Centre, a little bit of information about how the center was established, their vision, the different professionals who provide services in the center, and the community resources available and agencies that work together with the center to ensure that residents receive the care they need. Parkridge Centre enhances and supports the lives of individuals with specialized needs in a home-like environment. Their vision is “living each day to the fullest along life’s journey” (Parkridge Centre, 2000). The Geriatric Re-enablement Unit at Parkridge Centre has adopted the concept of a community mosaic where residents with similar needs are grouped together in small neighborhoods with consistent staffing. The focus is on improving quality of life and health care for residents and providing a more satisfying workplace for staff. Children and youth who have severe physical disabilities and/or compromised cognitive function and who reside within the Saskatchewan Health Authority are also residents at Parkridge Centre. There are six neighborhoods in four types of mosaics at Parkridge: a self-directed mosaic, a team-supported mosaic, a cognitively supported mosaic, and a behavioral supported mosaic. The makeup of each of these mosaics is described below:

**Self-directed mosaic**: Residents who require Level 3 (residents with advanced but steady physical or mental illness) and Level 4 (residents who require constant medical attention but do not need to be in hospital) care. They function at a moderate level of independence and are able to advocate for themselves (Parkridge Centre, 2017).

**Team-supported mosaic**: Residents who are both cognitively and physically challenged, and require Level 4 care and higher. The challenge to caregivers is to find a balance between
quality of life and quality of care, to have the residents’ best interests at the center of all care, and to make decisions and work collaboratively with family members (Parkridge Centre, 2017).

**Cognitively supported mosaic**: These are individuals who have been diagnosed with dementia and have wandering behaviors. These residents occupy a total of 36 beds. They are 65 and older and require Level 3 and 4 care (Parkridge Centre, 2017). For example, Eastridge 1 residents have been diagnosed with dementia; each resident has a private room and half bath. Movement in and out of this neighborhood is controlled by magnetic door locks and is monitored by an alarm system. A respite bed is available.

**Behavioral supported mosaic**: These are individuals with a traumatic brain injury, a disease involving some form of nervous system dysfunction, or a physical or cognitive developmental disability (Parkridge Centre, 2017). These residents require support for the behaviors associated with their condition. For example, Southridge 1 also known as South One houses 35 residents requiring behavior management; movement in and out of this neighborhood is controlled by magnetic door locks that are linked to an alarm system to ensure the safety of the residents.

**Services, Programming, and Community Resources**

There are different interdisciplinary services at Parkridge Centre, e.g. physiotherapy, occupational therapy, speech language practitioners, respiratory therapy, therapeutic recreation, social work, and a community day program. The interdisciplinary services and community resources within the Centre are listed below:

- Palliative care services are designed to meet the needs of residents and their families.

  The Sudden Illness Sudden Collapse form (Saskatoon Health Region, 2016) is used as an advanced health care directive when a resident does not have one.
• Physical services provide holistic medical management in collaboration with the residents.

• Skin integrity services provide assessment, treatment, and observation of stages 1 to 4 of skin integrity (Parkridge Centre, 2017).

• Occupational health and safety services ensure the safety of health care workers and residents.

• Social work services provide brief solution-focused therapy approaches, a person-centered approach, grief counseling, and intake referrals to support the residents as well as their family members.

• Finance department ensures that residents have access to their finances.

There are also various commonly used programming and community resources, some of which are listed below:

• Acquired brain injury outreach teams consisting of rehabilitation professionals located in Prince Albert, Saskatoon, and Regina provide services in their respective geographic areas.

• Access transit service allows residents who are unable to use the regular transit transportation to travel in safety and with dignity.

• The Alzheimer’s Society is an early intervention service designed to connect individuals and families affected by Alzheimer’s disease or another form of dementia with services and support immediately after diagnosis. There is a formal referral from physicians and health professionals, which allows for proactive contact with individuals and families (Parkridge Centre, 2017).
• The Cognitive Disability Strategy provides services and financial benefits for individuals with cognitive disabilities who have significant behavioral and developmental challenges (Parkridge Centre, 2017).

• The Community Living Association supports choices for people with disabilities and their families in the areas of education, employment, housing, recreation, and respite. These choices may include support settings, congregated settings, or a combination of both. They make sure families are aware of the choices available to them and then assist them to make informed choices.

• Community Living Service Delivery is a branch of the Ministry of Social Services, which works with people experiencing intellectual disabilities and helps them access a variety of community-based services. They ensure that the physical, emotional, and social needs of people experiencing intellectual disabilities are met and that they are able to live as independently as possible within their own communities.

• The Canadian Institute for the Blind (CNIB) offers a range of community-based programming and services that empower Canadians who are blind or partially sighted. Certified specialists provide training that enables people who are blind or partially sighted to develop or restore key daily living skills, helping enhance their independence, safety, and mobility (Parkridge Centre, 2017).

• Client Patient Access Services (CPAS) helps individuals to be as independent as possible by sorting out individual needs, looking at options and choices, and connecting individuals with a variety of appropriate services and resources.

• Cosmopolitan Industries enhances the quality of life for adults with intellectual disabilities (Parkridge Centre, 2017).
- Mental Health and Addiction Services provides assessment and support to people living with a mental health diagnosis.
- The Office of the Public Guardian and Trustee protects the property and rights of individuals. They hold and administer unclaimed property and administer the estates of deceased persons (Parkridge Centre, 2017).
- Saskatoon Abilities Council supports people with disabilities through programs and services to enhance their lives.
- Saskatchewan Assured Income for Disability improves the quality of life for people with disabilities.
- The Saskatchewan Association for the Rehabilitation of the Brain Injured provides psychosocial rehabilitation and recreation services for acquired brain injury survivors.
- Saskatoon Housing Authority.
- Supplementary health benefits.

In addition to the above, every long-term care facility is required to have a resident council comprised of residents who take the time to represent other residents, provide input on the care provided, and deal with issues affecting residents in the home. Resident council is the face of the resident and it collaborates with the directors and leadership team to ensure the smooth running of the facility.

Parkridge Centre is unique in the city of Saskatoon as it has a vast array of resources available on site. This aids in the transition for most residents. The next section of this document looks at the role of the social worker within a long-term care facility.
The Role of Social Workers in a Long-term Care Home

Social workers in a long-term care home provide residents and their family members with a variety of services as outlined below:

- Psychosocial assessment.
- Advocacy to ensure residents have a good quality of life and receive excellent care within the long-term care home (Canadian Association of Social Workers [CASW], 2002).
- Assistance in adjusting to life in a long-term care home.
- Resources as well as referrals to agencies that will better support each resident.
- Discharge planning and case management services to ensure continuity of care and access to services in the home or community that will benefit the resident.
- Education related to illness, including problem-solving and coping skills.
- Support in dealing with end-of-life and palliative care issues.
- Assistance with social issues ranging from relationships with significant others to hostility and violence (Simons et al., 2012).

