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Executive Summary
Approximately one-third of all people with dementia live in care homes. There is growing concern over the quality of care, which has been linked with stress and burn-out in the caring relationship. Reductions in burnout and improved quality of care can be achieved by addressing the training needs of nurses, who are in leadership positions in nursing homes.

This study set out to investigate the effectiveness of a Person-Centred (PC) ‘dual-element’ training intervention designed to reduce burn-out for nurses working with people with dementia in nursing homes. The study also explored whether clinical supervision sustained the impact of training if any, on burn-out and other staff outcomes.

Outcomes included nurses’ burnout, feelings of self-efficacy, person-centred approach, attitudes and leadership style. In addition the study investigated how the knowledge and skills taught were implemented in practice. Data was collected by means of standardised outcome measures and semi-structured interviews.

Findings:

The themes from the qualitative interviews included “Working in a stressful place”, “Bringing learning into the home”, “The impact of Supervision” “Listening to other people stories” and “Building
confidence”. The first theme “Working in a stressful place” reflected a range of factors which led the nurses to feel exhausted, unsupported and disempowered. The second theme “Bringing Learning into the home” reflected how the nurses had been able to bring what they had learnt from the intervention into the home and how they adapted the new learning so that it was appropriate for their place of work. The third theme “Impact of Supervision” demonstrated how the supervision appeared to support staff in the implementation of the new learning, encouraging experimentation and reflection. Through the supervision process the nurses were encouraged to work flexibly and creatively, adopting a solution focused approach to manage challenging situations at work. The fourth theme “Listening to other peoples stories” emerged as participants reported that the classroom training had provided valuable opportunities for sharing practice and experiences of working in a nursing home.

The Quantitative analysis demonstrated that a greater proportion of participants were less emotionally exhausted in the group with the additional supervision element than the group without. Participants receiving dual element training without supervision experienced increased in emotional exhaustion over time. The group receiving dual element training combined with supervision also scored significantly higher than the group without supervision on the attitudes to personhood score. No changes were observed in extent to which care staff rated their work and their care setting as person-centred, in leadership styles or confidence.

In terms of impact on the wider care environment the findings of the Dementia Care Mapping were mixed, however the results showed that the resident’s well-being improved in both groups following training compared to the control group. The qualitative interviews with care staff demonstrated that the care staff perceived the nurses as benefiting from the training in terms of improved in terms of self-efficacy, person-centred approach, and leadership.

Recommendations:

- Training programmes should be multifaceted and include active learning approaches and opportunities for networking.
- Good quality clinical supervision should be provided for carers and nursing staff and there should be a greater emphasis placed on non-managerial supervision and reflective practice.
- Follow-up should be provided post training to support staff in the implementation of the new learning, challenging old practices and bringing about change within the organisation where they work.
- Further research is required to support the development of strategies and interventions to reduce staff turn-over and burn-out and improve job satisfaction.
- Further research is required to identify effective mechanisms for clinical supervision in nursing homes. New knowledge and understanding about the enablers and barriers to conducting supervision in nursing homes should also be developed.
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Chapter 1: Background to the study

Introduction
There are currently approximately 800,000 people living with dementia in the UK (Alzheimer’s Society, 2013). The population is ageing and the expected rise in numbers in future generations is now well-known and widely quoted (Glasper, 2014; Grout, 2014). Approximately one third of people with dementia in the UK are cared for in a nursing home environment (Alzheimer’s Society, 2014). Concerns are frequently raised in the media about the quality of care in these environments (e.g. BBC Panorama 2014) and while for many care is of high quality and person-centred, this is not always the case (DH, 2013). The National Dementia Strategy (DH, 2009) requires the dementia care workforce to have ‘the necessary skills to provide the best quality of care’. Dementia care education has historically been limited in pre-registration nursing courses (Blakemore, 2014), despite the high numbers of people with dementia in general hospitals (DH, 2013), leading nurses to feel under-prepared (Gandesha et al, 2012). It has been suggested that education of both pre-and post-qualification nurses should include a stronger focus on dementia (Blakemore, 2014), and this is particularly relevant for those working in nursing homes. However, unlike their counterparts in primary and secondary care, nurses working in care homes often have limited opportunities for on-going training, may gain little or no respect and recognition for good work, and have very few opportunities for career growth (RCN 2012). There has been a recent emphasis on dementia awareness training which does not go far enough in improving the experience of people with dementia (Sheard 2009), or the culture of care (Independent Commission on Dignity in Care, 2012), and more in-depth training is needed. In our previous research, focus groups revealed that alongside traditional knowledge-based training delivered in the lecture room, nurses also wanted practical, hands-on training that models good practice, delivered by credible trainers (Smythe et al. 2014).

Living with dementia in care homes
The term ‘dementia’ refers to a range of progressive syndromes including Alzheimer’s disease, vascular dementia, Lewy Body disease and alcohol related dementia, all of which have a gradual impact on a person’s ability to remember, orientate themselves, communicate, sequence activities and keep themselves safe (Nazarko, 2013). People in later stages of dementia usually need assistance with managing personal hygiene and eating a healthy diet. They also tend to have difficulties in both understanding others and expressing themselves (Brooker et al. 2007).

A person with severe dementia may be orientated to a time in the past and believe that they are a young child or have parental or work responsibilities (Brooker et al. 2007). These issues often lead to frustration and behaviours collectively known as ‘behavioural and psychological symptoms of dementia’ or ‘indications of distress’ which include repetitive speech, resistance to care, disinhibition, aggression and crying (Parker et al, 2012). As a result caring roles can be very stressful for both family and professional carers (Adams, 2008). People with dementia who live in care homes may also experience difficulties because of the unfamiliar environment and because the person-centred ideal may not be a reality (May, Edwards and Brooker, 2009).
Cultures of Care

People in later stages of dementia need practical assistance with the functions outlined above. Some need emotional support for the emotional distress that can follow from feeling disorientated, separated from loved-ones and being recipients of personal care from people who may be perceived as strangers (Hammar et al, 2011). At the time when people most need to communicate their needs they are least able to do it, so staff need to develop insight into the person’s experience, preferences and communication styles in order to respond sensitively (May, Edwards and Brooker, 2009). Kitwood (1997) emphasised the benefits of a person-centred culture of care which aimed to change the approach from the previous ‘old culture’ organisationally-orientated care where lives were managed around the timetable that was convenient for staff and institutions. Kitwood suggested that much of the deterioration experienced by those with dementia is a result of the “malignant social psychology” within care settings, rather than being driven by an underlying progressive neurological disease (Capstick, 2008). Kitwood’s model also emphasised the benefits of a person-centred culture of care which aimed to change the approach from the previous ‘old culture’ organisationally-orientated care where lives were managed around the timetable that was convenient for staff and institutions (Kitwood, 1997). Therefore a person-centred approach involves understanding each person as an individual and focusing on their unique needs and abilities. Since then others have built on Kitwood’s ideas to acknowledge that caring has an impact on carers and their needs should also be recognised in recommendations for care delivery (Nolan et al, 2006, Adams, 2008). Despite the work of Kitwood and others, people with dementia living in care homes may still be cared for within institutional regimes that fail to recognise individual preferences and offer minimal meaningful activities (Harmer and Orrell, 2008).

Barriers

Roles involving nursing people with dementia in any environment are challenging, demand physical and emotional energy and require a range of skills that when carried out well are often invisible to others (Holman, 2014). However, the care assistants who carry out most of this work are among the lowest paid in the UK and are at high risk of job strain and burn-out (Koehler, 2014; Edvardsson et al, 2009). As with trained nurses, they receive mixed messages in the media about their worth, (Donelan et al, 2008) while being trained by people who may be perceived to be high on rhetoric and low on recent experience of the nitty-gritty of personal care (Adams, 2008).

The nurses who lead and manage teams of care assistants may be in different, but likewise in difficult, positions. Some, in first jobs post-qualification, may be charged with promoting high standards of care and ‘culture change’. Others may have chosen nursing home work to fit around family responsibilities or as a ‘step down’ from the demands of acute care toward the end of their careers. Nursing in a nursing home is challenging. Residents have increasingly complex needs; professional decisions have to be made independently, care needs to balance with costs and outcomes, and different pressures from owners, relatives, residents, colleagues and CQC inspections (and associated bureaucracy) to be managed, resulting in low levels of morale throughout the sector. Opportunities to ‘model’ good care may be limited by the need to spend time on medication administration and managerial aspects of the role (Smythe et al, 2014a).

Nurses find they are usually the only qualified staff member on duty and are responsible for a range of clinical, ethical and managerial decisions (Bedin, Droz-Mendelzweig and Chappuis, 2012). They may not
receive sick pay and some nurses report being expected to access learning in their own time (RCN, 2012). While care philosophies may speak of a person-centred approach, unspoken messages underscore financial imperatives and homes are often under-staffed (RCN, 2012). There is a perception that working with older people is of a low status (Fussell et al, 2009) and undervalued (RCN, 2012). Training is costly, and even when it is free, the backfill costs for qualified staff make it unaffordable for some organisations (Alzheimer’s Society, 2013) and it could be argued that the homes which need it most are least likely to access it. The nursing home context can thus raise barriers to the education of its nurses. Even when nurses are able to access training it can still be difficult for them then to lead changes within the culture of the organisation.

**Education that changes practice**

Education and training are seen as central activities that deliver changes in practice and although staff training in dementia care is widely promoted as being inherently ‘good’, with the ultimate goal of improving the quality of life and care for residents (Nolan, Davies and Brown et al, 2008), many training packages are found to have little or no impact after a short period of time (Mace, 2005). Indeed the literature reporting outcomes of such training programmes suggests that findings are equivocal and benefits inconsistent (Westermann et al. 2014). Training interventions can vary in length, some awareness-raising being as brief as an hour, while academic courses at higher levels may take years to complete. There is also a wide range of free online learning packages that offer excellent resources that explain the nature of dementia, offer insight into the experiences of people living with dementia and promote a positive person-centred problem-solving approach to care (e.g SCIE Open Dementia Programme 2009). While knowledge and understanding are an essential foundation, alone they do not necessarily lead on to doing things differently and superficial learning tends to have little or no impact (Sheard, 2009). Adult learners thrive in environments that respect their experience, focus on relevant activities and welcome discussion and challenge (Rogers, 2007).

**Our previous research into training needs and preferences**

Our previous research, which explored the dementia care training needs of specialist staff and nurses working in acute hospitals confirmed that adult learners prefer active, experiential approaches to learning and that these were successful in changing practice long-term. (Smythe et al, 2013; Smythe et al, 2014b).

We also found that while care assistants in specialist mental health services preferred to learn separately, they later revealed that some learning was difficult to implement as qualified staff were not always in tune with the person-centred approach. Some nurses and qualified social workers ‘sent themselves’ on courses that were designed for care assistants, which alerted us to the gap in provision for this group. The acute hospital nurses benefitted from in-practice reinforcement of classroom learning through a ‘working alongside’ approach to address particular practice problems, although this was difficult to implement in the acute setting.

**Chapter 2: Literature Review**

This review aims to provide a systematic and critical overview of research which examines effective ways of educating staff working with people with dementia in a range of settings. This chapter initially outlines
the method for the review, the quality review undertaken and the findings of the review. This is followed by a section focusing on systematic reviews. Empirical studies are then discussed. These have been grouped under the four main outcomes that they measure, focusing on reduction in levels of agitation, antipsychotic prescribing, quality of life and staff related outcomes, including burn-out.

Method:
A search of the literature was carried out to identify research on the development and effects of training interventions in dementia care. The aim was to include randomised controlled trials or un-controlled before-and-after studies, using validated quantitative outcome measures and well-designed qualitative studies, where the findings were presented thematically or narratively and evidenced through quotes. Articles that reviewed papers of this standard were also included.

The search included publications between 1990 and 2015 using the following databases Psych Info, CINAHL, BNI, EMBASE, OVID and MEDLINE and the Cochrane library to capture as many relevant citations as possible: Search terms relating to the condition (dementia OR Alzheimer), the intervention (Training* OR Education* OR Staff development* OR Workshop*) and the participants (Mental Health Personnel*, OR Nurses* OR Medics* OR Allied health professionals* OR Healthcare Professionals) were combined.

A total of 409 articles were found and titles and abstracts were reviewed. 386 papers were excluded as the focus of the training was not on management of dementia, (e.g. the study focused on detection rather than management). Of the remaining 63 papers, full text articles were assessed for possible inclusion. The references from these papers, including seven systematic reviews were also hand searched and the full texts of papers identified were requested if relevant. In total 33 empirical studies and eight systematic literature reviews were found that met the inclusion criteria and are therefore included in this review.

Quality Review:
In order to determine the quality of the 33 studies a critical appraisal framework was used. There are a number of quality frameworks available (Caldwell et al. CASP, 2005; Sale et al. 2002; Hill and Spittlehouse 2003), there is lack of consensus over the most appropriate aspects of research to include in these tools, and there is currently no “gold standard” (Katrak et al. 2004). For the purpose of this review a quality assurance checklist adapted from the American Academy of Neurology Clinical Practice Guidelines (2004) was utilized.

All included studies were assessed for quality using this criteria. The checklist was considered to be appropriate as it assessed aspects of the studies’ theoretical basis, design, measures, analysis and results; it was also suitable for quantitative and mixed method studies (see table 1).

Findings of the Quality Review
All the studies described their rationale and aims clearly, used appropriate methodology and clearly identified key variables. There were no qualitative studies; seven used mixed methodology (McCarron et al. 2008; Robinson et al. 2010; Clare et al. 2012; Leone et al. 2012; Feldt and Ryden 1992; Galvin et al. 2010). All of the papers were checked against each of the criteria of the quality assurance checklist. Studies were assessed according to description of intervention, training and participants, details of follow-up, analysis of confounding variables, appraisal of measurement tools and adequate reporting of
relevant results. However limitations were evident and these are discussed later in this chapter. Uncontrolled studies, before and after studies and randomised controlled designs (RCT’s) were included in the review. Randomised trials are the preferred design for studying the effects of healthcare interventions because, in most circumstances, the randomised trial is the study design that is least likely to be biased, however uncontrolled studies were included in the review because only a small number of RCT’s could be identified. It is acceptable to include uncontrolled studies in a systematic review, to supplement existing randomized trial evidence (Reeves et al. 2008). Risk of bias in non-randomized studies can be assessed in a similar manner to that used for randomised trials, although more attention must be paid to the possibility of selection bias (Reeves et al. 2008).

The training and educational interventions described in the 33 studies focused on four main outcomes: strengthening staff members’ expertise in supporting people with behaviours which challenge, (these are frequently referred to as “Behavioural and Psychiatric Symptoms of Dementia” “BPSD” which is a term drawn from the biomedicalisation of ageing and widely used in the literature); reducing antipsychotic prescribing; promoting the quality of life of the person with dementia, through supporting a shift from a biomedical model (the disease process) to more person-centred care (e.g. targeting resident’s psychosocial and emotional needs); and improving staff outcomes including a reduction in staff burnout or increase in confidence, knowledge and leadership. Therefore the findings from the reviewed papers have been grouped accordingly. In the sections below, first all of the eight reviews are summarised. After that, the empirical studies are reviewed with one section devoted to each of the four outcomes.
Systematic reviews

Eight systematic literature reviews which focused on staff training were identified (Spector et al. 2013; Eggenberger et al. 2013; Perry 2011; Richter et al. 2012; Moyle et al. 2010; McCabe et al. 2007; Livingston et al. 2005; Livingston 2014; See Table 1). This section summarises the scope, nature and conclusions of these reviews. Individual studies included within the identified systematic literature reviews which also met the inclusion criteria for this present review, have been included in their own right later in later sections.

The search strategies in the reviews were defined by the principles of systematic searching, and all used similar search strategies and methods for appraising the papers selected. All involved searches of four major data bases (PubMed, EMBASE, MEDLINE and PsychINFO). Other data bases used included CINAHL and The Cochrane Library. However this varied depending on the reviewer. One review focused on studies conducted within primary care (Perry, et al. 2011), while the remaining 7 reviews focused on institutional settings including nursing and residential homes.

Five reviews (Livingston et al. 2014; Livingston et al. 2005; McCabe et al.2007; Moyle et al. 2010; Spector et al. 2013) investigated the effects of educational interventions on the management of behaviours which challenge. Livingston et al. (2005) conducted a very broad systematic review of psychosocial approaches to the neuropsychiatric symptoms of dementia, including impact on care costs, quality of life, institutionalization, and decreased medication or restraint. The review included 162 studies in total, only nine of which investigated the effects of staff education on managing behavioural problems. Livingston et al.’s (2014) review was more specific and focused on the management of agitation in dementia; 33 studies were included, five of which focused on staff training. The review conducted by McCabe et al. (2007) covered studies on staff training programs to address behavioural problems in residential care. 19 studies were included; five of which were also reviewed by Livingston et al. (2005) (Cohen-Mansfield et al. 1997; Edberg et al. 2001; Hagen et al. 1995; McCallion et al. 1999; Brane et al. 1989). Moyle et al. (2010) included 17 papers in a review to identify the most effective training programs available for staff working with older people with mental illness. The paper included only one study (Coveo 1985: 1098) from the other reviews, possibly because the majority of papers focused on “behaviour skill training programs” aimed at managing the “Behavioural Signs and Symptoms of Dementia” (“BPSD”). Spector et al. (2013) reviewed twenty studies focusing on staff training interventions to reduce “BPSD”. Spector et al. (2013) included six studies from the review conducted by McCabe et al. (2007) (Burgio et al. 2002; Campbell et al. 2004; Magai et al. 2002; McCallion et al. 1999; Moniz-Cook et al. 1998; Proctor et al. 1999); four studies from Livingston et al. review (McCallion et al. 1999; Moniz-Cook et al. 1989; Schrijnenmaekers et al. 2002; Testad et al. 2005) and one study from the Moyle et al. review (McCabe et al. 2007). In total between them, these four reviews covered 42 different studies on the effectiveness of training staff to manage behaviour.
The objectives of the remaining three reviews were varied. Eggenberger et al. (2013) focused on communication skills training and included 12 studies. Richter et al. (2012) conducted a Cochrane Review which included four studies evaluating the effectiveness of psychosocial interventions to reduce medication in care home residents. Finally a review conducted by Perry et al. (2011) focused on studies conducted within primary care and included 5 studies in total, all of which aimed to determine the effects of educational interventions about dementia directed at primary care providers.

**Findings of the reviews**

All five reviews on the effectiveness of staff training in the management of behavioural problems found that there was some evidence to suggest that staff training interventions can positively impact on outcomes, including a reduction in behaviour problems, levels of agitation, staff burnout, depression, or anxiety (Livingston et al. 2005; Livingston et al. 2014; McCabe 2007; Moyle et al. 2010; Spector et al. 2013). Spector et al. (2013) also found some evidence that some interventions had a positive impact on staff self-efficacy and stress, although the results were mixed. Likewise McCabe et al. (2013) found that some studies indicated a reduction in staff turn-over and staff satisfaction. Moyle et al. (2010) noted that the majority of studies resulted in positive changes in staff knowledge and/or competency. Livingston et al. (2014) found that person-centred care, communication skills training and adapted dementia care significantly decreased agitation in dementia both immediately and for up to 6 months afterwards. However training in communication skills and person-centred care were ineffective without on-going supervision (Livingston et al. 2014). Livingston et al. (2014) recommended the development and evaluation of a manual-based training for staff focusing on changing culture in order to sustain change.

Eggenberger et al. (2013) concluded that communication skills training in dementia can significantly improve the quality of life and well-being of people with dementia and increase positive interactions. However inconsistent results were found regarding secondary outcomes including challenging behaviour, use of restraints and use of sedative drugs. Richter et al. (2012) showed a reduction in antipsychotic medication prescription rates as a result of the different educational interventions. Results on secondary outcomes were again inconsistent. Perry et al. (2010) found that educational interventions for primary care providers could improve detection of dementia; however it was also noted that educational interventions alone were not effective in improving knowledge, attitudes and health professionals’ behaviour.

In terms of the elements that led to better outcomes: Spector et al. (2013) found no links between the theoretical orientation of the training programmes and their effectiveness, or between the intensity of the training programmes and their effectiveness in reducing “BPSD”, except that when training was too brief, there did not appear to be sufficient “dose” of training to change care practice (Spector et al. 2013). Both Moyle et al. (2010) and Spector et al. (2013) found that staff training programmes were very dependent on organisational factors, such as management style and
care culture. Many of the reviews concluded that educational interventions are more effective and sustainable when combined with additional supportive measures and that on-going support and supervision is required to maintain positive outcomes (Eggenberger et al. 2013; Moyle et al. 2010; Spector et al. 2013; McCabe et al. 2007; Livingston et al. 2014). Moyle et al. (2010) identified the key features of successful staff education programmes as including planning the curriculum content with the audience so that their learning needs are met; focusing training on the needs of the residents and the model of care within the facility; and providing training at times to suit the audience. Richter et al. (2012) noted that the study with the most complex intervention, educational content, and absolute time spent on the intervention as well the greatest methodological rigour (Fossey et al. 2006) showed the greatest statistical difference in levels of antipsychotic medication use between groups of residents at the end of follow-up. Perry et al. (2011) concluded that educational interventions for primary care providers require active learning and need to be combined with social network strategies, reimbursement for training participation and quality of care as well as protocols for structured case management.

