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**Dementia Care Training for Residential
Care Workers: Building Residential Care
Workers' Own Views into A Conceptual
Model.**

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4th February 2018

ABSTRACT

This thesis is the result of research that investigated the views of residential care workers (RCWs) working with people with dementia about their perceptions of training for their dementia care role with older people.

Using a constructivist ontology and an interpretivist epistemology, the research investigates how care workers perceive their training and how they feel it can be applied to their working environment. RCWs were asked what they saw as the specific needs of residents with dementia, what training they had received, how useful they perceived the training to be, and what training they felt was still needed. Previous studies had put forward topics for inclusion into dementia care training, but very little research had asked RCWs themselves about their dementia training needs. Nineteen semi-structured interviews were carried out across three care home organisations during the summer of 2013 in the East of England.

Findings from thematic analysis showed that the care workers interviewed had very limited or no dementia training or assessment they could remember, and that training had generally been a negative experience. Dementia care trainers were not considered helpful or knowledgeable enough and RCWs identified that their learning needs had not been taken into consideration. The learning environment was viewed as unsuitable, usually a lounge or a bedroom where it was very cramped and RCWs were pulled out of training when there were limited staff numbers. Many challenges specific to caring with people with dementia were also identified: challenging behaviour, lack of time and resources, poor teamwork and communication and lack of organisational support all inhibited the development of person-centred care and training transfer into practice.

A conceptual model of the training and learning cycle is proposed as a way forward for dementia training. This model illustrates the training process from course creation through to satisfactory completion. Learning into practice is measured by care workers' knowledge, confidence, and competence. This assessment is a two-way

process between the learner and the mentor to ensure RCWs feel fully supported and recognised. Although this conceptual model has not been tested empirically, such a process is seen as a possible next step.

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In memory of my parents.

To my husband Nick for his constant love, reassurance, and patience. My son Mike, and my baby granddaughter Amelia.

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1 Introduction

1.1 *The Research Domain*

There has been growing policy and public concern for the welfare of older people with dementia residing in care homes, with numerous reports over several years highlighting incidents of neglect and abuse that have made headline news (Campbell 2013).

Dementia care has been a government priority for some time. In March 2012, Prime Minister David Cameron set a 'National Challenge' to drive major improvements in dementia care by 2015. In 2015, the challenge was extended to 2020. The advent of the principle of person-centred care (Kitwood, 1997) has gradually shifted the care of older people with dementia from institutionalised care and the biomedical model to person-centred care and the needs of the individual resident (Brooker and Woolley 2007), resulting in a need to develop different approaches to training for care workers. However, Carter (2015), suggested that the government drive has yet to make an impact on some of the worst-performing care homes (those rated as 'inadequate' or 'requires improvement' by the Care Quality Commission), with more than a quarter of these lacking when it comes to providing training on dementia. The Alzheimer's Society called for dementia training in care homes, as lack of training is an important cause of poor quality care (Alzheimer's Society 2015).

'Putting People First' (Department of Health 2007) set out the former Government's vision of achieving personalisation in public services. Personalisation raised a new set of questions about the training needs of the social care workforce. APPG (2009) identified that it is vital for people with dementia and residential care workers (RCWs) to be involved in any debate about taking forward the personalisation agenda and

issues around training. Literature on care worker views about training appeared limited.

The National Dementia Strategy (Department of Health 2009) promoted the idea that health and social care staff involved in the care of people with dementia should have the necessary skills to provide the best quality of care in the roles and settings where they work. This strategy identified the need for training and continuous professional development in dementia, and that a key objective is

“An informed and effective workforce for people with dementia.” (Department of Health 2009, p65)

The strategy recognised that residential care workers (RCWs) were central to the wellbeing and comfort of residents with dementia (Kitwood, 1997), and they had a difficult job dealing with the complex and diverse needs associated with the condition (Zimmerman et al 2005). Hence, there was a need for RCWs to have the specific skills and abilities to provide for the specific needs of older people with dementia, and to be supported in their work. The Department of Health has described the workforce as

“The single greatest asset social care services possess.” (Department of Health 2000, p3).

However, RCWs are low paid (Hussein and Manthorpe 2014), demoralized (Ericson-Lidman et al 2014), and have low self-esteem (Lloyd et al 2011). The National Minimum Data Set (Hussain and Manthorpe 2012) illustrates that the dementia workforce has significantly more representation of women and workers from Black and Minority Ethnic (BME) communities (particularly Asian). These identified characteristics need to be carefully considered when looking to input into the training of RCWs and the creation of a dementia care curriculum. The characteristics of the dementia care workforce are covered in greater detail in Section 2.2.

Before continuing, it is important to clarify what is meant by the different terms for RCWs used in this thesis. This is because some studies do not differentiate between residential or non-RCWs.

- Care Worker/Assistant – the front-line staff in all care settings. Their work is defined by a care plan, which is developed by a social worker or care manager to meet the assessed needs of the service user (NMDS-SC 2017).
- Dementia care workers (DCWs) – all care workers that care for people with dementia. These can be in a residential or non-residential setting.
- Residential care workers (RCWs) – the term used predominantly throughout the rest of this thesis. Within the residential care home setting, care workers care for residents with or without a diagnosis of dementia.

The term “Care Worker”, as defined by NMDS-SC (2017) was too generic for this research, although this term did not include professionals or senior care workers such as managers. It was therefore necessary to adopt a more limited definition, i.e. Residential Care Worker (RCW).

1.2 Background to the Research

CQC (2014) identified concerns with the variation of quality of care for older people with dementia. It is likely that someone living with dementia will experience poor care at some point while living in a care home (CQC 2014). CQC (2014) said that

“There are not always enough well-supported and trained staff (and with the right values) to care for people with dementia. Not all staff are equipped to understand what good dementia care looks like.” (p12)

Caring for residents with dementia means that RCWs themselves need to be supported to provide that care. Dementia care requires specific knowledge and the ability to apply that knowledge in an environment conducive to learning and support (CQC 2012). This is supported by Spector et al (2016), who reviewed and rated nineteen studies of staff training in dementia care, and concluded that

“Staff and resident well-being are inextricably linked.” (p1186)

Spector et al (2016) identified that for RCWs to provide adequate care, there needs to be more than knowledge. There need to be improvements in self-efficacy and competence.

I have previously worked as a qualified social worker within a team for older people. At that time in the mid-nineties, I discovered that little was known in residential care

about the specific requirements of residents with dementia. In fact, there was little discussion, if any, of residents' needs. Later, I was part of senior management for a company of privately owned care homes for older people and held responsibility for teaching social work principles and recent legislative requirements to management and senior management. It was this previous thinking and experience about dementia care and my teaching role that led to my doctoral research interest in what RCWs learn about dementia care, and how. Previous studies had put forward topics for inclusion in dementia care training (Teri et al 2005; Miesen 2010), but – as will be shown in Chapter 2's literature review – very little research had asked RCWs themselves about their dementia training needs (Innes 2002). This research contributes to the discussion of specific training needs for RCWs from the perspective of the workers themselves.

Factors Affecting the Residential Dementia Care Workforce

It is important to consider the needs of the dementia care workforce within the political, economic, and social context in which dementia care takes place, and to understand how these contextual factors influence the nature of both the workforce and the work it undertakes.

The number of people with dementia in the UK is growing. A report by Prince et al (2014) estimated that there would be 850,000 people with dementia in 2015, increasing to 1 million by 2025 and 2 million by 2051, provided increases are driven by demographic ageing. However, as the authors themselves acknowledge, these figures are uncertain, with future predictions based on a 'worst case scenario'. Comparable figures were created from research by Lewis et al (2014) for Alzheimer's Research UK, with 851,000 with dementia in 2015, 1.1 million by 2025 and 2 million by 2050.

The demand for more care will inevitably lead to an increased cost for care provision. Health and social care costs alone amounted to £14.6 billion in 2013, with unpaid care costs estimated at £11.6 billion, £26.2 billion in total (Prince et al 2014). Again, Lewis et al (2014) estimated the total cost of dementia at £23 billion, rising to £32 billion in 2025 and £59 billion in 2050. Addressing the increase in people with dementia and the associated costs of care is therefore seen as a priority (Thomas and Hollinroke 2014).

Since the later part of the 20th century, both Conservative and Labour governments have adopted a neoliberal stance. Under this approach, the Government set standards and budgets for services and then contracts them out to private business or voluntary organisations (Powell 2014). The introduction of the neoliberal approach, and its associated marketisation, to social care led to much greater private sector involvement. The UK Care Home Association reported that 92% of care homes registered with the Care Quality Commission were in the independent sector by 2009 (Eborall et al 2010). With the financial crash in 2008 there was an accelerated drive to reduce costs (Thomas and Hollinroke 2014), resulting in Central Government undertaking an austerity agenda, restructuring areas in which it takes responsibility (England 2010), with health and social care being one of the most heavily affected sectors (Coote 2011).

Wilberforce et al (2011) identify that local authority commissioning practices constrain the market, with some operating a 'cheapest first' policy. Running costs for private care providers remain very high (Lukhani & Whittell 2012), with the risk of care organisations collapsing like Southern Cross in 2011 (Ruddick 2015). Costs are increasing while local authorities are demanding cuts in prices and longer fixed-term contracts for the provision. Most recently, Humphries et al (2016) detail that it is only a matter of time before care providers collapse; 77 local authority areas had reported at least one care home provider had ceased trading in the previous six months.

The rise and fall of Southern Cross is an illustration of the concerns about marketisation of residential social care (Scourfield 2012). Southern Cross grew from operating 70 care homes in 2001 to over 750 in 2011, an expansion in capacity of over 1000% in ten years (Scourfield 2012). How had Southern Cross managed this?

**... this dramatic expansion appeared to be inspired less by the desire to meet the needs of the frail elderly population and more to do with treating care homes as a tradeable commodity and securing profits from asset stripping.”*
(Scourfield 2012, p140)

This asset stripping was primarily through the sale and lease-back of the care home properties, using the generated funds to grow the group through further mergers and acquisitions and pay higher rates of returns to investors (Scourfield 2012). It turned

Southern Cross into an operating company, providing care but not owning the underlying property assets (Burns et al 2016a). In 2011, unable to meet its annual rent commitments which were close to £250,000 owed to its various landlords who included international financiers, venture capitalists and private equity firms, Southern Cross went into administration (Scourfield 2012).

Burns et al (2016a) argue that the “unfair price narrative” (p20), i.e. price cutting by local authorities, was driven by the large adult social care providers in alliance with others (GMB Union, the Local Government Association and the Care and Support Alliance). These large providers (Four Seasons, Bupa, HC-1, Barchester, and Care UK) operate 19.8% of care home beds nationally, running a similar business model (Burns et al 2016a), with a return on investment (ROI) requirement of 11-12%. It is this level of return that Burns et al (2016a) argue was part of the perceived funding shortfall. If other businesses (Sainsbury’s, Tesco etc.) operate successfully with a 5-6% ROI, it would not be unreasonable for care home providers to do the same (Burns et al 2016a). However, to achieve a higher ROI, savings have been made in other areas, such as the pay and conditions of RCWs (Lymbery and Postle 2015, Burns et al 2016b), and through reductions in staffing levels, the area in which 60% of residential care home costs reside (Burns et al 2016b). The implications for RCWs is clear. Burns et al (2016b) stated that cuts in staff

“... lead to lower job quality because workers bear the brunt of the cutbacks. Lower job quality includes a) reduced rewards in the form of pay and benefits and b) fewer resources (reductions in staffing, longer working hours, and work intensification), less discretion, and fewer opportunities at work to provide decent care. Hence, lower job quality leads to poorer care because particular dimensions of job quality allow workers to provide better care.” (p995)

The provision of training is one of the areas affected in cost cutting exercises (Burns et al 2016b), and with staff shortages homes cannot afford to release an RCW for training elsewhere.

The social context of the residential dementia care workforce cannot be ignored. One way of understanding the social discourse around caring for people with dementia is to look at the way older people are perceived. Ageism is widespread, generally accepted, and largely ignored (Fealy et al 2012). Ageism has been defined as an

ideology that condones and sanctions the subordination and marginalisation of older people within society and legitimises (or at least ignores) poor quality care, neglect, and social exclusion (Milne 2010). Older people with dementia are not only exposed to the stigma associated with a mental disorder but also to age discrimination. Residential dementia care work takes place within an ageist and dement-ist care system.

Reviewing the political, economic, and social context of residential care homes for people with dementia illustrates the complexity of the field. The purpose of this research is not to provide a solution for the whole field, but to focus on training as only one of the potential remedies; others remain outside the scope of the thesis.

1.3 Aim and Objectives

The aim of my research was to discover views from RCWs themselves about the challenges of their work, what training they had received, its strengths and weaknesses, how it was delivered and assessed and what training they require to care for older people with dementia. Except for Menne et al (2007) and MacDonald et al (2004), little attention has been given to their perspectives. I aimed to model a dementia care curriculum for RCWs based on their views of training needs. As a result of the initial review of literature, an additional area came into focus: how care worker learning is transferred into practice and whether training is retained some months later.

Research Objectives

Having defined the aim of the research, a literature review was initiated to get a better understanding of its context and to develop clear objectives. Four objectives were devised;

1. Identify the specific needs of residents with dementia, as perceived by RCWs;
2. Identify the training needs for RCWs in terms of content and mode of delivery as identified by the RCWs themselves;
3. Provide data from RCWs that could inform the content and mode of delivery of a dementia care curriculum for RCWs;
4. Identify the training outcomes and how these could be measured reliably.