Social workers at Parkridge Centre perform the above roles and more. They shop for residents who do not have family members or friends within the city, especially those whose finances are managed through the Office of the Public Guardian and Trustee. Social workers assist residents in managing their finances, especially when there is no family involvement. They liaise with the finance department, collect the appropriate consent forms and tax documents to send to Edwards School of Business for residents who have chosen to have Parkridge Centre complete their taxes. Social workers assist in communicating, advocating, or requesting funds from outside financial institutions, such as the Public Guardian and Trustee, Ministry of Social Services, Canada Revenue Agency, SGI, NIHB, and other funding sources.
Social workers at Parkridge Centre also maintain long-term professional relationships with residents and their family members. They complete admission paperwork with residents and their family members, help with discharge planning, and organize family meetings (care conferences). They also provide social work assessment and case work services as part of an interdisciplinary team.

During my practicum at Parkridge Centre some of my responsibilities were:

- Looking after the respite admissions.
- Serving as the social worker in charge of the South One (S1) neighborhood, which houses residents who have been diagnosed with dementia and acquired brain injuries.
- Ensuring that all the needs of residents in S1 were met, especially those who didn’t have family members to support them.
- Organizing care conferences and ensuring the residents’ care plans were updated in conjunction with other health professionals working with the residents.
- Conducting home and site visits with the dementia assessment team to plan for the appropriate care for clients diagnosed with dementia.
- Ensuring that advanced care directives were in place for all the residents and, if there wasn’t one, filling out the Sudden Illness Sudden Collapse form (Saskatoon Health Region, 2016) to direct health professionals on decisions that would need to be made in case of an emergency.
- Using cognitive behavioral therapy (CBT) activities to engage residents who were still cognitively able to work on small tasks.
- Ensuring that all visits were documented following the standards of the Health Authority.
Advocating for clients who required programming but were unable to receive those services due to constraints and boundaries put in place by agencies. My practicum at Parkridge Centre provided me with a hands-on understanding of a social worker’s many roles within a long-term care home. It was supplemented by a literature review with a particular focus on cognitive behavioral therapy and systems theory as described in the next section.


**Literature Review**

In conducting my literature review, I focused on two main approaches, cognitive behavioral therapy and systems theory. In particular, I examined how both can be put into practice when providing care to older adults who have been diagnosed with dementia and their caregivers (family and professional) to ensure they get the care they need to maintain a good quality of life.

**Cognitive Behavioral Therapy**

Before commencing my practicum at Parkridge Centre, one of the objectives I had set for myself was to develop a working understanding of the use of cognitive behavioral therapy (CBT) when working with older adults. CBT is “based on a cognitive model of the relationship among cognition, emotion, and behavior” (Chand & Grossberg, 2013, p. 10). It aims to equip an older adult with skills to modify distorted underlying beliefs, principally through techniques of identifying and testing the validity of such biased thoughts (Wilkinson, 1997). Research has been conducted into CBT’s ability to change older adults’ ways of thinking, especially those who have been diagnosed with dementia, to help such individuals manage their negative thoughts as well as to help minimize caregiver stress. According to Palazzolo (2015), “CBT is a brief, structured psychotherapy that focuses on the key roles that cognitions and behaviors have in the onset and maintenance of mental illness” (p. 2). Another publication defined CBT as “a brief, structured psychotherapy that focuses on the key roles that cognitions and behaviors have in the onset and maintenance of mental illness” (Sorocco & Lauderdale, 2011). CBT is teachable and client-centered, which means it is easy to use with older adults. Parkridge Centre focuses on resident-directed care through language which provides a positive way to inspire residents. This allows residents to direct their own care by ensuring their voices are heard. As much as I would have
loved to use this therapy successfully with the older adults I worked with at Parkridge Center I quickly realized that it was very challenging due to the fact that it had a lot to do with one’s cognitive ability. I discussed extensively on the challenges I faced working with this population which is discussed in a later section of this document. CBT was rather helpful with caregiving and easing the stress of caring for older adults that have been diagnosed with dementia. However I felt I had to work with this population in order to have a good understanding of what it is to provide caregiving to them as well as be able to come up with recommendations that will benefit the caregivers and ease the stress of caregiving to older adults that have been diagnosed with dementia. Certain themes emerged from my research as outlined below.

**Transition.** What does transition mean for each individual? How does each individual adjust to this phase in life? These are two of the questions that arose as I read through the literature. Chand and Grossberg (2013) suggest that knowing the meaning of transition for each individual will greatly impact the way CBT can help them. Transitions can trigger different feelings or beliefs based on how it is interpreted. Some may feel they have enjoyed a good life and made use of the opportunities they had and some may feel they have experienced lots of missed opportunities and reflect on unattainable goals (Chand & Grossberg, 2013). Beliefs are usually based on an individual’s thoughts and how they perceive a situation or circumstance (Beck, 2011). I found this differed based on the culture each individual identified with. Some of the individuals and family members that I spoke with during my practicum talked a lot about things they had done and achieved before the progression of dementia and expressed feelings of depression based on their lack of independence. Some talked a lot about the losses they had experienced and sometimes they felt that, if they had not been diagnosed, they might have had an opportunity to pursue their unmet dreams. Some older adults also felt their sense of
independence had been taken away as they transitioned from their home to a long-term care facility. Transition-induced anxiety and depression is very common with older adults who have been diagnosed with dementia (Kraus et al., 2008). CBT helped some of the individuals that I worked with to reduce their level of anxiety as suggested in the literature (Kraus et al., 2008).

During my practicum I worked with some older adults who had been diagnosed with dementia and their family members. As I read through their charts, I came to understand more about their lives before the onset of dementia. Many of them had gone to school, gained an education, and worked in professions of their choice. They had built family lives of various types. There was a particular lady I did not work closely with; our only encounter was when she showed me her room. I had never seen such beautiful paintings before and I was just mesmerized by the artwork in her room. She told me it was her husband who had done all of the paintings while she did some other form of art, which complemented her husband’s paintings. Although she is still present, she is not able to create the beautiful artwork she used to create because she says she is unable to sit still. This is a very good example of life before and after being diagnosed with dementia.