**The reviews’ comments on quality of studies**

Spector et al. (2013) found numerous methodological weaknesses as many studies did not adhere to the recommended guidelines for the conduct of cluster randomised controlled trials. Cluster designs require a higher sample size to be adequately powered and the analysis needs to be adjusted for clustering effects (Woods and Russell, 2014). Only three studies included in the review adjusted for these effects in their sample size calculation (Chenoweth et al. 2006; Fossey et al. 2006; Proctor et al. 1999) or in their analysis (Chenoweth et al. 2006; Fossey et al. 2006; Teri et al. 2005). Spector et al. (2013) also found that some of the staff measures may not have been sensitive enough to detect change. Eggenberger et al. (2013) reviewed 12 trials, eight of which took place in nursing homes and four in home care settings. They identified only four RCTs with high quality ratings (McCallion et al. 1999; Burgio et al. 2001; Magai et al. 2002; Kuske et al. 2009) conducted in residential-care settings, while two good-quality RCTs and one Case Control Trial provided the main data to analyse the effectiveness of training in home care settings (Done and Thomas 2001; Teri et al. 2005; Haberstroth et al. 2006). Eggenberger et al. (2013) found that the majority of studies reported severe methodological challenges with high drop-out rates, (McCallion et al. 1999; Done and Thomas 2001; Haberstroth et al. 2006; Williams 2006). Perry et al. (2011) commented that the methodological quality of the studies was diverse and also noted that the most common limitation was the large proportion of participants lost to follow-up and the poor compliance to the intervention, as well as differences at baseline. McCabe et al. (2007) also identified systemic issues specific to conducting interventions in health and care home settings, such as difficulties in training all staff members, entrenched task-focused rather than client-focused practices and the heterogeneity of facilities. They also cite problems related to the operationalization of success, with a large range of methods used to measure outcomes.
Livingston et al. (2005) conclude that more high-quality research is therefore needed; it is also suggested that future research designs need to be multicentre, adequately powered, adhere to recommended guidelines and be conducted across languages and cultures. Characteristics of trainers should also be considered as well as implementation fidelity (Torgerson and Torgerson, 2008). According to Murfield et al. (2011) studies also need to deal with the many logistical barriers found in care settings such as nursing homes, including high staff turnover, reduced staff-to-resident ratios and inflexible organisations. In addition interventions should be better defined so that they can be manualised and replicated at a modest cost (Livingston et al. 2005). Many of the reviews encourage researchers to improve the reporting of important characteristics of the intervention and settings as well as details of the extent of the implementation.

**Empirical Studies:**
The 33 papers have been grouped in relation to the four main outcomes upon which they focus. Within each group studies will be discussed in relation to setting, nature of the intervention, methodological issues and outcomes.

**Outcome-Reductions in levels of agitation:**

**Setting:**
All nine studies which focused on reducing levels of agitation (Teri et al. 2005; Proctor et al. 1999; Visser et al. 2008; Testad et al. 2005; Chrzescijanksi et al. 2007; Deudon et al. 2009; Chenoweth et al. 2009; Moniz-Cook et al. 2008; Edberg and Hallberg 2000) were conducted within institutions e.g. residential homes, nursing homes and assisted living facilities, apart from the study conducted by Moniz-Cook et al. (2008), which took place within a community mental team. One study was conducted in France (Deudon et al. 2009) one in Norway (Testad et al. 2009), one in Sweden (Edberg and Hallberg 2000), three in Australia (Visser et al. 2008; Chenoweth et al. 2009; Teri et al. 2005) and two in the UK (Proctor et al. 1999; Moniz-Cook et al. 2008). Therefore there are likely to be structural and cultural differences between countries that may have contributed to the different findings, for example, different attitudes and options regarding the use of physical restraints among nursing staff in Australia and European countries (Australian Society for Geriatric Medicine 2005).

**The nature of the training intervention:**
The interventions are well described; five were grounded in the theory and philosophies of person-centred care (Kitwood 1997). Chenoweth et al. (2009) randomised staff to one of two interventions, either a two-day training session in person-centred care (PCC) or dementia care mapping (DCM). The PCC training was designed to challenge previously held beliefs, focusing on social interactions. For sites randomised to DCM, two care staff were trained to identify factors related to resident well-being. Staff in both groups also received on-going support for 4 months following the training. The Staff Training in Assisted-living Residents [STAR] program model used by Teri et al. (2005) had three priorities: reinforcing dignity and respect for residents, improving staff responsiveness to resident needs, building specific staff skills to enhance resident care. The intervention was...
conducted over 2 months by means of two half-day workshops and four individualised sessions. The intervention designed by Testad et al. (2009) intervention is described as “Relation-Related Care” (p82), and aimed to change knowledge, attitudes and care practices of care staff during a two day seminar which was followed by monthly group guidance for 6 months. In Chrzescijanski et al. (2007) Emotional Responses as Quality Indicators (ERIC) training also appeared to be based on a person centred approach; ERIC aimed to improve staff members’ understanding of the emotions and subsequent needs of the person with dementia. The intervention involved staff watching a 40 minute video. Following the training it was anticipated staff would reliably be able to record a range of different emotions. In terms of duration this intervention was very brief and there were no follow-up training sessions. The training programme implemented by Edberg and Hallberg (2001) consisted of a 2 day training programme focusing on individualised planned care; staff also received on-going supervision for 12 months.

The remaining studies instigated training based on behaviour modification (Cohen-Mansfield 1997; Stevens 1998). In Deudon et al. (2009) the programme began with a 90 minute teaching session on dementia, “BPSD”, and the use of “how to” instruction cards, summarising practical advice on how to deal with “BPSD”. The remainder of the training sessions consisted of weekly personalised training, advice and feedback over a four month period. The intervention in Moniz-Cook et al. (2008) was designed for Community Mental Health Nurses (CMHNs), and grounded in functional behaviour analysis as well as problem solving and coping with stress.

In addition staff received on-going supervision for the 18 month study duration. In Visser et al. (2008) staff were randomly allocated to education only or education plus peer support. The education programme consisted of eight units delivered twice a week for 1-1 ½ hrs. The first three were didactic and provided information on ‘dementia and behaviour symptoms’. The following five units were facilitated workshops based on a behavioural model. The peer support programme was run for 30 minutes after the education units and was designed to reinforce the educational material. In Proctor et al. (1999) the intervention was also based on behavioural management. Staff received seven 1 hour seminars. An experienced nurse then visited the home providing on-going support over 6 months.

Methodological issues:
All the studies described their rationale and aims clearly, used appropriate methodology and clearly identified key variables. However limitations were also evident. The studies conducted by Moniz-Cook et al. (2008), Edberg and Hallberg (2001) Chrzescijanski et al. (2007) used quasi-experimental designs rather than an RCT design. In the study conducted by Chrzescijanski et al. (2007) the resident acted as his/her own comparison pre and post training. The remaining five studies (Chenoweth et al. 2009; Deodon et al. 2009; Visser et al. 2008; Teri et al. 2005; Testad et al. 2009; Proctor et al. 1999) all used a cluster design i.e. randomising nursing homes rather than individual patients, to address the effect of staff training to control conditions and to avoid a contamination from the effect of the
intervention. However only three studies (Chenoweth et al. 2009; Proctor et al. 1999; Teri et al. 2005) adjusted their analysis for the cluster randomisation.

Sample sizes were frequently small and thus the generalizability of findings is reduced; the smallest sample was Edberg and Hallberg (2001) with 22 patients from two wards within one nursing home; the study conducted by Teri et al. (2005) was also limited with 25 staff and 31 residents from four homes, although the study’s findings were statistically significant. The largest sample was Deudon’s et al. study with 306 patients and 16 nursing homes, closely followed by Chenoweth et al. with 15 homes and 289 residents. Three studies (Proctor et al. 1999; Testad et al. 2009; Chenoweth et al. 2009) took differences in baseline characteristics into account during statistical analysis. Deudon et al. (2009) reported that there were differences at baseline which may have affected the generalizability and reliability of findings. This matter was not discussed in the remaining papers. In terms of participants few studies apart from those conducted by Chenoweth et al. (2007) and Testad et al. (2009) fully described their recruitment procedures and provided enough detail to determine transferability of results. Only two studies included follow up post intervention, at 6 months (Visser et al. 2008) and at 3 months (Deudon et al. 2009). Chenoweth et al. (2009) and Teri et al. (2005) were the only studies which ensured researchers were blinded to the treatment allocation.

When selecting outcome measures it is important to choose ones that are reliable and valid (Pallant, 2007). The majority of studies (Testad et al. 2010; Duoden et al. 2009; Chenoweth et al. 2009; Visser et al. 2008) rated agitation using the Cohen-Mansfield Inventory (CMAI) (Cohen-Mansfield, 1989). The CMAI is an interview based assessment instrument designed to measure frequency of 29 behaviours, observed by the caregiver over the previous 2 weeks. It is the most well-known scale used to measure agitation in dementia, demonstrating high levels of validity and inter-rater reliability (Moniz-Cook et al. 2008).

Several other studies (Proctor et al. 1999; Teri et al. 2005; Moniz-Cook et al. 2008; Chrzescijanski et al. 2007; Edberg and Hallberg 2001) rated agitation using less well known scales (Revised Memory and Behaviour Problems Checklist, RMBPC, Teri et al. 1992; an adapted version of the Gillesard Problem Checklist, Agar et al. 1997; The BAGS Aggression Scale, Queen Elizabeth Geriatric Centre, 1992; Critchton Royal Behaviour Scale, Proctor et al. 1999; Demanding Behaviour Assessment Scale (Hallberg and Norberg, 1993). In terms of reporting the psycho-metric properties of these scales it is noted that limited information was provided in all of these papers. Scales with poor inter-rater reliability may contribute to the lack of validity and generalizability of the study results.

**Outcomes:**
The results were mixed; six studies reported a significant reduction in levels of agitation post intervention (Chenoweth et al. 2009; Testad et al. 2010; Deudon et al. 2009; Teri et al. 2005; Moniz-Cook et al. 2008; Edberg and Hallberg 2001). Four of these (Chenoweth et al. 2009, Teri et al. 2005; Testad et al. 2005; Edberg and Hallberg 2001) used a person centred approach, while the remaining two studies used an approach based on functional analysis (Deudon et al. 2009; Moniz-Cook et al.
2008). Deudon et al. (2009) also found that a reduction in “BPSD” was still present 3 months after the end of the programme. All the studies with positive outcomes included on-going support or additional supportive measures post intervention.

Three studies found no changes in the levels of resident agitation post training: Proctor et al. (1999) and Visser et al. (2008) who used a behavioural model followed by on-going support post intervention; and Chrzescijanski et al. (2007) who used an approach based on behaviour modification with no follow-up post intervention. Small sample sizes are frequently cited as a reason for their negative findings, as this may significantly reduce statistical power to detect changes between groups (Richter et al. 2012). According to Button et al. (2003) a study with low statistical power has a reduced chance of detecting a true effect, but it is less well appreciated that low power also reduces the likelihood that a statistically significant result reflects a true effect. Visser et al. (2008) and Chrzescijanski et al. (2007) also noted that the residents’ behaviour was rated by the staff members who cared for them and who were involved in the education programme, which may have influenced the staff members’ ratings of behavioural problems. According to Visser et al. (2008) the results of their study revealed that a behaviourally based education programme was not an effective strategy.

**Studies with secondary outcomes focusing on management of agitation:**
The nine studies reviewed above used levels of agitation as their primary outcome measure. However, some additional studies included agitation as a secondary outcome and these are summarised in this section. Fossey et al. (2006) found that training and support failed to have a significant effect on any of their secondary outcome measures including agitation, measured using the CMAI inventory. The authors suggested that this may reflect difficulties inherent in the culture of care within nursing homes which make it hard to measure change in such a small scale trial. Monette et al. (2008) included frequency of disruptive behaviours as a secondary outcome and found that the frequency of disruptive behaviours decreased significantly over the 6 month period in the training group compared with controls. McCallion (1999) found communication skills training for nursing and auxiliary staff showed significant reduction in the level of resident’s aggression post-training and at 3 months. However Cohen-Mansfield (1997) found no significant change in the behaviour of residents post-training or at one-month follow up. Davison et al. (2007) found that a didactic and experiential eight week programme focusing on dementia related behaviours did not impact on levels of agitation.

**Summary and implications:**
In summary, the studies by Chenoweth et al. (2009) and Proctor et al. (1999) appear to meet most of the quality framework criteria and were the highest quality studies in this group. One of these (Chenoweth et al. 2009) showed positive effects of staff training on agitation in people with dementia but the other (Proctor et al. 1999) did not. The intervention by Chenoweth et al. was grounded in the theory and philosophies of person-centred care, whereas Proctor et al. (1999) was
based on behavioural management. In terms of outcome, it was noted that all the studies which demonstrated a significant reduction in agitation included on-going support post intervention, suggesting that this would be an important consideration in any training intervention. However the procedures and theoretical approach varied, and the outcomes varied, making it difficult to draw conclusions regarding the most effective approach to educating staff to reduce levels of agitation in people with dementia, though it appears that both PCC and behavioural approaches have the potential to bring benefit.

Outcome-Reduction in levels of Antipsychotic Prescribing:

Setting:
All five studies in this section (Monette et al. 2008; Fossey et al. 2006; Brooker et al. 2015; Avorn et al. 1992; Schmidt 1998) were conducted in nursing and residential homes. One study was conducted in Sweden (Schmidt et al. 1998), one in the USA (Avorn et al. 1992), one in Canada (Monette’s et al 2008) and two in the UK (Brooker et al. 2015; Fossey et al. 2006).

Nature of the intervention:
The programme by Avorn et al. (1992) was developed from previous research into drug-therapy decision making and concentrated on non-pharmacological solutions to behaviour and sleep problems (Avorn 1983). Schmidt et al. (1998) based their training on Medical Product Guidelines for pharmacists (SMPA, 1995). The program by Fossey et al. (2006) was described as comprising “whole home” issues. Underlying theories were named for several elements of the programme, including person-centred care (Kitwood, 1997), positive care planning (Edberg, 1999), antecedent-behaviour-consequence models and behavioural modification (Stevens 1999, Cohen Mansfield, 1997). The intervention programme by Brooker et al. (2015) was based on Fossey et al.’s (2006) study. Monette et al. (2008) based their programme on non-pharmacological approaches (Cohen-Mansfield et al. 2001; Teri et al. 2002).

Monette et al. (2008) administered three distinct sessions; one for nursing staff, one for physicians and pharmacists and one for care assistants. The core content of the sessions was similar, but was adapted to targeted groups. Sessions included understanding behaviour, non-pharmacological interventions, including successful communication, adaptation of the environment to prevent negative consequences and partnership with the family. All staff who attended were given a pamphlet summarising the key aspects of the session. In addition advice on antipsychotic prescribing was provided by in-house pharmacists post training. Schmidt et al. (1998) offered pharmacists five educational sessions, which focused on gerontology, communication skills, and problem solving. After the training, pharmacists held regular team meetings during a 12-month period, with nursing staff, doctors and nursing assistants, with the aim of improving prescribing through teamwork. Avorn et al. (1992) delivered four sessions over 5 months, which emphasised alternatives to medication and recognition of adverse drug reactions. Brooker et al. (2015) recruited a Dementia Care Coach (DCC) from each care home to model behaviours within the staff team. DCCs attended a
10-day structured training programme held in 2-day blocks across 3 months, followed by a 6-month supervision period. Fossey et al. (2006) offered staff weekly supervision over the study period (12 months). Their programme was also supported through classroom-based didactic training, skills modelling and supervision of groups and individual staff.

**Methodological issues:**
Brooker et al. (2015) and Monette et al. (2008) used a repeated measures design, with no control, to assess the impact of the intervention rather than an RCT. Monette et al. (2008) also recruited participants from one site only. The remaining three studies used an RCT design (Avorn et al. 1992; Fossey et al. 2006; Schmidt et al. 1998). Schmidt et al. (1998) measured antipsychotic prescribing one month before and one month after the intervention. This study had the largest sample with 1854 residents. The study conducted by Avorn et al. (1992) studied six matched pairs of nursing homes (823 residents). Avorn et al. (1992) measured drug prescribing levels at baseline and at the end of the five-month programme. Specifically developed software was also used daily to record all medications during the study period. Homes were matched in terms of size, ownership and level of drug use, and the measures were collected by a blinded observer. Fossey et al. (2006) included twelve specialist homes for people with dementia in the UK and patients were randomised to a training and support intervention (n=181) or usual treatment (n=168). Measures were collected at baseline, post intervention and at 12 months, by a researcher who was blind to the treatment intervention.

All the studies showed differences between groups in some aspects of baseline data. Only one study showed sufficient internal validity (Fossey et al. 2006). While the study conducted by Monette et al. (2008) lacked generalizability as the study involved only a single home, Avorn et al.’s. (1992) sample size was also limited. In the Schmidt (1998) study the methods of analysis were not adequate for cluster randomised trials, as care home clusters were not taken into account (Ritchter et al. 2012); neither were the outcome assessors blinded to the treatment allocation.

**Outcome:**
All of the studies demonstrate a reduction in anti-psychotic prescribing as a result of the different interventions. Three studies documented a significant reduction of the proportion of residents with antipsychotic medication as a result of the intervention (Fossey et al. 2006; Schmidt et al. 1998; Brooker et al. 2015) For Avorn et al. (1992) and Meador et al. (1997) it remained unclear if the reported differences between groups were statistically significant.

**Secondary Outcomes:**
Two studies included reduction of antipsychotic use as secondary outcomes (Chenoweth et al. 2009; Testad et al. 2010). Neither found statistically significant differences in the use of antipsychotic medication in the intervention homes post-training compared with control homes. Kuske et al. (2009) found no impact on the use of antipsychotics following a large scale study with 210 residents from 6 nursing homes.
Summary and implications:
All the studies appear to meet the quality framework criteria. Three of the papers (Fossey et al. 2006; Avorn et al. 1992; Schmidt et al. 1998) were included in a Cochrane Review of psychological interventions for reducing medications in care homes and therefore can be considered to be of good methodological quality (Richter et al. 2012). However the study by Fossey et al. (2006) appears to be of particularly high methodological quality. The treatment intervention in her study was substantially longer and more intensive than in the other studies as staff were supervised for 12 months. This study was one of the few studies reviewed to have evaluated the sustainability of the effects of training, using a robust longitudinal study design as the study also included long-term follow up.

In terms of outcome all five studies showed reductions in medication prescription rates as a result of the different interventions. Given that four of the five studies used training based on PCC and functional analysis, this supports the findings in the previous section, suggesting either of these approaches could be employed to reduce anti-psychotic prescribing. The fifth study (Schmidt, 1998) employed a medicines adherence approach to influence the number of drugs prescribed, and this was also found to be successful.

Outcome-Quality of Life:
Setting:
Only two studies Clare et al. (2013) and Brooker et al. (2011) included quality of life as the primary outcome. One study was conducted in nursing homes (Clare et al. 2013) and the other within sheltered housing schemes (Brooker et al. 2011). Both studies were conducted in the UK.

Nature of the Intervention:
The intervention tested by Brooker et al. (2011) was developed during a previous research stage (Brooker and Woolley 2007; Brooker et al. 2007). It encompassed a multi-faceted whole team approach including a specialist staff role (Enriched Outcomes Programme Locksmith), leadership, staff training, individualised care-work, community liaison and the provision of activities. The intervention in Clare et al.’s (2013) study was also developed from prior research (Clare et al. 2010; 2012). It was based on a PCC approach, and focused on enabling care staff to identify signs of awareness and responsiveness.

Clare et al. (2013) administered training sessions over an eight-week period. In weeks 1 and 2, care staff in each home participated in two 90-minute training sessions. In these sessions staff were encouraged to consider the residents’ awareness and were given guidance on developing their communication skills with severely cognitively impaired residents. Staff were then asked to observe a small number of residents using an individualised schedule. Individual support was also offered weekly between sessions. Brooker et al. (2011) employed a full-time senior staff member, “the Enriched Outcomes Programme Locksmith” whose aim was to focus on ‘unlocking’ the potential of residents and enable individual residents to enjoy an enriched lifestyle. The locksmith worked with
around 20-30 residents per scheme, identifying types of occupation and activity, utilising an enriched care planning approach and working directly with all direct staff-team members. During the first month of the intervention all staff within the EOP housing schemes received a one-day course in PCC dementia care. Senior staff also received a further three-day course.

Methodological issues:
A pilot cluster RCT design was used in both studies. Brooker et al. (2011) randomised ten housing schemes to receive either the EOP intervention or an active control intervention. However it is not clear from the paper how many residents were included. A repeated measures design was used with data being collected at baseline, six months, 12 months and 18 months. Clare et al. (2013) randomised eight care homes. Four were allocated to the intervention and four to the control condition. Measures were administered pre and post training. 66 residents and 65 care staff participated.

Clare et al.’s (2013) study lacks generalisability due to the small sample size. While the target number of homes was achieved, the number of residents and staff participating was lower than initially intended; therefore the study was under powered. In addition although the research workers were blind to group-allocation, their observations during the follow-up assessment enabled them to deduce which homes had been allocated to which condition. Brooker et al.’s (2011) findings also lack generalisability as all the study sites belonged to one extra care housing provider. Both studies used appropriate statistical analyses. In Brooker et al. (2011) the groups were unequal at baseline, however this was taken into account as a covariate in the statistical analysis. Brooker et al. (2011) also used an attention control, as an activity co-ordinator was employed in the homes not receiving the intervention. Attention control groups are often used in research testing the efficacy of psychosocial and behavioural interventions in order to control for placebo effects (Beal, Stuijbergen Volker et al 2009). According to Brooker et al. (2011) as their intervention was designed to be complex and multi-level, it is difficult to ascertain which were the most active features and therefore whether training, without the many other elements, would have led to a beneficial outcome.

Outcomes:
Brooker et al. (2011) initially intended the primary outcome measure to be based on Dementia Care Mapping (DCM) (Brooker, 2005). However, a quality of life measure, the QOL-AD (Logsdon, Gibbons and McCurry, 2000) was used instead as it allowed the researchers to directly collect meaningful data from a greater number of residents. The results demonstrated the residents in the intervention group rated their quality of life more positively over time; however, staff ratings of quality of life were not statistically significant. In Clare et al.’s study (2013) the Quality of Life in Late Dementia scale was used (QUALID; Weiner et al. 2000). Quality of life was rated independently by a family member and by a member of staff. Following the intervention, residents in the intervention group had significantly better quality of life, as rated by family members, than those in the control group but again care staff ratings of quality of life did not differ.
Studies with secondary outcomes focusing on quality of life:
Chenoweth et al. (2009) found no statistically significant results for quality of life measured by the QUALID in their study.

