Culturally and Linguistically Diverse Communities

Dementia Care Pathways Quick Reference Cards

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Vision

Culturally and Linguistically Diverse populations experiencing difficulties with memory loss or dementia are valued, their voices are heard and people are supported to live fulfilling, meaningful lives in their own home in a culturally sensitive manner and environment.

This set of Quick Reference Cards is designed to provide an on-the-spot point of reference for health professionals and care staff to care for people from Culturally and Linguistically Diverse backgrounds who may have signs of memory loss or have a diagnosis of dementia.

The cards are intended to be used in conjunction with a Consumer Directed Care (CDC) approach to care; being mindful that getting to know the individual, is fundamental to the provision of high quality care. You can find more information on CDC here **www.cshisc.com.au/media/295440/Consumer_directed_care_booklet_FINAL_web_version.pdf**

These quick reference cards are provided as a guide only. It is recommended that the resources on which they are based, listed on the cards, be referred to for more comprehensive and detailed information.

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Prior to meeting with a client for the first time

Prior to meeting with a client, their family or carers it is important to:

- Ascertain from the referral service or worker what they understand to be the needs and issues facing the client/family/carers and why they are making the referral.
- Ask the referral service or worker what assessments or background information they may have already collected, and whether they can share that information with you, to avoid duplicating assessments and questions that may have already been obtained.
- Organise a professional interpreter where appropriate (see **www.multicultural.vic.gov.au/images/stories/documents/2014/omac%20using%20interpreting%20services%20guidelines%20on%20policy%20and%20procedures%20online.pdf** for information on using interpreting services).
- If possible ascertain what culture the client may identify as and familiarise yourself with their cultural customs and beliefs. This will help you to be culturally appropriate during your visit (information on different cultures can be found here **www.culturaldiveristy.com.au/resources/practice-guides/cultural-awareness**).

Use information about specific cultures as a guide only, it is always important to identify individual needs and preferences. Within any culture, peoples' values, behaviour and beliefs can vary enormously.

If after meeting with the client, their family and carers you would like to make a referral to another agency, seek the client's permission to make contact and consent to disclose information and what they referral is for.

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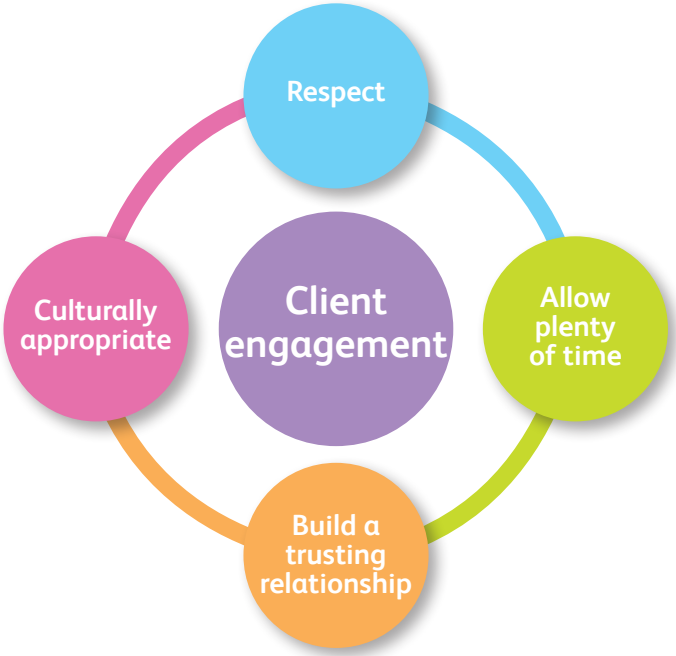

Client engagement

The clinician must always be attentive, responsive and respectful. Clients from CALD backgrounds must feel that the person they are engaging with is friendly, knowledgeable, helpful, approachable and most of all trustworthy. It is vital to build trusting professional relationships with the Client's family and carers, and also be culturally aware and appropriate. Ways in which you can build a trusting relationship with CALD client, their families and carers:

- Always treat people with respect
- Allow plenty of time when visiting clients, do not rush, building this relationship may take time
- Always use a qualified interpreter when required, briefing the interpreter on the situation prior to entering the clients home
- Avoid using family members or carers to provide interpreting as this may be counterproductive to the information you are seeking
- If you tell the client you are going to do something, make sure you follow through
- Conduct assessments in an informal and friendly manner with minimal use of forms and computers
- Be transparent and predictable, providing options whenever possible (e.g. where to meet, asking if they would like you to take your shoes off or close the door when entering their home).