RCWs' perceptions of the specific needs of people with dementia (the first objective) aimed to reveal how RCWs construct the needs of those they care for and how this influences their views on training. The second objective sought to establish the training content RCWs recognised as necessary, as well as their views on the preferred modes of teaching delivery.

The third objective was to input findings from the second and build them into a curriculum for RCWs, with the fourth objective focusing on the need to consider evaluation of training outcomes.

1.4 The Research Design

This research represents the culmination of a journey started at an earlier stage within my Professional Doctorate programme. The Critical Analytic Study (CAS) completed prior to the start of the thesis stage laid the foundations. The CAS started the initial investigation into the views of the dementia care workforce about the nature of the dementia care, their challenges and training needs, and highlighted a gap in research. This contributed to my understanding of how RCWs construct their role as carers, and their training needs as a result.

The literature review for the beginning of the thesis was built from this initial investigation, exploring views, subject content, modes of delivery, measures of assessment, and the characteristics of the dementia care workforce that might impact on learning. This helped shape my ontological and epistemological position as a researcher, discussed within the Methods chapter (Chapter 3). A qualitative research design was used to gather data directly from RCWs through individual face-to-face interviews in three different organisations in three different counties. A thematic framework was used for the analysis of the data.

Adult learning theory, emotion and learning, student-centred learning, and Honneth's (2005) recognition theory were drawn upon to help illuminate my findings, and to highlight a possible way forward for training RCWs in a supportive and learner friendly environment. Training transfer theory was used to help ensure that learning could be

successfully transferred into practice. This was adapted to contribute to the building of a conceptual model for dementia training.

1.5 Thesis Structure

Following this Introduction, there are five further chapters. Chapter 2 contains the Literature Review, reviewing the body of knowledge relating to my research objectives, which included the specific needs of people with dementia, the challenges faced by RCWs, and what have been identified as potential areas for a dementia care curriculum.

Chapter 3 defines the Research Methods used for my research. I explain my ontological and epistemological position, along with the research strategy and structure. Ethical considerations are identified. Reliability and validity are discussed in terms of the chosen method of data collection and dementia care being identified as a complex phenomenon. Data collection methods are explained outlining how care homes were chosen and how RCWs were chosen to be interviewed.

Chapter 4 explores the findings from one-to-one interviews with RCWs working with older people with dementia, which sought their views on training specific to dementia care. It includes their previous two years' experiences of training, the strengths and weaknesses of that training, the content and how it related to their daily practice, and methods used to deliver training. This chapter also identifies RCWs' feelings about working with the specific requirements of dementia care, and what form they thought dementia care should take.

Chapter 5 contains the discussion of the RCWs' views of the challenges of their role, the specific needs of residents with dementia, the barriers to implementing person-centred care, teamwork, and emotions and dementia care. It compares what RCWs believe to be important in their training with what is thought to be important in the Dementia Core Skills Education and Training Framework (Skills for Health 2015)¹

¹ Skills for Health, a not-for-profit organisation committed to the development of an improved and sustainable healthcare workforce across the UK. Established in 2002 by the UK Government as the Sector Skills Council for Health for the UK health sector, Skills for Health helps to inform policy and

Building on Baldwin and Ford's (1988) Training Transfer model, Grossman & Salas (2011) provide a lens with which learner characteristics of cognitive ability, motivation, self-efficacy and perceived utility of training are discussed in terms of their importance in the transfer of learning into practice. The chapter brings together Grossman & Salas' (2011) Training Transfer model with a student-centred learning approach, and Honneth's Recognition Theory (2005) to propose a way forward for dementia training, mode of delivery, and assessment derived from the views of RCWs themselves. It argues that this proposed conceptual model can be used to augment what has been identified by Skills for Health (2015).

Finally, Chapter 6 considers what conclusions can be drawn and reviews the effectiveness of the research approach against the original research objectives. The contribution to knowledge is then discussed, followed by the limitations of the research. Reflections on the doctoral journey are included and areas for further research are identified.

1.6 Summary

This Chapter has introduced the thesis and identified the focus and background of the research. It has documented the research aims, objectives, approach, and design, concluding with an overview of the thesis structure.

2 Literature Review

2.1 *Introduction*

This chapter considers what is already known about the views of RCWs on their training. There are three key components of the chapter; contextual information about the dementia care workforce and the tasks they undertake (covered in Sections 2.2 and 2.3); research into the training needs of RCWs along with the content and mode of delivery; and measures of training outcomes (Sections 2.4 and 2.5). The theoretical perspectives (Section 2.6) are used to investigate the nature of adult learning specifically for the learning needs of RCWs and the prominence of both the emotional needs of residents with dementia and RCWs themselves. Theory is used to highlight ways forward for learning to be transferred into daily practice. This is not to say, however, that theory is considered separately from the content and context components. For example, it is not possible to discuss and understand the literature on the needs of people with dementia without referring to Kitwood's (1997) work on person-centred care. As a result, theory has been combined with context and content to shed further light on the research topic.

2.1.1 Literature Review Objectives

The objective of this chapter is to review current literature to

- Ascertain the specific care needs of residents with dementia;
- Identify the training needs of RCWs as specified in the literature;
- Review current dementia care training content and modes of delivery;
- Assess possible measures of training outcomes;
- Establish the extent RCWs have been consulted about their dementia care training;
- Outline relevant theories to be used to provide a 'lens' through which the research can be considered.

From my personal experience, residential care staff care for both residents with dementia and residents who do not have the condition. As a result, RCWs must adapt their practice depending on the needs of each resident. Knowing the specific needs of residents with dementia could enhance care worker practice and help assess the suitability of training. Reviewing current dementia care training content and modes of delivery, along with possible measures of training outcomes, establishes a reference point for current dementia training for RCWs.

2.1.2 Literature Search and Review

The literature search and review of the content component (Sections 2.4 and 2.5) of the literature review was completed in two phases, both of which followed systematic searching principles. The first review was completed during a previous stage of the Doctor of Social Work (December 2010) for a Critical Analytic Study (CAS). The CAS identified the need for RCWs to identify training needs for their specific role in dementia care, the greater need for standardisation of training, and a reliable assessment of knowledge. The CAS was completed as a literature review and considered the same research domain and addressed the same objectives. As a result, the literature identified as part of the CAS was considered in scope for this thesis.

A further search was completed in February 2014 as an update to the search completed for the CAS. The two searches did not follow all five steps outlined by Petticrew (2001) for a systematic review. Assessing study quality and the synthesis of those studies that were most methodologically sound were not completed. A decision was made to use all the studies found by the search because there were so few were identified.

During both literature reviews, the databases Web of Knowledge, Scopus, ASSIA (Applied Social Sciences Index and Abstracts) and PsycINFO were used to search for literature in relation to the views of RCWs and their training needs, with the search limited to studies dated post-1997, after the publication of Kitwood's (1997) seminal work on person-centred care. Searching systematically, the terms used were grouped into categories as illustrated in Table 2.1. The search terms in each of the categories

were then combined to locate as many papers as possible. The references from papers identified as part of the search were also examined for relevant papers. It should be noted that there are national differences in job titles. For example, in some American studies (Dodson and Zinbarg 2007; Fazio et al 1999), the researchers identify nursing assistants in residential care that have similar status and characteristics to that of a residential care worker in the United Kingdom.

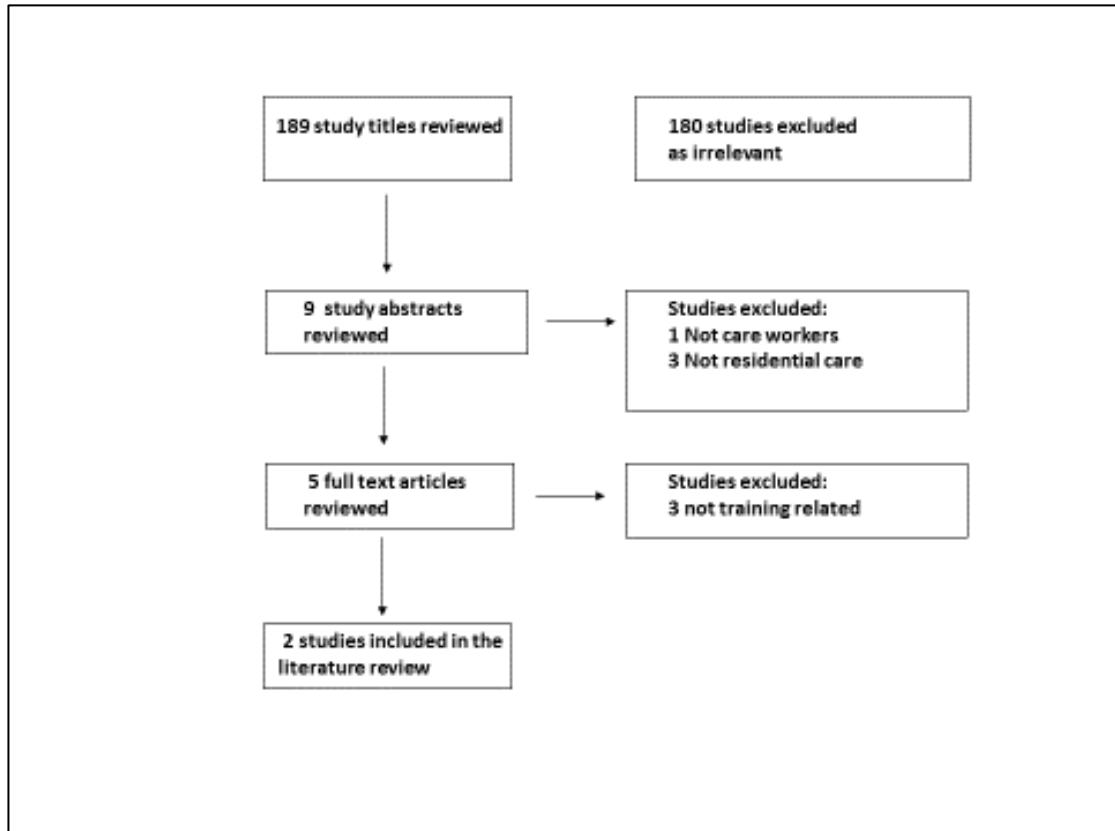
Table 2.1 Search Terms and Categories

Category	Search Terms
Workforce	"Care worker" "RCWs" "Residential Worker" "Residential Workers" "Nursing assistant" Nursing assistants"
Condition	Dementia Alzheimer's
Research Focus	Views Perspectives Consultation Opinions
Activity	Training Learning Education
Criteria of Interest	Outcomes Assessment

For inclusion in the literature review, papers had to address a training intervention for RCWs within residential care, with a preference for those that considered RCWs' views as part of the learning process. It was required that RCWs were consulted on their training needs or provided feedback as part of the training process once training had been completed. The last category, 'criteria of interest' was not a mandatory part of the overall search but used to identify specific papers that considered outcomes or assessment.

As the literature search and selection method followed were the same for both the CAS and the update for this research, the numbers have been combined in the literature selection flowchart (Figure 2.1). It was clear from the systematic search completed that the number of papers identified was limited.

Figure 2.1 Literature Selection Flowchart



The two identified papers were MacDonald et al (2004) and Menne et al (2007), both discussed in Section 2.4.2.

For the context component (Sections 2.2 and 2.3) of the literature review, a traditional literature review approach was used, based on the use of the Social Care Online (SCIE) database to identify peer reviewed and non-peer reviewed material (such as reports and papers not published in journals). The websites for Age UK (<http://www.ageuk.org.uk/>), the Alzheimer's Society (<https://www.alzheimers.org.uk/>), the Joseph Rowntree Foundation (<https://www.jrf.org.uk/>) and Community Care (<http://www.communitycare.co.uk/>) were also searched. The traditional approach was adopted on the basis that such a search

“... more often involve[s] general discussion of the subject with no stated hypothesis.” (Petticrew 2001, p99)

This was important, as the purpose of this part of the literature search was to identify current research information and did not require in-depth investigation into the full details of workforce composition and its development over a longer period. In the following sections, the context of the research, i.e. the dementia care workforce and the specific care needs of residents with dementia are discussed, followed by the content of the research, i.e. the training for residential care workers.

2.2 The Dementia Care Workforce

To understand how we may best meet the challenge of providing a meaningful dementia care curriculum and training for care staff, it is important to know something of the learner. The more we know about the identity of the learner, the context of the learning, and how learning is processed, the better able we are to design effective learning experiences (Merriam 2015). This section examines the common characteristics of the dementia care workforce, it will then look at the challenges RCWs face in the day-to-day care of dementia care residents and the concerns raised about the quality of care for residents with dementia.

2.2.1 The Characteristics of RCWs

To care for staff means to prepare them sufficiently (Kitwood 1998). However, Zimmerman et al (2005) identified that frontline staff are a neglected component of long-term dementia care. Innes (2009) identified similar, in that much of the dementia care workforce felt undervalued by the public, poorly supported, inadequately trained, demoralised, and that they receive little recognition for the work they do.

Talbot and Brewer (2016) sought to understand RCWs' experience of dementia with emphasis on the challenges they faced and the impact on their well-being. A small sample of eight RCWs were used to gather the data via semi-structured interviews. A small sample was used for interpretive phenomenological analysis. All RCWs were trained to at least National Vocational Qualification (NVQ) level two in healthcare, had at least six months experience working with dementia in residential care, and worked

at least 18 hours per week. Three participants had experience of dementia prior to their role, having had a family member diagnosed with dementia. The authors identified a lack of organisational support for RCWs, characterised by a reluctance from senior staff to appreciate their expertise, and they lacked recognition. RCWs felt a sense of being undermined by senior staff, and that this contributed to their overall feelings of self-worth in the care environment.