Summary and implications:
In summary the studies by Clare et al. (2013) and Brooker et al. (2011) appear to have robust designs, scoring highly on the quality framework. The studies were different in terms of population and intervention. However the outcomes were similar in that self-rated quality of life improved post-intervention. The findings reinforce that staff training can impact on resident quality of life, although Brooker et al. (2011) acknowledge it is difficult to differentiate the effects of the training from their broader intervention package.

Outcome-Staff related outcomes including burnout:

Setting:
Fourteen studies used staff related outcomes as their primary outcome measure (Magai et al. 2002; Finnema et al. 2005; Leone et al. 2012; Galvin et al. 2010; Davison et al. 2007; Kuske et al. 2009; Broughton et al. 2011; McCallion et al. 1999; Featherstone et al. 2004; Cohen-Mansfield et al. 1997, McCarron et al. 2008; Van Weert et al. 2004; Feldt and Ryden 1992 and Proctor et al. 1999). Twelve studies were conducted in nursing homes; one study was conducted in an acute hospital (Galvin et al. 2010) and one was conducted within an intellectual disability service (McCarron et al. 2008). The settings of the studies were varied; two studies were conducted in the UK (Proctor et al. 1999; Featherstone et al. 2004); one in Ireland (McCarron et al. 2008); five in the USA (Magai et al. 2002; Feldt and Ryden et al. 1992; McCallion et al. 1999; Galvin et al. 2010; Cohen-Mansfield et al. 1997), one in France (Leone et al. 2012); two in in Australia (Davison et al. 2007; Broughton et al. 2011), and one in Germany (Kuske et al. 2009) two in the Netherlands ( Van Weert et al. 2004; Finnema et al. 2005).

Nature of the Intervention:
Six studies (McCarron et al. 2008, Kuske et al. 2009 Featherstone et al. 2004; Galvin et al. 2010; Feldt and Ryden et al. 1992; Finnema et al. 2005) developed interventions based on comprehensive literature reviews along with insights identified from focus groups or consultations conducted either in the initial phases of the project or previous research. Eight studies fully described the underlying concepts and theories of their educational interventions (Magai et al. 2002; Van Weert et al. 2004; McCarron et al. 2008; Kuske et al. 2009; Featherstone et al. 2004; Cohen-Mansfield 1997: Proctor et al. 1998; Finnema et al. 2005). However the four remaining studies failed to do so, or only partially described their theoretical underpinnings (McCallion et al. 1999; Davison et al. 2007; Broughton et al. 2011; Leone et al. 2012).

were all designed to improve communication between caregivers and residents with dementia. The intervention by McCarron et al. (2008) used an andragological approach, which implied that the participants were central to their own learning and experts in practice. In Kuske et al. (2009) concepts included problem-based learning and the intervention emphasised improving participants’ knowledge, empathy and communication as well as reflection. A collaborative approach was used to develop alternative care practices along with case examples and self-reflection. Broughton et al. (2011) implemented a DVD-based programme which focused on environmental modification and communication strategies. McCallion et al. (1999) implemented a communication skills programme designed to address four areas: knowledge; verbal and non-verbal communication; memory aids and problem behaviours. Van Weert et al. (2004) used the implementation of snoezelen to teach nursing assistants how to apply high quality, person-centred care combined with sensory stimulation. Finnema et al.’s (2005) “emotion-orientated” care training focused on the experiences of the residents and staff members’ own experiences. Magai et al. (2002) focused on training in understanding non-verbal communication.

The six remaining studies were based on a behavioural management approach (Cohen Mansfield 1997; Featherstone 2004; Leone 2012; Davison 2007; Proctor 1998; Feldt and Ryden 1992). The intervention by Cohen-Mansfield et al. (1997) was based on the theoretical assumption that pacing/wandering are adaptive behaviours. The intervention by Featherstone et al. (2004) also used a similar “solution-focused” approach, which was employed to structure the training. The aims included creating change in three independent areas: knowledge, attitude and coping strategies to manage “challenging behaviour”. The intervention by Leone et al. (2012) was designed to provide on-site, hands-on-advice to care staff in the management of apathy in people with dementia; staff were also provided with guidelines on how to act to avoid or decrease the emergence of “BPSD”. In addition Davison et al. (2007) also used peer support groups as an alternative educative approach. Proctor et al. (1998) focused on the development of individualised, goal focused care, plans with a view to positively changing the residents’ behaviour. Feldt and Ryden (1992) based their programme on understanding behaviour and developing behavioural management strategies with individualised care planning. Finally the intervention by Galvin et al. (2010) focused on knowledge of dementia rather than a PCC or behavioural modification approach, and was based on Best Practice Guidelines.

The educational programmes took between one and 20 weeks. McCarron’s (2008) intervention was the most intensive, comprising 20 stand-alone one-hour sessions including an introduction to reflective practice and diary keeping, understanding PCC, ethics and decision making; in addition participants also received a self-directed student workbook. The use of reflective learning and case scenario discussion were central to the teaching programme (McCarron et al. 2008). This was closely followed by Van Weert et al. (2004) who offered a 4-day in-house education session, followed by an 18 month implementation period. An individualised care plan was written for each resident describing the required approach and staff were also offered three in-house supervision meetings. Finemma et al. (2005) offered a two-day course, and included a two week intermediary
period for homework; this was followed by a supervision period of nine months. Kuske’s (2009) intervention which consisted of 13 one-hour sessions, delivered over a three month period. The training was delivered in small groups and included modules on dementia, the environment and communication. Magai et al. (2005) offered a 10-hour programme, little information is provided regarding the content or method of delivery. McCallion’s (1996) programme consisted of five 45-minute groups, followed by four 30-minute individual conferences which permitted more personalized training and feedback. Proctor et al. (1998) administered a series of seven hour long seminars, followed by regular weekly sessions over a 6-month period, also with the aim of assisting staff to formulate individual care plans.

In Davison’s study the intervention consisted of eight 60-90 minute sessions and was delivered using a combination of didactic and experiential learning, both with and without the inclusion of five peer support sessions, which lasted 30-60 minutes. The intervention by Galvin et al. (2010) incorporated didactic information and group learning and consisted of 5 learning modules with very broad aims: signs and symptoms of dementia, screening tools, communication, safety interventions, and discharge planning. Featherstone et al.’s intervention (2004) also consisted of 6 one-hour sessions over a period of 6 weeks, similarly to Galvin et al.’s (2010) sessions, this also included both didactic information and group learning. The intervention by Leone et al. (2012) consisted of a didactic two-hour training session, this was followed by four hours of practical training once a month for four months. The intervention by Broughton et al. (2011) was the briefest, consisting of a 50 minute single intervention. Additional elements of the programme included a brief booklet, posters, and prompt cards.

It is noted that the intervention by Cohen-Mansfield (1997) was extremely limited as it comprised a single session of training, with no follow-up and little detail on the content or delivery of the training. Feldt and Ryden (1992) delivered an eight-part training programme, followed by support from a nurse specialist over a 6-week period, however it is not stated how many hours training or support participants received in total.

**Methodological issues:**

Seven studies used an RCT design (Finnema et al. 2005; Leone et al. 2012; McCallion et al. 1999; Kuske et al. 2009; Davison et al. 2007; Proctor et al. 1998; Magai et al. 2005). Kuske et al. (2009) conducted a three-arm RCT with six nursing homes including 96 staff members and 210 residents. Staff were randomised to either a waiting list control group, a relaxation group or the intervention group. Magai et al. (2005) also randomised homes to one of three treatment conditions. The experimental group who received the training, a placebo group who received an equal number of sessions but the material focused on behavioural aspects, and a waiting list control group. 99 residents and twenty staff participated. In Davison et al. (2007), McCallion et al. (1999) and Kuske et al. (2009) the waiting list control group received the intervention in a partial crossover design. The sample in Leone et al. (2012) study was the largest and included 16 nursing homes, with 230
residents and 132 staff. McCallion’s sample consisted of 2 homes and 88 nursing assistants. Proctor et al. (1998) included ten residential homes and two nursing homes and 98 care staff participated. Davison et al. (2007) randomised 90 staff to training, waiting list control or training with an additional five-session peer support group. Finnema et al. (2005) included 58 homes with 146 residents and 99 care staff.

Several studies used quasi-experimental designs (Cohen-Mansfield, 1997; Broughton et al. 2011; Galvin et al. 2010; Featherstone et al. 2004; Van Weert et al. 2004; Feldt and Ryden 1992). Van Van Weert et al. (2004) Feldt and Ryden (1992) and Broughton et al. (2011) all used a pre-test, post-test design. Broughton et al. (2011) initially randomly allocated homes as training or control homes, however to compensate for poor recruitment rates one of the control sites was assigned to the training condition, therefore the control and training groups were uneven in size. The sample included 52 staff, 37 training participants and 15 controls. Galvin et al. (2010) also used a pre-test, post-test design and included 540 staff members from 4 community hospitals. Van Weert et al. (2004) had 120 health care assistants and 120 residents recruited from 12 units at six nursing homes. Cohen-Mansfield et al. (2997) recruited a total of 174 staff members from 21 units in four homes. Sample size was severely limited in three studies (Featherstone et al. 2004; McCarron et al. 2008; and Feldt and Ryan 1992). Featherstone et al. (2004) recruited 20 staff in the training condition and 20 in the control condition from 2 different homes. The recruitment method for the homes was based on a “first come, first served” basis, which may have produced a bias in terms of staff motivation. Felt and Ryden (1992) sample included 17 nursing assistants; McCarron et al. (2008) had the smallest sample with 16 participants from two services. Four studies did not include a control-group (Cohen Mansfield et al. 1997; Galvin et al. 2010; McCarron et al. 2008; Feldt and Ryden et al. 1992). Findings from studies without a control group should be viewed with caution as it is not possible to be sure that the differences in the pre-test and the post-test are causally related to the intervention or due to recruitment bias.

Davison et al. (2007) and Kuske et al. (2009) collected measures at pre, post training and at 6 months after the training was completed. Magai et al. (2002) collected measures at baseline, 3, 6, 9 and 12 weeks after training. Leone et al. (2012) and Broughton et al. (2011) collected measures at baseline, post training and at 3 month follow-up. McCallion et al. (1998) conducted a follow-up at 3 months and 6 months. Galvin et al (2010) collected follow-up measures pre, post training and at 120 day follow-up. Cohen-Mansfield (1997) performed assessments at three time points: baseline, post-intervention and at 1 month post-intervention. Finemma et al. (2005), Proctor et al. (1998) and Van Weert et al. (2004) collected measure pre and post intervention. Featherstone et al. (2011) and McCarron et al. (2008) did not include any follow-up measures post training. Research failing to include a follow-up evaluation of outcomes must be viewed with caution as it is unclear if the changes would have been sustained.
The studies used a wide range of existing outcome measures. Kuske et al. (2009) used the Maslach Burnout-Inventory (Maslach et al. 1996), a scale designed to assess various aspects of the burnout syndrome (Maslach, 1981), the Knowledge and Competencies scale (Zimber et al. 2003), the Penn State Health Care-giving questionnaire (Spore et al. 1991) to measure levels of knowledge, and the Health Complaints Scale (Zeressen et al. 1976). Davison et al (2007) also used the Maslach Burn-out Inventory, as well as the Self Efficacy of Dementia Care, designed for the purpose of the study and the scale of Nursing Performance-adapted from a 24 version by Battersby and Hemmings (1991). Proctor et al. (1998) also assessed the psychological well-being of the staff with the General Health Questionnaire item (Goldberg and Hillner 1978) and the sources of Pressure Scale (Cooper et al. 1998).

McCallion et al. (1999) included two staff outcome measures, the Knowledge of Alzheimer’s Test (KAT) (Maas and Buckwalter 1990) and The Penn State Mental Health Questionnaire (MHQ) (Spore, Smyer and Cohn 1991). Featherstone et al. (2011) used the Controllability Brief Scale (AtCB) to assess thoughts and attitudes about challenging behaviour, at the time of publication this test was undergoing tests for reliability and validity (Dagan et al. 2011). The 17 item Dementia Quiz (Gilleard and Groom 1994) and the Dementia Quiz 2 (Powell and Featherstone et al. 2000) were also used to assess knowledge and the Coping Response Questionnaire (CEQ; Billing and Moos 1981) was used to assess cognitive and behaviour coping styles. Cohen-Mansfield (1997) used the Knowledge of Dementia and Pacing/Wandering Quiz (Spore et al. 1991), in which seventeen of the 19 items were taken from standardized instruments pertaining to knowledge of dementia (Reindl 1998; Spore et al. 1991; Dickmann et al. 1988). Additional items were chosen by consensus and a measure of internal consistency was obtained through an item analysis. A Staff Satisfaction Scale (SSQ) was designed to assess nursing staff member’s feelings and perceptions; the validation process is clearly described in the paper. Finemma et al. (2005) also used the General Health questionnaire (Golddberg and Hillier, 1979), the Organizational and Stress Scale (Bergers et al. 1986) which was used to measure perceived stress at work, as well as the and the Dutch Work Satisfaction Scale (Boumans 1990). Resident measures included CMAI (Cohen-Mansfield 1991) as well as a range of other existing instruments. Magai et al. (2002) measured interaction between residents and care staff and the affective state of care staff using the Brief Symptom Inventory (Drogatis and Spenser 1982). Resident measures included the CAMI (Cohen-Mansfield 1997) Cornell Scale for Depression (Alexopoulous et al. 1988) and a facial expressions of emotion scale was also used. Proctor et al. 1998 staff measures included the General Health Questionnaire (Goldberg and Hillier 1979) and the Occupational Stress Indicator (Cooper et al. 1988).

The remaining studies used a range of staff and resident outcome measures designed specifically for the study, which were usually based on the content of the programme (Feldt and Ryden 1992; Galvin et al. 2010; Cohen-Mansfield et al. 1997; McCarron, 2008; Broughton et al. 2008; Davison et al. 2007; Weet et al. 2004). Using tests or instruments that are valid and reliable is a crucial component of research quality (Kimberlin and Winterstein 2008). While designing measures for the purpose of a
study may be justified, it is noted that a number of studies (Galvin et al. 2010; McCarron et al. 2008; Broughton et al. 2011) fail to describe the validation process or report information on the psychometric properties of the scales used. Outcome data is likely to be negatively affected if a validated instrument is not used (McDowell 2006). In Galvin et al.’s study (2010) measures were designed to assess gains in knowledge and confidence, current practices and attitudes. Broughton et al. (2011) designed questionnaires to assess staff’s knowledge of strategies to support memory and communication in dementia and their opinions of the training. Van Weert et al. (2004) analysed video recordings using an observational tool based on Kitwood’s Dialectical Philosophy. Feldt and Ryden et al. (1992) used a measure developed to elicit the nursing assistant’s perceptions of the experience of caring for residents.

Three studies used qualitative methods to explore staff related outcomes. Leone et al. (2013) interviewed staff about their perceptions and knowledge of “BPSD’s”. The Apathy-Clinician version was also used to measure apathy (Leone et al. 2008). Galvin et al. (2010) conducted qualitative interviews to explore the challenges participants faced when working with people with dementia. Broughton et al. (2011) designed a semi-structured questionnaire to assess staff’s knowledge of strategies to support memory and communication in dementia and their opinions of the training.

Outcome:
The findings of the studies investigating staff outcomes consistently found improvements in the training group apart from the study conducted by Proctor et al. (1998) who found an increase in psychological distress amongst the control group, but not in the care staff receiving the training intervention.

Cohen-Mansfield et al. (1997) found that there was improved knowledge of dementia immediately following the training programme, but there was no significant change at one-month follow-up. Galvin et al. (2010) found that the training had an immediate impact on knowledge, confidence, and attitudes with lasting impact in 3 of 4 hospitals. Broughton et al. (2011) found the training group showed a significant improvement in knowledge of support strategies from baseline to immediately post training with qualified nurses also showing higher levels of care-giver satisfaction at 3 months. Van Weert et al. (2004) found the intervention resulted in a statistically significant increase in positive person work and a decrease in malignant social psychology following the intervention. Nursing Assistants in the experimental group also improved statistically in “positive Person Work” (Van Weert et al. 2004). Finnema et al. (2005) found nursing assistants in the experimental group who reported being able to apply emotion-orientated care skills, experienced fewer stress reactions.

Feldt and Ryden (1992) found there was a significant difference between pre and post test scores as staff viewed the task of caregiving significantly more rewarding and less frustrating. McCallion et al. (1999) found that there was a significant improvement in the ability of staff to manage verbally aggressive behaviours at 3 months and 6 months post-intervention, and physically non-aggressive behaviours such as wandering at 3 months post-intervention, but not for the aggressive behaviour.
The programme also resulted in reduced staff turnover. There was an improvement in knowledge of dementia among nursing assistants in the intervention condition; however this was not sustained at three months. Magai et al. (2005) found staff members’ affective state improved as a result of participating in the training.

Kuske et al. (2009) findings demonstrated that training had an impact on caregivers’ knowledge; however this was not sustained at 6 months follow-up assessment. Davison et al. (2007) and Kuske et al. (2009) found that their intervention had no impact on levels of burn-out. Davison et al. (2007) McCarron (2008) and Featherstone et al. (2011) found that the training produced significant changes in staff’s attitude and knowledge base post training. In Davison et al. (2007) the effects were sustained at six months post training.

The qualitative findings illustrated common challenges faced by staff working in acute hospital settings, including dealing with patient safety issues and lack of time (Galvin et al. 2010). McCarron et al. (2008) found that staff valued the educational intervention; however the narratives of the staff also suggested that the emotional costs and distress of staff is often fuelled by lack of resources, rather than by a lack of understanding of person-centred care. Feldt and Ryden (1992) found the interviews validated the qualitative outcome measures as staff reported the training had changed their way of providing care. Leone et al. (2012) reflected a positive change in caregivers’ perceptions of “BPSD”.

**Secondary outcomes:**

In the study conducted by Clare et al. (2013) qualitative data were also collected from staff regarding their experiences of the training; staff identified benefits in terms of understanding of resident’s needs. Brooker et al. (2015) collected both qualitative data and quantitative data regarding staff attitudes and knowledge; a statistically significant effect on person-centred attitudes was seen from the first phase of the programme, with a statistically significant effect on hopefulness seen from the combined effect of training and supervision. Knowledge of dementia also improved following the programme, but according to Brooker et al. (2015) the effect was not statistically significant as it was already very high at the start of the programme. Qualitative data emphasised the positive impact of participation on staff’s confidence and willingness to challenge and change practice.

Teri et al. (2005) identified staff skill and job satisfaction as secondary outcome measures, however no statistically significant differences were found, although according to Teri et al. (2005) improvements were in the expected direction. Chrzescijanski et al. (2007) found no change in staff attitudes post training, but states that these were consistently positive both before and after the training. Visser et al. (2008) also found no impact on staff member’s burn-out or attitudes. There was, however, a change in staff members’ attitudes about working with people with dementia.
Summary and implications:
The majority of studies investigating the impact of training on staff related outcomes had at least one positive finding. Studies demonstrated that training leads to increases in the knowledge and skill base of staff and may lead to greater staff satisfaction (Davison et al. 2007; Kuske et al. 2009; McCarron 2008; Featherstone et al. 2011; Broughton et al. 2011; Galvin et al. 2010; Mansfield 1997; Broughton et al. 2011), impacts on turn-over rates (McCallion et al. 1999), improves caregivers’ mood/affective state (Magai et al. 2002) and reduces stress (Finnema et al, 2005).

Overall summary of literature on staff training in dementia care
Staff outcomes are commonly assessed when looking at the impact of training. A wide range of outcomes have been used and while most studies found positive outcomes these findings are variable due to the different training approaches, measures, design, and sample size.

The majority of studies included only care staff and not nursing staff (Feldt and Ryden 1992; Proctor et al 1998, Van Weert et al. 2004; McCallion et al 1999; Featherstone et al. 2004; Brooker et al. 2015; Broughton et al. 2011; Kuske et al. 2009; Teri et al. 2005; Chrzescijanski et al. 2007; Proctor et al. 1999). Other studies included either the whole multi-disciplinary team (Davison et al. 2007; Avorn et al. 1992; Monette et al. 2008; Galvin et al. 2010), or did not fully describe the characteristics of the staff receiving the intervention (Visser et al. 2008; Testad et al. 2009; Chenoweth et al. 2009; Schmidt et al. 1998; Brooker et al. 2011; Claire et al. 2012; Leone et al. 2013; Cohen-Mansfield 1997). Only three studies (Monette et al. 2008; Moniz-Cook et al. (2008) and McCarron et al. 2008) offered distinct sessions for nurses.

The studies reviewed allow us to draw some conclusions about the current status of the literature. Studies to date have common limitations and methodological weaknesses, scientific rigour was generally limited within the reviewed studies. Methodological limitations included small sample sizes, relatively brief post-training follow up periods, lack of randomisation to training, and a general underutilisation of control groups. Non-random designs or designs without control groups were repeatedly used (Cohen-Mansfield, 1997; Broughton et al 2011; Galvin et al. 2010; Featherstone et al. 2004; Van Weert 2004; Feldt and Ryden et al. 1992). Seven studies used an RCT design (Leon et al. 2012; McCallion et al. 1999; Kuske et al. 2009; Davison et al. 2007; Proctor et al. 1998; Magai et al. 2002; Finnema et al. 2005). However they frequently failed to adhere to the recommended guidelines for the conduct of cluster RCTs (CONSORT, 2010). Cluster RCTs require greater complexity in in design and analysis, and a requirement for more participants to obtain the same statistical power study. Only one study described using methods of analysis appropriate for cluster randomisation (Proctor et al. 1999). Four studies reported insufficient sample sizes (Davison et al. 2007; Van Weert et al. 2004; Broughton et al. 2011; Featherstone et al. 2004). Reports of studies with small samples frequently include the mistaken conclusions that the groups do not differ, when in fact the sample was too small to justify such a claim.
Systemic issues specific to conducting interventions in health and care home settings are also evident, such as difficulties in training all staff members (Leone et al. 2012), in changing task-focused rather than client-focused practices (Kuske et al. 2009), large proportions of participants lost to follow-up (Broughton et al. 2011); poor compliance with the intervention (Kuske et al. 2009) and differences at baseline (Kuske et al. 2009; McCallion et al. 1999; Leone et al. 2012). It is also difficult to control for variables such as competence of the trainer and heterogeneity of care settings (Featherstone et al. 2004). Additionally, a large number of studies failed to describe, in sufficient detail, important aspects of the training method, theoretical underpinnings and duration (Feldt and Ryden et al. 1992; Cohen-Mansfield (1997); McCallion et al. 1999; Davison et al. 2007; Broughton et al. 2011; Leone et al. 2012).

