Dem@entoring

DEM@ENTORING

Live and learn – Innovative ICT based learning and mentoring approaches for Alzheimer's communities

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Training Course on e-mentor - Curricula

INTELLECTUAL OUTPUT 2 (IO2)

September 30 2019/May 15 2020/April 20 2021

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Executive Summary

Worldwide, around 50 million people have dementia, and every third second there is someone diagnosed with the disease. The number of people diagnosed with dementia are projected to increase significantly in the decades to come and the number of countries recognizing the need for making dementia a priority continues to grow. By incorporating ICT, the DEM@ENTORING project will provide an opportunity for people with a dementia disease, as well as their families and health professionals, to receive much of the information they need in order to improve their quality of life. The main idea of the DEM@ENTORING program, however, is to provide a training program in which families and professionals can become e-mentors, and later share their knowledge and skills by utilizing a fun and interactive online platform. This includes a dementia support group, through which the e-mentors can be reached in order to discuss relevant topics and form a network of knowledge exchange. The DEM@ENTORING training program is targeted towards individuals with an education comparable to the International Standard Classification of Education (ISCED) levels of 1+2+3.

The level of education and individual skills will be used in order to create an online profile for each e-mentor. The participants will then be trained through Open Education Resources (OER), in order for them to acquire the knowledge and skills necessary to provide e-mentoring to other individuals, either people living with dementia, their families or those in professional caring positions. To reach the objectives of the e-mentoring program, i.e. to transfer valuable skills to new or existing caregivers, to design OER material, to utilize 'personal mapping' for optimal matching with the mentors and to test knowledge and skills using self-evaluating tools, the program has been divided into three different courses, 1-3.

Course I: Knowledge and understanding of dementia diseases, will focus on the knowledge and understanding of dementia, and is divided into four different modules, each covering a particular topic (Introduction to Dementia and Cognitive Disorders; Behavioural and Psychological Symptoms of Dementia; Psychosocial interventions; and Risk and Medication Management). The modules are further divided into smaller sessions, ranging from two to

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seven in each module. The sessions will not take longer than 15 minutes to complete, and all modules will be followed by a quiz.

The second course, *Course II: E-mentoring knowledge,* is dedicated to the knowledge surrounding strategies for teaching and facilitating learning among adults. The content of this course is divided into five parts (Adult learning strategies and models; Strategies for facilitating adult learning; Strategies for online teaching, learning and feedback; Legal and behavioral aspects of online learning; and Debriefing and supervision), with each part comprising two to three smaller sessions.

Course III: E-mentoring Skills focuses more on the application of strategies and communication between mentor and mentee, and the content is divided into three parts (Communication with mentees; Strategies to facilitate learning; and Self-reflection on communication and facilitation skills) with each part comprising one to four smaller sessions. Courses I and II builds on the information acquired through interviews with people with a dementia disease, their families and health professionals, while course III to a larger extent relies on desktop research. The mode of teaching in courses II and III are also greatly influenced by short seminars held with different user groups, groups that consisted of people with a dementia disease, their families and health professionals. The different courses will all be separately evaluated using online surveys, targeting the relevance of the content and the learning outcome. An e-mentoring certificate is awarded to each participant upon successful completion of the DEM@ENTORING training program.

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Introduction

A new case of dementia is diagnosed every 3 seconds. Worldwide, around 50 million people have a dementia disease, and every year there are nearly 10 million new cases. The estimated proportion of the general population aged 60 and over with dementia at a given time is between 5-8%. The total number of people with dementia is projected to reach 82 million in 2030 and 152 in 2050 [World Health Organization, 2019]. It is estimated that two family members often act as carers for each person with dementia, which means that the number of those immediately affected by the disease reaches almost 150 million people.

Nationally the number of countries recognizing dementia as a priority and developing national strategies continues to grow. The first objective of Strategic Plan (2016-2020) of Alzheimer Europe is to "Provide a voice to people with dementia and their carers in order to be full partners in policy development, research and service design" [https://www.alzheimer-europe.org/Alzheimer-Europe/Our-work/Strategic-Plan-2016-2020]. Within the DEM@ENTORING project, people with dementia, their families and caregivers will have the potential to become fully aware of the disease and its consequences. The project will provide ways to enhance a better life and relief o caregiver burden, through the use of Information and Communication Technology (ICT) and through the transfer of knowledge via e-mentors.

During the project, family member and professional caregivers will be offered to become e-mentors to people with a dementia disease, families and professionals. All this will be realized by providing an educational program in a fun and interactive way.

The aim of this Intellectual Output is to provide carers with specific knowledge and skills, and to educate future e-mentors. The mentors will be trained on how to deal with the practical and psychological burden of dementia. This training program will focus on the needs of the carers, providing all the necessary information about dementia symptoms, progression and available treatments, specific skills enabling them to effectively cope with issues related to dementia, training in the management of the physical, psychological and financial burden of dementia. In addition, the mentors will be trained in mentoring skills in order to provide their knowledge and experiences to other carers, the mentees, through the online platform. By joining a dementia support group, the mentees will have the opportunity to meet and get to know others who are going through same experiences, and to discuss topics that are relevant to their situation. They will learn more about dementia diseases and how to cope with caring. Finally, they will be part of a peer support group (network) with people sharing common experiences.

The curriculum of Intellectual Output 2 (IO2) will encompass several components such as the e-mentors updated profiles, the actual training courses based on the learning outcomes principles and using a social learning model and the proposed accreditation structure according

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to EQF & ECVET as well as EQAVET principles. The courses will be designed and developed according to basic course and user-generated content (based on own experiences and knowledge) and e-mentoring knowledge and skills. The courses will be available in 6 languages. The curriculum will be tested and validated with end-users.

The DEM@ENTORING project will greatly support the effort of people with dementia and their families and carers by helping them improve daily life by the implementation of psychosocial interventions using ICT, such as tablets, laptops and iPads. When tablets, laptops and computers are used to deliver these interventions, the carers will benefit, largely due to the simple interface and the flexibility of the online platform. In addition, the target group will be able to improve their skills and competences in ICT and networking, participate in training events, meet other people and share knowledge, and to interact with stakeholders and educational providers.

Finally, through the targeted activities, they will try tools and non-formal learning methodologies.

- The courses are devoted to older adults themselves, as individuals and also as collectives belonging to an association, as they are the final target audience. Firstly, the approach will be mainly local by means of the pilot activities developed in the project. The effect of multiplier events could allow reaching also national and international audiences.
- Older adults, mainly informal caregivers at the local, regional, national and European level will benefit from the project. The approach will be mainly local by means of the pilot activities developed in the project.
- At the same time, since the training materials created will also address the role of family caregivers, we expect trained dementia care staff to improve their overall communication skills and ability to interact with them.