Innes (2009) identified that the low status assigned to people living with dementia is matched by the low status of the dementia care workforce. Fine and Glendenning (2005) suggested that care work had been traditionally seen as a 'taken for granted' female activity. Care work had been generally characterised by low pay and poor working conditions, with RCWs' acceptance of these conditions (Innes 2009; Hussein and Manthorpe 2014). Talbot and Brewer (2016) found that RCWS were not adequately trained to deliver specialist care despite the NDS (Dept. of Health 2009) recommendation that care staff should be trained to respond appropriately to dementia.

Inconsistent staffing levels are a characteristic of the dementia care workforce and identified as a barrier to quality care (Talbot and Brewer 2016). The turnover rate for the dementia care workforce in residential homes in England, in the independent sector, within the previous 12 months (to May 2017) is 32.6% (n= 286,275), (NMDS-SC 2017a). Skills for Care (2016a) estimate that the turnover rate of directly employed staff working in the adult social care sector was 27.3%, around 339,000 leavers per year. The turnover rate for care workers was 33.5%. Turnover rates have increased steadily, by 4.7% between 2012/13 and 2015/16, with a large turnover because of people leaving the sector soon after joining and difficulties in retaining younger workers (Skills for Care 2016a). It also includes a high number of care workers moving to other roles within the adult care sector (67%). Although this apparent churn of care workers retains skills within the care sector, it is still disruptive for the care organisations themselves (Skills for Care 2016a).

Hussein and Manthorpe (2012) used data from the National Minimum Data Set for Social Care (NMDS-SC) to investigate the characteristics of the social care dementia

workforce as presented by employers who completed the NMDS-SC. Hussein and Manthorpe (2012) revealed in their analysis of the National Minimum Dataset for Social Care (in June 2012) that there are some variations between the characteristics of the dementia care workforce and other RCWs with different client groups (those who do not work with dementia), for example, people with learning disabilities, or adults with mental health problems or long-term disabilities. These variations included that the dementia care workforce is more likely to be female, to work part time, to be employed by agencies, and that many work for medium-sized businesses. Skills for Care (2016a) estimated that 90% of the adult social care workforce were employed on permanent contracts; however, the figures from Skills for Care (2016a) include all care workers and are not limited to dementia care. RCWs are more likely to be working in private residential organisations, as residential care has been almost completely outsourced to private providers (Burns et al 2016a).

Hussein and Manthorpe (2012) highlighted that this workforce group is less likely to hold qualifications at NVQ 3 or above, an important skills gap. The dementia care workforce contained larger proportions of workers with no qualifications, as well as larger proportions of workers who were not working towards any qualifications (Hussein and Manthorpe 2012). Some RCWs have reading and writing difficulties. For example, Beer et al (2012) pointed out that their questionnaire for RCWs was written for a reading level of age thirteen.

Hussein and Manthorpe (2012) identified that the profile of the dementia workforce has significantly more representation of workers from Black and Minority Ethnic (BME) communities (particularly Asian). It must be noted that Skills for Care (2016a) recorded a significant regional difference in the employment of BMEs – 41% of the workforce in London, for example, compared to less than 10% in Northern England.

With high turnover rates and levels of vacancies, along with difficulties in retaining younger members of staff (Skills for Care 2016-a), care home providers often turned to alternate sources for staff recruitment (Hussein et al 2010). Consistent with research in the US (Rodriguez 2004), the main motive of the English care sector in recruiting migrants is their willingness to do work that may be unattractive and which the host

population may be reluctant to do, such as managing continence, end of life care and night or shift work (Hussein et al 2010). This gives rise to concern that language barriers may prevent verbal interactions with people with dementia that are meaningful to the RCW or the person with dementia (Innes 2009). However, within a setting where there is care of such vulnerable people, everyday communication is vital in understanding a person's needs.

RCWs care for vulnerable members of society. Given dementia care work has been so undervalued, it is not surprising that the related issues of education and development have been neglected (Kitwood 1998). It seems most RCWs enter dementia care work very ill prepared or have had no preparation at all (APPG 2009).

2.2.2 The Challenges for RCWs

Working with dementia can be a rewarding experience for RCWs, but they are also presented with many challenges (Beck et al 1999; Ericson-Lidman et al 2014; Talbot and Brewer 2016). Older people with dementia present specific challenges for RCWs, for which they have not received dedicated training (Beck et al 1999; Innes 2009; Talbot and Brewer 2016). The challenges faced by the social care workforce were acknowledged in the Cavendish Review (2013)². It acknowledged that helping with everyday personal tasks, like bathing older people with dignity and without hurting them, communicating with someone with dementia, and doing this with intelligent kindness, dignity, care, and respect, requires skill. However, the review identified that training for these important tasks is fragmented, and that individuals are taught different courses or bits of courses. Training people in different places, to varying standards, was inefficient, and was a safety risk (Cavendish 2013). Since the Cavendish Report was published, training for all care workers has been re-structured via the introduction of the Care Certificate (HEE 2015). The Care Certificate is discussed in further detail in Section 2.5.2.

² In the wake of reports of failings in hospitals and care homes, the Cavendish Review (Cavendish 2013), was an independent review requested by the Secretary of State for Health, into healthcare assistants and support workers in the NHS and social care settings. The review was to establish what can be done to ensure that unregistered staff in the NHS and social care treat all patients and clients with care and compassion.

In care homes, the average resident is now 85 years old and often very frail (Cavendish 2013). The Cavendish Review (Cavendish 2013) identify that the definitions of “residential” and “nursing” care have become blurred: residential care homes are places with increasingly very frail residents, many with dementia. People who would have been in hospital or a nursing home are increasingly placed into residential homes, thus demanding more of the RCW (Cavendish 2013).

Within the hierarchy of a care home, the RCWs are involved with body work (Kelly 2010). Body work is often seen as dirty work, it deals with fluids and excretions, and is considered distasteful, low status and demeaning (Kelly 2010). This devaluing of RCWs is reflected in reports that some residents have spoken to RCWs as servants (Burton 2013). Burton (2013) argued that generally

“Care homes have been regarded as outposts for outcasts, places that are necessary but unpleasant, and avoided at all costs.” (Burton 2013, p419).

and

“... generally governed and regulated by a powerful class of comparatively wealthy white establishment figures used to employing people to do dirty work for them, and often in contrast to the care staff group.” (Burton 2013, p419).

Edberg et al (2008) identified practical challenges such as limitations of time and resources in the UK, Australia, and Sweden. In addition, UK based literature highlighted challenges, including poor support from management, inconsistent staffing levels, and poor communication between staff, all of which have been identified as a barrier to quality care (Talbot and Brewer 2016; Lee et al 2016). Talbot and Brewer (2016) identified that role conflict can impact on care, in that RCWs often feel misunderstood and have reported that family expectations of care can differ from the care that can be provided in the time available, potentially leading to feelings of inadequacy for RCWs.

As dementia progresses, residents can develop challenging behaviours. These include restlessness, agitation, and physical and/or verbal aggression. These behaviours can be distressing, both for the resident and the RCW (Alzheimer’s Society 2013a).

Colomer and de Vries (2016) identified that the work of RCWs is both physically and emotionally draining. Residents can often present with complex needs, and the

challenges of the caregiving role may make RCWs vulnerable to burnout (Kokkonen et al 2014; Zwijsen 2015). The link between RCWs and burnout has been identified in previous research, where burnout included low mood, fatigue, loss of motivation (Schaufeli & Enzman, 1998), and being prone to injury and depression (Zimmerman 2005). Burnout is associated with high levels of stress, less willingness to help, low optimism and negative emotional responses to residents' behaviour (Todd and Watts 2005).

Undervaluation of social care has important adverse consequences for those working in the sector, service providers and residents with dementia. The most direct consequence is a high turnover of staff. This leads to reduced quality of care, and deterioration in organisational culture and employee morale (Alzheimer's Disease International 2013). This has also created enormous problems of continuity of care for residents and recruitment costs for employers (Cavendish 2013).

2.2.3 Concern for the Quality of Care for Residents with Dementia

There is not only an increasing demand for dementia care, but also growing policy and public concern about the quality of that care given to older people with dementia in residential care homes.

Poor quality care has continued to make headlines (CQC 2014). Care scandals have exposed a shameful absence of 'care' – including neglect of nutrition, hydration, pressure sores, lack of dignity and both unkind and ill-treatment in care homes (Lewis and West 2014). This has been partially attributed to lack of training. (Alzheimer's Society 2015).

What is poor care (or practice) and when does it become a safeguarding issue? Guidance published by SCIE (2015) explained that poor practice was one-off incidents, which may be unintentional and do not cause any lasting harm. Examples included a one-off medication error, or an incident of understaffing that had led to a person being left in an unchanged pad. Nonetheless the impact on the resident at risk can be just as great regardless of whether harm is intended. However, if poor practice becomes more than a one off, it can cause harm and can become abuse. SCIE (2015) guidance identifies examples of such potential safeguarding indicators as a series of medication

errors, changes in the behaviour of a resident, and signs of neglect such as unclean clothes.

Marsland et al (2015) identified that precise definitions of abuse are difficult to establish and have been frequently contested. Thresholds for abuse can be difficult to determine, as some actions are clearly recognised as abusive, whereas others occupy a grey area between poor practice and abuse, meaning they could be misunderstood and interpreted differently (Marsland et al 2015). Fyson's (2015) study of reliability and validity of safeguarding databases identified that the language associated with safeguarding had been used inconsistently with changes in how terminology was used over time. The Department of Health (2000) defined abuse as,

"...a violation of an individual's human and civil rights by another person(s)",
(p9)

which may not be intentional. An example given of unintentional abuse is neglect by a care worker who was unaware of the needs of the resident. This example reflects the finding of the CQC review that 29% of assessments in care homes did not identify all care needs (CQC 2015). These needs would have remained unmet until they were identified, thus making poor practice as identified by CQC a potential ongoing situation resulting in possible abuse.

Manthorpe et al (2012) identified that the risks of people with dementia to suffer from abuse, mistreatment and neglect were internationally recognised. According to the World Health Organisation (2017) data on the extent of the problem in nursing and care homes are scarce. A UK study by Cooper et al (2013) asked care workers to describe abusive or potentially abusive situations they have witnessed. All care workers described abusive situations occurring due to insufficient resources or competing demands. Some potentially abusive behaviours happened because care workers did not know enough about dementia. The study identified that residents may fear reporting abuse about people on whom they depend, and that care workers reporting abuse face potential adverse legal, employment and social consequences. Care home residents with dementia are more likely to have challenging behaviour and be dependent on others for personal care, all factors associated with a higher risk of

abuse (Cooper et al 2013). These concerns have brought challenges for research that have made the extent of poor care and abuse in care homes difficult to determine.

“No good single national level data source available, suitable for secondary analysis, covering the abuse, neglect and mistreatment of vulnerable older people in care homes and hospitals in England and so data concerning residents and patients with dementia in these settings are hidden.” (Manthorpe 2015, p276)

CQC (2015) reported that safety remains a major concern. Staff training was identified as one of the key drivers for improving the standard of care for people with dementia (APPG 2009), and ‘Recommendation 29’ of the Orchid View³ Serious Case Review (Georgiou 2014) was for care homes to demonstrate to CQC that staff have training. However, one of the concerns identified in the literature was how to measure the effectiveness of training. This is discussed in more detail in Section 2.8.3.

2.2.4 The Dementia Care Workforce: Summary of Findings

This section considered what literature has identified about the residential dementia care workforce. It reviewed the daily challenges by RCWs in day-to-day practice and the concerns raised by government bodies and the public. The low status attached to people with dementia is matched by that of the workforce that cares for them (Innes 2009). Quality of care is directly related to the quality of the relationship the person with dementia has with the RCW (Innes 2009). The common characteristics of the dementia care workforce therefore have the potential to undermine this relationship, particularly with inconsistent staffing levels (Talbot and Brewer 2016). The concerns for quality of care and its challenges - the financial cost, and the need for an increase in the numbers of skilled carers - are a common theme across literature for dementia care.

The lack of current literature that considers the views of RCWs, given their feelings of being undervalued, lack of self-esteem, the challenges they face and the concerns for

³ Orchid View, a care home accommodating up to 87 older people and older people with dementia, was closed due to safeguarding issues.

care, would suggest that research that considers the views of RCWs and their opinions on specific dementia care training is needed.

2.3 *Specific Care Needs for Residential Dementia Care*

The 1980s saw dissatisfaction with institutionalised care that led to an emphasis on the rights of people with dementia to live well (Brooker and Woolley 2007). This section examines the shift from institutionalised care and the biomedical model, to person-centred care and the needs of the individual resident. How dementia has been perceived, person-centred care, communication, selfhood, and positioning theory will each be covered in turn. These areas are important for care worker training as they address the specific needs of people with dementia and the nature of relationships between RCW and resident.

2.3.1 Perceptions of Dementia – Personhood and Power

Philosophers Descartes and Kant defined a person as having the capacity for rational thought and memory, and to be able to communicate this to other people (Smebye and Kirkevold 2013; Harrison 1993). With advancing dementia, these valued abilities are lost, personhood is eroded, leading to a loss of self (Smebye and Kirkevold 2013). However, Smebye and Kirkevold (2013) pointed out that selfhood has been reported even in persons with severe dementia.