It is clear that work is needed to assess the effects of the training interventions on stress levels and burn-out over longer periods of time and provide information on how on-going support or supervision may maintain any effects post-training. Seven studies (Clare et al. 2014; Brooker et al. 2015; Teri et al. 2005; Visser et al. 2008; Davison et al. 2007; Van Weert et al. 2006; McCallion et al. 1999) included on-going support following training. Six of these reported that the training impacted positively on staff outcomes. Two studies (Davison et al. 2007; Kuske et al. 2009) investigated the long-term effects of training on staff outcomes using quantitative outcome measures. Davison et al. (2007), who included on-going support, found benefits were maintained six-months post intervention; Kuske et al. (2009) who did not include on-going support found the effects were not sustained. Therefore there is tentative evidence to support the assumption that training combined with supervision or on-going support is likely to have a positive impact on staff outcomes. More adequately powered, high-quality research is therefore required (Livingston et al. 2005).

Characteristics of trainers should also be considered (Woods and Russell, 2014). Studies need to deal effectively with the many logistical barriers found in care settings such as nursing homes, including high staff turnover, reduced staff-to-resident ratios and inflexible organisations (Murfield et al. 2011). In addition interventions should be better defined, possibly through manuals, so that they can be replicated at a modest cost. Reporting of important characteristics of the intervention and settings as well as details of the extent of implementation also needs to be improved (Livingston et al. 2005).

Chapter 3: Focus Groups

In the following chapter the focus groups conducted to inform the design of the training intervention are described. The key features of an effective training programme include planning the curriculum content with the audience (Moyle et al. 2010). Therefore, it was important to consult staff in order to adapt the existing training programme for delivery to care home nurses. To do this, four focus groups were conducted with 11 qualified nurses working in nursing homes across the West Midlands.
Recruitment and data collection
Nursing homes were identified through the Care UK website and a flyer describing the nature of the study was circulated to them via email inviting participation from qualified nurses. Participation was voluntary and the sampling was purposive.

Method
The focus groups lasted approximately 1 hour and consisted of open-ended questions, in a semi-structured format. An interview guide focused on the competencies and skills necessary for working in nursing homes with people with dementia, nurses’ roles within the care homes and their experiences of past training.

Interview Guide
1. Would you be able to explain your role? What do you spend your time doing?
2. What sort of skills do you need to do your job?
3. Can you tell us about your previous training
4. Training is not always effective in changing practice; do you have any ideas or theories to explain this?
5. What would you like to see in future training?

The focus groups were audio-recorded, transcribed verbatim and anonymised.

Analysis
Transcripts were read independently by the research team. Thematic analysis was used to analyse the data, this is a method for identifying, analysing, and reporting themes within qualitative data (Braun and Clarke, 2006).

Findings
Four main themes were derived from the analysis of the transcripts: Responsibilities and frustrations, It’s not like the NHS, Barriers to learning, and Future training. The first theme evolved as participants described their roles and expressed their emotions about the associated responsibilities. This led to discussion about working in nursing homes, nurses’ perceptions of how this differs from working in hospital environments and the perceived relative value of work in each environment. In responding to prompts about learning needs, the nurses reflected on their previous experiences, noting the difficulties of applying traditional and online learning to practice and their need for active, experiential, relevant training interventions in which they felt supported by both peers and experienced educators and mentors.
Responsibilities and frustrations
Participants from all 4 focus groups mentioned directing and supporting staff as a main responsibility. However, the main impression from all the groups was of the overwhelming nature of the different responsibilities, complexity of the roles within a context of little support, considerable isolation and perceived low status of their work. Many reflected on their regret at having to leave behind the caring, person-centred aspects of nursing as they had little time to sustain relationships with residents due to the need to prioritise tasks (e.g., medication rounds, catheterisation, and dressings) ‘paperwork’ and management issues. The focus on tasks and management left many nurses feeling deskilled and regretful. They noted that unqualified carers had more contact and so developed the skills which they themselves felt they were losing.

"The nurses are pretty much in the supervisory role and it is hard. I think it is hard coming off away from the hands on role"

"I mean sadly, with the role of nurses and amounts of paper work and legal stuff that we have to do, nursing, you don't do as much nursing sadly. The carers are who are the front role"

"P1: Because it is the carers that tend to get caught up in situations that are confrontational, isn’t it? P3: Saying that are probably better than we are because they are much more hands on"

The lack of connection with those in their care was evident in other quotes, where residents were described unfavourably and without consideration of their personhood and experience. Below, the nurse perhaps under-valued the residents as individuals, conveyed in the perception of them as ‘unfresh’, while the second nurse viewed behaviour as a problem rather than a means of expression.

"That what is the problem with a nursing home, with dementia. It is not like working in a psychiatric hospital where people are fresh, and when they get better they are going back home"

"I mean, she started, she came here she was chucking things across the room. She was bum shuffling across the floor. It is really quite difficult (...) how to react to that?"

It’s not like the NHS (National Health Service)
Participants were asked general questions about their feelings about working in nursing home setting. Nurses reported feeling isolated and very different from their counterparts working in the National Health Service. They felt that other health care professionals perceived them to be unskilled, but they appeared ambivalent about their own abilities, describing conflicting feelings about the huge responsibilities and their ability to work independently.
"You know, what hospital are you working at? I am working in a nursing home...they think you have a half a brain here"

“We don’t have things on hand like dressings. We haven’t got a big drug pot, you know, big drug trolley that we can just fish things out of so I mean, yes it is different"

The findings indicated that many nurses working in nursing homes had stressors outside their working lives as well as in them. They were often single parents and needed to work close to home and schools, factors which meant they would be less likely to leave their job. They often had family caring responsibilities and they themselves reported poor physical and mental health. This was compounded by indications that they were under-valued by management, illustrated by poor training opportunities, career development, low pay and lack of support.

So staff appeared to recognise their own worth, but were angered by organisational factors that undermined this:

"I think traditionally, in comparison to the NHS settings, you know care homes particularly private care homes don’t pay the rates you could expect from the NHS. I would think that is the barrier to improvement. And I think equally retention is the problem, because when people come on a fairly low rate of pay and realise what it entails...they find that there is a lot expected of you"

"It is not like the NHS, you are very often just one nurse on the shift, on the unit. You haven’t got a colleague that you are working alongside very often so if you are not up there then there is no one to do your job"

**Barriers to learning**

We explored barriers to learning and participants’ experience of previous training in order to identify gaps in knowledge and inform design of the planned training. Poor quality and inappropriate levels of training were frequently reported as barriers to learning. Previous experience of training was often off-putting and perceived as inadequate, indicated by participants’ inability to recall what they had learnt, even recently.
"sometimes you just go through the e-learning training and bla bla bla dusted and you tend to forget”

"You have asked us before what was booklet one about and we already forgot what was it about”

E-learning is often free and nurses were expected to undertake training in their own time. Within a business model, investment in nurses’ education may be seen as counterproductive due to the high turnover of staff. In addition face-to-face training has extra costs related to backfill. Therefore many experiences of training reflected the ‘cheaper options’ such as workbooks, DVDs and computer-based learning, which were perceived as ‘very poor’, ‘pointless’ and ‘repetitive’

"I mean, it didn’t go down particularly well and I tried to implement it with, you know, it tended to be DVDs and sessions which the DVDs are very long...and it is about taking, depleting your staff off the floor”

These methods do not acknowledge the skills level and experience of the nurses and so do not reflect the principles of adult learning in which learners build on previous knowledge. In addition adult learners respond best to active, experiential, social learning opportunities in which they construct understanding together. If nurses took on learning independently, the support from their organisation could not be guaranteed, meaning they might have to attend training after a night shift or in their free time. This added extra pressures:

"What it is in a nursing home, it’s not like that you have a sunny day and you are off....So sometimes I had to go, finish here, go to uni, come back and I have to come to work. So I was really tired, I couldn’t just cope with everything ... so I had to stop at that time”

Future training
Nurses were clear on the content that they required in future training. Most focused on the knowledge and practical skills relevant to their roles. Gaps identified included lack of knowledge about dementia and progression of the illness.

"I think I would like more knowledge of details...the process of the diseases associated with dementia, not only Alzheimer’s. There are various diseases and just to be more in depth into dementia and progression of the illness"

"There should be more focus on dementia, because it is in every field of nursing, isn’t it?”

More than half of participants mentioned communication with people with dementia and their relatives as challenging, therefore it was evident training was required in this area. The skills required to communicate with relatives were identified as another gap. Relatives seemed to expect
the nurses to provide them with emotional support, and while family carers were no longer responsible for day-to-day care, they appeared to see ‘checking up on’ the nurses as part of a new role, acquired in the transition to full time care.

"Patients with dementia cannot say the words anymore.....How to communicate with them? We need more skills on how to really communicate so we know, you know, what they need.

"That requires a lot of skills...because some nurses find it so difficult to speak to relatives. Because it is a very sensitive issue and relatives ask. I think that’s another skill that would help and support nurses, to deal with that difficult conversation, issues...because some nurses find it very difficult"

Participants were asked to make suggestions for future training. Applicable ‘real-world’ relevance to practice was seen as central. Participants highlighted the need for interactive training and valued opportunities to listen to each other’s views and learn from each other’s experiences.

"And we are talking about being practical; we are providing care for people with dementia and you have to be practical"

“When you are in a group, you see other nurses who are from different backgrounds and when you are discussing in a group, you know from what others are saying.”

During the focus groups more than half of the participants mentioned the importance of training being available for all staff regardless of the role they are appointed to within a nursing home:

"I think when the carers do the same thing, then we are speaking the same language really, which helps"

A further gap that emerged from the focus groups was responding to indications of distress. Outdated language used in the focus groups demonstrated attitudinal issues congruent with “old culture” thinking, perhaps reflecting lack of training and the impact of workplace cultures.

"So I think more on how to handle challenging behaviours like that, with aggression, you know, put nurses and the carers to have training. Some of us here are RGNs and we haven’t had access to the patients so don’t really know how to handle that"
Summary

In our sample, the majority of participants focused on their responsibility for direction of staff when asked to describe the main aspects of their role. According to Wild et al. (2010) the practice interface is narrowing between nurses and care staff, with basic nursing skills being delegated and care staff undertaking what may have previously been considered nursing activities. Therefore it is unsurprising that our findings indicate that, although the input of knowledge and skills from registered nurses (RNs) is recognised as essential in supporting carers’ learning and practice, nurses are frequently undertaking management and supervisory roles rather than direct care. Reviews conducted by Baldwin et al. (2003) and Manthorpe and Martineau (2008) report similar findings.

Manthorpe and Martineau (2008) suggest some nurses may feel threatened by the presence of care workers who see their role as similar to that of the RNs. In addition there is a shortage of nurses in this sector and the workforce is ageing (Imison and Boher, 2013, Centre of Workforce Intelligence, 2013). According to Wild et al. (2010) organisations will employ greater numbers of care staff, a less expensive option, rather than RNs. Government policy reflects the changing definitions of what is considered nursing care; previously personal care was classed as something a nurse would do, but now this is classed as social care (Wild et al., 2010; Manthorpe and Martineau, 2008). Within a context of funding constraints it appears that traditional nursing skills are at risk of being devalued.

Technical procedures such as dressings and dispensing medication are, however, still regarded as constituting nursing care (Tadd et al., 2012). This is illustrated in the study findings as the participants indicated that these tasks are fundamental parts of their responsibilities. Participants therefore placed a great emphasis on their clinical skills; residents with increasingly complex needs mean that the technological aspects of care giving have increased significantly (Wild et al., 2010).

Several authors have recommended the need for care homes to have greater access to NHS nursing expertise not least because homes may be isolated and excluded from main stream care systems, as evidenced in our findings.

The isolation of staff working in nursing homes has been known for some time (Chambers and Tyrer, 2002; Davies, 2001; RCN, 2001). Our participants confirmed that they felt less valued than their counterparts in the NHS, despite perceived higher levels of responsibility. The RCN (2012) found that nurses’ experience of being treated fairly and valued equally in terms of career opportunities, pay and grading, and working hours is not consistent. This may also be tied in to social attitudes towards older people, negative media coverage and the low value society places on caring for older people (Jenkins and Macken, 2014).

Participants reported frustrations about managing staffing levels, lack of time to spend with residents and funding for training. They appeared to have all-embracing roles, doing everything and anything within the home but missing their identity as nurses and feeling undervalued. This is
consistent with a recent RCN report (2012) which highlighted low morale and extreme pressures at work within this sector.

Participants described training as inadequate with over-reliance on free online-learning, and repetitive mandatory training. Gaps in training (the nature of dementia, communication skills, how to respond to indications of distress) were identified along with a desire for practical hands on training. Staff also appeared to have limited access to training, possibly due to assumptions about caring being ‘natural’ rather than skills based (Brooker and Latham 2015) or insufficient resources which are the most widely cited barrier to training and education (RCN, 2012). Relative isolation may mean staff are not exposed to alternative practices and new thinking, which may lead to lack of awareness about the gaps in their own knowledge-base. The budget for training is often small and employers rarely provide additional financial incentives in recognition of new learning and responsibilities (Wild et al., 2010). Limited resources may also mean that managers tend to focus on legislative requirements and practical issues at the expense of non-mandatory training and promoting person-centred approaches that would enhance the quality of care. These lack of training opportunities may reinforce the perception of low-value accorded to nursing home nurses.

The focus group findings informed the content of the intervention, ensuring that the programme would meet the needs of the audience. This also ensured the complexity and content of the intervention would be acceptable to the participants (Craig et al. 2008).

Nurses working in nursing homes highlighted high levels of responsibility, low levels of support and remuneration and frustrations related to the complexities and demands of their role. They recognized training needs but highlighted the barriers to accessing training that may actually change practice. In order for training to be effective it should incorporate interactive, practical sessions with relevant content related to the needs of people with dementia. Training should be viewed as an opportunity to demonstrate the value of staff and should include all members of the staff team. Training should also include consideration of how barriers to high quality care can be overcome and so promote person-centred approaches for residents, staff and relatives.

**Chapter 4: Aims and Research Questions**

In the following chapter the study methodology, hypothesis and exploratory questions are set out.

**Summary of proposed study:**

We set out to investigate the effectiveness of training and supervision for nurses in care homes. The training consisted of a dual-element training intervention, combining classroom-based training, and in-house training. The effectiveness of training alone was compared with training as usual and training followed by supervision on immediate and longer-term outcomes (4 months post intervention for nurses working with people with dementia in nursing homes. Outcomes included nurses’ burnout, feelings of self-efficacy, person-centred approach, attitudes and leadership style.
The study also investigated how the knowledge and skills taught are implemented in practice. Data was collected by means of standardised outcome measures and semi-structured interviews.

**Hypotheses:**
1. The dual-element training will reduce staff burnout, increase confidence, and person-centred care, and improve leadership and attitudes compared with a ‘training-as-usual’ control group.
2. Clinical supervision following training will maintain any improvements from the dual-element training, compared with a group who receive the training but no follow-on supervision.
3. Is structured observation of residents feasible (using a method known as Dementia Care Mapping, DCM) and is the methodology potentially useful for showing the impact of training on the wider care environment and well-being of residents?

**Exploratory/Qualitative questions:**
1. How do nurses report that the knowledge and skills they have been taught are implemented in practice?
2. How do nurses report burnout has been affected by the training intervention?

**Design:**
The study was a pilot randomised control trial, to look at differences in outcomes between intervention groups, supported by qualitative interviews to look in greater depth at the impact of training on the experience of burn out and experience of the intervention. In order to test the hypotheses, nursing homes were randomly allocated to one of three groups (training + supervision, training alone, training-as-usual). Quantitative measures were taken at 4 time points, to allow comparison with regard to burn-out, person-centredness, leadership style, self-efficacy and attitude, to see if the outcomes are sustained (at baseline, immediately post training, at 10 months and at 14 months). Qualitative interviews with nurses who participated in the training + supervision and training alone groups, were used to understand the nurses perspectives on the training and the supervision and to explore how they have been able to apply the training in practice. In addition they explored whether supervision helped with this, as well as whether the training impacted on any feelings of burn out.

**Table 3. Study timelines**

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### Setting:
The study included nursing homes in the West Midlands, Worcestershire and Warwickshire identified through the regulator, the Care Quality Commission, as being registered to provide care for people with dementia.

### Participants and Eligibility Criteria:
Homes of any size, and from small, medium or large scale enterprises, including privately owned homes were eligible to participate if they had beds for people with dementia. They were required to commit to 2-3 of their nursing staff taking part in the study, this being the entire nursing establishment in the small homes and approximately 50% of the nursing establishment in the largest. Homes were excluded if they had been identified by CQC as being ‘at risk’, as advised by NIHR, since participating in research may distract from other areas of care.

Nurses who wished to take part in the training, were given the PI’s contact details. Potential participants who expressed initial interest were then given/sent an invitation letter and the study information sheet. The information sheet was followed up by a telephone call 3/4 days later to ask if they had any questions and whether they were interested in taking part or whether they would like longer to decide. If they wished to participate a mutually convenient time was arranged to meet at the home. Once participants had a chance to ask questions and felt that these had been adequately answered, informed written consent was obtained. All qualified nursing staff in the homes who agreed to take part were able to do so, so long as their managers consented and backfill could be arranged.
Consent:
Written informed consent was obtained from:

- The management of nursing homes
- Qualified nurses participating in the training

Invitation letters with reply slips and stamped addressed envelopes were sent or emailed to the managers of all Care Homes in the West Midlands, Warwickshire and Worcestershire area with places for people with dementia. The study team visited managers who replied and explained the study in more depth. There is consensus in the literature that support from management is invaluable when training nursing staff, ensuring staff have the opportunity to engage in new practices (Moyle et al. 2010; McCabe et al. 2007). Therefore it was envisaged that commitment from managers and organisational leaders would play a key role in the success of the study and delivery of the interventions.

Recruitment:
It was decided that we would aim to recruit 2-3 nurses per home. The literature suggests attendance at training programmes is often very poor and that care homes can find it difficult to release a large proportion of staff to attend training (Spector et al. 2013). Yet if only a small number of staff attend, the effect on the home may be diluted (Davison et al. 2007). Therefore participating homes were required to agree that they would release a minimum of 2 of their qualified nursing staff to undertake the training. If the manager was willing to support the study, the PI attended staff meetings in the home to ensure all nurses were aware of the study and could volunteer to participate. If meetings were not in place then the manager was asked to set up a convenient time for myself or another member of the research team to visit the home. The team encouraged managers to consider that all qualified nursing staff might benefit from the training and also that nursing staff should not be coerced into participating, if they did not wish to do so. This was also addressed in the informed consent process. Leaflets were also used to invite participation.

Sample:
A power calculation based on an 80% chance of obtaining a change of 5 points on the Maslach Burnout Inventory with a probability of 0.05%, revealed that an adequate sample size, per group, would be approximately 22 per group (Donner and Klar 2000). We therefore aimed to recruit 25 nurses per group.

The study sample consisted of 78 nurses who were allocated to one of the three conditions (training + supervision, training alone, training-as-usual. The target of 2 nurses per home however was not always possible, consequently there were 1-3 nurses per cluster (i.e. per Home) and 12-13 clusters (homes) within each group.
23 nursing staff received the training followed by four months of supervision (Group 1)

27 nursing staff received the training intervention alone (Group 2)

28 nursing staff received training-as-usual. This group was offered training after the final set of measures have been collected, as a gesture of good will but this will not be formally evaluated for the purposes of the study (Group 3)

The study participants were predominantly female, who had been qualified for 6 or more years. The majority of the sample also had extensive experience with working with people with dementia.

Gender of participant * Group 1,2,3

<table>
<thead>
<tr>
<th>Gender of participant</th>
<th>Group 1,2,3</th>
<th>Group receiving a dual element training followed by supervision</th>
<th>Group receiving a dual element training</th>
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Length of being qualified  Group 1,2,3

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<td>---------------------------------</td>
</tr>
<tr>
<td>1-2 years</td>
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</tr>
<tr>
<td>Total</td>
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**Length of experience of working with people with dementia * Group 1,2,3**

<table>
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<th>Group receiving a dual element training</th>
<th>Control group</th>
<th>Total</th>
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<tr>
<td>1 year or less</td>
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<td>3-4 years</td>
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Measures:
In the following section the measures for the study, participant timelines, methods for data collection, data management and analysis will be discussed.

Quantitative measures:
The impact of the training and supervision interventions on staff burnout, leadership, person-centred approach, and confidence will be evaluated. The primary outcome measure is burnout, and secondary outcomes are leadership, person-centred approach, attitude and confidence. All the outcome measures selected for this study have strong evidence supporting their validity and reliability.

The Maslach Burnout Inventory (MBI) measures rates of staff burn-out (Maslach et al. 1996). The MBI is designed to assess three core aspects of burnout; emotional exhaustion, depersonalisation, and lack of personal accomplishment. Each aspect is measured by a separate subscale. A high degree of burnout is reflected by high scores on the Emotional Exhaustion and Depersonalisation subscales. High scores on the Personal Accomplishment subscale are reversed when an overall burnout score is calculated.

The Person-Centred Care Assessment Tool (P-CAT). A 13-item tool which measures the extent to which care staff rate their work and their care setting as person-centred for those living there (Edvardsson et al. 2010).

The Approaches to Dementia Questionnaire is used to measure attitudes (Lintern and Woods 2000). This has been used as a measure of effectiveness of training interventions in a number of UK studies and assesses attitudes by a 19-item Likert scale, with two sub-scales of ‘hope’ and ‘recognition of personhood’.