In order to examine the effectiveness of the online training program, mentors will be assessed with questionnaires regarding Quality of Life (QoL), Mood, Satisfaction and Mentoring skills, before (T0) and after the participation (T1) in the training program.

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Part 1. E-mentors updated profile

The Dem@entoring training course is targeted towards those with an education comparable to International Standard Classification of Education, ISCED, levels 1-4, but can be used by people with all levels of previous education.

(http://uis.unesco.org/sites/default/files/documents/international-standard-classification-of-education-isced-2011-en.pdf). Information about individual skills, such as digital skills, transversal skills and competencies as well as language skills will be collected: (https://ec.europa.eu/esco/portal/skill?resetLanguage=true&newLanguage=en&skillFilterIndex=0). A profile for each mentor will be developed based on ISCED level and the individual skills. In particular the skills profile will be useful to support each mentor to tailor their own training course based on previous knowledge, skills and interests.

Part 2. E-mentors' training course

Methodology

2.1 Framework

The overall DEM@ENTORING framework for development of e-mentoring skills, targeting formal and informal caregivers as well as people with dementia, can be summarized in figure 1. The learning outcomes for all parts or courses are defined on unistructural and multistructural levels (Fink, 2013). Part 1 and part 2 (equivalent to courses 1 and 2) focus on knowledge related to dementia diseases and e-mentoring respectively, while part 3 (course 3) focuses on e-mentoring skills.

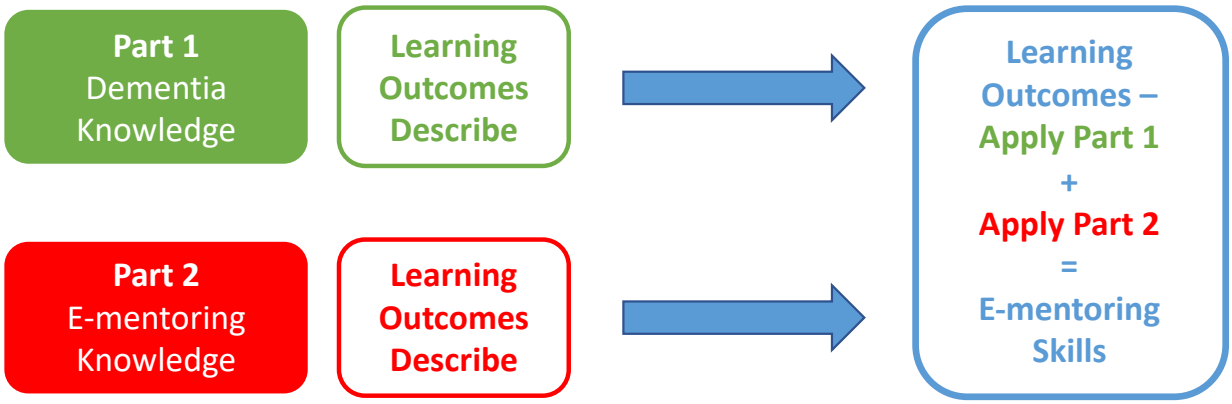

FIGURE 1: DEM@ENTORING SKILLS DEVELOPMENT FRAMEWORK

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The following sections provide an overview of the e-mentors and the e-mentoring program as a whole including the objectives it aims to pursue. In Annex A the reader can find the detailed storyboards for each one of the parts mentioned above in the framework, and in Annex B multiple-choice questions and quizzes that will be part of the DEM@ENTORING storyboards can be found.

2.2 E-Mentors

The main idea of the DEM@ENTORING program is to train dementia carers as e-mentors in order to provide mentoring to other carers in the setting of peer support groups as well as individually. Indeed, research has found that peer support can help carers in particularly stressful caring situations [ADI, 2015]. Carers of people with dementia experience greater strain and anxiety than carers of other older people. They may experience social isolation through lack of personal time and opportunities to socialize, and stigma leading to distancing themselves from family and friends. Without support, carers can feel emotional and physical burden, which can reduce the perceived level of emotional support and increase feelings of loneliness. Research has noted the importance of improving social relationships for carers [Bökberg, 2017; Chaudury et al. 2018] and peer support for carers is included in the recommendations of the National Dementia Strategy for England [Department of Health, 2009]. It has been suggested that peer support would directly enhance wellbeing by decreasing feelings of isolation and/or encouraging more effective coping strategies, and facilitating mental, emotional or cognitive change [Dennis, 2003; Charlesworth et al. 2011; Chiatti et al. 2018]. Therefore, a body of research is being established to assess contact for peer support interventions.

According to the Merriam-Webster Online Dictionary, a mentor is defined as a “source of wisdom, teaching, and support, and is not a person who observes and advises on specific actions or behavioral changes in daily work” (retrieved May 14, 2021). Mentoring consists of a long-term relationship focused on supporting the growth and development of the mentee. The difference between a mentor and a coach is that coaching involves a relationship of finite duration, with focus on strengthening or eliminating specific behaviors, here and now. Coaches help professionals to adapt behaviors that detract from their performance or strengthen those that support stronger performance around a given set of activities.

E-mentoring is a means of providing a guided mentoring relationship using online software or e-mail. It allows participants to communicate at their own convenience and beyond time zones since it eliminates the need for them to be in the same physical location E-mentors support the growth and development of others, in this case families and formal caregivers to people with dementia, and thus the people with dementia themselves, through an online service center [Williams et al. 2012; Kenan et al. 2018].

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2.3 The E-Mentoring Programme

The e-mentoring program aims to e-train mentors to provide e-mentoring consultations to families and carers of people living with a dementia disease. During the program, mentors will be trained through Open Education Resources (OER´s) to develop e-mentor skills and experiences in order to potentially provide e-mentoring to people with dementia and their families and caregivers. This means that, based on social learning models and theory, e-mentors will learn and practice how to transfer their knowledge, skills and qualifications to future mentees, as improved by the courses. The e-mentors will be trained through the DEM@ENTORING project's website. Experienced e-mentors will locate and motivate more users to attend.

2.4 E-Mentoring Program Objectives

- Transfer the knowledge, information and experience of people living with any kind of dementia, their families and caregivers (formal and informal), i.e. valuable skills, to new potential caregivers and people with dementia, or to existing ones.
- Design and create interactive advanced OER training material with gamification elements and based on a learning outcomes design, conforming to European Credit system for vocational Educational and Training (ECVET).
- Construct a digital personality of the participants, "personal mapping" for optimal matching with e-mentors.
- Testing of knowledge and skills (within online self-evaluating tools).