Whenever I had a chance to chat with individuals with dementia, they would tell me about what they used to do and things they usually had fun doing. Some even talked about their families and how they felt they had let their family members down. I began to think about how to help them manage their feelings in the moment and work with them “wherever they were”. CBT “aims to equip a patient/client with skills to modify distorted underlying beliefs principally through techniques of identifying and testing the validity of such biased thoughts” (Wilkinson, 1997, p. 53). I usually told them it was okay to show emotion but that it wasn’t their fault and they did not have to feel judged.
Behavioral techniques. According to Chand and Grossberg (2013), “behavioral techniques are used to bring about functional changes in behavior, regulate emotions and regulate the cognitive restructuring process” (p. 11). The concept of behavior change stood out in all my research, especially as it is impacted by the use of CBT. CBT tends to have a significant influence on behavior and how it can be managed. Older adults who have been diagnosed with dementia tend to exhibit different behaviors that may be new or strange. Some will become unable to recognize familiar faces, while others begin to exhibit violent behavior. CBT allows these behaviors to be managed using different techniques (Cox & D’Oyley, 2011). In my work at Parkridge Centre, one of the techniques that worked well was redirecting. I found that this helped a lot and sometimes just following the cues of the individual made a lot of difference and enhanced quality of life.

While working at Parkridge, I realized that dementia can affect anyone, regardless of age. Before going into the practicum I believed that dementia was an older-adult diagnosis, but on arriving at Parkridge I realized that this was not so because we had individuals as young as 50 who had been diagnosed with dementia. Although using CBT was very challenging with this group of individuals, the specific techniques allowed me to work with them; especially with caregivers, which I will expatiate more in the next section. CBT also taught me a lot about patience. I thought I had learnt to be patient when I had children, but I was wrong since doing my practicum at Parkridge taught me much more about patience and perseverance. When I meet an individual for the first time I usually try to get to know them, even though I may have read their file. I like them to tell me whatever they can remember about themselves. In our next meeting I usually go with activities that will help the individual that I am working with show me what they like and what they would like to achieve. Some of the worksheets I used at Parkridge
are shown in Appendices A and B (TherapistAid, 2012). The worksheets enabled me to connect well with the older adults and understand them better and helped the individuals to manage their thoughts, emotions, and behaviors. Sometimes we were unable to achieve anything, especially if the individual was unwilling to work with me, and this is where patience came in. However, there were times when the residents were waiting for me with great enthusiasm.

Research has shown that CBT is very helpful in dealing with depression and behavior disorders in older adults. Older adults with dementia are susceptible to declines in their health since most of the body’s functions are controlled by the brain; however, when the brain itself is distorted, there is little or nothing that can be done. When that is the case, we then seek ways to manage the diagnosis and maintain a good quality of life. Many older adults who have been diagnosed with dementia struggle with change since they are no longer able to manage on their own as they used to. They depend on others to assist them with various things like decision-making, personal care, and daily living.

Challenging behaviors in older adults who have been diagnosed with dementia can be stressful for caregivers. Krishnamoorthy and Anderson (2011) state that remaining calm and staying in control is usually essential in managing these behaviors. They also suggest that caregivers should view challenging behavior as a mode of communication rather than as a problem. Wilkinson (1997) used a case study to illustrate that using behavioral techniques helped to improve memory and eliminate caregiver stress. Caregiver stress when dealing with dementia resonates with me because I have a personal story to share. My father had a fall last summer and hit his head. He was taken to the hospital and was certified okay; however, we began to notice that he could not remember things as he did before and we had to take him to the hospital a second time. We were then informed that his frontal lobe had been affected, which was attributed
to the fall. We were also told that old age had set in for him and there was nothing that could be done. My mother is his sole caregiver and this has been very challenging for her because my father used to be very independent. It was very difficult for her to provide him with the care he needed due to his symptoms and behavior, which had been brought on by dementia.

Krishnamoorthy and Anderson (2011) have stated that “before any treatment can be formulated, the challenging behavior needs to be understood and for this a person-centered approach is essential” (p. 20). So, what is a person-centered approach/therapy?

Person-centered psychotherapy (also known as client-centered or Rogerian therapy) is a form of talk therapy developed by Carl Rogers in the 1940s and 1950s. The purpose of this form of therapy is to increase a person’s feelings of self-worth, reduce the level of incongruence between the ideal and actual self, and help a person become more fully functioning (Rogers & Rogers, 2012).

I told my mother that she would need to be very patient with my father and made her realize that it’s not him who is the problem but the disease he is struggling with. I gave her some behavioral techniques that might be useful in helping her to provide the care that my father needs and encouraged her to avoid confrontation but to try as much as possible to maintain eye contact with him. I also highlighted the importance of observing and reading his body language, which would help her relate with him and understand his needs better. So far this has been working well and it has allowed my mother to feel more confident in her ability to provide him with adequate care. This has eased the self-doubt and attendant frustration, resulting in her becoming less stressed.

**The role of the therapist.** The therapist’s role stood out in most of the literature I read and led me to consider the role of the therapist, their goals in working with an individual, and what they aimed to accomplish. When using CBT, the role of the therapist is very important in
ensuring that an older adult who has been diagnosed with dementia is still able to function well with the provision of some help. The therapist is usually in charge of therapy sessions and can keep the session on track. (Fischer, 2015). However, this is more difficult when working with older adults since they tend to digress a lot and need to be brought back on track. I found this was the case most of the time when I worked with the older adults and their caregivers at Parkridge. I had to be patient and try to ensure that some if not all of the session goals were achieved.

It is important to set boundaries in our work as social workers. Value Four of the Canadian Association of Social Workers’ (CASW) Code of Ethics refers to “integrity in professional practice” (CASW, 2005). Part of maintaining integrity in professional practice is setting boundaries when working as a therapist; it is important to state the purpose of the session and also the desired goals. As much as it is the goal of every therapist to achieve the goals they set with the clients they work with, it is also important to have a good understanding of the individual and his/her diagnosis using a person-centered approach. Krishnamoorthy and Anderson (2011) have suggested that, before commencing with sessions, it is important to have a good understanding of the behavior the individual might be exhibiting due to dementia and to set boundaries around those. During my practicum I had an opportunity to work with a lady and the first time I met her I introduced myself and told her a little of why I had been told to work with her. She gave me a brief history about herself and the things she used to enjoy doing at home prior to moving into Parkridge. Before going to meet her I had been given some information about her not wanting to be active and wanting everyone to do things for her. As we proceeded I mentioned to her that I might not do certain things for her if she asked. After I laid down the boundaries we spoke for some time and soon it was the end of the session for the day. The next
time I met her she told me she was not feeling well and she had already refused physical therapy for a couple of days. She had also been refusing to go out for her meals and wanted meals brought to her. When I walked in, she was sitting on the bed and she asked me to get her a cup of juice that was on the table beside her bed. I showed her where the drink was and asked her to pick it up; she did so reluctantly, but that affected the session for the day. I often noticed this while working at Parkridge Centre: if you did everything for the residents, they liked you, but it wasn’t good for them because physical movement is encouraged in order to maintain a good quality of life. Having the ability and the courage to say no, especially when working with older adults, is a good way of setting boundaries (Tumlinson, 2015). Although I find boundary-setting hard to do, it is usually very effective because the client understands why you are there with them. As much as I felt badly for not handing the cup of juice to the resident, I knew it was a good way to challenge some cognitive distortions e.g. “if they care about me they will give in to my wishes” but rather help her see that her team of health care professionals care about her and are working together for her good and wanted to ensure her continued quality of life.