The Geriatric Scale of Nursing Self Efficacy is used to measure nurses’ sense of self-efficacy in their work (Mackenzie and Peragine 2003). This is nine-item Likert scale which asks staff to rate their confidence regarding the care of people with dementia and management of difficult situations at work.

The Multifactor Leadership Questionnaire (MLQ) Form 5X measures a broad range of leadership types (Bass and Avolio 1994). The scale includes 36 items that are broken down into 9 scales with 4
items on each scale. It is anticipated that the training may enable staff to move towards adopting a transformational leadership style.

**Participant Qualitative Interviews:**
To explore the perceived impact of the training on practice from the perspectives of the staff who received the training, a small purposive sample of 8 qualitative interviews has been conducted with participants from group 1 and 2, the control group did not participate in the interviews. These took place shortly after the completion of the training and supervision for group 1 (i.e. at time 3) and shortly after completion of training for the training alone group, group 2 (i.e. at time 2).

The interviews explored how nurses perceive burnout and how this is expressed. The interview questions were drawn from the primary outcome, the Maslach Burnout Scale (Maslach et al.1998). Therefore participants were asked about “Emotional exhaustion” feelings of being emotionally strained and exhausted by their work; “Depersonalization” a lack of feeling toward residents care and treatment and “Personal accomplishment” feelings of competence and successful achievement at work. Other issues were also explored including confidence, leadership skills, and attitudes and their experiences of training and supervision.

**Participant timeline**

There was a 2-month recruitment period. This was thought to be adequate given the connections we already had with the care home sector. Nursing staff in the study were asked to complete the measures after randomisation (baseline), at 5 months (post-training), at 10 months (post supervision) and at 14 months (follow-up). The questionnaire pack takes approximately 30-45 minutes to complete.

**Data Collection**
At baseline, after informed consent had been received from home managers and from nursing staff who were going to participate, packs of questionnaires were provided on paper, in sufficient numbers for all staff in each of the participating homes. Those taking part were asked to complete these and return to the research team. The team returned to the home at each of the four time points.

The qualitative interviews with nursing staff were conducted after the final phase of the intervention (i.e. following the end of supervision sessions for the training-and-supervision condition and following training sessions for the training alone condition). These were carried out on a 1:1 basis, face-to-face at the care home in a private, quiet room at an agreed time which was convenient for the participant. The interviews lasted approximately one hour and were audio recorded (with the participant’s consent).
Data Management
Each nurse participant was allocated a number, and this number was used to identify their questionnaires and interview transcripts. All questionnaires and transcripts were filed separately from the consent forms and stored in separate locked cupboards in the Research and Innovation Department at the Barberry, Birmingham and Solihull Mental Health Foundation Trust. The qualitative data was anonymised during transcription and analysed by the study team.

Data Analysis
The following section describes the method of analysis for both the qualitative and quantitative data.

Quantitative data:
At the outset the quantitative data was analysed using SPSS, a software package for statistical analysis. Initially descriptive statistics were explored and then inferential testing was carried out. As a random effects model was used for the analysis of variance (ANOVA) (Donnel and Kläs 2000). ANOVA which was used to compare the differences between the repeated measures variable (time) and the group variables (conditions). The primary analysis compared levels of burn-out between the three conditions and across the four time points. We expected there to be no differences at baseline, but hypothesised that at time 2, groups 1 and 2 would have lower burn-out than group 3; at time 3, group 1 would have lower burnout than group 3, and group 2 would be intermediate; and at time 4, group 1 would sustain any reduction better than group 2, while groups 1 and 2 having lower burnout than group 3. Similar analyses was conducted regarding leadership, knowledge of person centred care, attitude and confidence. Multiple imputation routines were used to calculate the averages and input any missing data.

Qualitative data:
The interviews were recorded and transcribed verbatim. Template Analysis (TA) was used to analyse data from the interviews. This is a process for organising and analysing textual data according to themes (King 1998). TA places emphasis on comparison across individual cases and allows the researcher to compare the different perspectives of participants (Crabtree and Miller 1999). Central to the technique is the development of a coding template and the use of priori codes. To develop these codes the half-way position described by Waring and Wainwright (2008) was adopted, where codes are developed based on the theoretical position of the research as well as after exploration of the data from initial interviews; therefore four exploratory interviews were conducted with existing research participants (nurses) in order to develop a template for the remaining analysis.

Chapter 5: Interventions
In this chapter the person-centered training intervention and the supervision which was delivered post training intervention will be described.
Person-Centred Training:
The content of the training programme was designed to encourage staff to understand the perspective of the person with dementia and to be able to take a relationship-centred approach (Brooker et al. 2011; Nolan et al. 2008); as well as the meaning and role of activity and opportunities for developing effective communication skills and person-centred planning (Edvardsson et al. 2007). (See Appendix 1 for outline of the training). The training content also included leadership skills training with a view to encouraging staff to work collaboratively and to enable them to bring about positive change (Gould and Reed 2009). (see Appendix 1 for content of Classroom training)

The programmes included in the literature review demonstrated substantial variability in the length of interventions (1-22 sessions). However if the intervention was less than 1 hour, there did not appear to be an adequate amount of training to bring about sufficient change (Richter et al. 2012; Spector et al. 2013) and the intervention with the greatest absolute time spend on training showed the greatest difference (Fossey et al. 2006). On this basis, the amount of time to be spent on the training intervention was dictated by a combination of the need to cover certain topics, and pragmatic considerations about what would be feasible for most trainers to deliver at reasonable cost, and most homes to release staff for. Therefore the training consisted of a 5-day classroom-based programme; followed by 2 x 7 hour sessions of in house sessions.

The training comprised didactic information, facilitated workshops and hands on in-house training. This style of delivery was designed to assist in promoting change in practice, as it has been reported that effective training programmes offer interactive and multi-faceted approaches (Kuske et al. 2007).

The classroom training took place at Birmingham City University, and was delivered by an experienced senior lecturer from the School of Nursing in 5 days (10am–3pm) over a 2-week period. This distribution of days enabled the homes to backfill for the nurses who were attending the training. The classroom-based learning aimed to enhance knowledge of person-centred care and foster the development of communication, problem-solving and self-directed learning skills. The in-house training (see Appendix 2) was delivered in the care homes by an experienced RMN, and provided opportunities for modelling of person-centred care skills (Kitwood 1997), and for ‘deep learning’ of the skills taught in the classroom (Gibbs 1992), through collaborative working alongside those staff who had received the classroom training. The in-house sessions took place on a 1:1 basis at a pre-arranged time, convenient for the home and member of staff, in a communal area, such as the lounge or dining room. Each session lasted approximately four hours. Home managers were asked to ensure adequate cover was available while staff attended the training. To ensure implementation fidelity of the work-based sessions (Fabiana et al. 2014, a manualised approach was adopted (Woods and Russell 2014; Livingston et al. 2014), and the PI provided regular supervision for the RMN. In the event of these sessions being cancelled these were re-arranged at a mutually convenient time.
The training was not accredited, however to ensure it was appropriate a representative of a care home organisation was invited to join the trial steering group. The study team took on-going advice from this organisation on the training content, materials and programme to try and ensure relevance and acceptability.

**Supervision:**
The review demonstrated that training programmes are more effective and sustainable combined with other factors such as additional support and supervision, and that training alone is not enough to change practice (Eggenberger et al. 2013; Moyle et al. 2010; Spector et al. 2013; McCabe et al. 2007; Livingston et al. 2014). Therefore following completion of the work-based sessions participants randomised to Group 1 received supervision, which was delivered by the PI. This took place in a quiet room at the professional’s workplace, on a 1:1 basis, at a pre-arranged time for 1 hour, once-monthly. The literature suggests supervision is most effective on a once-monthly basis for a period of not less than 60 minutes (Edwards et al. 2005). Due to the study time lines and resources available it was decided that it would be possible to implement supervision for 4 months post intervention. The manager of each home was informed in advance about the supervision session taking place, this was to ensure that backfill was available at the agreed time.

A range of supervision records were kept, including an introductory questionnaire, contract, a record of meeting dates and times, and an outline of aims and objectives as agreed between the supervisor and supervisee at the beginning of each session.

Ground rules and responsibilities were clearly defined and a contract of commitment was signed both by supervisor and supervisee at the outset of the series of supervision sessions. This agreement was based on the recommendations of the Royal College of Nursing and focused on: “commitment to confidentiality, open and honest learning, sharing best practice, seeking research for evidence-based practice, facilitation new learning opportunities, relevance to clinical practice, active listening, an organisational-wide perspective, provision of training and emotional support, a formalised method of recording, creating opportunities for improvements and techniques to manage team dynamics” (Royal College of Nursing, 2002: 22).

**Chapter 6: Findings**

**Impact on the Wider Environment**

**Dementia Care Mapping:**
We conducted Dementia Care Mapping (DCM) in 3 care homes which were randomly selected from the all the homes participating in the study. We observed 5 residents in these homes 1 hour before lunch on 4 separate occasions (baseline, at 5 months, at 10 months and then again at 14 months). Mapping took place in communal areas (Brooker and Surr, 2005). After each 5 minute period (a time
2 types of codes are used to record what has happened to each individual. The mapper also made a decision for each time-frame, based on behavioural indicators, and the relative state of affect and engagement experienced by the person with dementia. This is called Mood-Engagement Value (ME). ME values are averaged over the mapping period to arrive a Well/Ill being score (WIB score). This provides an index of relative well-being for particular time period for an individual or a group. DCM also looks at how residents spend their time and this is linked to relative ill and well-being. (For example if a resident is enjoying doing a crossword with care worker this would be recorded as well-being). The reason we used DCM was to investigate whether the training had any impact on the resident’s well-being and the wider care environment.

**Group 1: Training followed by supervision**

**Group 1 (T+S) Baseline**

- It appears that the group of participants spent most time (85% of time) in the positive mood and engagement state (+1, +3, +5 reflecting well-being) during the mapping period. Although, as seen from the graphs above, participants spent more than half of their time (58% of time) in a neutral mood state (+1) where they did not show overt signs of positive or negative mood and although they were alert, their engagement with people, activities or objects around them was brief and intermittent. A negative mood state (-1 reflecting ill-being) where participants showed small signs of unhappiness represented 15% of the time their spent in ill-being during the time mapped.
It appears that the group of participants spent most time (65% of time) in high potential categories (A, D, E, F, G, P, V) during the mapping period, which is a significant indicator for quality of care. Although, when looking at the behavioural category profile of the group above, there is not much of the diversity within the high potential categories observed during the map. In addition, participants seemed to spend 20% of their time in withdrawn behaviours which is represented by categories C and N. When in these behaviours participants did not show any signs of engagement with themselves or the world around them, either actively or passively which may result from an environment which is not providing adequate support for engagement. Furthermore, participants spent 15% of time in a passive engagement category (category B). However, participants did not spend any of the time in behaviours related to agitation or distress.

Group 1 (T+S) T2
It appears that the group of participants spent most time (91% of time) in the positive mood and engagement state (‘+1’, ‘+3’ reflecting well-being) during the mapping period. Although, as seen from graphs above, participants spent more than half of their time (66% of time) in a neutral mood state (+1) where they did not show overt signs of positive or negative mood and although they were alert, their engagement with people, activities or objects around them was brief and intermittent. A negative mood state (‘-1’ reflecting ill-being) where participants showed small signs of unhappiness represented 9% of the time their spent in ill-being during the time mapped.
It appears that the group of participants spent most time (63% of time) in high potential categories (A, D, F, G, P, R, T) during the mapping period, which is a significant indicator for quality of care. Although, when looking at the behavioural category profile of the group above, there is not much of the diversity within the high potential categories observed during the map. In addition, participants spent as much as 30% of time in a passive engagement category (category B). Furthermore, participants seemed to spend 5% of their time in withdrawn behaviours which is represented by category N. When in these behaviours participants did not show any signs of engagement with themselves or the world around them, either actively or passively which may result from an environment which is not providing adequate support for engagement. However, participants did not spend any of the time in behaviours related to agitation or distress.

Group 1(T+S) T3
It appears that the group of participants spent most time (61% of time) in the positive mood and engagement state (‘+1’ reflecting well-being) during the mapping period. Although, as seen from graphs above, participants spent more than half of their time (61% of time) in a neutral mood state (+1) where they did not show overt signs of positive or negative mood and although they were alert, their engagement with people, activities or objects around them was brief and intermittent. A negative mood state (‘-1’, ‘-5’ reflecting ill-being) where participants showed small and on some occasions very great signs of unhappiness represented as much as 39% of the time their spent in ill-being during the time mapped.
• It appears that the group of participants spent most time (63% of time) in high potential categories (A, F, P, R, T) during the mapping period, which is a significant indicator for quality of care. Although, when looking at the behavioural category profile of the group above, there is not much of the diversity within the high potential categories observed during the map.

• Furthermore, participants seemed to spend as much as 47% of their time in withdrawn behaviours which is represented by category C and N. When in these behaviours participants did not show any signs of engagement with themselves or the world around them, either actively or passively which may result from an environment which is not providing adequate support for engagement. In addition, participants spent 17% of time in a passive engagement category (category B). Participants did spend 8% of time in behaviours related to agitation or distress (category U).

Group 2: Training alone
Group 2 (T) Baseline

• It appears that the group of participants spent most time (91% of time) in the positive mood and engagement state (‘+1’, ‘+3’ reflecting well-being) during the mapping period. As seen from graphs above, participants spent more than half of their time (57% of time) in a considerable positive mood state (+3) where they did show clear signs of happiness, contentment, pleasure, relaxation, and comfort and their engagement with people, activities or objects around them was considerable. A negative mood state (‘-1’ reflecting ill-being)
where participants showed small signs of unhappiness represented 9% of the time their spent in ill-being during the time mapped.

- It appears that the group of participants spent most time (72% of time) in high potential categories (E, I, L, P) during the mapping period, which is a significant indicator for quality of care. Although, when looking at the behavioural category profile of the group above, there is not much of the diversity within the high potential categories observed during the map. Furthermore, participants seemed to spend 2% of their time in withdrawn behaviours which is represented by category C. When in these behaviours participants did not show any signs of engagement with themselves or the world around them, ether actively or passively which may result from an environment which is not providing adequate support for engagement. In addition, participants spent 19% of time in a passive engagement category (category B). Followed by 6% of time in behaviours related to agitation or distress (category U).
It appears that the group of participants spent almost their whole time (99% of time) in the positive mood and engagement state (‘+1’, ‘+3’, ‘+5’ reflecting well-being) during the mapping period. 1% that is not represented in a graphical form, was accounted for sleeping in a relaxed and comfortable position. As seen from graphs above, participants spent almost equal amount of time in a neutral mood state (+1) where they did not show overt signs of positive or negative mood and although they were alert, their engagement with people, activities or objects around them was brief and intermittent or in a considerable positive mood (‘+3’ reflecting well-being) where they were showing clear signs of happiness, contentment, pleasure, relaxation and comfort and their engagement with people, activities or objects around them was considerable. Participants did not spend any of their time in a negative mood and engagement state.
It appears that the group of participants spent most time (70% of time) in high potential categories (A, D, F, G, L, P, T) during the mapping period, which is a significant indicator for quality of care. Although, when looking at the behavioural category profile of the group above, there is not much of the diversity within the high potential categories observed during the map. In addition, participants spent as much as 22% of time in a passive engagement category (category B). Furthermore, participants seemed to spend 8% of their time in withdrawn behaviours which is represented by category N. When in these behaviours participants did not show any signs of engagement with themselves or the world around them, either actively or passively which may result from an environment which is not providing adequate support for engagement. However, participants did not spend any of time in behaviours related to agitation or distress.
It appears that the group of participants spent their whole time (100% of time) in the positive mood and engagement state (‘+1’, ‘+3’, ‘+5’ reflecting well-being) during the mapping period. As seen from graphs above, participants spent more than half of their time (60% of time) in a considerable positive mood state (+3) where they did show clear signs of happiness, contentment, pleasure, relaxation, and comfort and their engagement with people, activities or objects around them was considerable. Participants did not spend any of their time in a negative mood and engagement state.
It appears that the group of participants spent most time (82% of time) in high potential categories (A, E, F, L, T) during the mapping period, which is a significant indicator for quality of care. Although, when looking at the behavioural category profile of the group above, there is not much of the diversity within the high potential categories observed during the map. In addition, participants spent as much as 15% of time in a passive engagement category (category B). Furthermore, participants seemed to spend 2% of their time in withdrawn behaviours which is represented by category N. When in these behaviours participants did not show any signs of engagement with themselves or the world around them, ether actively or passively which may result from an environment which is not providing adequate support for engagement. However, participants did not spend any of time in behaviours related to agitation or distress.
It appears that the group of participants spent most time (90% of time) in the positive mood and engagement state (‘+1’, ‘+3’ reflecting well-being) during the mapping period. Although, as seen from graphs above, participants spent more than half of their time (53% of time) in a neutral mood state (+1) where they did not show overt signs of positive or negative mood and although they were alert, their engagement with people, activities or objects around them was brief and intermittent. A negative mood state (‘-1’, ‘-3’ reflecting ill-being) where participants showed small and also considerable signs of unhappiness represented 10% of the time their spent in ill-being during the time mapped.
It appears that the group of participants spent 50% of time in high potential categories (A, D, F, O, P, Y) during the mapping period, which is a significant indicator for quality of care.

Also, when looking at the behavioural category profile of the group above, there is not much of the diversity within the high potential categories observed during the map. In addition, participants spent as much as 25% of time in a passive engagement category (category B). Furthermore, participants seemed to spend 18% of their time in withdrawn behaviours which is represented by category N. When in these behaviours participants did not show any signs of engagement with themselves or the world around them, either actively or passively which may result from an environment which is not providing adequate support for engagement. Participants did spend a significant amount of time (8%) in behaviours related to agitation or distress (category U).

Group 3 (TAU) T2

It appears that the group of participants spent most time (85% of time) in the positive mood and engagement state (‘+1’, ‘+3’ reflecting well-being) during the mapping period. Although, as seen from graphs above, participants spent more than half of their time (66% of time) in a neutral mood state (+1) where they did not show overt signs of positive or negative mood and although they were alert, their engagement with people, activities or objects around them was brief and intermittent. A negative mood state (‘-1’ reflecting ill-being) where participants showed small signs of unhappiness represented 15% of the time their spent in ill-being during the time mapped.
It appears that the group of participants most of the time (71% of time) in high potential categories (A, D, F, K, P, T, V, Y) during the mapping period, which is a significant indicator for quality of care. Also, when looking at the behavioural category profile of the group above, there is not much of the diversity within the high potential categories observed during the map. In addition, participants spent as much as 28% of time in a passive engagement category (category B). Furthermore, participants seemed to spend 2% of their time in withdrawn behaviours which is represented by category N.

When in these behaviours participants did not show any signs of engagement with themselves or the world around them, ether actively or passively which may result from an environment which is not providing adequate support for engagement. Participants did spend a significant amount of time (13%) in behaviours related to agitation or distress (category Y).

Group 3 (TAU) T3
It appears that the group of participants spent most time (96% of time) in the positive mood and engagement state (‘+1’, ‘+3’ reflecting well-being) during the mapping period. 1% that is not represented in a graphical form, was accounted for sleeping in a relaxed and comfortable position. Although, as seen from graphs above, participants spent more than half of their time (55% of time) in a neutral mood state (+1) where they did not show overt signs of positive or negative mood and although they were alert, their engagement with people, activities or objects around them was brief and intermittent. A negative mood state (‘-1’ reflecting ill-being) where participants showed small signs of unhappiness represented 3% of the time their spent in ill-being during the time mapped.
It appears that the group of participants spent more than half a time (59% of time) in high potential categories (A, F, K, L, Y) during the mapping period, which is a significant indicator for quality of care. Also, when looking at the behavioural category profile of the group above, there is not much of the diversity within the high potential categories observed during the map. In addition, participants spent as much as 18% of time in a passive engagement category (category B). Furthermore, participants seemed to spend 24% of their time in withdrawn behaviours which is represented by category N. When in these behaviours participants did not show any signs of engagement with themselves or the world around them, ether actively or passively which may result from an environment which is not providing adequate support for engagement. Participants did spend 3% of time in behaviours related to agitation or distress (category Y).

Summary Dementia Care Mapping:
- It seems that residents well-being in nursing homes from group 1 (where nurses attended the dual element training followed by supervision) at T2 (after the training) improved comparing to baseline data. It appeared that residents spent more time in a positive mood and engagement state (85% of time at baseline, 91% at T2) and less time in a negative mood state (15% of time at baseline, 9% of time at T2). In terms of time spent in high potential categories, at T2 it reduced slightly from 65% at baseline to 63%. However, the amount of time spent in passive engagement behaviours did increase, as participants spent 15% of their time in these categories at baseline and 30% at T2. The improvement was seen however in the number of withdrawn behaviours as participants spent 20% of their time in these behaviours at baseline and only 5% at T2. At T3 however (after staff received supervision), it appeared that residents spent less time in the positive and engagement state
(61% of time) and more in a negative mood state (39%). In terms of time spent in high potential categories, at T3 it stayed exactly the same as at T2 (63%). The time spent in passive engagement behaviours did decrease however, as participants spent 17% of their time in these categories at T3 and 30% at T2. Nevertheless, at T3 as much as 47% of the time participants spent in withdrawn behaviours. At T2 it was only 5% of their time. Moreover, at T3 participants did spend 8% of time in behaviours related to agitation or distress. Participants did not spend any of the time in behaviours related to agitation or distress at baseline or at T2.