2.5 Learning Outcomes and Content (Curriculum, 2,5 credits)

The e-mentoring program comprises three courses, equivalent to Part 1 and Part 2 in the project proposal.

- **Course I:** Knowledge and understanding of dementia diseases.
- **Course II:** E-mentoring knowledge (not stated in the proposal but decided to add along the project process since it was considered necessary).
- **Course III:** E-mentoring skills.

The three courses build upon each other.

The content of the curriculum reflects the knowledge generated in IO1. More specifically, the interviews with people with dementia, and their caregivers respectively generated important knowledge about needs and preferences related to the three courses. In particular, the content of courses I and II were underfed by the interviews. The participants in IO1 expressed that they required knowledge related to aggressive and passive behavior (BPSD) and other symptoms a dementia disease and what they could do themselves to mitigate the consequences in daily life. Emotional support was asked for, as was tips and tricks to solve everyday situations to the

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benefit of all. The care staff requested more information about technology and other devices, while at the same time expressing stress in relation to mal-functioning technology. Care staff also expressed the need for support and understanding from the general public. In relation to course II an interest in learning more about how to both coach and mentor others was expressed. The content of course III to a larger extent relies on desktop research supported by results from interviews. In addition, short seminars and workshops with different user groups organized by the partners contributed to the content and mode of teaching in particular courses II and III.

The user groups consisted of people with dementia and their carers (both formal and informal). The workshops also involved formal caregivers and health professional students in the following ISCED levels (see http://uis.unesco.org/en/topic/international-standard-classification-education-isced):
3: Upper secondary, vocational level;
4: Post-secondary non-tertiary, vocational level, and;
6: Bachelor's or equivalent, vocational level.

The content of the curriculum is to the major extent possible to adapt to the participant's own knowledge and skills. This means that the course participants may skip course I entirely or only take parts of it, depending on previous dementia knowledge and dementia care experiences as well as their learning preferences. The participants can choose to return to course I after having taken parts of courses II and III, which are both mandatory. Course II is to be passed before the start of course III.

Based on the social learning model applied, courses II and III will emphasize interactive learning activities including gamified elements. Thus, the course participants will engage in joint learning and feedback activities, to various extent under supervision by the course leader depending on level of knowledge, skills and learning preferences.

Social learning models are developed from social learning theory [Bandura, 1963; 2002] on learning process and social behavior, proposing that new behaviors can be acquired by observing and imitating others. Learning is seen as a cognitive process taking place in a social context. Learning can occur purely through observation or direct instruction, even in the absence of motor reproduction or reinforcement. Learning also occurs through the observation of rewards and punishments, a process known as vicarious reinforcement. When a particular behavior is rewarded regularly, it will most likely persist. In social learning models, emphasis on the important roles of various internal processes in the learning individual.

During the development process (courses II-III) seminars were held with end-users:

- In Sweden, regular meetings with people with dementia, their families as well as formal caregivers in different municipalities were held to follow the IO2 process. In October 2019 and during 2020, the general public was invited to conferences and seminars

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where the project was presented. The development process also included seminars with students in health care professional training, and registered health care professionals.

- In Poland, 36,6 participated on regular basis (every first Saturday of each month) in meetings with non-formal caregivers organized by Lodz Alzheimer Association in their premises so to provide information on the Dem@entoring project progress IO2 included.
- In Denmark DCHE engaged with both municipality institutions, patient organizations, and MoH networks to ensure input from both stakeholders, and end-users.
- In Greece, Athens Alzheimer Association organized numerous educational programs and support groups for caregivers of people with dementia. The three educational 2-hour seminars took place from September 2019 until February 2020, teaching family caregivers how to deal with the practical and psychological burden of dementia. Also, we organized counseling meetings, individually or in groups, with the caregivers of the people that participate in the activities of the Dementia Day Care Center. These programs focus on the specific needs of the caregivers, providing all the necessary information about dementia symptoms, progression, and available treatments, particularly skills enabling them to cope with the physical, psychological and financial burden of dementia effectively. Finally, we requested caregivers that participated in the programs mentioned above to provide feedback regarding the outputs of the IO2 material.

Course I is divided into four course modules, each in turn divided into several sessions (see Appendix). Each session will not take more than 15 minutes, most often shorter time. At the end of each session, quizzes for self-testing are provided. However, due to the fact that this course is not a prerequisite for taking courses II and III, no formal testing of the participants knowledge will be made. After taking course I, the participant becomes a Dementia Friend and earns the badge associated to it.

2.6 Course I: Knowledge and understanding of dementia diseases (0,5 credits)

After the course the mentor should be able to:

- describe the five most common cognitive disorders, the seven A's of dementia and the cognitive domains most commonly affected by a dementia disease.
- describe the most common behavioural and psychological symptoms (BPSD) associated with a dementia disease and the most common behaviour management components and strategies.
- describe the most common caring strategies related to communication and behaviour, socialization, nutrition as well as activity, participation and physical exercise.
- describe different psychosocial interventions related to cognitive and multisensory stimulation, physical activity and exercise as well as the use of different welfare technologies.
- describe different strategies for the prevention and treatment of accidents and injuries in the home.

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- describe issues specifically related to palliative care and end-of-life.
- describe strategies related to empowerment and client advocacy.
- explain the most prominent legal issues in relation to dementia care.

Modules

1. Introduction to Dementia and Cognitive Disorders (Sessions 1.1-1.2)
   1.1 Difficulties in cognition
   1.2 The most common cognitive disorders

Short quiz

2. Behavioural and Psychological Symptoms of Dementia (BPSD) (Sessions 2.1-2.7)
   2.1 Challenging behaviours associated with dementia
   2.2 Psychosocial management of BPSD, including a care plan
   2.3 Principles of care for people with dementia regarding BPSD
   2.4 Communication and understanding behaviour
   2.5 Socialization
   2.6 Feeding and nutrition
   2.7 Activity and participation

Short quiz

3. Psychosocial interventions (Sessions 3.1-3.4)
   3.1 Cognitive stimulation
   3.2 Multisensory stimulation
   3.3 Physical activity and exercise
   3.4 Use of welfare technology

Short quiz

4. Risk and Medication Management (Sessions 4.1-4.4)
   4.1 Home accidents prevention
   4.2 Physical and pharmacological restraints
   4.3 Abuse
   4.4 Sexuality

Short quiz
The quizzes after each module are designed for self-evaluation purposes. One response alternative out of three is correct. Correct answers are presented.
After completion of module I, the participant becomes a Dementia Friend. This course is not mandatory but preferred. It can also be taken after courses II and III.