Foucault (1988) argued how prevailing systems of knowledge about mental illness are historically grounded, and have been used as systems of control. This concept could be applied to dementia. For example, Lyman (1989) argued that dementia was something that needed to be treated and justified the control of people using physical or chemical restraints. The biomedical model documents the losses as the self erodes until there is no self left, and what is left is a failing body that needs to be managed and controlled (Behuniak 2010). People with dementia were reduced to a catalogue of cognitive defects and behaviour disorders, ignoring other facets of what it is to be human (Kontos 2003).

The discourse around the nature of dementia and medical practices have influenced the power relationship between care giver and the care recipient and shaped issues

such as the kind of care given and who will provide the care (Dunham and Cannon 2008). For example, May's (1973) analysis of power interpreted the biomedical model as practising 'power as control'. This is pertinent for RCWs' understanding of when decisions are made regarding care. Who makes decisions? How and in what way are decisions made? What understanding of power is reflected in the care of people with dementia (Behuniak 2010)?

Older people with dementia have been labelled as aggressive. Although literature has used other terms, such as challenging behaviour (Miesen 2010), the term aggression is still reflected in literature and has been identified as one of the three commonly occurring behavioural symptoms of dementia, along with agitation and rejection of care (Choi et al 2017). Residents with dementia often need a lot of physical help with daily living tasks necessary for good health and hygiene. Providing that care involves control over the behaviour of a person and involves the direct regulation of the body or bio-power (Foucault 1990). Foucault referred to bio-power as the outcome of the historical processes by which

"...there was an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations." (Foucault 1990, p140)

Residents with dementia may feel in a powerless position when being told they need to wash, or have their clothing changed. It is this powerlessness that can lead to aggression and violence (May 1973). The author proposed that in every human life power exists as a potentiality – an urgent human quest for significance.

Building on May's work, Kitwood recognised the power potentialities that remain by insisting that the person still exists (Behuniak 2010). It was Kitwood's (1997) seminal work on person-centred care that charged the dominant medical paradigm as being unnecessary and contributing to care practices that involved moral deficit and warehousing (Kelly 2010). Kitwood (1997) challenged the bio-medical model with his understanding of dementia and the perception of personhood, defined as,

"A status or standing bestowed upon one human being, by others, in the context of social relationship and social being. It implies recognition, respect and trust." (p8)

Nolan et al (2006) argued that the term 'person-centred' failed to recognise the importance of relationships, in that it is focused on the person being cared for, and have argued that the term 'relationship-centred care' is more appropriate. However, McCormack (2004) argued that although an importance of relationships in person centeredness could not be disputed, the term 'relationship' in Kitwood's definition reflects only one component of the concept. McCormack (2004) identified that

"...context, place and self are other components of the concept, and thus it could be implied that person-centred care is a more inclusive term than 'relationship-centred care'." (p33)

Kitwood (1997) proposed that the social and emotional history of people with dementia, their cultural values, and daily care practices can exacerbate the condition. Kitwood called this 'malignant social psychology,' a term he used to describe ways in which the person with dementia is depersonalized and invalidated (Kitwood 1997). Although this term had been criticised because there was no reference to the agency of people with dementia, in that they were passive recipients of external forces (Bartlett and O'Conner 2010), Kitwood (1997) argued that 'malignant social psychology' damaged, fragile self-esteem and personhood, leading ultimately to the loss of self that is widely attributed to neuropathology. Sabat and Harre (1992) identified that they held a similar view to Kitwood and argued that there are aspects of the person where the loss of self is directly related to the ways in which others view and treat the person with dementia. Potkins et al (2003) identified growing support for Kitwood's view that what is termed 'inappropriate' behaviour is an expression of unmet need. Downs & Bowers (2009) identified that the main needs people with dementia seek to address through their behaviour are physical pain and discomfort, lack of social contacts, loneliness, boredom, inactivity, sensory deprivation, and depression through lack of positive experiences or lack of control.

There is an understanding that aggression or violence is a response to assaults on these expressions of power, and that power should be positive and integrative, working with and for the person, and not against (Behuniak 2010). A social constructivist approach to dementia focusses on supporting the development of a person's power

potentialities, recognising the need for self-assertion and self-affirmation (Behuniak 2010).

Person-Centred Care

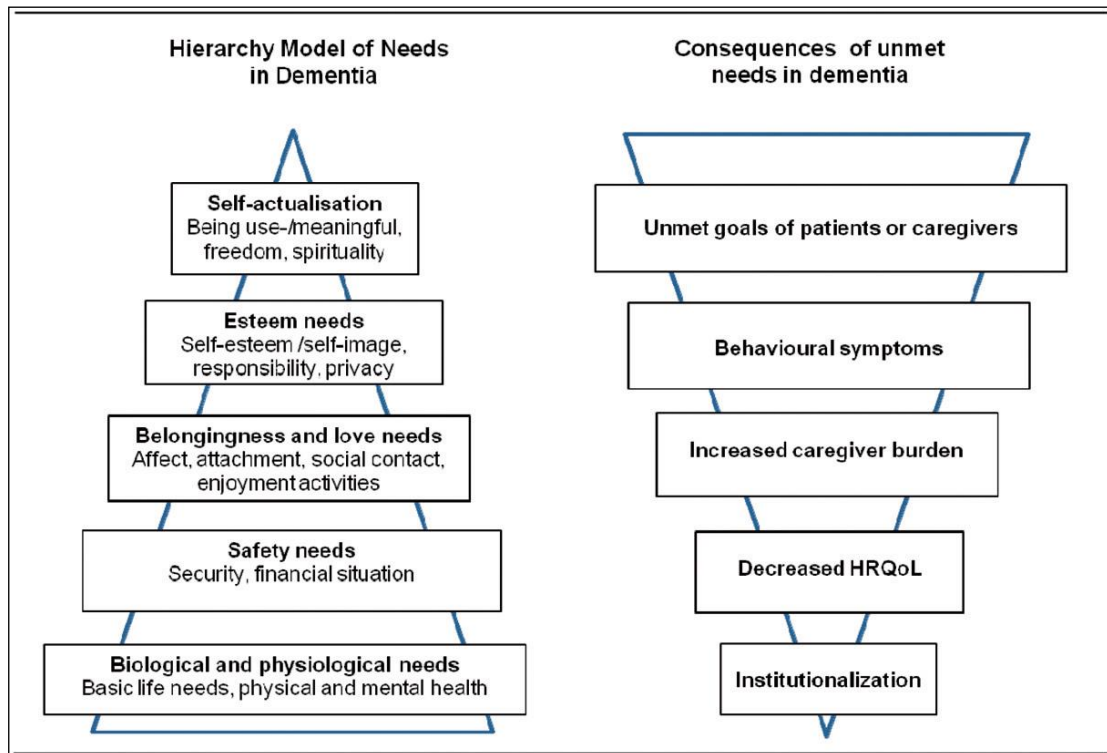
Person centred care may mean different things to different people and in different contexts (Brooker 2016). However, it has become generally described as outlining a social, humanistic, and holistic perspective on how to promote care for people with dementia (Edvardsson et al 2014). Kitwood (1997), in terms of the needs of people with dementia, held the assumption that all human beings have five fundamental psychological needs:

- Comfort, the provision of warmth and strength;
- Attachment, the forming of specific bonds or attachments;
- Inclusion, being part of a group;
- Occupation, being involved in the process of life;
- Identity, having a sense and a feeling of who one is.

Kitwood was inspired by Maslow's hierarchy of needs model and this has been used as a framework for understanding how the needs of vulnerable people could be met (Umoren 1992; Zalenski & Raspa 2006). Downs & Bowers (2009) proposed that people with dementia, in common with all people, have higher order needs, such as those Maslow identified, for social contact and sensory stimulation. A person with dementia may not be able to recognise, express or resolve these needs, but this does not mean the person no longer has them.

Building on Maslow, Schölzel-Dorenbos et al (2010) proposed a Hierarchy Model of Needs in Dementia (HMND) that could offer a new theoretical framework to address the relationship between levels of need as shown in the Maslow pyramid (Figure 2.2), and the consequences when needs remain unmet.

Figure 2.2 - Hierarchy Model of Needs in Dementia (Schölzel-Dorenbos et al 2010)



Kitwood theorised that treating dementia primarily as a physical disease overlooked the brain's plasticity as well as the psychosocial aspects of identity (Doll et al 2016). He held that using a psychological approach may help enable an individual to remain intact as a social and communicative being despite the presence of pathological processes in the brain. His theory suggested that some of the deterioration that was seen in people with dementia was not caused by the disease, but by how persons were treated. Kitwood later (1997) theorised that person-centred care could be effective in reversing aspects of the psychosocial degenerative course of dementia and perhaps prevent destruction of personhood. This idea is consistent with research by Passalacqua and Harwood (2012), who found that a person-centred approach to dementia care is associated with improved well-being for residents and reduced burnout in staff. Passalacqua and Harwood (2012) used a pre-and post-test design with four one-hour workshops over four weeks. The workshops were built around the theoretical work of Kitwood and Brooker, and were intended to increase person-centred communication, beliefs, and attitudes among dementia care givers in a long-term care facility. A small sample of 26 RCWs was identified, all of which attended at least two workshops and completed pre-and post-test measures. As attendance was

not mandatory and outside working hours, 100% attendance was not expected. Post-test measures were six weeks after intervention. It would have been interesting for a follow up at three and six months, but the facility has a 30% annual turnover of staff, so it is possible that the RCWs who attended the intervention may not have been available to measure. Materials at pre-test were adjusted as English literacy skills and reading abilities were challenged. 11 RCWs (42%) were not native English speakers.

Brooker (2016) built on Kitwood's work that used a VIPS model to

"...spell out the different threads of person centred care whilst maintaining the sophistication of Kitwood's original vision." (Brooker 2016, p12)

The four elements were: valuing people with dementia and those that care for them; an individual approach; understanding the world through the perspective of the resident; and that all human life is grounded in relationships with a need to provide a social environment that compensates for impairment and provides opportunities for personal growth (Brooker 2016). McCormack (2004) proposed that the person-centred concepts that underpinned gerontological nursing were: being in relation; being in a social world; being in place; and being with self.

Although medicine can do little to stop the destruction of brain cells, much can be done on a social level if contact is maintained at a personal level (Shenk et al 2002). A person-centred approach is recognized as needed to meet the more specific and often complex needs of people with dementia (Martin et al 2002), and has shown a significant improvement in reducing agitation (Chenoweth et al 2009). If this approach has been successful in addressing the specific needs of people with dementia, perhaps a similar approach could be used in training to address the specific learning needs of RCWs. A person-centred approach is a fundamental principle of dementia care, and is embedded in the language of multidisciplinary practice (McCormack 2003). Edvardsson et al (2014) said

"....person centred care represents best practice care of people with dementia, and that person-centred care is associated with positive outcomes for resident wellbeing as well as for staff strain and satisfaction" (p3)

Therefore, any curriculum for RCWs needs to take person-centred care into account.

2.3.2 Communication

The ability of people with dementia to communicate their needs can diminish. Dementia can affect expressive and receptive language abilities and can impact upon the level of functioning and the ability to care for oneself (Potkins et al 2003, Downs & Bowers 2009). Communication is vital and central to supporting personhood (Downs & Bowers 2009). Residents need to be seen less as passive recipients of care, and more as people with rights and opinions that RCWs need to listen to and engage in meaningful interaction with (Young & Manthorp 2009). Kitwood (1997) proposed five indicators of personhood that are applicable to communication and the associated behaviours: recognition, negotiation, collaboration, facilitation, and validation.

Communication between RCWs and the person with dementia has been recognised as key to understanding needs (Allan & Killick 2009). This is particularly pertinent considering the findings of studies that have identified that the average resident with dementia spent just 2% of the day in communication with RCWs (Ward et al 2005). Non-verbal communication has been identified as a way that residents with dementia communicate in meaningful ways for others to interpret, and as a potential resource for RCWs to use to preserve self-identity and improve quality of life for residents (Hubbard et al 2002; Small et al 2003). Part of person-centred care is embracing the role of non-verbal behaviour, to embrace the communication that still exists rather than concentrating on its decline (Hubbard et al 2002). The kinds of changes seen in the way people with dementia communicate do not always arise from damage to the brain, but from psychological factors, such as depression and loss of confidence (Allan & Killick 2009).

2.3.3 Selfhood and Positioning Theory

Dementia care is an area of change (Innes et al 2006) and, building on a person-centred approach, Kelly (2010) has argued that developing a selfhood approach with a person-centred approach during interactions between staff and resident can lead to an improvement of staff behaviours with positive outcomes for the person with dementia. Kelly (2010) proposed that

“There is scope for incorporating this developed selfhood framework into staff training, for it has the potential to transform practice and the experiences of people with dementia in receipt of care.” (p103)

Sabat & Harre (1992) identified that the ‘self’ in dementia includes three aspects. It is suggested that Self-1 can be expressed verbally, for example, ‘That’s mine’. Self-1 remains largely intact, even with severe cognitive decline. Kelly (2010) identified Self-2 as comprising of a person’s physical, mental, or emotional characteristics; this remains largely intact through cognitive decline but becomes vulnerable when difficulties associated with dementia are attributed to the person. This could be interpreted as Kitwood’s notion of malignant social psychology (Kitwood 1997). This is a term for interaction and relationship that diminishes a person’s personhood (Sabat 2009). Self-3 is the publicly presented aspect of self; it is constructed through interaction with others and is more vulnerable to damage than either Self-1 or Self-2 (Kelly 2010). This appears pertinent to the training of RCWs, and is supported by Ryvicker (2009), who proposed that as the self is constructed through social interaction, a person may be influenced by the reactions of others towards them. Brandstadter & Greve (1994) have identified that all people, but especially people with dementia, are dependent upon social interactions for the creation and maintenance of their personhood and sense of self.