- It seems that residents well-being in nursing homes from group 2 (where nurses attended the dual element training only) at T2 (after the training) improved comparing to baseline data. It appeared that residents spent much more time in a positive mood and engagement state (91% of time at baseline, 99% at T2) and no time in a negative mood state (9% of time at baseline, 0% of time at T2). Also residents showed a very high positive mood and engagement (+5) for 12% of their time whereas they did not show any of very high positive mood and engagement at baseline. In terms of time spent in high potential categories, it reduced slightly from 62% at baseline to 60% at T2. On the contrary the amount of time spent in passive engagement behaviours did increase, as participants spent 19% of their time in these categories at baseline and 21% at T2. The same trend was seen in the amount of time spent in withdrawn behaviours as participants spent 2% of their time at baseline and 8% at T2. At T3 (at follow up), it appeared that residents spent all of their time (100%) in the positive mood and engagement state with 60% of time being a considerable positive mood state and engagement (+3) and 6% of time being a very high positive mood. Residents did not spend any time in a negative mood and engagement state. In terms of time spent in high potential categories, it increased from 60% at T2 to 80% at T3. Whereas, the time spent in passive engagement behaviours did decrease, as participants spent 21% of their time in these categories at T2 and 15% at T3. In addition, at T3 only 2% of the time participants spent in withdrawn behaviours. At T2 it was 8% of their time.

- It seems that residents well-being in nursing homes from group 3 (treatment as usual) at T2 did not improve comparing to baseline data. Firstly, it appeared that residents spent less time in a positive mood and engagement state (90% of time at baseline, 85% at T2) and more time in a negative mood state (10% of time at baseline, 15% of time at T2). In terms of time spent in high potential categories, it increased from 50% at baseline to 71% at T2. The time spent in passive engagement behaviours did increase too, as participants spent 25% of their time in these categories at baseline and 28% at T2. Moreover, amount of time spent in withdrawn behaviours decreased as participants spent 18% of their time at baseline and only 2% at T2. At T3 however it has changed as it appeared that residents spent more time in the positive and engagement state (96% of time) and much less time in a negative mood state (3%) than at baseline or at T2. In terms of time spent in high potential categories, it
decreased from 71% at T2 to 56% at T3. The time spent in passive engagement behaviours did decrease too, as participants spent 28% of their time in these categories at T2 and 18% at T3. In addition, at T3 only 2% of the time participants spent in withdrawn behaviours. At T2 it was 24% of their time. In addition, participants did spend significantly less amount of time (3%) in behaviours related to agitation or distress at T3 compared to T2 (13%).

- In terms of impact on the wider care environment the findings of the Dementia Care Mapping were mixed, however the results showed that the resident’s well-being improved in both groups following training compared to the control group.

**Interviews with care staff:**

6 interviews were conducted with care staff who worked in the care homes where the nurses received training. There were some indications that the care staff perceived that the training had made an impact on the care provided within the home and on the nurses practice.

Two of the six care staff made references to the nurses appearing more confident. Several carers also reported noticing changes in terms of the nurse’s leadership and management styles. There were also many examples of the nurses disseminating what they had learnt in the training.

Carer: “Um, I think she’s calmer… if she’s calmer you feel calmer. If other people around you are calm, then you feel calm. So I’d say a little bit”.

Carer: “Um more leadership I suppose. She has more confidence in being a leader, but she is also deputy as well, so whether that confidence has come from the training you know or a bit of each; being a deputy and the training”.

Interviewer: “Have you noticed any changes in the way your team is managed since the training?”

Carer: “I wouldn’t think it’s changed but if you go to him, he is more knowledgeable to what he is talking about, so its no good going to a manager who hasn’t got a clue, and asking them and then he gives you this story, whereas now we feel he understands what we are saying because he has been on the course and we know he knows about it rather than giving us gibberish really”.

Carer: “Yes, one of the nurses came back and I don’t know how recently she’d been on the training but she came back quite excited by what she’s learnt and what she’s heard and she shared some stuff with us, not that we had the time to do it but she had a book with her as well about something to do with dementia and said it was worth us reading it but it went to one of the carers and I haven’t seen it since or heard about it”.

Interviewer: Have you noticed any changes in the way your team is managed since your nurses have attended the training, in the way they supervise, in the way they delegate to staff or in handover?”
Carer: “Yes in handover and different schedules, yes you can see an improvement...Handover is more detailed....”

“Yes probably role modelling. Because when you have specific questions they will talk to you and explain things to you and show you different processes that they do even in terms of what charts they use or what scales they use for pressure relief and things like that, they are quite happy to go through with you and explain. Again its time and it’s not something they will go out of their way to teach you it’s if you ask the question then you will get the information”

In terms of attitude the care staff felt that the nurses had appeared to benefit in terms of managing difficult situations and adopting a flexible person centred approach;

Carer: “He’s been helping us to cope with the challenging behaviour that some of the residents can show sometime because there are situations when you really don’t know how to handle them. So he’s been helping with that quite a lot”.

Interviewer: “Do you think he was helping a bit more after he had the training or was it as before?”

Carer: “Yes, he’s coming up with different strategies to cope with different people and they do seem to be working, obviously they can be a bit hit and miss sometimes depending on the person. They do seem to be helping.....It is helping because we have one lady at the minute whose behaviour is getting quite bad, so she tends to respond better to him because he has got all these ideas, so we just go and get him when we need help”.

Carer: “Well, the thing that the one nurse said that I remember is; because sometimes we have trouble with some of our sisters eating, so for feeding them and so on their very reluctant to eat and drink so she said she learnt some stuff about its helpful if you actually sit with them and eat with them and have a drink with them so it’s not actually you just sat their feeding them. So it just becomes just like a normal thing of you sat there having a meal together. I thought that was quite nice and interesting. There was also something about, I don’t know whether this came from your training but something about the night staff will where pyjamas because then if the patients get up they can see that its night time and its normal to go to bed and just to make everything normal. So they were all wearing pyjamas! Because if they get up and see everyone in uniform, properly dressed it’s very much a care setting and it can be quite distressing”.

Summary
The qualitative interviews with care staff demonstrated that nurses had improved in terms of self-efficacy, person-centred approach, and leadership skills.

Findings: Qualitative Interviews
The results from the qualitative interviews are presented under four main headings, each heading corresponding to theme, being discussed. Direct extracts provided by the staff are presented in italics from interviews. Only a limited selection of the many exemplar quotes are provided.

**Theme 1: “Working in a stressful place”**

This theme emerged from quotes reflecting the range of factors which led the nurses to feel exhausted, unsupported and disempowered. Physical and emotional exhaustion, poor coping strategies and unhealthy habits combined to exacerbate the impact of unsupportive environments. This theme was by far the most significant to be developed from the interviews and there was a wealth of data relating to staff feeling unsupported at work and undervalued by their organisations. This is demonstrated in the quotations below:

“Because it’s like ... you give someone a drop of blood, but they want two drops, so you give them three drops and it keeps going and going, you know and now I’m always lifeless. Because I can’t give any more blood, do you know what I mean? I can’t give any more to this organisation. If burnout means that I’ve done my job, then yes I’ve done my job. I can’t take this home any further.

The nurses were clearly in need of support. As the lone qualified member of staff they were isolated and had no colleagues to turn to for clinical guidance, reassurance or peer support.

“Yes, and then you have to make sure they are alright and take over and take them off but nobody comes into the office and takes you off. Nobody says to you, you’ve had enough now, so down to the staff room. And you know it’s difficult to get supervision here. Hold on, I can’t remember the last time I had supervision and that’s down to staffing and not having enough nurses and managers and having to do shifts because there are no nurses”.

The nature of the workload combined with staff shortages meant that the nurses were aware that no one else was there to solve any problems that arose in their absence. This led them to feel ‘on duty’ even when at home.

“It’s like if you’re off today you’re thinking oh no I’ve got to go to work tomorrow. You just can’t relax at home because you’re even having calls at home, so you couldn’t even have an off day”. We didn’t have a manager at that time and it was a big home as well, so everything was on top of the nurse to manage each and everything. So there were about 30 residents and you did everything, even the social worker meetings and everything done by nurses so it was very stressful. So you’re on the floor and managing as well.

**Presenteeism**

Despite the pressures, the nurses appeared to feel a compulsion to ‘be there’. They often recognised this was unhealthy but were unable to explain their own behaviour.
“It makes me think I’m not good at it, and I get angry with myself, well why can’t you do it, other people manage… they do. They have got different ways and different approaches and I want to get everything done…I need to carry on until I’ve done it and if it half kills me I’ll carry on…”

“It’s ridiculous… I’ve been here 8 years and I’ve never had a day of sick. I know it’s ridiculous. It’s a bit sort of addictive…. oh my God I’ve done 28 shifts out of a possible 30 something and that means something is wrong isn’t there? ….”

This approach seemed designed to prevent complaints or safeguarding issues, but meant there was no scope to be creative or manage the home in a positive way, leading to feelings of inadequacy and lack of personal accomplishment.

“At times I felt discouraged, just sometimes I feel like why am I doing this?”

There were also negative outcomes for the organisation in terms of increased sickness, absenteeism and staff turnover as demonstrated in the quotations below;

“The motivation levels, the morale, you know people wanting to leave and look for other jobs…”

“They also had a big staff turnover, people came and went all the time and so there was no continuity. The residents didn’t get used to faces, they used a lot of agency nurses so there was no continuity so I suppose that didn’t help”.

**Impact on health**

The high demands, including pressure to work long (sometimes unpaid) hours, appeared to be associated with physical and emotional symptoms of stress. Participants reported adopting unhealthy coping strategies (such as smoking and drinking) and prioritising client well-being over that of their families. Several interviewees highlighted that these physical symptoms were having a negative impact on their life and health.

“It happened twice at work where they had to call for an ambulance for me and that was due to stress at work. It was related to the acidity and the gas but it was like a crushing; a severe pain like a heart attack, I was really sweaty and when you’re in a medical field, you know what’s happening”.

“I tried to diagnose myself a lot of the time because I was getting tired and feeling so unwell so I visited my GP and after some bloods it was found that I was pre-diabetic if you like, and I’m not eating or drinking properly at work, so I’m not taking care of myself really. On my days off it’s spent recovering if you like, because of being exhausted at work and because of the amount of hours at work. I’ve neglected myself and I’m caring for other people and putting everyone else first and you’re just overloaded”.

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The health problems affected the nurses’ emotional well-being at home, which led on to an impact on relationships with others. The nurses were aware of the negative consequences of their behaviours, and expressed concern for their own long-term well-being:

“I work very long hours ... but I need to stop doing that now because it’s taken a toll on my health and my mental state so I will do whatever I think is necessary to do but no more now, and that’s it, because if not I’m going to kill myself”.

“When I came back I was still stressed out about it and felt burnt out at the end of the shift. I wouldn’t even smile and when I got home the children would run away... yes it affected my personal life because I would get home after twelve hours, I couldn’t walk or talk, let alone eat, it affected my life as a whole”

Theme 2: “Bringing learning into the home”
Participants reported how they had been able to bring what they had learnt from the training into the home and how they adapted the new learning so that it was appropriate for their place of work. This included the use of new leadership approaches and strategies for managing stress at work which were both part of the curriculum.

Participants favoured the active learning methods e.g. role play, group exercises and discussion used in the classroom and found these particularly enjoyable.

“because there was something different about it .... (talking about a group exercise).. It was just a good way of getting people to remember the session, being a little bit quirky, I like that”

“We did loads, the leadership bit was when we did the role play, that was good, and a lot we did on dementia and following through, and picking up on the communications and behaviours, although we still need behaviour training, not for the residents, for the staff!

Following the intervention, the nurses reported feeling more confident about their abilities and described feeling empowered to share learning with others:

“.... After the training I really do.... feel more confident. I’ve actually seen I have moved in leaps and bounds. For anyone else, I don’t know, but I think the training was made for me. It helped me as an individual.”

“It’s made a difference, in the sense that personal contact with other people was much better and I had more confidence to do supervisions and I had more confidence in my practice as well”.

Enhanced confidence enabled the nurses to share new knowledge and influence care. This had a subsequent impact on ‘presenteeism’ and workload management:
“Before the training I used to find pride when people phoned me at home…. And I felt glad that people are phoning me. But when ... actually mentioned that when you’re team can’t deal without you, then you’re doing something wrong, it really made me think, I really need to share the education And when you do, things you just go smoothly so now I can go for a meeting for two hours and they don’t look for me because they know what they’re doing and why they’re doing it”.

Permission to delegate and role playing of strategies seemed particularly helpful:

“I don’t need to do everything myself. That’s the one thing I learnt as well. It’s a 24 hour service and you need to share the jobs, especially if somebody has the skills to do the job. It makes it much easier for me now and I’m quite confident to delegate now because at times I felt I needed to do the job as I’m the nurse…”

It was evident that staff adopted a person centred approach following the intervention. While participants did not explicitly use this term, to know the person history and understand their identity appeared to be something which they now considered.

“And we’ve actually got a woman here at the moment that has Alzheimer’s and it was her birthday a few days ago and she kept saying to everybody, how old are you? 21 ½ nearly. Well we never really....So that if she is in that sort of age, in her early twenties, to get her daughter to try and think of things she can talk about to see if she can have a conversation with her mum about something her mum will remember”.

The skills based training appeared to be a particularly beneficial aspect of training in terms of enhancing the participants’ confidence as the trainer was able to provide positive feedback on practice in the home, this part of the training also provided opportunities for embedding and reinforcing good practice within the home. Positive reinforcement was valued and seemed to boost morale:

“It became light and airy and everybody was happy and ....came and said it was fab. She said it was a great place and she said you know the environment is very welcoming, everybody’s morale is up and motivation is good. I was bubbling because I was getting all this good feedback now”.

“Everybody needs some praise and a pat on the back and when you don’t get it you know so when the change comes around and you do you do feel really valued you know especially because within yourself your feel undervalued you act that way and when your praised and valued you act that way as well”.

Theme 3: Impact of Supervision
There were numerous examples in the interviews where the supervision appeared to support staff in the implementation of the new learning, encouraging experimentation and reflection. Through the
supervision process participants were encouraged to work flexibly and creatively, adopting a solution focused approach to manage challenging situations at work:

“Like I say, the things that we’ve discussed in the training were generalised in the group, but afterwards bringing into the home the bits we have learnt but then it’s tweaking it for here. For me, for my staff and also tweaking it for nights, because that’s different from days. So the supervision brought it more centred for me, for my staff and residents”

The supervision model gave the nurses permission to direct responsibilities back to their teams, rather than taking on everything as the senior member of staff. Socratic questioning was used, an approach which this participant was able to adopt in her own role supervising others:

“When speaking about supervision....I found it really helpful especially when you have to supervise the carers or the senior care nurse.  I’m even using it when they are asking a lot of questions. So we will ask them a question like ‘which way do you feel better? So we are not telling them ‘you do it this way’ and they will get the feeling that they have told you what the solution is”

Theme 4: “Listening to other peoples stories”
The fourth theme emerged as participants reported that the classroom training had provided valuable opportunities for sharing practice and experiences of working in a nursing home. This is particularly salient as staff working in nursing homes felt that they were very isolated. They seemed to feel reassured that “everyone was in the same boat” and “they were the same as everyone else”. They were interested in getting tips from each other and sharing ideas with a view to problem solving and generating ideas for managing difficult situations at work.

“I remember thinking how lucky I was, by listening to other people’s stories and how they work and their work conditions and I’m thinking, no, I couldn’t work in that.

“Yes it was a really good eye opener because you tend to feel a little bit isolated when you’re having troubles at work and you feel oh God our home is the only one going through this, you know other homes can’t be like this but going in and sitting in the classroom especially when we did like the group sessions and things like what goes on in our homes it really opened my eyes to know that actually everybody has got the same similar kind of problems so it was really nice to feel like Oh God it’s good to know that were not the only ones because you do tend to get a bit, are we being picked on? So you know it’s nice to know that were not, you know any different from anybody else.  We have the same sort of problems with the kitchen staff and with the caring staff and the relatives and all the normal types of things.”

Summary

Our findings confirmed those from previous studies indicating that working as a nurse in nursing homes is stressful physically emotionally, ethically and socially (Engstrom, Skytt and Nilsson 2011, Jakobsen and Sorlie 2010, Schmidt et al 2012, Westermann et al 2014, Willemse et al 2014). When
morale is low, practitioners may react by withdrawing and limiting exposure to meaningful relationships (Taylor 2015) and in common with other study findings, while nurses were aware of the importance of a person-centred approach, they were often unable to put this into practice which, compounded by feelings of inadequacy (Jakobsen and Sorklie 2010), added to the pressure they felt. In common with other studies (Schmidt and Distal 2013) the nurses in our study described feeling overwhelmed by the demands of their roles and physically and emotionally exhausted.

Workers have the right to just and favourable conditions at work (United Nations General Assembly 1948) but the accumulation of devaluing but normalised experiences in nursing home work (low pay and few opportunities for example) have a negative impact on health over time (Sojo Wood and Genat 2016). The nurses’ accounts indicated that at times they feared their choice of profession and the subsequent demands put upon them would have a negative impact on their life expectancy. This did not seem to be melodramatic; many of the nurses in our study had been diagnosed with serious long-term conditions. As the person in charge, it was necessary for nurses to focus on residents and carers’ well-being, partly due to legal and professional requirements and partly as a result of the demands of colleagues they managed. In order to cope with these priorities, nurses sacrificed attending to their own needs.

In response to frequent media attention (e.g. Panorama 2014) to safeguarding issues in nursing homes, nurses shared their anxieties about the potential for blame and shame to be attached to them should the home’s practice be criticised. In internalising a sense of a critical observer, they aimed to protect themselves from potential accusations of abuse, but in doing so they colluded with their own exploitation, for example by working long hours, unpaid overtime, managing the home while off duty and arranging their personal lives around the needs of the organisation. This combination of perceived lack of control, high levels of responsibility and anticipated criticism is recognised as damaging for workers and known to lead to burnout and ill health (Engstrom, Skytt and Nilsson 2011).

Caring for people with dementia, whose distressed behaviour can be challenging, is also associated with poor physical health for their nurses, together with high levels of burnout (Cookson et al 2014, Schmidt et al 2012). Maladaptive coping or defence mechanisms include ‘projection’ (Diehl et al 2014) and in this study nurses’ lack of self-confidence seemed to predispose towards projection of anxiety about performance onto colleagues so that delegation became difficult, adding to overload and increased pressure. Psychoneuroimmunology theory suggests that long term stress has an impact on the immune system and results in vulnerability to long term health problems (Kendall-Tackett 2015). The old provision for mental health nurses to retire at 55 (‘mental health status’) was based on actuarial realities, in that MH nurses were not expected to live post retirement for so long as other professionals. It seems there may be a risk that this pattern will be repeated for nursing home nurses. The nurses in our study mentioned fearing for their own long-term well-being and certainly it seemed that they experienced barriers to participating in protective behaviours (such as
spending time with family, having professional support to manage workloads and off-duty) that would protect their own health, while using harmful temporary stress management strategies such as smoking and drinking alcohol.

There is a shortage of nurses worldwide (Schmidt et al 2012) and in the UK (RCN, 2012). In this context and perhaps due to ageist values, nursing home nursing is perceived as low status and these environments to be undesirable workplaces (Kubicek, Korunka and Tement 2014). Conditions are often perceived as poor (Kubicek 2014); these perceptions were confirmed in our study as we came across instances of unpaid overtime, lack of sick pay, inadequate provision for breaks and high staff turnover (Hussein et al. 2015). These unsupportive workplace conditions would not be tolerated by other professionals, but nurses tend not to be confrontational or political and do not have well organised unions. In fact some nursing homes in our study forbade employees to join unions. Workplace stress is associated with high levels of absenteeism, sick leave and staff turnover (Westermann et al 2014). When unhappy with conditions nurses it seems move on to the next job in another home (Flackman et al. 2008).

Nursing is still an overwhelmingly female dominated profession, strongly identified with cultural beliefs about the role of women as being caring, giving and supportive to others (Weaver et al 2013). Professionally highlighting ‘caring’ as a core value (NMC, 2015) in combination with belittling stereotypes such as ‘angels’ risks reinforcing devaluing gender-based perceptions of a nursing career choice as a ‘natural’ outcome of a kindly personality, which may hinder nurses in recognising that their own needs are equal to those of others, leaving them open to exploitation. In failing to challenge stereotypes nurses undermine their position as professionals who deserve recognition for their skills and responsibilities rather than qualities which are perceived as ‘natural’ and so not professionally or financially acknowledged. Fearon and Nicol (2011) theorise that burnout is the outcome of a breach of a ‘psychological contract’ of mutual expectation, when there is a disparity between the amount a person gives and receives in their workplace, while Jakobsen and Sorlie (2010) suggest that conflict between core cultural values around meaning, identity and solidarity and material values such a power and money lead to feelings of alienation, frustration and burnout.

Learning is a form of investment in oneself and being supported to learn indicates valuing by the person or organisation enabling this opportunity (RCN, 2012). This in itself perhaps counteracts some of the devaluing message previously explored. The learning opportunities designed for the programme aimed to model a person-centred approach toward the participants and to assist them in building useful skills for dementia care practice, coping with stress and for leadership. The programme also included simple tips for prioritising and managing tasks. The team hoped that this would be empowering, which seemed to be the case, as many participants mentioned using the approaches they had experienced themselves when supervising unqualified staff as well as when caring for residents. Having a sense of ‘job control’ is associated with person-centred practice and
more positive engagement with work responsibilities (Kubicek et al 2014) and seems to be protective by mitigating the consequences of job demands (Schmidt and Diestal 2013).

Experiential learning is associated with enhanced empathy and compassion and a more holistic approach to the care of people with dementia (Adefila et al 2015). Most of the learning opportunities were based around games exercises and simulation which enabled participants to learn directly by making meaning from experiences. Classes took a constructionist adult-orientated approach to learning, in which previous learning is taken as a strong base from which to develop and which is associated with better engagement (ref). In modelling a person-centred approach (Rogers 1994?, Kitwood 1997), the tutors got to know each participant, recognising and respecting their strengths and values. In common with person-centred therapy, the problems and tasks for the group were based around their own stories and perceptions of relevant problems, so that to an extent each group designed their own learning experiences.