Another role of the therapist in any session is to maintain an interaction with the client. It is not always easy to connect with clients and it usually takes a few sessions before clients begin to warm up to the therapist. It is the role of the therapist to not give up but to continue to work towards making the connection and ensuring that the interaction is maintained both in and between sessions. Chand and Grossberg (2013) suggested that it is important for the therapist to make “appropriate adaptation” when needed, i.e., when one process is not working, it is important to seek other ways to enhance interaction in order to achieve the session’s goals. When working with older adults who have been diagnosed with dementia it is particularly important to use fewer words, speak slowly, and be conscious of their body language. Chand and
Grossberg (2013) also suggest it is important to present new information along with some of the previous experiences they have had as that adds to their cognitive repertoire, which makes learning easier by connecting new information with previous life experiences.

In making a connection with a client, it is very important for the client to feel comfortable in their environment and have a sense of safety. In my case, I usually met residents in their rooms and, because it was summer, some residents would request we meet in the courtyard to get some fresh air. We would walk together from their room to the courtyards or gardens. I usually allowed them to pick the spot where they would like to sit but would have informed them earlier that we might not be able to talk about private issues due to confidentiality. The residents, based on how advanced their dementia was, would be mindful of what was being said and some would decide to sit away from other people so that they were still able to talk and share freely. As I stated earlier, the use of CBT for me was challenging due to the population I worked with. However, use of CBT still greatly impacts caregiving for this population, which is discussed further in the next section of this document.

**Systems Theory**

The second approach I reviewed was systems theory, which focuses on working with individuals and groups, as I consider an individual and their family members to be a group. My question regarding this theory was: How can systems theory inform the use of CBT? My practicum experience shed light on this question and I was able to focus on both theories and understand how they are interwoven and can be used successfully when working with individuals who have been diagnosed with dementia. This helped me to understand family members’ concerns in providing care to individuals who have been diagnosed with dementia.
Firstly, what is systems theory? Mele, Pels, and Polese (2010) explained systems theory as “a theoretical perspective that analyzes a phenomenon seen as a whole and not as simply the sum of elementary parts” (p. 127). I also like the definition used on the Good Therapy website (2017) which defined this approach as “The multidisciplinary study of systems to investigate phenomena from a holistic approach, systems, which can be natural or man-made and living or nonliving, are found in many aspects of human life.” Both definitions note that systems can be made up of different elements, i.e., internal and external, but they influence each other. Individuals cannot be separated from their environment because they influence each other.

Systems theory usually considers the whole rather than the part, i.e., a portion of a thing cannot be focused on but rather the whole (Checkland, 1999). An example is the human body, which is made up of different systems (e.g., nervous system, digestive system, reproductive system, etc.). The body cannot function as a whole unless all these systems work. This is the concept behind systems theory. Individuals who have been diagnosed with dementia share a common diagnosis. However, these individuals vary in class, gender, race, etc. and all these factors affect their systems, making them exhibit various challenging behaviors, which are a result of the factors that make them unique. I was able to observe the use of systems theory in practice at Parkridge Centre and also immersed myself in the relevant literature. Outlined below are the major themes that emerged from the literature and ways in which I was able to apply them in practice during my practicum.

**Interaction.** An important concept behind systems theory is its focus on interaction (Mele et al., 2010). Systems theory is heavily influenced by interactions and how these can cause a certain behavior in an individual. People are wired to communicate and this allows interactions to happen (Walker, 2012). Individuals are not able to cope if they are unable to interact with one
another; it is, therefore, an essential part of human lives. Although individuals who have been diagnosed with dementia may not be able to communicate their needs, they still need to interact with family members and health care professionals to ensure a good quality of life. A focus on interaction allows for a better understanding of an individual, their functioning ability, as well as what outcomes to expect (Mele et al., 2010).

During my practicum I was able to understand the value placed on interaction. I had the opportunity to observe other health care professionals who provided care to individuals in South One. I observed that they maintained interaction with these individuals throughout the time that they were with them. A particular gentleman who had been diagnosed with dementia had refused to eat and the nurse who was working with him asked why he had not been eating, and all he said was that he did not feel like it. The nurse, having tried different methods, decided to call a family member who spoke with the gentleman on the phone. You could see his face light up as he spoke on the phone. Later he told the nurse that he had missed his brother and wanted him to visit, but unfortunately his brother could not make it at the scheduled time; hence, he refused to eat. This gave me a better understanding of how important interaction is for people.

**Relationships.** Systems theory observes the ways in which relationships are made and organized (Walker, 2012). As mentioned earlier, individuals cannot be separated from their families. Systems theory acknowledges this connection, hence observing the relationship between an individual and their family will help the therapist better understand family dynamics (Flammand, 2018). Rather than tackling a problem by dealing with the individual on their own, systems theory works to involve the broader family with the hope of understanding the relationship that the individual has with the rest of the family members while also looking at
other factors in the family that could contribute to a person’s behavior (Walker, 2012). Walker (2012) listed some key points when working with individuals from a systems theory perspective:

- The parts of a family are interrelated.
- A part of a family, i.e., an individual, cannot be understood in isolation from the rest of the system.
- Family functioning cannot be fully understood by simply understanding each of the parts separately because all of these parts make up the family.
- Family structures and organization are important factors that determine the behavior of family members.

When dealing with individuals it is important to know that such individuals have a relationship with other members of their family; hence, they cannot be separated. Based on my experience at Parkridge Centre, it is very important to work with families as a whole, and I found it was easy for me since the Centre uses a family-centered model in providing care to their residents. This means that family members are involved in the care provided to individuals in the Centre.

Part of my objective as a student social worker was to understand the importance of systems theory and how it can be used with individuals who have been diagnosed with dementia. The care conferences held every year are an example of the relationship that is maintained to ensure that an individual is well taken care of, irrespective of their diagnosis. As social workers we ensure that the voices of the vulnerable are being heard. Walker (2012) identified the need for social workers to discover their core skills, in order to enhance decision making and care planning which will be unique to each individual and their personality. During my practicum experience I worked alongside individuals and their family members. Most of the individuals I worked with had been deemed incapable of making decisions; hence the onus fell on family
members to make decisions on their behalf. Also, because many of them were cognitively impaired, they relied on their family members for their daily needs, e.g., toiletries, clothes, shoes, etc. This is why I tried to maintain a good relationship with the family members because the individuals that I worked with relied on them so much. Some also had family members managing their finances and ensuring their bills were paid on time as well as taking time out of their busy schedules to visit.