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2.7 Course II: E-mentoring knowledge (0,5 credits)

After the course the mentor should be able to

- describe different adult learning strategies and models
- describe different communication methods and strategies useful in mentoring/coaching situations
- describe different strategies for facilitating adult learning
- describe different strategies for online teaching, learning and feedback
- describe legal and behavioural aspects of online learning
- describe different strategies for debriefing and supervision
- describe the boundaries of an e-mentor

Content

1. Adult learning strategies and models (Sessions 1.1-1.2)
   1.1 Social interaction learning – "learning with others"
   1.2 The role of the physical, organizational and psychosocial context in learning

2. Strategies for facilitating adult learning (Sessions 2.1-2.4)
   2.1 Building on previous knowledge
   2.2 Use of the context for learning
   2.3 Use of cases and examples
   2.4 Use of blended learning

3. Strategies for online teaching, learning and feedback (Sessions 3.1)
   3.1 Methods and strategies for online communication

4. Legal and behavioural aspects of online learning (Sessions 4.1)
   4.1 Confidentiality and privacy

5. Debriefing and supervision (Sessions 5.1)
   5.1 Strategies for debriefing and supervision

Short quiz

Course II prepares the participant for becoming an e-mentor by providing knowledge necessary to develop the e-mentoring skills targeted in Course III. Course II was not outlined in the project proposal but it was found necessary to add also a separate course related to knowledge necessary to have as an e-mentor. It was also considered to be easier to understand the different sections.

At the end of Course II there is a test quiz available with associated questions related to the content (ANNEX B, 5. Course II -Mentoring knowledge Test and Quizzes). After course II, 100%

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of the questions should have been answered correctly in order to pass and continue to course III.

After completion of course II, the participants will have earned the “mentor scholar” badge.

2.8 Course III: E-mentoring skills (1,5 credit)

After this course the e-mentors should be able to:

- apply and personalize strategies to facilitate learning among the mentees.
- apply and use the online platform format to support and guide the mentee.
- reflect upon the own communication and learning facilitation skills.
- recognize the need for debriefing and supervision/mentoring/coaching in the role of a mentor.
- identify situations where the obligations of the e-mentor end.
- develop and maintain a positive and friendly mentoring situation.

Content

1. Communication with mentees (Session 1.1-1.2)
   1.1 Mentoring process-skills
   1.2 Mentoring skills

2. Strategies to facilitate learning (Sessions 2.1-2.3)
   2.1 Guidelines for starting an online mentoring Peer Support Group
   2.2 Use of online platforms to support learning
   2.3 Management of material and media on the Moodle platform

3. Self-reflection on communication and facilitation skills (Session 3.1)
   3.1 Self-reflection and feedback.

Short quiz

<u>Cases</u>

After course III, six short cases illustrating potential mentor or mentee skills and preferences (three in each category) are presented. In particular they stimulate self-reflection and feedback (3.1). The cases can be used for individual reflections but are designed to be discussed among course participants.

At the end of Course III there is a test quiz available with associated questions related to the content (ANNEX B, 6. Course III E-mentoring skills Test and Quizzes). After course III, 100% of the questions should have been answered correctly in order to pass and continue to becoming an advanced mentor and gain the respective badge.

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Course III includes also interactions with the course management in order to develop the skills necessary. The learning outcomes, the content of course III as well as the cases presented provide the basis for learning and applying social learning. That is, both content and form of teaching and learning target such models.

In addition to courses I-III, the DEM@ENTORING platform will include an online mentoring platform with subscription for dementia caregivers. An online service centre will be available especially addressing people with dementia, linking the group members together in interactive learning and feedback activities.

The courses and the related training material will be OER´s accessible as e-mentor-learning through multiple devices, a user-friendly system allowing collaboration and exchange of knowledge and skills. The system will be highly interactive and dedicated to increase the quality of life of people with dementia. Throughout the courses' gamification elements will be applied to enhance learning. Examples of gamification elements are: quizzes after each course module

Evaluation

Each course will be evaluated separately using an online survey, targeting the relevance of the content for the participant's own needs, as well as learning outcome achievement. Likert scale response alternatives will be used.

In addition, the programme will be evaluated in full by way of the following:

a) An online survey using the same principles as for each course separately.
b) For each participant, the number of visits to each module and session.
c) User-friendliness and usability of the platform.

3 Examination and Certificate

After successful completion of the online training an e-mentoring certificate can be achieved. In order to receive an e-mentoring certificate the participant need to pass the quiz for course II and course III (e-mentor knowledge and e-mentoring skills respectively) with at least 75%.

4 Conclusion

This Intellectual Output (IO) is primarily oriented towards the creation of the DEM@ENTORING curricula and act as the basis for the design phase and testing of IO3. It involves all the appropriate plans on how to proceed with the courses on e-mentor, and the new curricula that will have to be developed within the project. The final outcomes of IO2 will power-up the work conducted within IO3 which will develop the whole DEM@ENTORING ecosystem, taking into

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account the feedback and outcomes from IO1 and IO2, and the technological competence in the form of tools and components.

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References

Alzheimers Disease International, ADI. World Alzheimer Report 2015. The Global Impact of Dementia. An analysis of prevalence, incidence, cost and trends. 2015.

Bandura, A. (2002). "Growing Primacy of Human Agency in Adaptation and Change in the Electronic Era". *European Psychologist*. **7** (1): 2–16. doi:10.1027//1016-9040.7.1.2.

Bökberg, C. (2017). Care and services at home for persons with dementia. Structure, process, and outcomes. (Doctoral thesis, University of Lund, Lund). https://doi.org/10.13140/RG.2.2.22397.97764

Chaudhury H, Cooke HA, Cowie H, Razaghi L. The Influence of the Physical Environment on Residents With Dementia in Long-Term Care Settings: A Review of the Empirical Literature. Gerontologist. 2018 Sep 14;58(5):e325-e337. doi:10.1111/j.1532-5415.2007.01169.x. https://www.researchgate.net/publication/314514461_The_Influence_of_the_Physical_Environment_on_Residents_With_Dementia_in_Long-Term_Care_Settings_A_Review_of_the_Empirical_Literature

Charlesworth, G., Burnell, K., Beecham, J. *et al.* Peer support for family carers of people with dementia, alone or in combination with group reminiscence in a factorial design: study protocol for a randomised controlled trial. *Trials* **12,** 205 (2011). https://doi.org/10.1186/1745-6215-12-205.