2.3.4 Recognition Theory and Dementia Care

This section considers Honneth’s (2005) work on recognition theory, subsequently expanded by Houston (2015), and how it holds relevance for the dementia care workforce, their specific training needs, and people with dementia. Although Honneth (2005) based his theoretical work within the field of social work, there are many features in common with RCWs and residents with dementia. Indeed, recognition theory can be used to explore the interconnectedness between RCWs and residents with dementia.

Honneth’s work (2005) focused on social-political and moral philosophy, especially in relations of power, recognition, and respect. As human beings, our integrity is associated with forms of recognition or reciprocal approval by others. If we perceive that we are recognized by others like us, then we are closer to personal self-

development. When that same perception has a negative content, this lack of recognition of our identity represents limitations in our development. This has parallels with what has been identified in literature about the residential dementia care workforce and older people with dementia in residential care, in that both groups are perceived with little status or recognition. Dementia is known to impact upon and change a person's sense of identity and self. There has long been a stigma around age, mental disorder, and feelings of powerlessness. Residents with dementia are cared for by a group who identify themselves with being low paid, are unrecognised, and whose work is undervalued. According to Honneth (2005), identity conditions our perceptions of self, others, and the social world. Desired attributes such as self-respect, self-confidence, self-efficacy, and self-esteem are based on a flourishing identity.

An interconnection between identity formation and the attainment of well-being holds importance for residents with dementia (Sabat & Harre 1992). This closely resembles Kitwood's theory of personhood in dementia, discussed in greater detail in Section 2.3.2. Kitwood and Bredin (1992) argued that personhood is not the property of the individual, but is a status that can only be provided or assured in the context of mutually recognizing, respecting, and trusting relationships. Surr (2006) identified that residential care brings additional threats to self, and highlights the importance of interpersonal relationships. To assist preservation of self in people with dementia, care staff should be aware of providing opportunities for self to be supported (Surr 2006) and of the dangers of failing to do so.

Honneth (2005) suggested three spheres of recognition for positive relation to self: receiving love, care and positive regard; rights; and appreciation of a person's skills and contribution to the community. This, too, resonates with the six psychological needs for dementia identified by Kitwood (1997); those of attachment, love, comfort, identity, inclusion, and occupation. Honneth's work has highlighted that recognition in the first dimension of love is demonstrating emotional care. Downs & Bowers (2014) have identified this with supporting care staff, explaining that staff work at an emotional level as well as addressing physical care needs.

Houston (2015) acknowledged that social work theorists have written favourably about Honneth's work. For example, Jull (2009) identified with the notion of recognition as a counterbalance to forms of judgement that lead to labelling and stigma. Houston (2015) argued that it is important for vulnerable service users not to see broken images of themselves refracting shame and stigma. Such negative images are what Honneth (2005) called the "*abyss of failed sociality*" (p155), which attenuates the self and its creative capacity. It could be argued that this term resonates to some extent with Kitwood's (1997) "*malignant social psychology*" (p8). This was a term Kitwood used to describe a range of interactions with RCWs that could be detrimental to resident's wellbeing, whether this was intentional or not. Burton (2013) identified malignant social psychology (Kitwood, 1997) with the deeply rooted psychological and social systems of care homes, and argued that any workplace is a psychosocial system where powerful formal, informal, conscious, and unconscious forces interact. However, these forces are intensified and magnified within the life of a care home. Burton (2013) has compared the psychological and social dynamics of a care home to a large family. Residents live in communal intimacy and exposure, and the RCWs work in an emotionally demanding, intense and anxiety provoking, intimate proximity.

Kitwood (1997) identified that a person with dementia may experience disempowerment, invalidation, infantilisation and objectification if individuality and personhood were not maintained. This has relevance given that people with dementia have been described as the most stigmatized people in society (ADI 2013; Alzheimer's Society, 2013), and reflects the similarities between people with dementia and the care workforce. For example, Innes (2009) identified that people with dementia continue to be excluded from society and placed in residential care, and those who care for them are on the margins of society whose work is considered of low value.

The importance for RCWs from the first dimension of recognition theory, primary relations of love (Honneth (2005), lies in the fact that caring for people with dementia is an emotional role that provides for specific needs and emotions. According to Brooker (2016), RCWs need to demonstrate emotional care - "*It is not what is done, but how it is done*" (p89). Self-confidence is considered a 'practical relation to self' within recognition theory. However, literature has identified that RCWs do not feel

self-confident in their role (Stewart et al 2000), which can have an impact on their ability to care (Innes 2009). RCWs have also identified that they are on the receiving end of physical and verbal abuse. This in turn has been shown to have a negative impact on care. This is a 'form of disrespect' according to recognition theory - disrespect of both RCWs and people with dementia.

The second dimension of recognition theory is '*legal relations involving rights*'. Literature has identified that RCWs have expressed that they like to have a sense of '*doing a good job*'. This is linked with feelings of self-respect and self-worth (Dalley and Dennis 2001). However, the time that is needed with residents with dementia to form all-important relationships, to be able to understand the ways in which each person with dementia communicates, and to provide constant reassurance, is simply not available. This too has an impact on how care is delivered and reduces person-centred care to one that is task-oriented.

The third dimension of Honneth's work (2005), '*community relations that value strengths and build solidarity*', resonates with the findings from literature on the dementia care workforce (Section 2.2.1). The relevance for RCWs here is that they do not feel valued or recognised by the wider community. RCWs often feel devalued and disrespected, one example being that RCWs often say "*I'm just a care worker*" (Brooker 2016, p60).

Houston (2015) added to Honneth's work by creating a fourth dimension, that of a person's capacity to change. The author suggests that this recognizes the self as a work in progress rather than a static object. The importance of capacity to change for care worker training lies in, for example, the ability to absorb their training and apply it to their daily practice with the objective of improving care. What is known about the dementia care workforce from the literature is detailed in Section 1.3.1. This illustrates several areas (self-esteem, etc.) that would require changes to increase the effectiveness of training. Table 2.2 illustrates the original work of Honneth (2005) with the additional dimension from Houston (2015). The contents of this figure demonstrates the importance of recognition theory for both the RCW and the resident with dementia, both individually and as a lens to compare the two groups. Of specific

importance is the row labelled 'practical relation-to-self', as it illustrates areas that have already been highlighted for the dementia care workforce and for residents with dementia.

Table 2.2 A Fourth Dimension of Recognition: Facilitative Relations of Change (Houston 2015)

<i>Forms of recognition</i>	<i>Primary relations of love</i>	<i>Legal relations involving rights</i>	<i>Community relations that value strengths and build solidarity</i>	<i>Facilitative relations, encouraging personal change</i>
<i>Dimensions of personality</i>	Needs and emotions	Moral standing	Worth	Cognition and emotion
<i>Mode of recognition</i>	Demonstrating emotional care	Showing respect	Appreciating a person's strengths and contribution to a community	Instilling hope and belief in one's capacity to change oneself
<i>Developmental potential</i>	Security and resilience	Empowerment	Competence	Optimism and internal locus of control
<i>Practical relation-to-self</i>	Self-confidence	Self-respect	Self-esteem	Self-belief and self-efficacy
<i>Forms of disrespect</i>	Abuse	Denial of rights	Denigration and insult	Reinforcing learned helplessness
<i>Threatened component of self</i>	Physical and emotional integrity	Social Integrity	Dignity	Human agency

The value of recognition theory is that it parallels the experiences and feelings of both the RCW and the resident with dementia, and how this can impact on care. Recognition theory aids the identification of the need to address these experiences and feelings by supporting and recognizing the value of both groups. It supports the arguments concerning the learner characteristics as part of training transfer (covered in more detail later in this chapter) and reflects what literature has identified as potential insights towards a dementia care curriculum. The research itself supports recognition theory as it intends to gain the views of the RCWs themselves, recognizing their contribution to making improvements to care through training.

2.4 Training and the Dementia Care Workforce

Several themes have emerged when looking at training for RCWs: the lack of training specifically for dementia care, the variation in content and delivery of training, the quality of dementia care trainers, and changes in the culture of care in recent years. A key absence is the views of RCWs, which have rarely been considered. This section looks specifically at these topics in greater depth.

2.4.1 Evaluating Dementia Care Training

Dementia care training in care homes in the UK has been found to be unstructured, patchy, or non-existent. Downs and Bowers (2015) identified that dementia care training is minimal or none is given at all. Limited attention has been paid to the sustainability of education in care homes for people with dementia (Stolee et al 2009). Aylward et al (2003) noted that

“Because of the lack of follow-up evaluation, there is minimal evidence that knowledge gained from training programs is sustained in the long term.” (p259)

A more recent study confirmed that there is still limited evidence of regular and rigorous evaluation of the effectiveness of training programs (Beeber *et al.*, 2010). The Office for Public Management (OPM 2009) identified that the degree and quality of dementia training for care home staff has been found to vary, although minimum standards for care training, such as Manual Handling, First Aid, Fire Safety, and Food Hygiene (not dementia training) were a legal requirement as they were covered by the Health and Safety Executive (HSE). At the time of the report (OPM 2009), these subjects had to be completed by all RCWs on an annual basis, with records kept by the care homes and checked at each CSCI (Commission for Social Care Inspection, the forerunner of CQC) Inspection (APPG 2009). These subjects are still a requirement for RCWs and the training records are checked by CQC.

APPG (2009) expected that care staff would be encouraged to take dementia training in addition to mandatory training. The amount of time spent training would vary from a single session lasting one or two hours to day-long sessions completed over a period of months. Most interventions were based upon comparatively small amounts of training, amounting to the equivalent of one or two working days (Moriarty et al 2010).

The National Audit Office (NAO 2009) identified that training for dementia in the health and social care sector is not regarded as a priority, and that lack of funding means homes give the most basic dementia training, often by distance learning, which trainers have identified as inadequate to provide an appropriate level of care (NAO 2009). Smaller care home organisations may not have a dementia training budget at all.

The Office for Public Management (OPM 2009) carried out research in the NHS East of England region

“The research sought to gain an understanding of the current state of dementia training provision in the East of England, to conduct a skills gap analysis, and to inform the development of a strategic roadmap to address such gaps.” (OPM 2009, p1)

The research consisted of three stages;

- A mapping exercise that aimed to assess the current provision of dementia training and development in the East of England. Figure 2.3 details the organisations and sector involved in the mapping exercise;
- Stakeholder interviews with four groups of stakeholders: trainers and training providers, health/social care professionals, carers (formal and informal), and people with dementia. 57 qualitative interviews were completed;
- Consensus workshops with training providers, health/social care professionals, and senior stakeholders and commissioners.

The findings identified that there is a wide range of training programmes and delivery methods being used, which are mostly not accredited.

APPG (2009) suggested that the lack of agreed standards on levels of training or a nationally recognised dementia-specific qualification means that there is insufficient guidance on what might constitute a curriculum. Calls for the standardisation of dementia training have come from the Alzheimer’s Society (2011), who stated that dementia is a core part of the work of most healthcare professionals and, therefore, dementia training content must be standardised. The Royal College of Nursing (RCN 2012) has consistently stated that health care assistants across all care settings (RCW) must have a programme of standardised training. The National Audit Office (NAO, 2010) observed that most workers came into contact with people with dementia yet there was no required basic training covering dementia,

“Addressing this training gap will require concerted action over several years by a large number of training and education bodies, most of which are independent of the Department and the NHS.” (NAO 2010, p8)

Various approaches have been taken to gauge the effectiveness of training and learning outcomes delivered to direct RCWs. Hughes et al (2008) examined the factors that determine the level of knowledge and confidence of dementia care staff across 30 care homes. These included 16 residential care homes, 5 nursing homes, and 9 dual registered homes. From a total of 914 members of care staff across the 30 homes in the study, staff employed in residential homes accounted for 36% (n=329), dual registered homes, 40% (n=366), and nursing homes 24% (n=219). A total of 254 (28%) care staff completed a questionnaire (Hughes et al 2008). Most respondents (84%) were care nursing assistants and the remainder were senior care staff. According to Robson (2011) there is little agreement on what is considered a good response rate, but most would consider 60% as acceptable. It would seem, therefore, that the response to the questionnaire distributed by Hughes et al (2008) was low, being less than half that. The findings of the study, therefore, should be treated with caution. Within the study, confidence was measured by rating the RCWs' level of expressed competence in five hypothetical situations involving the care of people with dementia. RCWs were presented with questionnaires with four confidence level options for each situation ranging from 'very confident' to 'call for help'. However, confidence does not equal competence and the terms should not be used synonymously (Stewart et al., 2000). According to Stewart et al., competence represents what individuals know about their ability and is based on their previous experience of a task. Confidence is a judgement that influences whether an individual is willing to undertake an activity. Knowledge was measured by 12 questions as part of a questionnaire, and four case scenarios with multiple choice options (Hughes et al, 2008): seven items relating to recognition of symptoms of dementia and one item that related to the relationship between dementia and ageing.

Using questionnaires and hypothetical scenarios with RCWs may result in misinterpretation, as the Hughes et al (2008) study does not mention consideration of the literacy levels of the RCWs. It is possible that, given the educational and diverse

profile of RCWs, they may not have been able to read or understand the case scenarios or the options given. This may have impacted on the response findings. For example, in their findings for knowledge, between 10% and 28% were unsure of the correct response to five symptoms associated with dementia, with the authors identifying an error rate ranging from 16 - 33%. The reasons for this error rate are not specified.