- Explain your job using simple terms (avoid jargon or acronyms) and what you can offer by providing examples
- Explain the concept of confidentiality in clear, simple terms as well as limitations of confidentiality in relation to your duty of care. This may be a new concept to your clients
- Ask permission of the client if you can take notes, and offer to share what you have written, this will enable them to remain in control and reduce their anxiety about people accessing their information
- Explain the purpose of any assessments and forms, and why you need to document information, what will be documented, where it will be kept, and who will have access to it and how it may be used
- If after meeting with the client, their family and carers you would like to make a referral to another agency, seek the client's permission to make contact and consent to disclose information and what the referral is for.

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Culturally appropriate history taking

A thorough client history will form the foundation of the assessment process. The same information that you would normally gather for an English speaking client needs to be gathered for a non-English speaking client. However, you may need to allow extra time for this process with this group of clients and the history taking needs to be culturally appropriate and sensitive. Sensitivity will need to be given to issues such as trauma, war experiences, migration, family separation and education level.

The Respect tool may help in the appropriate use of assessment instruments and history taking.

Recognition	Value every person equally not matter their Culture, Race, Colour or Religion.
Empathy	Understand the clients condition from their perspective.
Safety	Provide culturally safe practices to ensure there is no assault, challenge or denial of an individual's identity.
Privacy	Acknowledgement of the right for a client to confidentiality.
Engagement	Be attentive, listen and value what the client is telling you.
Culturally appropriateness	Ensure everything you do as a clinician is appropriate to a clients identified culture.
Timing	Be sensitive to when you plan, schedule or arrange for something to occur that it is appropriate for where the client is at.

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Assessment Tools

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Assessment tools

Assessments also provide opportunity to understand your client's needs, strengths, resources, co-morbidities and goals as well as their housing, finance, social and family supports and existing relationships with other service providers.

During the assessment you will also have opportunity to explore their cultural identity and cultural needs.

The essential function of an assessment is to understand the client on their own terms, this includes:

- How they perceive **their** needs, problems and issues
- The solution **they** want
- The goals **they** would like to achieve
- The resources **they** feel they can draw on
- They strengths that **they** can draw on
- **Their** perception of their own deficits, barriers and limitations that could influence them reaching their desired goals and outcomes.

The Rowland Universal Dementia Assessment Scale (RUDAS) is a short cognitive screening instrument that is designed to minimise the effects of cultural learning and language diversity on the assessment of baseline cognitive performance.

Whilst the RUDAS instrument is considered one of the most appropriate tools for assessing baseline cognitive performance, clinicians must also determine:

- When to administer an assessment tool
- Who is qualified to administer it
- Who is qualified to interpret the score
- What to do with the results

Referral should be made to the local CDAMS or ACAS team for assessment and diagnosis.

There are guidelines available to assist with screening and diagnostic assessments of non-English speaking people with dementia available here:

https://fightdementia.org.au/sites/default/files/20101224-Nat-CALD-Screening Guidelines-07May.pdf.

Information of the RUDAS scoring, interpretations and actions are included with the scale (see the RUDAS information at **www.dementia-assessment.com.au/cognitive/index.html#rudas** for further information).

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Goal setting and Care Planning

When goal setting within care planning it is important that this is undertaken with the client, their family and carers to ensure it reflects the clients own expressed care and cultural needs. This will also ensure that all members of the team are working towards the same goals with the same expectations.