Chiatti C, Rodriguez Gatta D, Malmgren Fänge A, Scandali VM, Masera F, Lethin C. Utilization of formal and informal care by community-living people with dementia: a comparative study between Sweden and Italy. *International Journal of Environmental Research and Public Health,* 2018. 15(12), 2679.

Dennis C: Peer support within a health care context: A concept analysis. Int J Nurs Stud. 2003, 40: 32 1-332.

Department of Health: Living Well with Dementia: A National Dementia Strategy. London. 2009

Fink LD. Creating significant learning experiences. San Francisco: Jossey-Bass. 2013

Kenan D, Enisa M, Derin A. (2018). Mentorship strategies in teacher education. Hershey, PA. IGI Global.

The Merriam-Webster Online Dictionary.

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World Health Organization, WHO. Dementia. Available at https://www.who.int/news-room/fact-sheets/detail/dementia; 6 January 2019.

Williams S, Sunderman J, Kim J. E-mentoring in an online course: Benefits and challenges to e-mentoring. International Journal of Evidence Based Coaching and Mentoring. 2012;10:109–123.

Additional reading

Edvardsson D, Fetherstonhaugh D, Na, R. Promoting a continuation of self and normality: person-centred care as described by people with dementia, their family members and aged care staff. J Clin Nurs. 2010. 19;17-18: 2611-2618. doi: 10.1111/j.1365-2702.2009.03143.x

Genova L. Still Alice. Simon & Schuster Ltd. ISBN 10: 1471140822. 2010.

Lethin C. Informal caregivers of older persons with dementia in eight European countries. Experiences, support, well-being and burden. (Doctoral thesis, University of Lund, Lund). 2016. http://portal.research.lu.se/portal/sv/publications/informal-caregivers-of-older-persons-with-dementia-in-eight-european-countries-experiences-support-wellbeing-and-burden(fc8fefbc-5274-41c5-9fa0-2dcdb300523d).html.

Lethin C, Hanson E, Margioti E, Chiatti C, Gagliardi C, vaz de Carvalho C, Malmgren Fänge A. Support Needs and Expectations of People Living with Dementia and Their Informal Carers in Everyday Life: A European Study. *Social Sciences*. 2019, 8, 203; doi:10.3390/socsci8070203.

Malmgren Fänge A, Schmidt SM, Nilsson MH, Carlsson G, Liwander A, Dahlgren Bergström C, Olivetti P, Johansson P, Chiatti C. (on behalf of the TECH@HOME research group*). The TECH@HOME study, a technological intervention to reduce caregiver burden for informal caregivers of people with dementia: study protocol for a randomized controlled trial. Trials. 2017;18, 63.

Malmgren Fänge A, Carlsson G, Chiatti C, Lethin C. Using sensor-based technology for independence and safety – the experiences of people with dementia and their families. Scand J Caring Sci. 2019; Oct 15. doi: 10.1111/scs.12766.

McCormack B. Person-centredness in gerontological nursing: an overview of the literature. J Clin Nurs. 2004. Mar; 13(3a):31-8.

Panza F, Seripa D, Solfrizzi V. et al. Targeting cognitive frailty: Clinical and neurobiological roadmap for a single complex phenotype. J Alzheimers Dis. 2015; 47: 793–813.

Pillemer K, Suitor JJ. Peer support for Alzheimer's caregivers: Is it enough to make a difference? Res Aging. 2002;24: 171-192. 10.1177/0164027502242001.

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Rogers NT, Steptoe A, Cadar D. Frailty is an independent predictor of incident dementia: Evidence from the English Longitudinal Study of Ageing. Scientific Reports. 2017;16;7(1):15746. doi: 10.1038/s41598-017-16104-y.

Searle SD, Rockwood K. Frailty and the risk of cognitive impairment. Alzheimers Res Ther. 2015; 7(1): 54.. doi: 10.1186/s13195-015-0140-3

Thordardottir B, Malmgren Fänge A, Lethin C, Rodriguez Gatta D, Chiatti CJ. Acceptance and use of innovative assistive technologies among people with cognitive impairment and their caregivers: a systematic review. BioMed Res International, 2019, ID 9196729.

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PART 1, TOPICS	LEARNING OUTCOMES
1. Introduction to Dementia and Cognitive Disorders (1.1-1.2)	After this section, the mentor should be able to describe the five most common cognitive disorders, and the cognitive domains most commonly affected by a dementia disease.
2. Behavioural and Psychological Symptoms of Dementia (BPSD) (2.1-2.7)	Knowledge about the most common BPSD associated with cognitive disorder and the most common behaviour management components/strategies.
3. Psychosocial intervention (3.1-3.4)	Knowledge about psychosocial interventions related to cognitive and multisensory stimulation, physical activity and exercise as well as the use of different welfare technologies.
4. Risk and Medication Management (4.1-4.4)	Knowledge about strategies for the prevention and treatment of accidents and injuries in the home.

Outcome, describe	S# and Type	Media Files	Visual Instructions/Developer Notes	Page/Media Text (On Screen)
Introduction to Part 1	Lecture	Video		
1.1 Difficulties in cognition	Lecture Quiz	PPT AAADRD	•	•
1.2 The most common cognitive disorders	Lecture Quiz	PPT AAADRD	•	•
2.1 Challenging behaviours associated with dementia	Lecture Quiz	PPT AAADRD	•	•
2.2 Psychosocial management of BPSD, including a care plan	Lecture Quiz	PPT AAADRD	•	•
2.3 Principles of care for people with dementia regarding BPSD	Lecture Quiz	PPT AAADRD	•	•
2.4 Communication and understanding behaviour	Lecture Quiz	PowerPoint LU	•	•
2.5 Socialization	Lecture Quiz	PowerPoint LU	•	•

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2.6 Feeding and nutrition	Lecture Quiz	PowerPoint LU	•	•
2.7 Activity and participation	Lecture Quiz	PowerPoint LU	•	•
3.1 Cognitive stimulation	Lecture Quiz	PowerPoint LU	•	•
3.2 Multisensory stimulation	Lecture Quiz	PowerPoint LU	•	•
3.3 Physical activity and exercise	Lecture Quiz	PowerPoint LU	•	•
3.4 Use of welfare technology	Lecture Quiz	PowerPoint LU	•	•
4.1 Home accidents prevention	Lecture Quiz	PowerPoint LU	•	•
4.2 Physical and pharmacological restraints	Lecture Quiz	PowerPoint LU	•	•
4.3 Abuse	Lecture Quiz	PowerPoint LU	•	•
4.4 Sexuality	Lecture Quiz	PowerPoint LU	•	•