The research by Hughes et al (2008) provides an insight into the potential 'added value' of training for RCWs and suggests that RCWs in residential care homes appear to have received very little training in dementia. This concurs with my own professional experience and serves to enhance the requirement for discovering the training needs for RCWs from the RCWs themselves.

2.4.2 The Training Agenda - the Contribution of RCWs

Finding evidence of RCWs being consulted about their training needs proved to be challenging. Menne et al (2007) is one of the few pieces of literature that attempted to examine the training needs of direct RCWs and their supervisors through consultation (n=644). The research, based in the United States, investigated the training and continuing education provided to direct RCWs or nursing assistants (RCWs), doing so across three different settings: nursing homes, home health agencies and assisted living facilities (residential care homes). The purpose was to

"...examine the training needs of RCWs and their supervisors in the three settings in order to provide information on how to improve training." (Menne et al 2007, p94)

The focus of the article was how initial training was followed up with continuing education and assessing how helpful this continuing education was. The article appeared to give insights into what format of continuing education RCWs would prefer (interactive learning, eLearning, etc.) and the subject areas covered. However, the instrument used to gather data on the adequacy of initial training, job orientation, mentorship and continuing learning is not focused enough to draw meaningful conclusions. The use of the three-point Likert scale seemed too broad to capture gradations in the usefulness of training. The same can be said for the presentation of the findings for continuing education coverage, which was limited to not

covered/covered/very helpful. This makes it difficult to judge how effective the training approaches were overall. However, the article did illustrate the importance of mentoring and continuing education after training, with nearly 90% of respondents (n=575) stating it was somewhat or very helpful.

A Canadian study by MacDonald et al (2004) addressed the learner's perspective about training needs for dementia. It also explored through learner perspectives a method of delivery, that of eLearning. Its purpose was to develop an eLearning programme to enable RCWs and nursing staff to acquire skills and knowledge to manage difficult behaviours associated with dementia, provide improved care to residents and a better service to residents' families. As didactic teaching methods used in long term care facilities have often been deemed ineffective (Coulson 1994), an eLearning programme, the authors argued, provided an alternative way of approaching care worker dementia training and learning. Their sample size was small, having nine participants. Focus groups were used to gather data. Their data analysis involved searching the interview transcripts for information that would aid in the design, development, and delivery of a dementia care programme. Five major themes were identified: time, technology, content, teamwork, and delivery. However, the study did not address how eLearning training was to be assessed. This meant there was no way to measure success of the programme objectives. Although MacDonald et al (2004) conclude by advocating the use of eLearning as a good tool for RCWs they also identified challenges in terms of its use, including lack of technology (PCs), suitable training environments, and time in which to complete a course of learning. There was a recognised spread of experience with the use of technology, some RCWs having very limited experience, and some not having a computer at home. The study recognised the need for an online facilitator who can help should the learner have difficulties with the training or the technology. Given the RCW profile, the facilitator may need to support an RCW in person, especially if using computers is a new skill. Therefore, an 'on site' facilitator as opposed to an 'online' facilitator, as used in Attack and Rankin (2002), may have proved more helpful. However, eLearning did provide the ability for an RCW to complete training, when facilities are available, at a time convenient to them.

2.4.3 Dementia Care Trainers

There have been concerns about the training of RCWs and the trainers themselves. An analysis of 300 inspection reports from the Care Quality Commission (Carter 2015) found that more than a quarter of homes rated 'inadequate' (125) and 'requires improvement' (125) had gaps in dementia training. Even specialist dementia care homes were failing to provide training on the condition to their staff. There were also concerns about the quality of dementia care from government regulators and the public, which highlighted the way older people in residential homes are cared for (APPG 2009). It would seem common sense to ask RCWs where they felt gaps in training were, and what training is needed to address these concerns. The OPM (2009) report highlighted that many dementia trainers remain unaccredited, and questions have been raised over their suitability to train. Overall, delivery and type of training is at the discretion of the care organisation, and therefore varies enormously. Downs and Bowers (2014) identified that there is no legal obligation to provide dementia-focused training. It is left for care homes to decide what training to offer RCWs. It is sometimes developed 'in house' and sometimes brought in from outside training agencies.

There appears to be very little consistency in what is being offered in different care home facilities. In addition, the trainers themselves may vary in experience and teaching ability. This is supported by CQC (2014); their report discovered that inspectors and providers indicated that the quality of training could be variable. In some cases, it was found that care home training did not always appear to be of a quality or format that had any significant impact on practice, staff knowledge or skills (CQC 2014). This seems contrary to the Skills for Care guidance that states

"...when workers are expected to perform any tasks that are not covered by the Common Induction Standards, appropriate training must be provided before the work is undertaken." (Skills for Care 2010a, p2)

2.5 Curricula for RCWs – A Review

In England, The National Dementia Strategy (Department of Health 2009), and the National Institute for Clinical Excellence (2006) identify that all care staff should receive access to specific dementia training. However, there are no guidelines suggesting which training programmes may be the most effective (Spector et al 2013). This section

addresses existing literature on curricula for RCWs and the methods of appraisal suggested.

2.5.1 Looking at Dementia Care Curricula

What does the literature suggest a dementia care curriculum for RCWs might look like? The Department of Health released a training guide for the dementia care workforce (Department of Health 2011b). This identified eight core principles and matched the guidance with suggested National Occupational Standards. It was envisaged that any organisation using these principles would

“Embed them in their culture, their agreements with partner agencies and their own policies and practices.” (p2)

Table 2.3 – Core Principles for Supporting People with Dementia (Skills for Care and Skills for Health, 2011)

Principle	Description
Principle 1	Know the early signs of dementia.
Principle 2	Early diagnosis of dementia helps people receive information, support and treatment at the earliest possible stage.
Principle 3	Communicate sensitively to support meaningful interaction.
Principle 4	Promote independence and encourage activity.
Principle 5	Recognise the signs of distress resulting from confusion and respond by diffusing a person’s anxiety and supporting their understanding of the events they experience.
Principle 6	Family members and other carers are valued, respected, and supported just like those they care for and are helped to gain access to dementia care advice.
Principle 7	Managers need to take responsibility to ensure members of their team are trained and well supported to meet the needs of people with dementia.
Principle 8	Work as part of a multi-agency team to support the person with dementia.

The Core Principles (Figure 2.4) could contribute to a conceptual framework for a Dementia Care curriculum, in terms of subject areas to be covered.

2.5.2 Do Curricula Exist?

During this research, the Alzheimer's Society was contacted via telephone to discover if a recognised dementia care curriculum existed. Their answer was that *"it sounds like a good idea."* A similar response came from CQC. The National Audit Office (NAO, 2009) identified that training for dementia is often not regarded as a priority, and that lack of funding means that homes give only the most basic dementia training. This recurring theme of cost restrictions has already been identified earlier. The training that is given has been identified as inadequate to provide an appropriate level of care, and smaller care home organisations may not have a dementia training budget at all. The review by Carter (2015) found that of the 250 homes rated as 'requires improvement' or 'inadequate',

"Almost half (49%) of the homes told to improve by the CQC were breaching regulations that require them to ensure a suitably trained and supported workforce." (Carter 2015)

The research process for the OPM (2009) identified that there is a wide range of training programmes and delivery methods being used that are mostly not accredited. The APPG (2009) suggested that the lack of agreed standards on levels of training or a nationally recognised dementia-specific qualification means that there is insufficient guidance on what might constitute a dementia care curriculum.

The Alzheimer's Society was contacted to ask about the research literature used to develop their courses. Their reply was that the training materials used are all based around a person-centred, strengths and feelings-based philosophy. The society ethos for dementia care training is strongly embedded in the principles of the work of Tom Kitwood in putting the person first, and Bere Miesen who founded The Alzheimer's Café concept⁴ (Alzheimer Café, 2014). The Alzheimer's Society has developed an

⁴ An Alzheimer Café is a type of post-diagnostic group intervention, held monthly, that provides education, information about dementing illnesses, as well as various types of support for people with dementia and their carers, and interested others. ACs take the form of 'a social gathering' in a café-like setting where people meet easily. ACs help support people with dementia and their family or friend carers to stay connected. AC's are organised and held by a steering committee who are knowledgeable about dementia, and organise the provision of the AC with local volunteers and caregiving professionals.

updated training programme for working with dementia. Its curriculum content is claimed to be ideal for induction, and contains the experience of people with dementia, communication, values and attitudes, teamwork, activities, personal care, maintaining and building relationships and understanding behaviour that challenges.

The work of Miesen (2010) has been used to guide the Alzheimer's Society course curriculum. The topics that Miesen (2010) suggested should go into a dementia curriculum are those of intimacy and sexuality, aggressive behaviour, power and powerlessness, truth and honesty, the paradox of normality, adoption and (counter) transfer. Miesen (2010) suggests that a dementia care curriculum would need to consider what RCWs need to know about:

1. The underlying causes of challenging behaviour;
2. What must be done to facilitate (emotional) processing of a situation when confronted with challenging behaviour;
3. What skills are needed to deal with challenging behaviour.

It has been suggested that RCWs need to recognise their own behaviour and to adapt it, and then adapt again with the progression of the disease (Miesen 2010). In a systematic review of qualitative studies about living well in care homes, Bradshaw et al (2012) suggested that the quality of life for the person with dementia is very much determined by the quality of the physical and emotional relationship between resident and their RCW. This could be viewed as a specific and necessary skill and one that contains an emotional element. When one considers this skill and the responsibility that comes with it, it could be argued that the dementia RCW has more of a professional task than is generally recognised within society.

American research by Fazio et al (1999) developed a training curriculum for activity-based Alzheimer's care. Activities help establish individuals' identities and reflect skills, interests, and beliefs; and, for many people, activity is synonymous with living (Fazio et al 1999). The foundation of the Fazio et al (1999) curriculum content is to emphasise that activities reflect the interests, strengths and needs of the individual and are part of daily life in the care home and are not always planned or timetabled. Everyday interaction can be an activity, for example, tidying or setting the table. Research

suggests that activity-based care has many positive outcomes for individuals with dementia. For example, Zimmerman et al (2005), and Brooker et al (2007) have identified that activities can provide enriching opportunities and increase well-being.

Fazio et al (1999) produced curriculum content from the views of a wide range of different professionals, agencies, and RCWs involved with dementia care. For example, authors of dementia care literature and the National Board of Directors of the Alzheimer's Association had input into the curriculum. The curriculum bears some resemblance to Teri et al (2005) and Peterson et al (2002), in that it was the development of techniques that incorporate the individual strengths, needs, interests, and abilities of 'care receivers' and 'care givers'. It is noteworthy that Fazio et al (1999) identified the importance of the individual person with dementia and the individuality of RCWs, themes that have been identified previously when discussing person-centred care and student-centred learning.

That RCWs are required to recognise their own behaviour is supported by Teri et al (2005) and Kitwood (1997). Teri et al (2005) organised a curriculum to teach care staff to identify factors within the environment and within their own interactions with residents that can be altered to improve the care of residents and reduce resident distress. They included the activators, behaviours, and consequences of behavioural distress as part of their course content, as this was a behaviour-based approach that addresses behaviour change interventions. Teri et al (2005) found that staff receiving the training were successful in reducing the level of resident affective and behavioural distress but did sound a note of caution due to the small size (n=25) of the study. Teri et al (2005) also noted that the facilities involved were eager to participate.

The influence of these factors within the built and social environments reflect Kitwood's view that dementia can be understood as a socially embedded experience, the result of a set of interactions between neurological impairment, health, life history, their social environment and malignant social psychology (Allan and Killick 2009).

The 2000 Care Standards Act sprang from recognition that although a well-trained workforce is central to the delivery of high-quality care, the existing workforce was undertrained. It introduced regulations that stipulated that each home owner had to

ensure that both the number of staff employed, and their skills, should be appropriate for the needs of the service users, and that all employees were receiving appropriate training and development (Gospel and Lewis 2011). The requirements in the Care Act (2000) led to the creation of the Common Induction Standards (CIS) (SCIE 2012) and the National Minimum Training Standards (NMTS) (Skills for Care and Skills for Health (2013)).

The Care Act (2014) updated the original regulatory framework defined in the 2000 Care Act, because of recommendations from the Cavendish Review (Cavendish 2013). This resulted in the introduction of the Care Certificate in 2015. The Care Certificate (CC) built on the Common Induction Standards (CIS) (SCIE 2012) and the National Minimum Training Standards (NMTS) (Skills for Care and Skills for Health (2013)). It was introduced in April 2015 and developed jointly by Skills for Care, Health Education England, and Skills for Health (HEE 2015).

“The introduction of the Care Certificate will provide clear evidence to employers, patients and people who receive care and support that the health or social care worker in front of them has been trained and developed to a specific set of standards and has been assessed for the skills, knowledge and behaviours to ensure that they provide compassionate and high-quality care and support.” (HEE 2015, p2)

The Care Certificate is the minimum training supervision and assessment for staff new to social care and is considered part of induction and contains 15 standards (HEE 2015). Standard 9 is an awareness of mental health, dementia, and learning disability. Within the Care Certificate, Level 2 and 3 qualifications are those designed to demonstrate occupational competence and include an option to take a generic, dementia or learning disabilities pathway (Skills for Care 2016). The mandatory units at level 2/3 are closely aligned to the Common Induction Standards.

The Dementia Core Skills Training and Education Framework (DCSTEF) (Skills for Health 2015) was commissioned and funded by the Department of Health and developed in collaboration by Skills for Health and Health Education England (HEE) in partnership with Skills for Care specifically for health and RCWs working with people with dementia.