Although they may seem different, systems theory and CBT go hand in hand. Based on my experience, they complement each other and can be used together, especially when dealing with individuals who have been diagnosed with dementia and other psychological problems. The next section takes a closer look at the role of caregivers when looking after older adults with dementia.
The Role of Caregivers Looking After Older Adults with Dementia

Caring for older adults who have been diagnosed with dementia can take a toll on the caregiver. Alzheimer’s disease is described as “the most common form of dementia is a progressive, degenerative loss of cognition affecting physical and cognitive function, socialization, and behavior” (Messinger-Rapport, McCallum, & Hujer, 2006). Caring for someone with dementia can be very challenging and frustrating and can lead to physical or violent aggression towards the individual living with dementia. Providing care for an older adult always requires a lot of patience, but caring for older adults who have been diagnosed with dementia requires even more patience and perseverance as discussed earlier.

Older adults living with dementia cannot function well, so the caregiver’s role in their lives is very important (Forstmeier, Maercker, Savaskan, & Roth, 2015). Brodaty and Donkin (2009) have stated that “Without caregivers, people with dementia would have a poorer quality of life and would need institutional care more quickly, and national economies would be swept away by the advancing demographic tidal wave.”(p. 217). It is very important for caregivers to have a good understanding of dementia and how it can best be managed. For example, many times older adults who have been diagnosed with dementia do not have control over their behaviors and cannot comprehend the fact that they will need to rely on another person for care and support in order to continue to have a good quality of life (Satre, Knight, & David, 2006).

Caregivers, apart from professional caregivers (e.g., nurses, doctors, care aides in a long-term care home), are usually family members. Various burdens; physical, financial, and emotional; are associated with their role as caregivers (Connell, Janevic, & Gallant, 2001). Social demographics also play a role. Based on my observations during my practicum, the majority of the family caregivers were women, either spouses or daughters, and I attribute this to
females having a caring and loving nature. This is not to say the male gender cannot provide care, but it does correlate with what I noticed during my practicum and what is stated in the literature (Messinger-Rapport et al., 2006).

Culture also plays a significant role in how caregiving is provided. I have shared a personal experience about my father with my mother being his sole care provider. In Nigeria, children tend to provide care to their parents as they grow older. Parents will move in with their children and live with them until they pass on. My grandmother had lived with us till she passed on at 102 years old. In Nigeria, there is a sense of community where family members support one another.

Nigeria has a culture which encourages children to take care of their parents as they get old. Keeping the elderly at home creates a good relationship among family because life is too short. This gives family enough time to spend some time with their loved ones, thus appreciating every moment they have with each other. There are no regrets felt by the children when these elders die because they will never forget the days they had together, which is a memory that will stay with them for a long time. (Ubaike, 2015)

At present, both my parents live in their own home and my siblings take turns to visit and provide support. A long-term care home is not an option for us because it is not the norm in our culture, and my parents will move in with us when they are ready. During my previous work with KidsFirst, I worked with a young mum from Pakistan who at the time was providing care for three children under five as well as her aged mother-in-law. She told me that once parents in her culture grow older they usually move in with their children.

Providing care to older adults is very demanding and individuals who perform this task should be provided with significant support. How then do we provide support to caregivers,
especially those who provide care to older adults living with dementia? Knowledge of available resources that can provide support is crucial. Physicians also play an important role with this population and their caregivers and are able to connect them with the resources they need on time. (Sadowsky & Galvin, 2012). Parkridge Centre usually offers respite care, defined as “planned or emergency care provided to a child or adult with a special need in order to provide temporary relief to the family caregiver of that child or adult” (Lifespan Respite Care Act, 2006). Respite care allows families to take a break from caregiving. Some of the families I worked with were going on a trip and respite care ensured that their family member would be well cared for, even when they were not available. Meeting and talking with other caregivers of older adults provides a sense of community in which caregivers can support one another by sharing experiences that could benefit others.

I will adopt the themes that came up in my research of CBT used with caregivers because it provided information on how older adults living with dementia can be well taken care of. It also allows caregivers to understand the behaviors that this population can exhibit as a result of their diagnosis. The behavioral techniques suggested will help caregivers manage these behaviors and continue to ensure that they are provided with good quality of life. The role of the therapist can as well be the role of the caregiver because they are providing care to the individual.

The aim of CBT for caregivers is to modify dysfunctional thoughts about caregiving and increase the provision of gratifying activities to care recipients. CBT for caregivers includes relaxation techniques and skills for seeking help. Applying CBT to caregiving for people with dementia generally allows them to learn specific cognitive and behavioral
skills for coping with the problems of people with dementia and to familiarize themselves with such skills. (Kwon, Ahn, Kim & Park 2017, p. 402)

The research also further explains that CBT can help caregivers develop skills that will continue to maintain the quality of life of people diagnosed with dementia and help in reducing their own psychological distress (Kwon et.al. 2017).

During my practicum, I had the opportunity to share some of the information I received with caregivers of older adults living with dementia. One of the caregivers I had worked with expressed her concerns with struggling to understand why her mother behaves the way she does. She stated that her mother does not like to do things herself and was always demanding help. I explained the diagnosis to the caregiver and also encouraged the use of some behavioral techniques used in CBT. A greater understanding of the demands on caregivers of older adults living with dementia was an important part of the professional development I received during my practicum at Parkridge Centre. I discuss my professional development in greater detail in the next section.
Professional Development

Value Three of the CASW Code of Ethics (Canadian Association of Social Workers, 2005) talks about service to humanity, which I believe is the bulk of what we do as social work professionals. Essentially social workers should strive to provide service in any area they can in order to meet the needs of the clientele they are working with. The wealth of knowledge I gained during my practicum at Parkridge Centre is something I will not forget. I was able to work with different professionals brainstorming about how to provide the best care for the residents and to learn about the policies, mandate, treatment philosophy, and methods of providing care to seniors at Parkridge Centre. I was able to train and work with some departments which would not have been possible if I had not been a practicum student. I worked alongside the dementia assessment team, which is the only one we have in Saskatchewan. The dementia assessment team (DAT) provides support to individuals who have been diagnosed with dementia and are exhibiting behaviors that make it difficult for caregivers to provide care. The team is made up of a social worker, psychologist, occupational therapist, and a psychiatrist. One good thing about this team is that they are able to meet people in their homes or in the facilities where they are receiving care. Referral to the DAT is usually made by a physician or a care provider. I had the opportunity to go with the team to one of the long-term care facilities in a smaller community outside of Saskatoon to meet two individuals who had been referred to the team. The psychologist went in to meet the individuals while the social worker, who was my supervisor, and I stayed in the office to read their charts. Later, we all talked together and came up with suggestions for how to best provide care for these individuals.