Multiple Choice Questions, see: www.h5p.org

PART 2, E-MENTORING KNOWLEDGE			**LEARNING OUTCOMES**	
1. Adult learning strategies and models (1.1-1.2)			Be able to describe different adult learning strategies and models and different communication methods and strategies useful in mentoring/coaching situations	
2. Strategies for facilitating adult learning (2.1-2.4)			Be able to describe different strategies for facilitating adult learning	
3. Strategies for online teaching, learning and feedback (3.1)			Be able to describe different strategies for online teaching, learning and feedback	
4. Legal and behavioural aspects of online learning (4.1)			Be able to describe legal and behavioural aspects of online learning	
5. Debriefing and supervision (5.1)			Be able to describe different strategies for debriefing and supervision and the boundaries of an e-mentor	
Outcome, describe	**S# and Type**	**Media Files**	**Visual Instructions/Developer Notes**	**Page/Media Text (On Screen)**

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1.1 Social interaction learning	Lecture Quiz	PowerPoint LU	• Done	•
1.2 Intro on the importance of the learning context	Lecture Quiz	PDF ANS	• Done	•
2.1 Building on previous knowledge	Lecture Quiz	PPT ANS	• Done	•
2.2 Use of the context for learning	Lecture Quiz	PPT ANS	• Done	•
2.3 Use of cases and examples	Lecture Quiz	PPT ANS	• Done	•
2.4 Use of blended learning	Lecture Quiz	PPT ANS	• Done	•
3.1 Methods and strategies for online communication	Lecture Quiz	PowerPoint LU	•	•
4.1 Confidentiality and privacy	Lecture Quiz	PowerPoint (DCHE)	•	•
5.1 Strategies for debriefing and supervision	Lecture Quiz	PPT (DCHE)	•	•

Multiple Choice Questions, see: www.h5p.org

PART 3, E-MENTOR SKILLS	LEARNING OUTCOMES
1. Communication with mentees (1.1-1.2)	Be able to apply and personalize strategies to facilitate learning among the mentees and use the online platform format to support and guide the mentee
2. Strategies to facilitate learning (2.1-2.3)	Be able to apply and personalize strategies to facilitate learning among the mentees
3. Self-reflection on communication and facilitation skills (3.1)	Be able to apply and reflect upon the own communication and facilitation skills

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Outcome, apply	S# and Type	Media Files	Visual Instructions/Developer Notes	Page/Media Text (On Screen)
1.1 Mentoring process-skills	PPT	AAADRD	•	•
1.2 Mentoring skills	PPT	DCHE	•	•
2.1 Guidelines for starting an online mentoring Peer Support Group	PPT	AAADRD	•	•
2.2 Use of online platforms to support learning	Lecture, PPT, Video	Video. 36.6	•	•
2.3 Management of material and media on the Moodle platform	Video	Video. Word file. Screenshots. 36.6	•	•
3.1 Self-reflection and feedback	Lecture, PPT	DCHE	•	•

Multiple Choice Questions, see: www.h5p.org

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5 Annex B: DEM@ENTORING – Quiz, Multiple-choice questions

1. Introduction to Dementia and Cognitive Disorders (1.1-1.2)

1.1 Difficulties in cognition	
1.1.1	What is usually the first cognitive function to be affected when a person has a dementia disease?
	1. Language (False) 2. Short-term memory (True) 3. Perceptual-motor function (False)
1.1.2	What is agnosia?
	1. Loss of language skills, including the ability to speak, understand, read or write (False) 2. The person is unable to brush their teeth (False) 3. Inability to recognize things through the senses: sight, sound, taste, touch and smell (True)
1.1.3	What is apathy?
	1. Inability of or lack of interest to initiate activities, or staying involved in a conversation or task (True) 2. Inability to recognize things through senses (sight, sound, taste, touch, smell) (False) 3. Loss of language skills, including ability to speak, understand, read or write (True)
1.2 The most common cognitive disorders	
1.2.1	Which is the most common dementia disease?
	1. Lewy Body Dementia (False) 2. Alzheimer's disease (True) 3. Vascular dementia (False)
1.2.2	What is one of the most common and early symptoms of dementia?
	1. Loss of appetite and wandering (False) 2. Aggression, apathy and deterioration of the ability to verbally communicate (False) 3. Loss of short-term memory and disorientation regarding time and location (True)
1.2.3	How many years can a person with dementia live with the disease?
	1. 2-5 years (True) 2. 5-10 years (False) 3. Hard to predict (True)

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2. Behavioral and Psychological Symptoms of Dementia (BPSD) (2.1-2.7)

2.1 Challenging behaviors associated with dementia	
2.1.1	What is the best course of action when a person with dementia has sleep disturbances?
	1. Exhaust the person until he/she falls sleep (False) 2. Discuss the sleep disturbances with the doctor to see if further medication or other interventions are required (True) 3. Ignore the symptoms and they go away (False)
2.1.2	Which of the following is considered as BPSD, commonly seen in persons with dementia?
	1. Inability to infer thoughts, feelings or emotions of others (False) 2. Elevated self-esteem and grandiosity (False) 3. Repetitive behaviour and mood disturbances (True)
2.1.3	As a caregiver, how would you deal with a person's with dementia irritability?
	1. Give the person time to calm down and focus on a pleasant activity (True) 2. Impose your opinion, demand the person to stop being agitated (False) 3. Give the person time to calm down (False)
2.2 Psychosocial management of BPSD, including a care plan	
2.2.1	Which of the following are the most appropriate and efficient management strategy for a person with dementia in a psychological or behavioral crisis?
	1. Bringing family and friends in order to “cheer up” the person (False) 2. Routines for the day with pleasant and planned activities with simple instructions (True) 3. Physical exercise regardless of personal wishes to maintain mobility and good health (False)
2.2.2	How can you communicate with the person with dementia to understand their behaviour?
	4. You don´t since it´s useless to try to communicate (False) 5. You let the person with dementia walk around (False) 6. You try to recognise patterns in their behaviour (True)
2.2.3	As a caregiver, how would you deal with a person's with dementia irritability?
	1. Give the person time to calm down and focus on a pleasant activity (True) 2. Impose your opinion, demand the person to stop being agitated (False) 3. Give the person time to calm down (False)
2.3 Principles of care for people with dementia regarding BPSD	
2.3.1	What are the basic psychological needs of the person?
	1. They need to be reassured and not abandoned (False) 2. Need for comfort and attachment, inclusion in a group, to be occupied in activity, maintain a sense of identity in continuity with the past and, and the need to love and feel loved (True) 3. The person need to be included in a group and occupied in some activities (False)
2.3.2	Can a formal or informal caregiver try to prevent BPSD?
	1. Yes, by isolating the person from others (False) 2. No, it’s impossible to prevent (False)