Goal Setting

- Allow time for family and carers to also express their goals and needs (this is vital in ensuring the client is well cared for and supported)
- Identify and prioritise realistic goals together, ensuring the goals highlight their strengths
- Give the client the opportunity to express what they would like to achieve, they may wish to do this by talking, writing, drawing or showing you photos or items
- Discuss possible options and opportunities that are culturally appropriate and available to assist with ensuring the client's goals can be achieved
- Identify gaps that you may need to fill whilst waiting for service providers to become engaged as you may find waiting lists for some services
- Review goals regularly with the client as these can change frequently.

Care Planning

- Ensure care plans align with the goals set with the client
- The care plan should target interventions to assist people to maximise and enhance their independence, choice and quality of life and minimise support required, enabling people to remain active and involved in their own health, wellbeing and participation in the communities
- Care planning must incorporate culturally appropriate interventions
- Include what family and carers needs are (this may incorporate a separate care plan for their needs)
- Timeframes should be incorporated into care plans to ensure progress and regular review of care plans will ensure the client's needs are being met in a timely and culturally appropriate manner.

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Care Plan monitoring and review

Care plan monitoring enables the clinician to re-evaluate the status of a client, their goals and needs and the interventions and services currently in place to address those needs.

It will enable evaluation of the progress towards the goals identified by the client, their family and carers and assess whether the provided interventions and services are being utilised and implemented in accordance with the care plan, including cultural appropriateness, and determine whether problems in service delivery require changes to the goal, care plan or service. Evaluation of a clients status will also allow for new goals, strategies and interventions to be put in place should new and emerging issues arise.

The frequency of monitoring varies depending on the intensity of the client needs and the type of services being provided.

What might trigger care plan reviews?

- Communication for client/family regarding changes to client need
- Feedback from support workers through service delivery observation
- Scheduled date for review

Reviews allow time for reflecting with the person on their progress towards their goals.

You may wish to ask the client these questions during the review:

- Are the interventions or services meeting your needs?
- Has it met your expectations?
- Are the goals we initially spoke about still meaningful and achievable?
- Do you want to alter a care plan to better suit your needs?

If changes to care plans do occur it is important that the adjustments are communicated to other people or agencies involved in using that care plan.

Case Study example

Mr L. and his wife Regina, have always been involved in their local community and until late have been active members of the Greek Senior Citizen's Club. Following some decline in memory over the past few years, Mr L. was seen by a Geriatrician and diagnosed with Alzheimer's disease.

Mr L. has continued to decline cognitively and his wife is concerned for his safety and she has no support. They have no children, and are unsure who may be able to help them. They do not want to go into residential care.

The coordinator from the Greek Senior Citizen's club made contact with them as they had not been attending to make sure they were well, as they had not been attending. Regina told the coordinator that Mr. L is not doing so well, that he has reverted to speaking Greek and he is having problems with incontinence and not sure how to get help.

The coordinator contacted RDNS for an assessment of Mr L. as well as provision of support and information. A nurse visited Mr L. and Regina at their home with a Greek interpreter to assist in communicating with Mr L. Mr L. was very suspicious as to why someone was visiting them and did not want to communicate.

The nurse was able to talk to Mr L. about other things such as his home in Greece, what he used to do for a job and about his garden. This enabled the nurse to build a rapport with Mr L. and eventually over a few visits he

became trusting enough to speak about the difficulties he was experiencing.

Over the coming visits, assessments were performed, and goals and care planning started to take shape. Mr L. and Regina was very specific about what assistance they required. They both wanted a male to assist with showering Mr L. and needed guidance on incontinence issues. Mr L. stated that he didn't want to go to the Senior Citizen's Club as he was frightened of soiling his pants in public. The goals were agreed on and care plans devised.

Over the coming months Mr L. was being showered three times a week by a male care attendant. Toileting regimes and continence appliances were sourced along with funding. This enabled Mr L. to rejoin the Senior Citizen's Club confident that if he had an accident it would not be noticed by anyone.