“In particular, the aim is to support the development and delivery of appropriate and consistent dementia education and training for the health and care workforce.” (Skills for Health 2015, p6)

Tier 2 of the DCSTEF was designed explicitly as a guide for those caring for people with dementia (Table 2.4). However, subjects are not mandatory, and it is not clear if RCWs were consulted as part of the creation process.

Table 2.4 Dementia Core Skills Training and Education Framework (2015, p7)

HEE (Health Education England) Tier	Matched social care workforce group
Tier 1: dementia awareness raising, in terms of knowledge, skills and attitudes for all those working in health and care settings	Group 1: all of the social care workforce – dementia awareness
Tier 2: knowledge, skills and attitudes for roles that have regular contact with people living with dementia	Group 2: people working in social care who are providing personalised direct care and support to people with dementia
Tier 3: enhancing the knowledge, skills and attitudes for key staff (experts) working with people living with dementia designed to support them to play leadership roles	<p>Group 3: registered managers and other social care leaders who are managing care and support services for people with dementia</p> <p>Group 4: social care practice leaders and managers who are managing care and support services and interventions with people with dementia which includes social workers, and occupational therapists working in social care</p>

The Care Certificate and the DCSTEF provide what is seemingly a step-change in training for care workers and specifically for RCWs. If this training was compulsory, such a change could be expected. However,

“...it is up to the employer to decide whether the Care Certificate is appropriate.” (HEE 2015, p2)

and

“The employer is responsible for assuring the quality of the teaching and assessment of the Care Certificate.” (HEE 2015, p9)

CQC has an 'expectation' that employers induct, support, and train their staff appropriately and that they

"...should be able to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction". (CQC 2015a)

If employers are not working towards the Care Certificate, then CQC 'expect' that employers' own training is robust and comprehensive. This means employers may look to using outside providers.

The curriculum content identified in dementia care training varies depending on the training provider, although some areas overlap. As an illustration, Appendix 1 summarizes many training vendors, the courses on offer and the curriculum content for each course.

2.5.3 Measuring Learning Outcomes

What does the literature tell us about learning outcomes and how they can be measured reliably? Visser et al (2008) investigated the impact of RCW education on the behaviour and quality of life of residents with dementia and looked at RCW attitudes about working with dementia. RCWs (n=52) completed pre-and post-intervention measures and were split into three groups; education-only group (n=10), education and peer support (n=17), and the control group (n=25). There was a very high attrition rate amongst the education-only group (many RCWs resigned). Therefore, this group's sample size at follow-up was very small (n=6) and it was excluded from follow-up analyses. The attrition rate was low in the education and peer support and control groups (15 and 14% respectively). However, the attrition rate in the education-only group was much higher at 50%. Their findings revealed that RCW members that received education and peer support perceived an increase in their skill and knowledge, suggesting that organizational factors are critically important to staff education for both RCWs and residents with dementia. Spector et al (2016) identified the importance of organisational factors and argued that there needs to be further research into the factors that may facilitate transfer of learning.

In a review of effectiveness of dementia training, Spector et al (2016)) identified the poor quality of available evidence, making it difficult to draw firm conclusions. The authors highlighted that as a result, there are no guidelines that suggest which training programmes maybe the most effective. Spector et al (2016) identified methodological weaknesses that made it difficult to evaluate effectiveness.

Social work researchers have identified levels of learning outcomes. These are general learning outcomes rather than directly for dementia. Carpenter (2011) carried out a review of outcomes and measures for social work training, stating that the most widely used classification for learning outcomes was devised by Kirkpatrick (1967) and used four levels of outcomes for educational programs: learners' reactions to learning; acquisition of learning and skills; behaviour change; and results in terms of outcomes for users.

Carpenter (2005) proposed an adaptation of Kirkpatrick's (1967) model to contain:

- A modification in attitudes and perceptions towards service users, their problems, needs, circumstances and care.
- Changes in organisational practice where this may change the delivery of care attributable to an educational programme.

These outcomes could provide the foundation for RCW training assessment. Carpenter (2005, 2011) also suggests research designs for assessing outcomes – pre-test and post-test being one of the basic ways of assessing training outcomes. However, it would not test whether that training has transferred into practice. This would seem to suggest that a further assessment would be required within a reasonable timeframe after the training had been completed to ensure that the RCW's training had been transferred to practice. To identify how successful training had been transferred into everyday practice, there would need to be evidence from the RCWs themselves about post-training change in addition to that of a mentor or assessor.

Elliott et al (2012) completed a systematic literature review of intervention studies that were aimed at enhancing dementia care or workforce capacity. Only six out of seventy-four intervention studies met the criteria that focused on care worker and organisational outcomes in dementia care, and only one published review of dementia

interventions was dementia specific. However, all studies addressed qualified residential care nurses and not the unqualified RCWs. The review found that all had methodological concerns (such as not stating specific hypotheses, insufficient information on training intervention, no baseline, no acknowledgement of limitations). This reflected the concerns specified by Beeber et al (2010), and subsequently by Spector et al (2016), although each used a different method to measure the quality of the studies. Although the literature had identified how the quality of relationships and meeting emotional needs work towards the well-being of both RCWs and residents with dementia, these aspects seemed to be ignored in training modules of rigorously tested interventions (Elliott et al 2012; Spector et al 2016).

In a separate systematic literature review exploring the impact of RCW training on outcomes in dementia care, Spector et al (2016) found that three studies identified that improving staff knowledge had a small but significant increase in stress following training. This highlighted the importance of wider organisational issues, and the need for supporting care worker training in the classroom and in the work environment. However, Zimmerman et al (2005) noted that the increase in stress after training was more relevant to the work environment (i.e. working with residents with dementia) than the training per se.

Schepers et al (2012) proposed a measurement of competence using the 'Sense of Competence in Dementia Care Staff' (SCIDS) measure. This was a Likert Scale based instrument created to be user friendly for RCWs, consisting of 17 statements describing various competencies associated with care for residents with dementia. It was proposed that SCIDS could be used to assess the impact of training or to assess the perceived abilities and skills required to carry out dementia care. The researchers identified that a strength of the SCIDS as a tool is its flexibility across various settings, including residential care and hospitals. SCIDS items are specific to certain roles and responsibilities rather than situation specific. A limitation of the SCIDS is that participants did not use the full item scales of the SCIDS, but predominantly used the two top answer options, indicating a ceiling effect for the tool and its subscales and limiting variance within the data. The SCIDS measure has been used subsequently by

other authors to measure perceived RCW abilities and skills and the impact of training (Mullan and Sullivan, 2016; Pleasant et al, 2017; Streater et al, 2017).

Surr et al (2017) completed a literature review that focused on the identification of the factors associated with effective dementia education and training for health and social care staff. Most articles identified were from the United States (38%) and the United Kingdom (20%) and described training programs predominately delivered to staff working in care homes (49%) and aimed at nurses (34%) and RCWs (37%). The review found that fifty of the studies reported on the impact of education and training on outcomes, split between people with dementia, staff, and family members. However, details of how long after the intervention such impact was assessed were not included. Surr et al (2017) argued that despite the body of educational theory and research on workplace education, understanding of what constitutes effective education and training for the dementia care workforce is poorly understood and seldom considered when developing programs. Learning-related outcomes were reported in nearly two thirds of the studies (n=109), with the outcomes categorised as knowledge, attitudes, confidence, perceived confidence, and self-efficacy, with a number (n=37) reporting on the impact of training on staff confidence, competence, and self-efficacy in delivering dementia care training. There remains limited available evidence of education and training efficacy (Surr 2017).

2.5.4 Summary

The Alzheimer's Society reported that training should focus on a person-centred, and feelings based philosophy, and their training is built around the work of Kitwood (1997) and Miesen (2010). Both identify that excellence in dementia care was underpinned by the knowledge and the emotional relationship with the RCWs supporting them, and their ability to adapt to a resident's changing needs.

A wide range of training programmes exist but remain mostly unaccredited, with a lack of agreed standards on what training should contain and are not mandatory. Even the latest dementia training curricula to date, The Dementia Core Skills Training and Education Framework (Skills for Health 2015) is aspirational - private residential care organisations are under no obligation to fulfil these training suggestions. The

Framework (Skills for Health 2015) provides objectives for each of the training modules but leaves the assessment of outcomes to training providers.

In terms of measuring learning outcomes, Spector et al (2016) identified that a wide variety of unstandardized outcome measures were used and, as a result, it

“...may also have increased bias, making it difficult to draw reliable conclusions about effectiveness.” (p15)

Methodological weaknesses within the studies under review made it difficult to evaluate effectiveness of training (Kuske et al 2007; Elliot et al 2012; Spector et al 2016). These authors identified how building relationships and emotional needs had links to the well-being of both RCWs and residents with dementia, but that these aspects were ignored in training modules of rigorously tested interventions (Ellen et al 2012; Spector et al 2016). Kuske et al (2007) identified that the important factor was whether training could be transferred into practice and sustained over a period of time. The theory of training transfer, the emotional aspects of the RCW role and its influence in care worker learning are addressed next.

2.6 Theoretical perspectives and RCWs' training needs.

Beer et al (2012) have stated that no single, comprehensive educational model has been adopted for teaching RCWs how to interact with people with dementia. It is therefore necessary to look at adult learning theory in a wider context to inform discussion of how the specific training needs of RCWs can most appropriately be met. The focus is on the use of student-centred learning, as RCWs are adults whose learning is completed for application to a specific role (Beer et al 2012). Emotion is examined, given the effect of the emotional nature of their caring role on the student's ability to learn (Beer et al 2012). This section also considers the use of training transfer theory, as the learning process should extend into use in everyday working practice.

2.6.1 Student-Centred Learning

Carl Rogers, the father of client centred counselling, is associated with extending the student-centred learning approach into a general theory of education (Burnard 1999). According to Hannafin et al (1997), it was constructivist learning theory that acted as

a source for the development of student-centred approaches. Constructivist learning theory defined learning as

“...an active process in which learners are active sense makers who seek to build coherent and organised knowledge.” (Mayer 2004, p14)

The literature appears to present different ideas about the student-centred model of learning, and there is some confusion about what student-centred learning is (Beaten 2010). For example, Lee et al (2003) proposed that student-centred learning is focused on the student ‘doing’, so that the learning is active, with an emphasis on deep learning and understanding, and on mutual respect between the learner and facilitator. According to Innes (2010), student-centred learning means that the training should enable participants to draw upon their experiences, reflect and then work through exercises of a problem-solving nature.

2.6.2 Student-Centred Learning and RCWs

Innes (2010) argued that if we are hoping to achieve care practice in person-centred care, then it is not only logical but also imperative that staff be treated in a person-centred way. Just as person-centred care attempts to put the person at the very heart of their care, student-centred learning attempts to place the experiences of the learner at the centre of their dementia care training (Innes 2010). Kitwood (1998) seemed to go further, suggesting that training for dementia care should involve RCWs reflecting on their practice and lowering defensive barriers. It is thought that this will enable RCWs to give more of themselves and be able to deliver person-centred care (Innes 2010). Beer et al (2012) concurred with the student-centred learning philosophy and stated that there is a need for a comprehensive educational model that teaches RCWs how to provide meaningful interactions with residents with dementia.

A study by Beer et al (2012) tested a module’s effect on RCWs’ (nursing assistants) perceptions of dementia and their ability to care for people with advanced dementia. The study used a post-test only randomized control group design selected for its ability to measure differences in perception and attitudes. The independent variable in this study was the targeted training, which comprised two levels: those who did versus those who did not receive the training. 47 participants were randomly assigned to two

separate groups. One group was given targeted training on advanced dementia. The other group received training without dementia input. Both groups then took the post-test survey.

The training module relied upon a learner-centred philosophy. Beer et al (2012) found that there are benefits for both residents with dementia and RCWs, as the link between student-centred training and delivering person-centred care increases job satisfaction, retention, and a perception of competence. Winzelberg et al (2005) also found that student-centred training had a positive effect on person-centred care

“Education in person-centred care helps positively change care worker perceptions so they are able to view those with dementia as having the capacity to engage in relationships.” (p112)

Student-centred learning, as an approach for dementia care training, has a great deal to offer. However, as Beer et al (2012) found, it does not provide the complete answer. Beer et al (2012) found that training was effective in improving RCWs’ understanding of the need for meaningful contact with residents with dementia. However, it was not successful in improving care worker comfort level or perceived skills in working with dementia. Within this study, RCW comfort was a component in the test about attitudes and responses to working with dementia, and how training could reshape attitudes and responses for the benefit of both RCW and the resident.

In terms of adult learning theory, it might therefore be useful here to consider more than student-centred learning. Given that RCW comfort is thought to be beneficial in working with advanced dementia and for the wellbeing of both resident and RCW, and that quality of care for the resident centres around their relationship, it is necessary to consider the emotional aspect of teaching and learning with RCWs.

2.6.3 Emotion and Adult Learning

Merriam (2008) pointed out that throughout a large part of the 20th century adult learning was understood as a cognitive process, one in which the mind took in facts and information, converting it all to knowledge, which then could be observed as subsequent behaviour change. It is now seen as a multifaceted activity to include a much broader activity involving the environment, the body, the emotions, and the

spirit as well as the mind. Dirks (2008) acknowledged that within the last twenty years, the emotional aspects of teaching and learning in adults have become a major theme in scholarly literature and professional development programmes. Jarvis (2006) and Merriam et al (2007) proposed that there is a central and holistic role of emotion in reason, rationality, learning and making meaning. As Jarvis (2006) summarized

“Emotions can have a considerable effect on the way we think, on motivation and beliefs, attitudes and values.” (p 102)

What might the emotional aspects of adult learning theory have to offer in supporting RCWs in their learning? King (2012) argued that care work – which they define broadly to include occupations such as nursing or child care – is unique in the extent to which workers in caring occupations are centrally concerned as a core part of their role in the welfare of their clients, and often feel some affection toward the people they care for. In this respect, care work is unlike that of manufacturing physical products like that on an assembly line (England and Folbre 1999).