A solution-focused approach was used to address problem-solving, self-care and management needs and leadership approaches. The solution-focused approach is empowering because it focuses on personally identified goals and small steps and puts control into the hands of the client (Fowler 2007) in this case the nurses. The nurses expressed valuing the care assistants they managed, and though many expressed frustration with some of the behaviour of their unqualified colleagues, they were able to empathise with the context of little control that the care assistants could exercise over their working lives (Fowler, 2007). The interviews confirmed that in being listened to and experiencing empathy the nurses were then able to show these qualities more easily to others, a factor that seemed to be reinforced and maintained significantly through the work-based learning and clinical supervision that followed the classroom based training.

Discussions formed a large part of the learning experience, and the tutors ensured they responded emotionally as well as educationally to participants’ input. Warmth humour and mutual support was apparent in each group. In feeling valued, participants were able to value each other and to consider alternative perspectives for understanding their work environments. One of the themes reflected how the participants valued learning from each other, that it was reassuring to realise that other people had similar problems and that they could share solutions. Learning from other peoples’ stories was a central feature of the nurses’ positive feedback. Telling stories is congruent with the culture of nurses’ professional life (Sandgren et al. 2006), it is an acknowledged informal method for sharing values and reinforcing norms within teams (Sandgren et al. 2006). For the nurses in this study, the stories were crucial in reducing the sense of isolation and increasing the feeling of being in a similar situation to others, which was experienced as mutually supportive and reassuring, perhaps because when similar experiences emerged, responsibility could no longer be attributed to an individual (the nurse themselves) but instead could be perceived as systematic (Sojo Wood and Genat 2016), thus enabling the nurses to reject blame.
Vachon (2016) suggests that those who feel secure are able to empathise more effectively and that self-compassion is the key to compassion, while Willemse et al (2014) suggest that person-centredness is associated with staff as well as service-user well-being. Thus it seems that experiencing person-centred attention enables a person to manage their own emotions more effectively and to offer more effective emotional support to others. Clinical supervision could be argued to be similar in intention and experience to person-centred counselling, in focusing on the client, and it uses many of the same techniques (Teasdale et al. 2008).

The nurses who experienced supervision were able to articulate how meaningful their work was to them and this could have resulted in a more genuine ‘deep acting’ response to the stresses of managing high levels of emotional labour successfully. They noted an increase in confidence and emotional well-being and greater willingness to share their knowledge. It is possible that receiving person-centred warmth and unconditional positive regard met the nurses’ emotional needs and so had an impact in reducing maladaptive coping strategies while enabling more positive strategies to flourish.

The work-based learning and clinical supervision elements used Socratic questioning to further empower the nurses to develop and test their own solutions. Dilworth et al (2013) found that clinical supervision validates nurses in their work, enables them to change practice and can improve satisfaction while decreasing stress and burnout. Fearon and Nicol (2011) add that clinical supervision enables a sense of control to be re-established, as nurses feel more confident in their own problem-solving abilities. Having experienced this one to one support and guidance through clinical supervision, the nurses in our study were able to adopt the same skills and use them to develop others, and so delegate more. This fostered both self-confidence and confidence in their team, which had a subsequent impact in freeing up their own time and energy and, as Dilworth et al suggested, reducing stress and burnout.

Not ‘needing to be there’ so much featured within this theme. The nurses seemed to feel less inclination to be indispensable. Whereas previously some nurses enjoyed the feeling that no one could cope without them, this had a negative impact overall. However, they were able to let it go, compensating for the reduction in time taken doing tasks with more time offering support guidance and encouragement to others, thus indirectly having a positive impact on care. Kubicek Korunka and Tement (2014) suggest that having medium levels of job control is associated with better outcomes, for both staff and patients, as nurses feel more dedicated to their work and have more energy to commit to it.

Receiving personal feedback seemed to be a clear factor in building confidence. Nurses in nursing homes do not always receive clinical supervision (Bush, 2005) and feedback may only be given in response to a problem. In receiving ‘positive strokes’ the nurses were given permission to accept and value their own strengths. In a culture where nurses are generally under-valued and extra work is seen as normal, perceived minor improvements often remain unacknowledged. Recognising good
practice is a powerful reinforcer that builds confidence and commitment and is easily spread within a team. Taking a person-centred approach to nursing care leads to feelings of increased confidence (Willemse et al. 2014) as does improving workload control (Kubicek et al. 2014) and for our participants feeling more competent and confident led to a reduction in stress levels, which persisted beyond the time frame of the supervision intervention, even though the workload remained the same.

The implications of our findings are that there are ethical and business reasons to teach nurses working in nursing homes about high quality dementia care and leadership skills, and to support them and reinforce their personal development with a working-alongside model and clinical supervision. This training approach reinforces the value of nurses, including importantly to the nurses themselves. Reducing staff turnover is essential to the smooth running of the home and to the well-being of people with dementia, who are better nursed by people who know them well, understand their life history and are committed to a person-centred approach. Delivering care from a person-centred perspective is dependent on staff too meeting their needs for Personhood. This implies recognition, respect and trust (Kitwood 1997). The physical health of nurses also needs attention and working conditions should be designed to facilitate nurses taking care of their own physical and emotional health.

The outcomes of the training intervention indicate that nurses are able to manage their own and others’ workloads more effectively, regain a sense of hope and commitment and potentially reduce the staff turnover rates which are so damaging to residents with dementia (Hussein et al. 2015) and costly in terms of recruitment.

Four main themes were identified in the qualitative interviews. The first “working in a stressful place” highlighted the difficult nature of working in this setting. The findings indicated staff were experiencing isolation, low levels of morale and extreme pressure at work. High levels of work strain and low levels of work satisfaction and organizational work pressure are associated with increased rates of staff turnover (Hussein et al. 2015). The economic costs of high turnover and vacancy rates are considerable if training, loss of skills and experience, and recruitment and induction costs are taken into account. High levels of vacancies and turnover rates also impact on service quality in several ways. The most apparent ones are the level of risk associated with an understaffed service or with staff who do not have enough experience or skills to meet users’ needs and lack of continuity of care. High turnover has been associated with lack of competence, high levels of burn-out and low levels of work-satisfaction (Edvasson et al. 2009).

The Second theme “Bringing Learning to the home” demonstrates staff were able to apply the learning to their work. Educational interventions need to be creative, stimulating, challenging, emotionally engaging and relevant in order to address these core aspects (Rogers, 2007). They need to have outcomes that aid qualified nurses to apply and share principles of good practice, to lead confidently and support colleagues so that their needs are met as well. In addition nurses need to be
able to cope with their own stress and responses in emotionally intelligent ways, often with minimal immediate support. Nurses need to truly understand and value a person-centred approach, where life histories and compassion underpin everything from assistance with practical daily care to provision of personally relevant activities and emotional and spiritual support. Insight and empathy motivate, while clinical and leadership skills are required to enable nurses to make the vision real for residents, staff and visitors.

Quantitative findings
In the following chapter the findings from quantitative data are presented.

Burnout
Using the Maslach Burnout Inventory (MBI), the level of burnout the participants were experienced was assessed at four time points; at baseline measures (T1) taken before the training intervention commenced, T2 post training, T3 following supervision, and at T4 three months after T3. Analysis is focused on investigating two overarching hypotheses for three sub-outcome measures of burnout; emotional exhaustion, depersonalisation and personal accomplishment:

1. There is no difference between intervention groups at each time point
2. There is no difference in each intervention group over time.

More substantial all-group, all-time-point analyses were not available on this data owing to the nature of the data type (ordinal, more specifically, it is not continuous).

Emotional Exhaustion
A Kruskal-Wallis test was conducted to ascertain whether there were any differences in MBI_EE score between the group receiving dual element training plus supervision (group 1), the group receiving dual element training only (group 2) and the control group (group 3), and applied independently to each of the four data collection time points; namely baseline, T2, T3 and T4. At baseline and T2, median MBI_EE scores were similar and were not statistically significantly different between intervention groups, X2(2) = 2.042, p = 0.360 and X2(2) = 4.541, p = 0.103 respectively. This also confirms that the groups at baseline did not significantly differ following randomisation. MBI_EE scores were statistically significant at T3, X2(2) = 7.057, p = 0.029 and T4, X2(2) = 10.022, p = 0.007.

The Kruskal-Wallis test is an omnibus test and is unable to ascertain between which two groups the difference is significant. Subsequently, pairwise comparisons were conducted using Dunn’s test with a Bonferroni correction for multiple comparisons and adjusted p values are presented. At T3, statistically significant differences in median MBI_EE scores were present between the group receiving the dual element training plus supervision (group 1) and the group receiving dual element training alone (group 2) (11.883, p = 0.029). The same difference was present at T4 (11.899, p =
0.005). According to the visualisations (presented in Figures 1 and 2), a greater proportion of participants receiving dual element training with supervision achieved lower MBI_EE scores than the group without supervision at both T3 and T4. This suggests that at T3 and T4, a greater proportion of participants were less emotionally exhausted in the group with the additional supervision elements than the group without. No differences were found between both groups and the control group, who received no training.

**Figure 1: group MBI_EE scores as a percentage by category at T3**
To determine whether each intervention group changed over time, each intervention group was tested using the Kruskal-Wallis test. Across the four time points, the intervention delivering dual element training only (group 2) saw statistically significant changes in median MBI_EE scores ($X^2(3) = 23.977, p < 0.005$). Dunn’s test for multiple pairwise comparisons with a Bonferroni correction was applied to the data. Statistically significant differences in median MBI_EE scores were detected at time points 2, 3 and 4 in comparison to baseline indicating that, at all times points, changes from baseline were present (baseline: $T2 p = 0.017$, baseline: $T3 p = 0.001$, baseline: $T4 p < 0.005$). Examination of Figure 3, which presents the data as the frequency, rather than percentage, suggests that median MBI_EE scores increased over time; participants receiving dual element training only experienced increased emotional exhaustion over time.
The control group also exhibited a statically significant change in median MBI_EE scores ($X^2(3) = 12.201$, $p = 0.007$). Dunn’s test with a Bonferroni correction identified the difference to be between baseline and T3 only ($16.485$, $p = 0.006$). Examination of Figure 4 suggests that these changes occur as a result of a decreasing level of ‘low’ MBI_EE experienced by participants. However, this group suffered a high attrition having recruited 23 participants, but only 5 participants completed the study. The decline in the proportion of people scoring ‘low’ on the MBI_EE may be as a result of the individuals scoring low leaving the study. Participants whose outcomes are positive, may not have a vested interest in remaining engaged with the study, which could explain the high attrition of participations with low emotional exhaustion.
Depersonalisation

A Kruskal-Wallis test was conducted to ascertain whether there were any differences in MBI_DP score between the group receiving dual element training followed by supervision (group 1), the group receiving dual element training only (group 2), and the control group (group 3), applied independently to each of the four data collection points; namely baseline, T2, T3 and T4. Analyses indicate there is no statistically significant difference between intervention groups at each time point (baseline $X^2(2) = 2.042, p = 0.360$; T2 $X^2(2) = 4.828, p = 0.089$; T3 $X^2(2) = 1.423, p = 0.491$ and T4 $X^2(2) = 0.302, p = 0.860$).

To determine whether each intervention group changed over time, each intervention group was tested using the Kruskal-Wallis test. When examining the differences across time within each intervention group, no group demonstrated statistical significance (group 1 $X^2(3) = 7.401, p = 0.060$; group 2 $X^2(3) = 5.301, p = 0.151$; group 3 $X^2(3) = 1.399, p = 0.706$).

Personal Accomplishment

A Kruskal-Wallis test was conducted to ascertain whether there were any differences in MBI_PA score between the group receiving dual element training plus supervision (group 1), the group receiving dual element training only (group 2) and the control group (group 3), and applied independently to each of the four data collection time points; namely baseline, T2, T3 and T4. At baseline, T3 and T4, median MBI_PA scores were similar between the groups and were not
statistically significantly different between intervention groups, $X^2(2) = 2.472$, $p = 0.291$ and $X^2(2) = 1.365$, $p = 0.505$ and $X^2(2) = 3.762$, $p = 0.152$ respectively. MBI scores were statistically significant at T2, $X^2(2) = 8.600$, $p = 0.014$.

The Kruskal-Wallis test is an omnibus test and is unable to ascertain between which two groups the difference is significant. Subsequently, pairwise comparisons were conducted using Dunn’s test with a Bonferroni correction for multiple comparisons and adjusted $p$ values are presented. At T2, statistically significant differences in median MBI_PA scores were present between the group receiving the dual element training plus supervision (group 1) and the group receiving dual element training alone (group 2) ($14.258$, $p = 0.010$). Examination of figure 5 indicates that the group receiving dual element training with supervision had lower personal accomplishment than the group receiving training without supervision at T2.

To determine whether each intervention group changed over time, each intervention group was tested using the Kruskal-Wallis test. When examining the differences across time within each intervention group, no group demonstrated statistical significance (group 1 = $X^2(3) = 2.751$, $p = 0.432$; group 2 $X^2(3) = 1.894$, $p = 0.595$; group 3 $X^2(3) = 1.287$, $p = 0.732$).

**Figure 5: group MBI_PA scores as a percentage by outcome category at T2**

To determine whether each intervention group changed over time, each intervention group was tested using the Kruskal-Wallis test. When examining the differences across time within each intervention group, no group demonstrated statistical significance (group 1 = $X^2(3) = 2.751$, $p = 0.432$; group 2 $X^2(3) = 1.894$, $p = 0.595$; group 3 $X^2(3) = 1.287$, $p = 0.732$).
Burnout Summary

Emotional Exhaustion
At T3 and T4, a greater proportion of participants were less emotionally exhausted in the group with the additional supervision element than the group without.

Participants receiving dual element training without supervision experienced increased emotional exhaustion over time.

Depersonalisation
No change occurred to the depersonalisation measure.

Personal accomplishment
At T2, participants who received training with supervision had lower personal accomplishment than the group receiving training alone.

Personal accomplishment did not change over time for any
Self-Efficacy
A Kruskal-Wallis test was conducted to ascertain whether there were any differences in self-efficacy score between the group receiving dual element training plus supervision (group 1), the group receiving dual element training only (group 2) and the control group (group 3), and applied independently to each of the four data collection time points; namely baseline, T2, T3 and T4. Analyses indicate there is no statistically significant difference between intervention groups at each time point (baseline $X^2(2) = 0.543, p = 0.762$; T2 $X^2(2) = 0.050, p = 0.975$; T3 $X^2(2) = 3.888, p = 0.143$ and T4 $X^2(2) = 5.610, p = 0.061$).

To determine whether each intervention group changed over time, each intervention group was tested using the Kruskal-Wallis test. Analyses indicate there is no statistically significant difference across time for each intervention group (group 1 $X^2(3) = 3.238, p = 0.356$; group 2 $X^2(3) = 2.480, p = 0.479$; group 3 $X^2(3) = 0.083, p = 0.994$).

Approaches to Dementia
Hope
A Kruskal-Wallis test was conducted to ascertain whether there were any differences in the Approaches to Dementia_Hope score between the group receiving dual element training plus supervision (group 1), the group receiving dual element training only (group 2) and the control group (group 3), and applied independently to each of the four data collection time points; namely baseline, T2, T3 and T4. Analyses indicate there is no statistically significant difference between intervention groups at baseline, T3 and T4 (baseline $X^2(2) = 1.264, p = 0.532$; T3 $X^2(2) = 0.319, p = 0.853$ and T4 $X^2(2) = 1.047, p = 0.592$). Statistical significance was achieved at T2, $X^2(2) = 6.173, p = 0.046$.

The Kruskal-Wallis test is an omnibus test and is unable to ascertain between which two groups the difference is significant. Subsequently, pairwise comparisons were conducted using Dunn’s test with a Bonferroni correction for multiple comparisons and adjusted p values are presented. At T2, statistically significant differences in median hope scores were present between the control group (group 3) and the group receiving dual element training only (group 2) ($13.541, p = 0.039$). Figure 6 identifies that the group receiving dual element training only had significantly higher hope scores than the control group. No other differences were detected.
To determine whether each intervention group changed over time, each intervention group was tested using the Kruskal-Wallis test. Analyses indicate there is no statistically significant difference across time for each intervention group (group 1 $X^2(3) = 5.834$, $p = 0.120$; group 2 $X^2(3) = 4.389$, $p = 0.222$; group 3 $X^2(3) = 6.347$, $p = 0.096$).

A Kruskal-Wallis test was conducted to ascertain whether there were any differences in the Approaches to Dementia_Personhood score between the group receiving dual element training plus supervision (group 1), the group receiving dual element training only (group 2) and the control group (group 3), and applied independently to each of the four data collection time points; namely baseline, T2, T3 and T4. Analyses indicate there is no statistically significant difference between intervention groups at baseline, T2 and T3 (baseline $X^2(2) = 1.496$, $p = 0.473$; T2 $X^2(2) = 1.735$, $p = 0.420$ and T3 $X^2(2) = 1.935$, $p = 0.380$). Statistical significance was achieved at T4, $X^2(2) = 9.873$, $p = 0.007$.

The Kruskal-Wallis test is an omnibus test and is unable to ascertain between which two groups the difference is significant. Subsequently, pairwise comparisons were conducted using Dunn’s test with a Bonferroni correction for multiple comparisons and adjusted $p$ values are presented. At T4, statistically significant differences in median personhood scores were present between the group receiving dual element training only (group 2) and the group receiving dual element training with supervision (group 1) ($12.532$, $p = 0.005$). Figure 7 shows that the greatest difference in average scores for the personhood score was seen between the group receiving dual element training with supervision and the group receiving dual element training only. No other differences were detected.
To determine whether each intervention group changed over time, each intervention group was tested using the Kruskal-Wallis test. No statistically significant difference was present across time for the control group ($X^2(3) = 1.007, p = 0.800$). Analyses indicate there was a statistically significant difference across time for group 1 ($X^2(3) = 7.891, p = 0.048$). Dunn’s test for multiple pairwise comparisons with a Bonferroni correction was applied to the data. Statistical significance occurred between baseline and T4 ($-21.083, p = 0.035$), whereby participants receiving dual element training with supervision had increased personhood score by T4 from baseline, which increased at every time point, as seen in Figure 8.
Statistical significance was also achieved for group 2 ($X^2(3) = 8.652, p = 0.034$). Dunn’s test for multiple pairwise comparisons with a Bonferroni correction was applied to the data and found statistical significance occurred between T2 and T4 (21.202, $P = 0.030$) where the personhood score at T2 was greater and this difference was statistically significant (see Figure 9).
Person Centred Care P-CAT

A Kruskal-Wallis test was conducted to ascertain whether there were any differences in P-CAT_personalising care score between the group receiving dual element training plus supervision (group 1), the group receiving dual element training only (group 2) and the control group (group 3), and applied independently to each of the four data collection time points; namely baseline, T2, T3 and T4. At baseline, T2 and T3, median P-CAT_personalising care scores were similar and were not statistically significantly different between intervention groups, $X^2(2) = 0.987$, $p = 0.638$ and $X^2(2) =$

Approaches to Dementia

Hope

At T2, Group 2 scored significantly higher than the control group

Personhood

At T4, the group receiving dual element training with supervision scored statistically significantly higher than the group without supervision on the personhood score.

The personhood score increased steadily over time and was statistically significant by T4 from baseline for the group receiving dual element training with supervision.

For the group receiving dual element training without supervision, a decline in personhood score was observed from T2 to T4 and this was statistically significant.
2.622, \( p = 0.270 \) and \( X^2(2) = 2.111, p = 0.348 \) respectively. P-CAT_personalising care scores were statistically significant at T4, \( X^2(2) = 12.555, p = 0.002 \).

The Kruskal-Wallis test is an omnibus test and is unable to ascertain between which two groups the difference is significant. Subsequently, pairwise comparisons were conducted using Dunn’s test with a Bonferroni correction for multiple comparisons and adjusted \( p \) values are presented. At T4, statistically significant differences in median P-CAT_personalising care score were present between the group receiving the dual element training plus supervision (group 1) and the group receiving dual element training alone (group 2) (13.799, \( p = 0.001 \)).

To determine whether each intervention group changed over time, each intervention group was tested using the Kruskal-Wallis test. Analyses indicate there is no statistically significant difference across time for each intervention group (group 1 \( X^2(3) = 5.834, p = 0.120 \); group 2 \( X^2(3) = 4.389, p = 0.222 \); group 3 \( X^2(3) = 6.347, p = 0.096 \)).

**Leadership**

There was no change in the key aspects of Transformational leadership; Idealised Influence (attributes and idealised behaviours) (A) scores. Drop-out rates were incredibly high, particularly in the control group, this may have affected the study results. For instance, those who did not remain in the study could have shared a particular characteristic e.g. poor leadership, leaving the higher quality leaders in the control group and therefore making the difference between groups smaller and undetectable.
Chapter 7: Discussion

In the following chapter we will discuss the study limitations, the barriers and challenges faced when conducting the study, issues for consideration and finally the study recommendations.

Limitations:
In our study we needed to recruit 30 nursing homes in order to have sufficient power to detect a significant change in staff on our primary outcome measure. Care homes had frequent changes in management while the study took place; along with concerns about releasing staff which are discussed below this led to difficulties obtaining an adequate sample due. There were also problems ensuring implementation fidelity and poor compliance resulting in study intervention not always being standardised across all the nursing homes. A systematic review conducted by McCabe et al. (2007) identified systemic issues specific to conducting interventions in health and care home settings, such as difficulties in training all staff members, entrenched task-focused rather than client-focused practices and the heterogeneity of facilities. Perry et al. (2011) commented that the methodological quality of the studies in this setting are very diverse and also noted that the most common limitation was the large proportion of participants lost to follow-up and the poor compliance to the intervention, as well as differences at baseline. Study dropout rates were 50 in the by the end of the data collection period. This is due to the nature of the workplace and associated high levels of churn.

Challenges of conducting research in care homes:
When conducting the study the study team encountered numerous challenges these are discussed below and include ethical issues, recruitment, implementing of the intervention, and raising concerns, this lead recommendations regarding conducting research within this setting.
Research Ethics Committees/Ethical Issues

Complex ethical issues arose from our study design, including concerns the content of the training programme and participants’ equal access to it, capacity issues for those with dementia and safeguarding.