Regina was put in contact with Carer's Victoria for guidance and counselling about how to best look after herself. Alzheimer's Australia were notified of the situation and Mr L. and Regina now attend cafe groups to meet people in the same situation and share and listen to others stories.

When the care plan was reviewed Mr L. and Regina were much better positioned to access suitable health care services when they needed to. Regina has contacted the council and now has someone once a week to help with cleaning the house.

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Exit planning

Exit plans should always contain the following:

- Measurement of change in health status
- Satisfaction with service
- Perception on improved quality of life
- Review of goals
- Referral to other agencies if further support is required.

It is important to never rush this stage; you do not want the client, family or carers to feel abandoned or alone.

The client, family and carers should be educated to help identify early warning signs as needs change over time and a relapse care plan for them to use may be of use including contact details of services to contact should they require assistance.

Always make sure that they know how to contact you if they need further guidance or support.

Always provide follow up with a phone call to monitor the situation as needs may change and further assessments, guidance or support may be required.

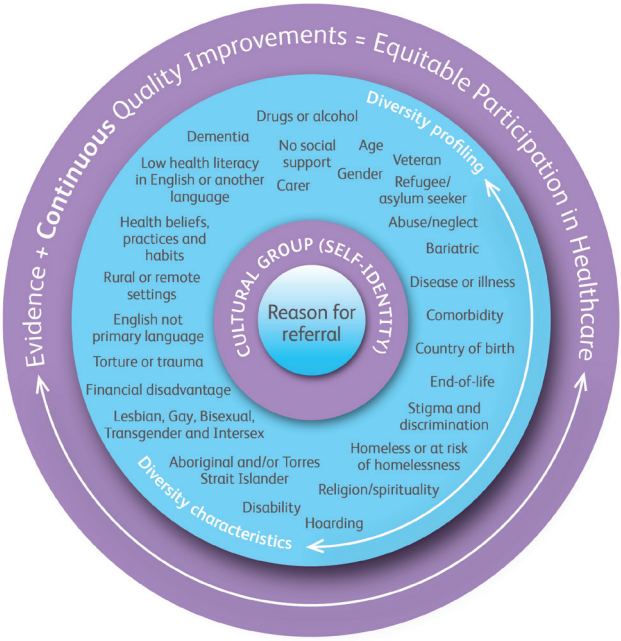
Some of the things that show they may be ready to exit from support:

- They have met all the goals they set out
- They are managing their goals without your assistance
- They feel they do not require further assistance
- Family and carers are happy and managing their situation well.

RDNS Diversity Conceptual Model

The Diversity Conceptual Model supports thinking about Diversity at RDNS. It assists RDNS to think, understand and solve problems associated with client and population diversity and possible associations with disadvantage.

The model encourages use of evidence and continuous quality improvements to inform and create opportunities for more equitable participation in healthcare and wellbeing through policy, planning and practice.



Further information and support

The below organisations may useful when working with clients from Culturally and Linguistically Diverse Communities.

Alzheimer's Australia **www.fightdementia.org.au**

Australian Multicultural Community Services **www.amcservices.org.au**

Australian Multicultural Foundation **www.amf.net.au**

Carers Australia **www.carersaustralia.com.au**

Centre for Cultural Diversity in Ageing **www.culturaldiversity.com.au**

Centre for Culture, Ethnicity & Health **www.ceh.org.au**

Centrelink **www.humanservices.org.au**

Cognitive Dementia and Memory Service **www.health.vic.gov.au/subacute/cdams.htm**

Community Migrant Resource Centre **www.cmrc.com.au**

Council of the Ageing **www.cota.org.au**

Dementia Behaviour Management Advisory Service **www.dbmas.org.au**

Department of Health **www.health.gov.au**

Federation of Ethnic Communities' Councils of Australia **www.fecca.org.au**

Health Translations **www.healthtranslations.vic.gov.au**

My Aged Care **www.myagedcare.com.au**

Office of the Public Advocate Victoria **www.publicadvocate.vic.gov.au**

RDNS **www.rdns.com.au**

Translating and Interpreting Service **www.tisnational.com.au**