During these visits I was able to learn the signs of dementia as well as coping skills for caregivers, i.e., health professionals and family members. I realized there is a difference between
the behavior and emotions caused by dementia. Some of the signs of dementia are hallucinations, delusions, repetitive vocalizing, pain, etc. Use of the direct observation tool (DOS) was also recommended (DeMarco, 2018). DOS is a tool that shows patterns of behavior on one page, charted over a seven-day period using color coding. Behaviors may include sleeping, physical aggression, and hitting. An interpretation of the DOS is provided in Appendix C. When working with older adults who have been diagnosed with dementia it is important to take note of the “three D’s”; dementia, depression, and delirium; because they all work together. Working with the dementia assessment team also taught me how to use the pain assessment scale which is used in advanced dementia (Saskatchewan Health Authority, 2018). The scale allows symptoms to be placed in categories in order to ascertain the diagnosis; however, sometimes symptoms don’t fit into categories, which can make it hard to ascertain a diagnosis.

I also had training in gentle persuasive approaches in dementia care, which is training in how to understand a person with dementia and how to interact well with them. The training also explained the relationship between the disease and a person’s behavioral response (Bliss, Martin, & Kafato, 2014). Person-centered care is very useful in providing a foundation for this philosophy in care settings. Kitwood (1998) pointed out the difference between a person and their disease and emphasized that individuals with dementia are individuals first with many remaining strengths. This helped me to understand that older adults who have been diagnosed with dementia had other lives before their diagnosis and should be treated with respect and patience. I learned how words can be used to make a positive impact in the life of an individual. It also taught me to always figure out the trigger for every emotion shown or observed and ensure that I leaned towards the positive emotions rather than the negative ones. One of the psychologist’s suggestions was removing oneself from the situation, i.e., if an individual begins
to exhibit some behaviors, the caregiver is encouraged to leave the situation and come back later. “Going with the flow” was another suggestion because it just makes things easier for the person who has been diagnosed with dementia. Current research also suggests that meeting individuals where they are at and validating their present situation is also helpful (DeMarco, 2018). The use of reset techniques and redirecting is also encouraged.

Additionally I was trained in purposeful interaction, which centers on ensuring that I am able to have meaningful interactions with people who have been diagnosed with dementia. This training enabled me to have a better understanding of how to provide care to individuals who have been diagnosed with dementia and how to best meet their care needs. During my practicum I noticed that some of the residents had suicidal ideations and I had to ensure their safety before talking through the issues with them. One resident always talked about how much she would like to move out, but unfortunately there was nowhere else she could move to, based on her diagnosis as well as her impaired mobility. My supervisor and I worked with this resident to ensure that she continued to get the care she needed to sustain a good quality of life.

During my practicum, I was usually the one who met with people and their family members since I was responsible for the respite admissions. This gave me an opportunity to meet with residents and their families, talk about their diagnosis, daily routine, and things they have always loved to do; which allowed the health professionals to construct a care plan that guided service delivery for the individual while they were at Parkridge Centre. Sometimes the family members who were seeking respite for their loved ones asked questions that I was unable to answer so having the support of my supervisor, nurses, and quality-of-life managers was invaluable.
I was assigned as the social worker for the South One neighborhood, which had approximately 35 residents who had been diagnosed with some form of dementia or acquired brain injury, and I had the privilege of working hand in hand with different health care professionals. This allowed me to view other people’s perspectives as well as their ideas and brainstorm together in order to ensure that residents’ care needs were met. I was astonished at how much the caregivers genuinely cared about the residents’ best interests, ensuring that they were provided with the best care. I was also able to link my training with the themes that emerged in my literature review and to share what I had learned with other health care providers and family members. I was able to learn a lot, which will be very useful for me in my future social work practice. This learning also included the ethical considerations underlying the care of older adults with dementia as outlined in the following section.
Ethical Considerations

During my practicum I ensured that ethical considerations were a top priority and I was able to guide myself with the CASW Code of Ethics (CASW, 2005). I count myself privileged to have been able to do my practicum at Parkridge Centre where they uphold very high ethical standards. I found that working alongside other social workers who were bound by the same Code of Ethics made my job a lot easier.

Confidentiality was observed and respected and was always emphasized during our social work huddles as well as when we were observing rounds with other health professionals. We usually referred to residents by their first names and the first letter of their last name. This upholds Value Five of the CASW Code of Ethics (CASW, 2005), which upholds “confidentiality in professional practice.” This value was well observed at every point of contact with residents, which kept residents and their family members safe.

The concept of dependency fits well with social work and anti-oppressive practice. Many older adults tend to rely on family members and a health care team for support and are sometimes taken advantage of. Some anti-oppressive theories ascertain that power and institutions can be oppressive (Dominelli, 2002). Parkridge was quite different from other care homes I visited during my practicum. In other care homes there are usually set times for meals, but in Parkridge the management and health care professionals tend to work with the residents’ wishes, which is why a care plan is necessary. The care plan also supports the vision of Parkridge Centre, which focuses on resident-directed care, supporting the systems theory school of thought that an individual who has been diagnosed with dementia cannot be separated from the things they are used to (Checkland, 1999). The care plans list the residents’ preferences and the health care professionals tend to work with what has been stated by the resident, the resident’s caregiver, or
family members. Older adults tend to become more dependent on their caregivers and sometimes look to family and caregivers to make some decisions for them. Having an anti-oppressive practice enables the residents to feel less needy and to play a role in their own decision-making or the creating of their own care plan.

Older adults in long-term care homes are very vulnerable as they are dependent on the health care professionals around them for most of their care needs. This can sometimes put social workers and other health care professionals in the position of being authoritative and making decisions based on what they feel is best for the resident. During my practicum there were times that older adults did not have family members to make decisions for them and usually the decision-making was left in the hands of the physicians, nurses, and social workers working with them. Value One of the CASW Code of Ethics (CASW, 2005) reminds us to show “respect for the inherent dignity and worth of persons”.

As a social worker I sought to advocate for equitable treatment as well as ensure that people are connected with the resources they need in accordance with Value Two of the CASW Code of Ethics (CASW, 2005), “pursuit of social justice.” In considering the resources for older adults in long-term care homes who had been diagnosed with acquired brain injuries (ABI)\(^1\), I was surprised to learn that preference was given to older adults who had ABI from sources other than drug use or indecent lifestyle. I worked with a lady who was diagnosed with ABI due to drug use and I tried to find programming that would help her, but this proved difficult. Many of the places I contacted said she did not meet the criteria or was outside the agency’s age criteria.

\(^1\)“An acquired brain injury is damage to the brain after birth and is not due to a congenital disorder developmental disability or a process which progressively damages the brain” (Chen, Bushmeneva, Zagorski, Colantonio, Parsons, & Wodchis, 2012)
Inability to provide the resources needed for this individual made me reflect on how important it is to ensure that everyone has the individual’s best interests at heart and that there should not be roadblocks put in place, especially when it has to do with the health and quality of life of individuals. This may require a person-in-environment approach rather than simply judging the individual.