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	3. Yes, by recognizing and taking care of psychological needs (True)
2.3.3	How can you take care of a person with dementia regarding BPSD?
	1. You need to understand the profound reason underlying the BPSD to answer in a correct and reassuring way (True) 2. Only pharmacological treatments can be used (False) 3. You should counter the person in an authoritative way (True)
2.4 Communication and understanding behaviour	
2.4.1	For people with dementia behavior is a form of
	1. Negotiation (False) 2. Communication (True) 3. Socialisation (False)
2.4.2	How can you communicate with the person with dementia to understand their behavior?
	1. You don´t since it´s useless to try to communicate (False) 2. You let the person with dementia walk around (False) 3. You try to recognise patterns in their behaviour (True)
2.4.3	What other factors than the dementia disease can change behavior?
	1. Vision, hearing and pain (True) 2. There are no other factors (False) 3. Animals and pets (False)
2.5 Socialization	
2.5.1	What do we mean by socialization for a person with dementia?
	1. Socialization provides a controlled, yet varied climate of both human and environmental interaction (True) 2. Socialisation for people with dementia includes only joining associations, networks and FaceBook (False) 3. Socialisation for people with dementia is only available in nursing homes and day care centres (False)
2.5.2	What are the four key reasons for socialization of people with dementia?
	1. Gain a greater sense of inclusiveness and belonging, improve brain health, strengthen connection to time and place and enhance and maintain focus (True) 2. Gain a greater sense of inclusiveness and belonging, improve physical health, strengthen connection to time and place and enhance and maintain focus (False) 3. Gain a greater sense of inclusiveness and belonging, improve brain health, strengthen connection to person and situation and enhance and maintain focus (False)
2.5.3	How do you choose the best time and place for socialization of people with dementia?
	1. Socialization should be planned for the time of day when the person is feeling his/her best. Avoid “sun-downing” and crowded places. (True) 2. Socialization can be planned any time of day and when it is most convenient for you. This can be late afternoon and late evenings as well (False) 3. Socialization should be planned for the time of day when the person is feeling his/her best, avoiding exercise and physical activities (False)

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2.6 Feeding and nutrition	
2.6.1	How do you make the mealtime as pleasant as possible
	1. Serve the person with dementia three large meals per day (False) 2. Never use colour contrast of the plate to distinguish the food (False) 3. Sit with the person while eating, to create a friendly atmosphere (True)
2.6.2	It´s common that people with dementia have trouble swallowing. How can you help?
	1. You serve the person with dementia the same food as everybody else (False) 2. You can use a thickening agent and pureed foods rather than thin liquids (True) 3. If the person chokes you are not allowed to help with Heimlich manoeuvre (False)
2.6.3	If the person with dementia needs to be fed, how do you best feed them?
	1. Offer one food item at a time. Make sure he/she has swallowed before offering the next bite. Demonstrate and cue eating behaviour (True) 2. You don´t need to do anything. It is an ordinary meal situation and does not need any preparation (False) 3. Take the person to a nice restaurant with many people, which enables socialization and interaction (False)
2.7 Activity and participation	
2.7.1	How can you enhance an activity to help a person with dementia?
	1. By telling them once and then they know how to do it (False) 2. By showing them how to do it so that they can imitate me (True) 3. By writing instructions so that the person can read and follow them (False)
2.7.2	How can you organize the home environment to facilitate activity?
	1. By letting all things be exposed so that the person with dementia has a lot of clothing, spices etc to choose from (False) 2. By using the same colour on everything, so that they don't get distracted (False) 3. By removing things so that the person has limited things to choose from. (True)
2.7.3	How can you use the outdoor environment for activity and participation in the later stages of dementia?
	1. People with dementia should never go out since the environment is too complex and difficult to understand. (False) 2. By visiting well-known places or taking short walks (True) 3. By going long walks in the forest so that they exercise their muscles (False)

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3.Psychosocial intervention

3.1 Cognitive stimulation	
3.1.1	Cognitive stimulation typically involves a set of tasks designed to reflect:
	1. Physical function (False) 2. Cognitive function (True) 3. Psychological function (False)
3.1.2	When is Cognitive Stimulation Therapy (CST) used?
	1. In the late stage of dementia (False) 2. It is never used in dementia (False) 3. In mild to moderate dementia (True)
3.1.3	What kind of tasks can CST involve?
	1. Physical games, dance and activities, different sounds like music or water, and talking about childhood as well as games (True) 2. CST involves tasks that challenge the person and are totally new to them, like skydiving or bungee jumping (False) 3. CST involves tasks that are relaxing for the professionals (False)
3.2 Multisensory stimulation	
3.2.1	Tactile stimulation for persons with dementia is known to
	1. Improve their appetite (False) 2. Improve their well-being (True) 3. Improve hearing and vision (False)
3.2.2	Olfactory stimulation is considerably more than sensory stimulation such as:
	1. Stimulates the brain, improves cognitive functioning and is calming (True) 2. Olfactory stimulation is only good for dry skin and other skin conditions (False) 3. Olfactory stimulation is never used in dementia care, only in child care (False)
3.2.3	What is a Snoezelen room?
	1. It is a room filled with coloured calming lights for staff to relax in during their work shift (False) 2. It is a room with a bed where staff can take a nap “snoeze” during their work shift (True) 3. A Snoezelen Room is a therapeutic environment created to provide stimulation for people with dementia (False)
3.3 Physical activity and exercise	
3.3.1	Why is it important to be physically active when you have a dementia disease?
	1. They have to be able to take care of themselves (False) 2. Physical activity stimulates the cognitive function and can slow down the progression of the disease (True) 3. Otherwise they won’t eat (False)
3.3.2	What can you do to stimulate physical activity?
	1. Play Sudoku or Jigsaw puzzles (False) 2. Put on the music and dance (True)