Subsequent to our submission to the ethics committee specific queries included:

- Would NHS indemnity be appropriate for research carried out in the nursing homes?
- Would Site Specific Assessments for non-NHS sites (e.g. each nursing home) be required?
- Would the research involve adults who were unable to consent for themselves?
- How would we address issues around consent if the study included adults who may lack capacity?
- If the home was part of a larger organisation, would we be able to ensure care home managers notified home owners?
- How would we justify selection of participants i.e. ensuring care home managers do not only approach those staff or residents who they think “deserve” to participate?
- Could we ensure the home is not left understaffed while the staff are participating in the study?
- Did we have appropriate procedures in place in the event of abuse and/ or malpractice or negligence being discovered or disclosed by participants?
- How could we ensure privacy and anonymity of research participants if the research is to be undertaken in public areas (e.g. Dementia Care Mapping, qualitative interviews)?

Questions from the committee proved extremely useful, for example in clarifying the research question, developing the details of the intervention, responding to abuse in practice and advice to simplify the research design.

Recruitment

Our approach to recruiting nursing homes was based on a practical guide for researchers on how to conduct research in nursing homes (DeNDRoN, 2013). Recruitment was also facilitated by researchers’ previous experience and familiarity with nursing home settings. Our experiences taught us that the barriers to nursing home recruitment are considerable and can risk undermining a study if not planned for.

The team needed to be flexible, patient and creative to overcome the difficulties in recruitment. The process took much longer than anticipated; there were financial implications from recruiting more
widely. It became apparent that the recruitment challenge needs to be met by the use of multiple strategies that reflect the heterogeneity of the care home sector (Davies et al, 2014). Fostering and sustaining relationships appeared to be the absolutely essential to recruiting participants (Goodman et al., 2011, Davies et al., 2014, Garcia et al 2013).

We recommend allowing extensive planning that builds in time for each step in recruitment including time to build relationships, and be flexible in the face of unexpected hurdles. Nursing homes are more highly regulated than other health care settings, and staff spend significantly more time making sure that the home meets its quality requirements (Hanson et al., 2010). This may be one of the reasons why some care providers are wary of the time demands of research participation (Davies et al 2014; Garcia et al 2013). Nursing home staff may have little interest (Davies et al. 2014) or limited experience in taking part in research (Goodman et al., 2011) or may mistrust researchers’ motives, fearing intent to expose poor practice (Garcia et al 2013) rather than to improve care (Hanson et al., 2010). Joseph Rowntree Foundation (2012) identified that research focuses too often on poor practice and blame. Managers and staff members may not want their usual routines interrupted or the residents to be disturbed by the activities of a research study (Shin 2013). In a busy home it can be problematic for staff to find enough time to participate in research, which has to take second priority compared with care. These difficulties may be exacerbated as staff work shifts and weekends and many homes have staff who work part-time or flexibly (DeNDRoN, 2013). Therefore it can be challenging to ensure that the research intervention is delivered and that data is collected on time.

Implementing the intervention

Implementation of the intervention required sensitive tailoring that had to take into account the pragmatics of working with staff in the constraints of the real world of the homes. This threatened implementation fidelity. Fidelity of intervention delivery refers to the extent to which interventions are delivered as intended, with adherence to specifications in intervention manuals (Lorencatto et al, 2013). In our study, it was difficult to follow the protocol, stick to the agreed timelines and deliver the intervention as planned due to changes in the rota or sickness, absenteeism, organisational factors; management style and care culture (Spector et al. 2013). When research is conducted at the workplace, nurses may be concerned with work disruption and increased demands on their time (Cleary, 2004). Cleary (2004) also discussed how researchers may be viewed by personnel as working in ivory towers and out of touch with the realities of long-term care settings, this experience was shared by the research team, for example, one participant stated, “You’re from NHS – fairy-tale world….”. The in situ intervention demanded flexibility in its application, yet also carried credibility as it involved the trainers modelling aspects of the application of knowledge in the care environment. Positive experiences as research participants encouraged the nurses to further their education and recognise their own expertise.
However, due to high staff turn-over it was difficult to ensure participants remained in the study. Reasons for drop-out included; pregnancy, illness, long holidays, family difficulties and leaving for new jobs. When possible the participant was followed-up in a different nursing home, with the agreement of the home manager. This may affect the validity of the study however we felt it was important to take a pragmatic approach. During implementation, it is also important to support all members of the research team. It is therefore essential to have clear agreements with the home and protocols for reporting any concerns.

Raising concerns
In the course of our study we observed high quality care delivered by committed, caring nurses. Out of 30 homes, in two we became aware of neglect and teasing of residents, illegal deprivation of liberty, inadequate fire escape provision, under staffing and fraudulent use of funding. In each of these cases the researchers have an obligation to raise concerns with the appropriate regulator (in UK, Care Quality Commission). Witnessing abuse or neglect or hearing about it in the classroom, caused conflict for the researchers and ethical dilemmas around when would be the best time to report concerns. However, the team recognised and acted on the duty to escalate concerns promptly, guided by the duty to prioritise needs of people using services, act as an advocate and be open and candid (Nursing and Midwifery Council 2015), following the framework for adult safeguarding under the Care Act (2014) and our conditions of ethical approval. An unanticipated consequence was when home managers made allegations towards research participants (nurses) in reports that appeared to be retaliatory.

Once a concern has been reported to regulators the home may withdraw cooperation with the study. This means that the researchers will no longer have any chance of changing practice within that home and that subsequent studies may be refused access (Garcia et al 2013). Consequences also arise for individual nurses where poor practice has been observed and reported. In most of the examples in our study nurses moved on, which both makes it harder to keep them in the study and increases ‘churn’ which is damaging to residents (McGilton et al 2014). Unanticipated ethical consequences of the study therefore included increased risk of job insecurity for participants and staff turnover for homes, while coping with ethical issues reduced study power and validity.

Recommendations for conducting Research in Nursing Homes
Our experiences lead us to recommend:

- Ensure sufficient time and financial resources.
- Ethical approval requires justification of every aspect of the study; prepare to respond to the particular questions outlined above.
- Invest time into forming relationships with homes
• Empathise with nursing home staff who have very challenging roles, work long hours and are often taken for granted: aim to work collaboratively.

• Manage expectations: clarify timescales and the nature of interventions and advise on longer-term benefits of research.

• Be prepared to be patient, flexible, understanding and resilient, to persevere and to be mutually supportive.

• Have structures in place where you can debate and devise strategies to cope with setbacks. Our steering group included a home manager and former carer whose ideas were invaluable.

• Be aware of the possibility of poor practice and the need to respond appropriately.

• Ensure participants have a good experience so as to minimise dropouts and promote willingness to take part in future studies. Be punctual, polite, friendly and professional.

• Hold regular meetings and provide supervision for the research team to allow time for reflection, help manage stress and ensure effective completion of the study.

Research offers benefits for people living and working in nursing homes. For nurses these include education, development of new skills, to have their voice heard and experiences validated, networking opportunities, profile raising, empowerment and the satisfaction of contributing to creation of knowledge. Benefits for residents include improved standards of care and quality of life.

For researchers benefits include the chance to make a difference to care and insight into a different world. Therefore committing to overcoming the barriers to conducting research in care homes identified in this paper can contribute to advancing care standards.

**Summary:**
Well-designed research is essential to inform the development of high quality person-centred care and nursing homes should be supported and encouraged to take part. Extensive planning and preparation for ethical approval and recruitment are essential steps in the process. The pressures on nurses working in nursing homes can make it difficult for them to prioritise research amongst their professional responsibilities. Understanding their perspectives, clear communication, building relationships and being flexible patient and creative can help researchers recruit and support
**Issues for consideration:**

**Clinical Supervision**

Challenges to delivering high quality care in nursing homes include isolation, low levels of morale, little respect for staff, few opportunities for career growth, and extreme pressure at work. Our study also found staff felt exhausted, disempowered, and unsupported. Recent reports have indicated that cultures of care in care homes need to be addressed, through improved workforce support and supervision. This is as well as the development of explicit leadership in nursing and strengthening of other professional values (RCN, 2012). A culture of good supervision can have a positive impact on an organisation’s performance, supporting staff to practice effectively and development of skills. The study findings demonstrated that supervision appeared to support staff in the implementation of new learning, encouraging flexibility and creativity. Supervision was also been found to have a positive impact on confidence and attitudes. Professional supervision has been evidenced to be associated with job satisfaction and commitment to the organisation and is significantly linked to employees’ perceptions of the support they receive from the organization (CQC, 2008). Clinical supervision can offer ways of staff sharing information on how to deliver and sustain effective care, empower staff and support them in providing care (Teadsdale et al. 2008). Therefore greater emphasis needs to be placed on non-managerial supervision and reflective practice, rather than tick box approaches to the acquisition of skills and knowledge. There are aspects of the work that are difficult, and may have an emotional cost, especially when it seems that nobody appears to value the work undertaken (Tadd et al. 2013). The study findings demonstrated that nurses need to be given opportunities to reflect and discuss issues with colleagues, the impact on them and their work.

The study findings highlight that there are major issues in care homes. High staff turn-over has profound negative effects on the care of people with dementia and frail individuals with multiple health conditions. Stand-alone training interventions are not an effective means of changing management style or bringing about sustainable changes in care culture (Sheard, 2008). Research is needed into better ways of changing care home culture, improving job-satisfaction and reducing burnout. According to SCIE (2012), research has demonstrated that good supervision is associated with higher job satisfaction, greater commitment to the organisation and better retention of staff. Supervision appears to help reduce staff turnover and is significantly linked to employees’ perceptions of the support they receive from the organisation (Teadsdale et al. 2008). The study findings demonstrated participants were less emotionally exhausted in the group with the additional supervision element than the group without. Literature also suggests good supervision correlated with perceived worker effectiveness (SCIE, 2012) and there is some evidence that group supervision can increase critical thinking (Hanson and Arnetz, 2007). Indeed our findings demonstrated that staff felt more confident following the training, this enabled them to share knowledge and influence care. A restorative/supportive approach to supervision was used in the study as supervision works best when attention is paid to task assistance, social and emotional support and to engendering a positive relationship between supervisors and supervisees (Teadsdale et al. 2008).
Training Interventions

We developed a multifaceted, creative approach to training and development with active learning approaches to learning and opportunities for networking. The training was able to meet the needs of nurses working in care homes and overcome some of the barriers of access and attendance. Professional development should be more than a “one off” training event (Spilsbury et al. 2015). The supervision the skills based training, supported the delivery of good quality of care. Leadership and modelling of appropriate attitudes and behaviours were also key to improving the care quality (Tadd et al. 2013). Adults see learning as a social experience and learn best by ‘doing’ (Race, 2006). Active experiential approaches to learning are more likely to ‘stick’ (Beard and Wilson, 2006) while reflection and discussion in small groups enables participants to build personal meanings from learning (Biggs and Tang, 2011). Educational interventions that change practice tend to be emotional, personal and interactive experiences that are felt as inspirational and transformational, affecting ‘hearts and minds’ (Sheard, 2008). In addition the on-going impact of educational programmes depends partly on the support available from leaders within the organisation (Cleary et al, 2010) and mutually between colleagues who attend the same training programme (Mace, 2005). Training should enable staff to support workers, promote team working (Tadd et al. 2013). Therefore training programmes need to provide opportunities for networking, take into account the organisational contexts within which outcomes are expected to be applied and take steps to anticipate. They should also address barriers within these contexts, then develop strategies that will increase the likelihood of training making a long-term difference to practice.

Recommendations

Training programmes should be multifaceted and include active learning approaches and opportunities for networking.

Good quality clinical supervision should be provided for carers and nursing staff and there should be a greater emphasis placed on non-managerial supervision and reflective practice.

Follow-up should be provided post training to support staff in the implementation of the new learning, challenging old practices and bringing about change within the organisation where they work.

Further research is required to support the development of strategies and interventions to reduce staff turn-over and burn-out and improve job satisfaction.

Further research is required to identify effective mechanisms for clinical supervision in nursing homes. New knowledge and understanding about the enablers and barriers to conducting supervision in nursing homes should also be developed.
Chapter 8: Project Steering Group
A project steering group met on every 2-3 months. A carer who had a family member diagnosed with dementia living in a care home was a member of the group. Other members of the group included an independent care home provider and care home manager. PI (Analisa Smythe) and fellow co-investigators, Dr Peter Bentham (Consultant Working Age Dementia), Catharine Jenkins (Senior Lecturer Birmingham City University), Professor Jan Oyebode (Bradford University). As well as members of the study team, Philip Dee (statistician, Birmingham City University) Magda Jowita Galant-Miecznikowska (Research Worker) and Jane Dyer (Research Nurse). The steering group’s activities concentrated on providing practical advice on how to make the training interventions user friendly and overcoming barriers to recruitment.

Chapter 9: Ethics

Ethical Considerations
The confidentiality and anonymity of research participants was maintained throughout the study, information will not be accessible to outside parties, all data was anonymised and no information can be linked in any reports to any individual participant or nursing home. It was made clear to participants that the supervision was strictly confidential at all times under normal circumstances. However it was stated that on very rare occasions, for instance where something illegal occurs or is shared with supervisor, breaches of the NMC professional code of conduct or infringes of policies and procedures, the supervisor may be obliged to ensure the supervisee’s manager is informed. The RCN guidelines for supervision (2002) were followed and a contract was signed both by supervisor and supervisee at the outset of the series of supervision sessions ensuring the supervisee is made aware of these conditions.

Ethical Approval
Ethical approval for the study was received from NRES Committee East of England on the 6th June 2014. Reference 14/EE/0168 IRAS ID 15922. Approval has also been obtained from Bradford University Ethics department.

Chapter 10: Dissemination of study findings
Two papers have been published the first describing the challenges faced when conducting research in this setting (Jenkins et al. 2014) and the second regarding the study progress (Smythe et al. 2014). A paper has been submitted reporting on the findings of the focus group conducted to refine the study intervention described in Chapter 3
We plan to publish the findings from the study in healthcare journals and present at conferences to specialists working in the Dementia field. A paper has already been accepted for this year’s NET conference.

The results of the study will be disseminated to participants by post, and participants will be welcome to contact the research team to discuss the study findings if they wish.

References:


Brooks, J., McCluskey, S., Turley, E., King, N. The Utility of Template Analysis in Qualitative Psychology *Research Qualitative Research in Psychology* 12 ,2, 202-222.


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Goldberg,D. and Hillier,V. (1978) A scaled version of the GHQ. Psychological Medicine, 9, 139-145.


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## Appendix 1: Classroom Training

### Professional Development Learning Programme (University-based learning)

#### Timetable overview

<table>
<thead>
<tr>
<th>Day</th>
<th>Theme</th>
<th>10.00-11.30</th>
<th>11.45-1.00</th>
<th>1.30-2.30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 1.</td>
<td>Knowledge and empathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mon</td>
<td></td>
<td>What is dementia? Recognition and assessment</td>
<td>The experience of dementia</td>
<td>Becoming a ‘Dementia friend’ joining a national initiative that will help people living with dementia feel included in their communities.</td>
</tr>
<tr>
<td>2.</td>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tues</td>
<td></td>
<td>Advanced Communication skills for working with people with dementia</td>
<td>Communication skills for working with colleagues and relatives</td>
<td>Practising communication skills eg explaining issues to relatives, breaking bad news</td>
</tr>
<tr>
<td>3.</td>
<td>Minimising problems and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weds</td>
<td>maximising well-being</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Addressing ‘indications of distress’/‘challenging behaviour’</td>
<td>Activities, interventions and environment</td>
<td>Looking after your own mental health and supporting other people (preventing dementia/responding to mood issues).</td>
</tr>
<tr>
<td>Week 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Leadership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mon</td>
<td></td>
<td>Leadership styles and skills: identifying stress and introducing</td>
<td>Delegation skills and care planning</td>
<td>Time management</td>
</tr>
</tbody>
</table>

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Day 1  Theme: Knowledge and Empathy

<table>
<thead>
<tr>
<th>Day</th>
<th>Knowledge and empathy</th>
<th>What is dementia? Recognition and assessment</th>
<th>The experience of dementia</th>
<th>Becoming a ‘Dementia friend’</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mon</td>
<td></td>
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</tr>
</tbody>
</table>

Learning Outcomes

By the end of the day, you’ll be able to:

- Explain the different types of dementia to colleagues residents and their relatives
- Outline the symptoms of dementia, describe how you would recognise it and outline the assessment process
- Convey knowledge of and empathy with the experience of a person living with dementia
- Explain the ‘Dementia Friends’ initiative and choose to become a Dementia Friend

Session Contents

- Introduction to the physiology of the brain and its functions, the nature Alzheimer’s Disease, vascular dementia, Lewy Body disease and fronto-temporal dementia, with a brief overview of other types, including alcohol related dementia.
• The signs and symptoms of dementia. Recognising dementia and assessment strategies and processes

• Societies’ views of people with dementia – issues resulting from stigma, the experience of dementia (related to reduced functioning and independence, mood, relationships and identity).

• The National Dementia Strategy (2009), Dementia Friendly Communities and the Dementia Challenge, including Dementia Friends. A Dementia Friends session with the opportunity to commit to becoming a Dementia Friend.

**Day 2 Theme: Communication**

<table>
<thead>
<tr>
<th>2. Tues</th>
<th><strong>Communication</strong></th>
<th>Advanced Communication skills for working with people with dementia</th>
<th>Communication skills for working with colleagues and relatives</th>
<th>Practising communication skills eg explaining issues to relatives, breaking bad news</th>
</tr>
</thead>
</table>

**Learning Outcomes**

By the end of the day, you’ll be able to:

• Explain the reasons for sensitively adjusted communication approaches that support people with dementia

• Demonstrate relevant skills to colleagues and residents’ relatives, offering a model for others to follow

• Take a person-centred approach to relationships with others that supports respectful communication with residents, relatives and staff

• Use a sensitive, structured approach to breaking bad news

**Session Contents**

• The nature of communication difficulties experienced by people living with dementia

• Communication strategies (channelling, validation, the VERA approach (Blackhall et al 2011))
Perspectives of family members
The SPIKES (Baile et al 2000) approach to breaking bad news

Day 3 Theme: Minimising problems and maximising well-being

<table>
<thead>
<tr>
<th>3. Weds</th>
<th>Minimising problems and maximising well-being</th>
<th>Addressing ‘indications of distress’/’challenging behaviour’</th>
<th>Activities, interventions and environment</th>
<th>Looking after your own mental health and supporting other people (preventing dementia/responding to mood issues)</th>
</tr>
</thead>
</table>

Learning Outcomes

By the end of the day, you’ll be able to:

- Interpret the behaviour of people with dementia in relation to unmet needs
- Lead interventions that meet the emotional and social needs of people with dementia
- Promote a person-centred approach to care that minimises distress associated with provision of personal care
- Suggest environmental changes that enable improved functioning for people with dementia
- Recommend lifestyle changes that reduce risk of dementia (and use them yourself)
- Respond sensitively to low mood in yourself and others and take simple steps to improve confidence, meaningfulness and well-being

Session Contents

- Causes of distress for people living with dementia, indications of unmet need, assessing causes of behaviour that is difficult for others to cope with
- Person-centred interventions (life stories, meaningful activities, fun) and practical, sensitive approaches that enable relaxed personal care
- The physical environment and easy adjustments that make a difference (lighting, décor, signage, temperature)
• Recognising low mood, protecting well-being, responding to colleagues’ expression of emotion

Day 4 Theme: Leadership

<table>
<thead>
<tr>
<th>4. Mon</th>
<th>Leadership</th>
<th>Leadership styles and skills: Identifying stress and introducing supervision</th>
<th>Delegation skills and care planning</th>
<th>Time management</th>
</tr>
</thead>
</table>

Learning Outcomes

By the end of the day, you’ll be able to:

• Explain the importance of leadership and describe an approach to leadership that will enable you to lead practice change

• Positively influence care quality

• Contribute to a positive organisational culture that values and supports colleagues’ development

• Use time management strategies to prioritise and achieve objectives.

Session Contents

• Defining leadership and evaluating alternative styles, adopting and enhancing positive and transformational leadership characteristics

• Role modelling and motivating others

• Problem solving, using a solution-focused approach, team learning strategies

• Emotional intelligence

• Time management – simple tips and useful strategies

Day 5 Theme: Problem-based learning
Learning Outcomes

By the end of the day, you’ll be able to:

- Liaise with others to clarify the nature of difficulties
- Develop strategies to address work-related problems, taking a solution-focused approach
- Synthesise your learning from the programme and apply it to real-life issues
- Coordinate with fellow students to develop your support network

Session Contents

- Problem-based learning, applying learning to real-life scenarios (determined by students’ needs)
- Practising techniques using role play
- Identifying priorities and planning for the future
- Developing a professional support network, using social media for support and learning

*Learning activities will be supported by an online ‘moodle’ resource and hard copy work-book*

**Appendix 2: Skills based training**

Confidentiality
10 minute check-up: before each session a conversation clarifying expectations and boundaries, stressful issues, session focus, discussing changes made leading on from previous learning

Session 1.

**Communication**- With staff, relatives and service users. Modelling. Q&A

- Observe communication with relatives, residents, colleagues, manager.
- Feedback what did they do well/ And less well? Could communication be improved? What made a difference, what could be built on, what do you want to change or develop?
- Quality of interaction

Session 2.

**Stress Management**- What has been difficult? eg., Challenging behaviour, care planning, relationships with colleagues

- Work-life balance
- Strategies for managing stress
- Identifying signs of stress and recognising stress in others
- Review care plans

Session 3

**Environment and activities**- Facilitation, delegation, supervision

- Appraise the environment. What’s good/bad?
- Is outside space used?
- How are decisions made about layout?
- Is the environment person-centred? Can residents easily find their way around?
• Do individualised / person centred activities take place? Is the life history of the person used in planning activities?

• Review care plans

Session 4

Managing self and others- Supervision, solution-focused planning, hand overs

• Observe handover

• Is person centred care discussed?

• Are there formal team meetings to discuss the residents care?

• Are systems for clinical supervision in place?