Assuming the responsibility of being the social worker for the South One neighborhood as an intern, allowed me to meet family caregivers, work on care plans for each resident, and coordinate care conferences. A care conference usually comes up once a year and the different health care providers are in attendance, including the physician and family members. The unique thing about this is that the conferences go ahead even when family members don’t show up, which shows the passion health care providers have towards the care being provided at the Centre and in upholding Value Three of the CASW Code of Ethics, which identifies the importance of “service to humanity” (CASW, 2005). Social workers have advocated and will continue to advocate until there is a change for the better. For example, Drover (2008), on behalf of the Canadian Association of Social Workers, advocated for senior women whose income was too low to sustain them to receive an increase in their Guaranteed Income Supplement (GIS) so that they were able to meet their daily needs.

In addition to reflecting on ethical practices, my practicum showed me that there are challenges in any setting. The challenges I faced during my practicum are described in the following section.
Challenges

My practicum experience was worthwhile; however, as in any setting, there were challenges, which I viewed as opportunities to grow and do better. I had done a lot of research on cognitive behavioral therapy (CBT) and looked forward to using it with some of the older adults in the long-term care home who had been diagnosed with dementia. Chand and Grossberg (2013) noted that “clinical experience indicates that older adults in relatively good health with no significant cognitive decline are good candidates for CBT”. (p. 12). However, I quickly realized that dementia impairs older adults’ cognitive ability, which makes it challenging to use CBT effectively. Although I was able to use the approach with some older adults, it was difficult because their cognitive ability is unable to store as much information as it used to. A 2019 article by the Alzheimer’s Society stated, “CBT in its current form cannot be used to help people with dementia as it requires thinking and memory abilities that may be affected by the condition.” As a result, CBT can be very challenging to try to use with older adults diagnosed with dementia. For example, I had to do a lot of rescheduling of meetings. Sometimes when I met individuals at the time slated, they were sleeping or engaged in some sort of therapeutic session, i.e., occupational therapy or physical therapy. I usually suggested I could come back at a later time or day if they were willing. I was supposed to meet one-on-one with one of the ladies in the neighborhood and as I got there I met her on her way out with family. I would have loved to have had the opportunity of using CBT with a lot more people. However, this is where patience comes into play; I had to be understanding and move at their pace. I did observe a change in the level of anxiety of older adults that I worked with simply based on the fact that I would be using some CBT techniques with them. This is supported by research stating that “case reports have
shown positive results of CBT for anxiety and depression in persons with dementia.” (Kraus et al., 2008, p.2).

Coming into this practicum I was under the impression that caregivers were taking away too much of older adults’ independence and began to research ways in which they could provide care without taking away people’s independence. This practicum opened my eyes to the struggles that caregivers go through in order to provide care for their loved ones. I had the opportunity to meet a couple where the husband had been diagnosed with dementia. He still remembered all he used to do and relives it all the time. He talked as if he was still working and was surprised when his wife said that he had stopped working a few years back. His wife was struggling with how to manage his care at home and sometimes did not feel safe around her own husband. So many of the things he used to do were no longer possible because it might be risky. For example, the wife said he was no longer able to cook because he usually doesn’t remember that he is cooking and has in the past forgotten things on the stove, which is a safety concern. However, the husband believes he is able to continue to do all these things; he doesn’t realize that his cognitive ability has been impaired and feels that his independence is being taken away from him. I am very passionate about older adults maintaining their independence and this challenged my way of thinking since I could not provide a right or wrong solution to this aspect of providing care for older adults who have been diagnosed with dementia.

Another task that was very challenging for me was when I had to fill out the Sudden Illness Sudden Collapse (SISC) form (Saskatoon Health Region, 2016) with family members whose loved one did not have an advanced care directive (ACD) before being diagnosed with dementia. The form is usually filled in with two health care providers in attendance, so I usually had nurses with me to fill out these forms. A copy of the form can be found in Appendix D. I
found it very difficult to ask family members about the questions on the form. SISC lists the family members’ wishes in case of a serious incident, and most family members have a hard time making these decisions, especially when the resident has been deemed incapable of making the decision themselves. The onus is on the Power of Attorney if the resident has one, or on the next of kin. Family members are usually distraught when these questions are asked and sometimes question themselves as to whether they are making the right decisions. Some make decisions based on the age of the resident and some family members will insist that all measures be taken even though those measures might cause more harm than good. When filling out these forms with family members I usually read out the options available for them to choose from. If a family member insisted that all measures be taken to save the resident’s life, the nurse might talk about the damage that may be done to a rib, especially if the resident is old and frail. The nurse spoke based on the health of the resident and what they thought was most ideal, but families were not aware of this and sometimes believed having the measure put in place would help save their family member. I met with a family member who kept asking me if she was making the right decision and asking herself if the decision she was making was what the individual would have chosen. This individual did not have any surviving siblings and so did not have anyone to talk to. I marveled at the burden of care put on caregivers, the decisions they have to make, and the guilt they may feel about possibly making wrong decisions.

By the end of my practicum experience, I came to the realization that there is so much more to caregiving than can be observed with the physical eye. Family caregivers, as well as health care professionals, may go through emotional, psychological, and physical stress that they cannot explain. I have a better understanding of how to cope with a family member who has been diagnosed with dementia and how to work with them without depriving them of the things that
they are still able to do. I am also mindful of encouraging caregivers to maintain self-care because it is an important aspect of their life that they need to focus on in order to avoid burnout. Caregivers are constantly thinking of what their family member needs or if they are comfortable, but they forget about themselves and they begin to feel overwhelmed with having to do too much while still asking themselves if they are doing enough. I implored caregivers that I worked with to take time for themselves because the health care staff members at Parkridge were already doing a good job of ensuring that residents’ care needs were met.
Conclusion

The months I spent in the field for my practicum have been life-changing for me as they enhanced my social work skills through applying the principles of CBT to caregiving using a systems theory framework. I had the opportunity to work with older adults diagnosed with dementia as well as various health care professionals, which allowed me to explore and learn about methods of providing care to older adults, which was a part of my learning objective. Exploring systems theory and cognitive behavior therapy in the literature review helped me to grow and gain more understanding. It allowed me to understand the values of social work and how these play into my work as a social worker. It also allowed me to view challenges as opportunities for growth that would allow me to forge ahead in my social work career.