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	3. Buy new shoes (False)
3.3.3.	Which is the type of physical activity that is most positive for people with dementia?
	1. Slow walks without increasing pulse (False) 2. High intensive, anaerobic training (False) 3. Aerobic training with increasing pulse (True)
3.4 Physical activity and exercise	
3.4.1	Why is it important to be physically active when you have a dementia disease?
	4. They have to be able to take care of themselves (False) 5. Physical activity stimulates the cognitive function and can slow down the progression of the disease (True) 6. Otherwise they won't eat (False)
3.4.2	What can you do to stimulate physical activity?
	4. Play Sudoku or Jigsaw puzzles (False) 5. Put on the music and dance (True) Buy new shoes (False)
3.4.3.	Which is the type of physical activity that is most positive for people with dementia?
	1. Slow walks without increasing pulse (False) 2. High intensive, anaerobic training (False) 3. Aerobic training with increasing pulse (True)

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4. Risk and medication management

4.1 Home accidents prevention	
4.1.1	How can you arrange the home environment to prevent a fall and enhance activity?
	1. To see to that the light bulbs aren't too strong so that the person with dementia doesn't get dazzled (False) 2. Remove loose carpet and see to that the light is strong (True) 3. Light candles and put many rugs on the floor to make it cosy (False)
4.1.2	Why are people with dementia extra vulnerable to hazards in the home?
	1. They are old and lack social contacts (False) 2. Their cognitive decline makes it difficult to orientate in the home (True) 3. They become colour-blind so it is difficult for them to see objects (False)
4.1.3	What are the main risks for the person with dementia after a fall?
	1. They won't be able to walk the stairs afterwards (False) 2. They will become afraid of doing things, and lose their strength, stamina and balance (True) 3. They stop doing their laundry and need help from others when going shopping (False)
4.2 Physical and pharmacological restraints	
4.2.1	When is consent for restraints needed from a person with dementia?
	1. You can decide for yourself if it's for protective purposes (False) 2. You always need consent even though it's for protective purpose (True) 3. You don´t need consent for protective purpose (False)
4.2.2	What are the negative consequences of physical and pharmacological restraints?
	1. Physical and pharmacological restraints only affect the staff and informal caregivers (False) 2. It may have negative impact on the person's dignity and self-esteem, which is already fragile (True) 3. There are no negative consequences of these restraints (False)
4.2.3	How do we avoid the use of physical and pharmacological restraints?
	1. It is not avoidable (False) 2. With person-centred care (True) 3. Forcing or limiting False)
4.3 Abuse	
4.3.1	People with dementia are more at risk of fraud than other people. Which signs of fraud should you be alert to?
	1. There is lots of food in the refrigerator (False) 2. Invoices and cash withdrawals of high amounts of money (True) 3. There is more mail than usual (False)
4.3.2	Physical abuse is common. Which signs should you be aware of?
	1. Broken bones and other injuries (False) 2. Clothes that have been torn (False) 3. Bruises and scratches (True)

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4.3.3	Psychological abuse is not uncommon. What could be the signs?
	1. The person has nightmares and stops eating and doesn't take the medication (False) 2. The person changes behaviour and might become afraid of certain people (True) 3. The person wants to go out for a walk all the time (False)
4.4 Sexuality	
4.4.1	What is the definition of sexuality?
	1. It´s only sexual intercourse (False) 2. Sexuality includes sexual intercourse and fantasy but also the experience of our gender, sexual identities or being asexual (True) 3. It´s only sexual fantasies (False)
4.4.2	Does the dementia disease affect the person's sexuality?
	1. Yes, always and it´s the same for all persons with a dementia diagnose (False) 2. This varies and sexuality can be difficult for the person with dementia to express (True) 3. No, never and it´s the same for all persons with a dementia diagnose (False)
4.4.3	Can any ethical issues arise by a dementia disease?
	1. No, never and it´s the same for all persons with a dementia diagnose (False) 2. There may be issues related to consent and ethical boundaries, complicated by the dementia disease (True) 3. Yes, always and it´s the same for all persons with a dementia diagnose (False)

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5. Course II -Mentoring knowledge Test and Quizzes

Question	Options[1]
1. Why is the social context important for the mentor-mentee relationship?	1. It affects what people learn. 2. It affects how people learn. **3. It affects both how and what people learn.**
2. Why should mentors take into account the mentees' background before starting the programme?	1. It helps the mentor assess whether the mentee really needs support or not. **2. It helps mentors adapt the learning material, so that the mentees can better understand the context for their mentoring programme.** 3. It helps mentors shorten the mentoring programme, thus saving time for themselves and the mentees.
3. What is a learning context?	1. It includes the characteristics of the place/s where people learn. **2. It includes all the external factors that provide meaning to someone's learning experience and affect the learning performance.** 3. It includes the learning climate and how much the learner feel part of the learning experience.
4. What do we mean by blended learning?	**1. It is an approach, which combines online educational opportunities with traditional place-based classroom methods.** 2. It is an approach, which combines different online adult learning strategies. 3. It is an approach, which combines different online learning experiences (simulations, case studies, etc.).
5. Confidentiality is an important component of a successful mentor-mentee relationship. How can it be ensured?	**1. It is important for the mentor and mentee to be able to have an open and honest conversation about what they expect in terms of confidentiality.** 2. It is key that legal guidance is provided to both the mentor and the mentee before starting the relationship.

[1] Correct answers indicated in bold.

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	3. A confidentiality template should be signed by the mentee before starting the mentoring relationship.

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6. Course III E-mentoring skills Test and Quizzes

1. Why is self-reflection useful as a mentor?	**1. It prompts thinking about my role as a mentor, skills and knowledge, and how a mentor influences and impacts on the mentee's development.** 2. It allows me to think about my strengths and opinions and forward them to the mentee. 3. It helps me to evaluate the mentor-mentee relationship and make adjustments to it.
2. Why should a mentor give feedback to the mentee?	**1. Feedback allows the mentor to acknowledge your mentee's strengths and to motivate the mentee to work on areas of weakness.** 2. Feedback to the mentee is required as part of the formal evaluation procedure in order for the mentor to become an advanced mentor. 3. Feedback allows the mentee to reflect on weaknesses in order to change the behavior or to read more about what skills are necessary to have as a mentor.
3. There are different ways of working as a mentor. Which ones are correct?	**1. Counselling, virtual/e-mentoring, coaching** 2. Counselling, role model, e-mentoring 3. E-mentoring, lecturing, coaching
4. Why is trust important in a mentor-mentee relationship?	1. Without trust the mentee will not reveal their personal issues for the mentor 2. Trust is necessary in order to get good scores as a mentor **3. Without trust the mentees can't develop their strengths and weaknesses and move on with their life.**
5. What are the core mentoring skills?	1. **Active listening, trust building, encouraging, goal identification**

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	2. Feedback, inspiration, trust building, encouraging 3. Evaluation, inspiration, trust building, active listening.

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