The field experience allowed me to practice some skills as well as develop confidence in a clinical setting which was supportive to learning. I was able to observe my supervisor as well as other health care professionals ensuring a good quality of life for Parkridge Centre residents. I had the opportunity to work and make connections with diverse people with different socio-economic backgrounds. I was able to focus on my practicum and contribute as much as I did because I was not working at my regular job at the time and this allowed me to stay dedicated during my time at Parkridge. The social work team I worked with is one of the best I have ever worked with, which made learning easy for me. In addition, the ability to connect with my professional associate during my practicum made it very easy for me to achieve my practicum goals and objectives. This practicum has allowed me to grow independently as well as within a group, and this will show in my future work as a social worker.
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Recommendations for social service training, staffing, and roles in interdisciplinary care.

*Journal of the American Medical Directors Association*, 190, e9-190.e15.


doi:10.4135/9781446270141.n1


https://www.who.int/healthinfo/survey/ageingdefnolder/en/
Appendix A

**Behavioral Activation**

You can begin to decrease depression by engaging in activities you find enjoyable, and by taking care of responsibilities that you have been neglecting.

List three activities you enjoy:
1. 
2. 
3. 

List three responsibilities you need to take care of:
1. 
2. 
3. 

Try doing at least one activity or responsibility each day. Use the following scale to rate your depression, pleasant feelings, and sense of achievement before and after the activity.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Minimal</td>
<td>Slight</td>
<td>Mild</td>
<td>Moderate</td>
<td>A Lot</td>
<td>Higher</td>
<td>Very High</td>
<td>Extreme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity (location, date, time)</th>
<th>Depression</th>
<th>Pleasure</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After</td>
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<td></td>
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<tr>
<td>Before</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provided by [TherapistAid.com](https://TherapistAid.com) © 2012

(TherapistAid, 2012)
Appendix B

About Me
Sentence Completion

I was really happy when...

Something that my friends like about me is...

I’m proud of...

My family was happy when I...

In school, I’m good at...

Something that makes me unique is...

(TherapistAid, 2012)
## Appendix C

Color/Number Code for Interpreting the Direct Observation Tool (DOS)

<table>
<thead>
<tr>
<th>Code</th>
<th>Colour</th>
<th>Target Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>Blue</td>
<td>Sleeping in bed or chair</td>
</tr>
<tr>
<td>3</td>
<td>Green</td>
<td>Awake/Calm</td>
</tr>
<tr>
<td>4</td>
<td>Pink</td>
<td>Verbal Disruptions</td>
</tr>
<tr>
<td>5</td>
<td>Yellow</td>
<td>Restless/Pacing</td>
</tr>
<tr>
<td>6</td>
<td>Orange</td>
<td>Exit Seeking</td>
</tr>
<tr>
<td>7</td>
<td>Purple</td>
<td>Verbal Aggression</td>
</tr>
<tr>
<td>8</td>
<td>Red</td>
<td>Physical Aggression</td>
</tr>
</tbody>
</table>

(Adapted from the Northern SK Dementia Unit, Saskatchewan Health Authority, 2018)
Appendix D

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan
LONG TERM CARE

HOME:
SERIOUS ILLNESS-SUDDEN COLLAPSE PLAN
Page 1 of 4

I shall be engaged in decision-making, as long as I have capacity to make my health care decisions. This document comes into effect ONLY during times when I lack capacity, and thereafter my proxy(s) or substitute decision maker must be engaged in the decision making process. I have the right to choose not to complete this plan.

**Section A**

In the event I have a serious illness or sudden collapse and am unable to communicate my wishes during this time. This section is in effect.

<table>
<thead>
<tr>
<th>Should I experience a serious illness or sudden collapse (Initial one option):</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Support my natural death.</td>
</tr>
<tr>
<td>___ ONLY provide medical interventions available at this long term care home.</td>
</tr>
<tr>
<td>___ Transfer me to the hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If my heart stops beating or I stop breathing (Initial one option):</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Do NOT call 911. Support my natural death.</td>
</tr>
<tr>
<td>___ Call 911, begin CPR and transfer me to hospital.</td>
</tr>
</tbody>
</table>

**Section B**

In the event I have a permanent loss of capacity and have a serious illness or sudden collapse. This section is in effect.

<table>
<thead>
<tr>
<th>Should I experience a serious illness or sudden collapse (Initial one option):</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Support my natural death.</td>
</tr>
<tr>
<td>___ ONLY provide medical interventions available at this long term care home.</td>
</tr>
<tr>
<td>___ Transfer me to the hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If my heart stops beating or I stop breathing (Initial one option):</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Do NOT call 911. Support my natural death.</td>
</tr>
<tr>
<td>___ Call 911, begin CPR and transfer me to hospital.</td>
</tr>
</tbody>
</table>

**Instructions for Physician for Section B:**
1. Section A will no longer be in effect when section B is signed & dated by the physician.
2. Physician signature indicates that the resident has permanently lost capacity.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of Physician</th>
<th>Date</th>
</tr>
</thead>
</table>

**Instructions for resident with capacity who completed this Advance Care Directive:**
1. Date, sign & write your name below, if you are physically able to.
2. If you are physically unable to sign, then another person may complete this plan and sign on your behalf. The signature of this person must be witnessed. The witness must also sign.
3. A person appointed as a proxy or a proxy’s spouse cannot sign as a witness.1

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of Resident</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Signature of the person who is signing on my behalf</td>
<td>Date</td>
</tr>
</tbody>
</table>

---

1 The Health Care Directives and Substitute Health Care Decision Makers Act, 1997, s. 16.2 ibi

Word Form #103319 12/15 Category: Care Plans/Outcomes
**SERIOUS ILLNESS-SUDDEN COLLAPSE PLAN**

**Proxy(s) contact information:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Alternate Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Instructions for proxy(s) or Substitute Decision Maker, where resident lacks capacity:
1. Name, signature and date of the proxy or substitute decision maker who completed this plan. This plan is designated as an Advance Instruction.
2. Substitute decision maker signs only when there is no appointed proxy.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of proxy</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Instructions for substitute decision maker:
1. If the substitute decision maker signed above, then provide the Substitute Decision Maker’s contact information below.

<table>
<thead>
<tr>
<th>Name &amp; Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Alternate Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other nearest relatives contact information:

<table>
<thead>
<tr>
<th>Name &amp; Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Alternate Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Instructions for Physician/Designate or two treatment providers:
1. Name, signature & date of the Physician or Designate indicates they assisted in the completion of this plan. Indicate below who completed this plan.
2. Two treatment providers are to complete this plan when they initial page two. Name, signature and date of two treatment providers indicates resident lacks capacity AND does not have a proxy or substitute decision maker (i.e. no nearest relative). Indicate below who completed this plan. This plan is designated as an advance instruction.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of Physician or Treatment Provider &amp; Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of Designate or Treatment Provider &amp; Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SI-SC Plan Review: (Staff should refer to the policy for direction on SI-SC Plan review).
1. Name, signature & date below indicates annual review without changes to this plan.
2. Two treatment providers must do annual review, if they had completed it before.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of Designate or Treatment Provider &amp; Title</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
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(Saskatoon Health Region, 2016)