The dementia care role involves a great deal of emotional work or emotional labour (Mann & Cowburn 2005). Emotional labour was first defined by Hochschild (1983), and has been described as the effort involved when employees regulate their emotional display to meet expectations specific to their job role (Brotheridge & Lee 2003). According to Phillips (1996), emotional labour in health care has considerable significance for a resident who often experiences pain, anxiety, or panic. This would seem to indicate that emotional labour can have an emotional impact on both care worker and resident. Emotional labour (Hochschild 1983), one component of care work, helped to establish its uniqueness. King (2007) acknowledged that work-related emotions are more than just emotional labour, and referred to the work of James (1992), who identified that other component parts for care work as organisation, and physical labour. King (2007) emphasised the importance of relational care in emotional labour, which he saw as

“...constructing a connection between care provider and care recipient that is respectful and reciprocal” (p202)

and requiring

“...particular skills and knowledge if care is to be appropriately provided and mutually satisfying.” (p203)

King (2012) argued that

“Care work needs to be conceptualised in a way that recognises the importance of the relational ties which are inherent in the work and which inform much of care workers’ orientation to care work and their satisfaction with it” (p52)

One cannot help but notice that there are parallels between emotional learning theory and many of the specific challenges and particulars of the RCWs’ dementia care role and the environment in which it takes place. Dementia care, by its very nature, is a highly emotive topic (Dirkx 2008). From professional experience in training within a dementia care environment, curriculum content can be, and often is, emotional for all. This is supported by Dirkx (2008), who acknowledged that curricular content stimulates powerful emotions among adult learners. Within dementia training, RCWs relate highly emotional experiences in daily practice - what happened and how this has made them feel.

In a discussion piece, Bierema (2008) reviewed learning and emotion at work and how this may impact on well-being, identity development, and power relations. Emotional labour requires workers to emote states that may be inconsistent with their authentic feelings. This discrepancy between felt and displayed emotion is known as emotional dissonance (Bierema 2008). Emotional dissonance is a key factor in contributing to job exhaustion and job satisfaction (Lewig & Dollard 2003), and hiding negative emotions has been linked with burnout (Brotheridge & Grandey 2002, Mutkins et al 2011). Imbalance between dissonance and rewards (esteem, money, security) has been found to create even more emotional exhaustion (Lewig & Dollard 2003). These findings concur with those identified in Section 2.2.1, where I discussed the characteristics of RCWs.

King (2012) found that one of the most common emotions described by RCWs in care work with older people is frustration. This finding was established by drawing from a broader investigation of work/life intersections in caring for older people. Surveys were used that reported on the characteristics and experiences of RCWs, and were supplemented with semi structured interviews that captured workers’ experience of

performing care work in their own words. Of the 100 interviews taken from the survey participants, 50 were RCWs and 50 worked in homes of older people in the community (King 2012). Frustration was identified with lack of resources, with connections to residents, lack of time, unrealistic demands of work and ultimately, with their capacity to provide the type of care they feel they ought to deliver. Talbot and Brewer (2015) argued that this complex nature of care provision contributed to a sense of powerlessness, in that whilst person centred care strategies were being implemented, task orientated care remained dominant. Frustration is not a benign emotion, and can be viewed as a form of emotional dissonance stemming from the need to engage in emotion management with both RCWs and residents (King 2012).

When considering learners' emotions, Opengart (2005) acknowledged that emotional work frames emotional learning in the workplace. For the learner, Short and Yorks (2002), in a summary of literature investigating the role emotions play in learning, recognised how emotions can inhibit learning for participants, as lack of confidence, fear of failure and previous negative experiences dictate the learner's emotional state. This is confirmed by the social constructivist view of emotion, which proposes that a past unpleasant experience is a learned, constructed process (Dirkx 2008). This perspective for dementia training holds interest for the implications that emotional experiences have for the RCW's sense of self and their relationships with others, meaning residents with dementia and other staff (Dirkx 2008). Bierema (2008) finds that workplace educators can play a significant role in emotion learning, and training may be provided to teach appropriate emotional responses.

If an RCW had poor learning experiences in school, then facing a new educational experience can trigger painful memories (Harmer 2001). Many RCWs have had poor or limited education and low expectations of personal achievement. An illustration of this from my own professional experience occurred when one care manager who started as a care worker, explained that she had been told by her parents that she was stupid and would end up working in the '*knicker factory*' all her life. Some care managers have admitted that past experiences of learning were such that until they got to know me, they wouldn't sleep for days before my training sessions. These incidents illustrate how

daunting the prospect of training can be and emphasises the need to acknowledge this reality.

2.6.4 Training Transfer Theory

Although adult learning theory investigates the way that adults and by extension RCWs learn, any consideration of dementia care training needs to go beyond curriculum and investigate how and whether the learning is put into everyday practice.

The goal of training is positive transfer to the workplace (Berry and Morris 2005). Training transfer can therefore be used as an extension of adult learning theory to investigate the extent to which RCWs learn and are able to transfer that learning into everyday practice and was a key focus for this research. Clarke (2013), in a systematic review of literature concerning in-service training, argued that learner characteristics, training design and delivery, and the workplace environment influence whether training transfers to the job. The author states that

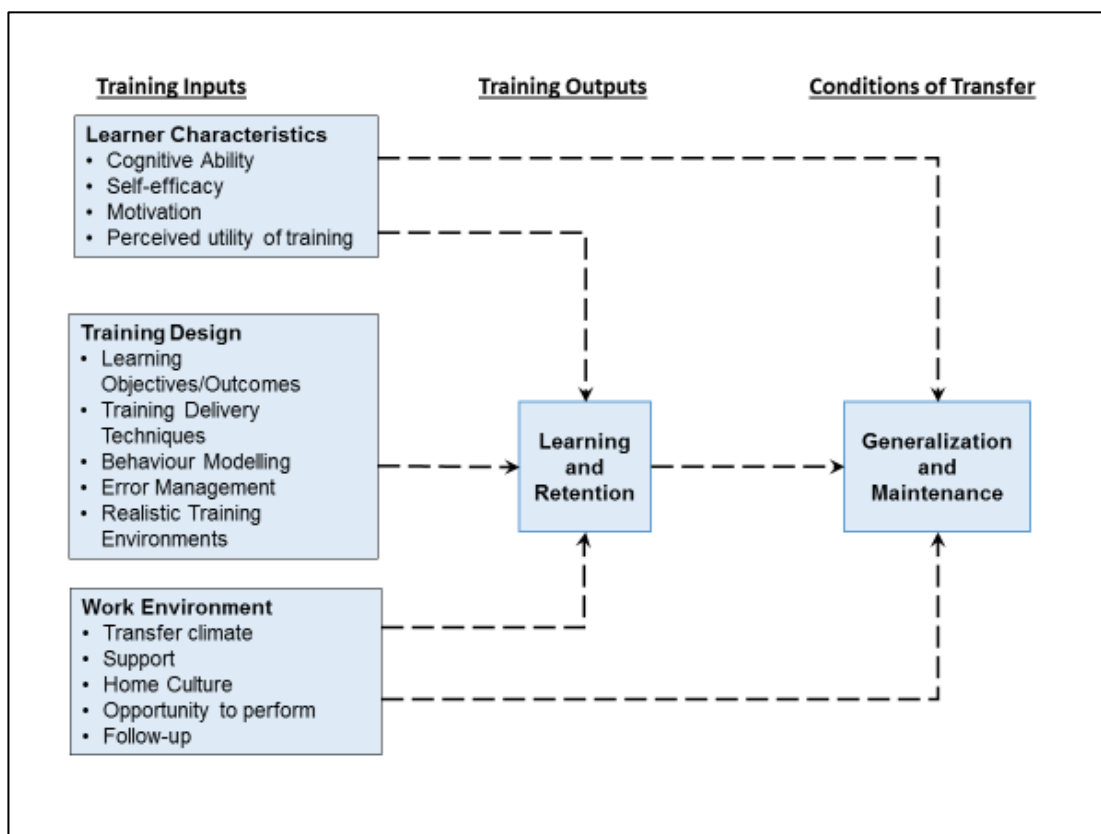
“Without a focus on the transfer of training the contribution of training to the quality of care will remain illusory.” (p15)

Positive transfer of training is defined as the degree to which learners effectively apply the knowledge, skills, and attitudes gained in a training context to the job (Newstrom 1986). For transfer to have occurred, learned behaviour must be generalised to the job context and maintained over time on the job (Broad & Newstrom 1992). How might this be achieved given what we know about the nature and characteristics of the dementia care workforce and the nature of their challenges?

Baldwin & Ford's (1988) seminal transfer model was defined as the ability to apply skills from the learning environment to the job. Baldwin & Ford (1988) stated that three training inputs were required for learning transfer to the workplace: trainee characteristics, training design and the training environment, including a supportive work environment. Grossman & Salas (2011) adapted the model of Baldwin & Ford (1988) through a review that identified those factors that showed the most consistent relationships with training transfer via a review of training transfer literature (see Figure 2.3).

This provides an overarching view of training transfer, but the original label of ‘trainee characteristics’ seems inappropriate as most RCWs are not trainees. For this research (to maintain continuity), Grossman & Salas (2011) Trainee Characteristics has been relabelled Learner Characteristics.

Figure 2.3 The Training Transfer Model (adapted from Grossman & Salas, 2011)



The three Training Inputs from Figure 2.3 are discussed in more detail below under separate headings.

Learner Characteristics

Burke and Hutchins’ (2007) extensive review of 170 articles of training transfer revealed learner characteristics that seemed pertinent to the dementia care workforce, particularly those of cognitive ability, self-efficacy and motivation. To what extent might these characteristics help the understanding of the training of RCWs? Each will be considered in turn.

Cognitive ability is thought to be a strong predictor of transfer outcomes. It has been identified as mental ability (Burke and Hutchins 2007). Grossman and Salas (2011)

classified cognitive ability with aptitude assessments. Given what has been identified about the dementia care workforce (Section 2.2.1), the use of aptitude tests for RCWs would seem inappropriate and time-consuming prior to any training. For this research, it is the ability to learn and to transfer that learning to the workplace that is important. Therefore, recognising the cognitive ability of care workers is fundamental in producing the appropriate training materials, the delivery and use of teaching methods and measuring learning outcomes.

Self-efficacy is how a learner makes judgement about their ability to perform a given task.

“Self-efficacy refers to an individual’s belief in their ability to accomplish specific goals. In any given situation, these beliefs affect the choices people make, the actions they pursue, how much effort they will expend, how perseverant and resilient they will be in the face of obstacles, and how much stress and anxiety they will experience.” (Mackenzie & Peragine 2003, p291)

According to Schepers et al (2012), a sense of competence in dementia care is a belief in one’s capacity to care for people with dementia across a range of dementia-specific roles and responsibilities. Mullan and Sullivan (2016) have found that implementing person-centred dementia care is positively associated with care staff sense of competence. Self-efficacy in dementia care is associated with lower levels of staff burnout (Duffy et al 2009). It would seem then that self-efficacy is important in dementia care training.

Motivation to learn is reported as having a substantial impact on training effectiveness (Grossman & Salas 2011). Knowles (1980) specified many assumptions of adult learning theory, namely that:

- Adults need to know why they need to learn something before doing so,
- They are motivated to learn something if they perceive the need and,
- The most potent motivators for learning are internal pressures such as a desire for increased job satisfaction, self-esteem etc.

Training motivation refers to the intensity and persistence of effort that trainees apply in learning activities, before, during and after training (Tannenbaum and Yuki 1992). Motivation for RCWs to attend training is a key problem identified in the research. Edwards et al (2003) point out that rostering of staff to attend training can be

particularly challenging in long-term care where most staff work part-time and there is more motivation to undertake the tasks they are employed to complete rather than training, which they may see as an impediment to completion of their work. Edwards et al (2003) discovered that even with strategies and incentives to maximise attendance, staff attendance at training sessions was disappointingly low, despite efforts made to accommodate the learners. Discussions with staff were held about location and day for the training. This resulted in the same session being offered twice in the same week to accommodate shift working and to maximise the ability of staff to attend. The low attendance illustrates the importance of staff motivation prior to course attendance.

Facteau et al (1995) studied the extent to which attitudes and beliefs about training influence pre-training motivation and the survey participants' perceptions of the extent to which they can transfer their training back to their job. The study considered a 967-person sample and indicated that pre-training motivation has an important influence on how much trainees learn. Although their study was not directly related to RCWs, it is pertinent to consider with what is already known about care staff and training: namely, that motivation for training is limited because most RCWs lack confidence due to their own perceived lack of ability and have had previous poor learning experiences. According to Facteau et al (1995), for transfer to occur, trainees must believe that they are capable of learning, that their effort to learn will change their performance, and that a change in their performance will lead to valid outcomes.

Perceived utility of training concerns the value associated with the training by the potential participants. This links back to the previous paragraph where learners must believe that the learning will have a positive outcome. Perceived utility does go further than motivation in that learners assess how the training matches what they do within their role, so the necessity and utility of the training must be communicated to RCWs (Grossman & Salas 2011).

Training Design and Delivery

For successful design and delivery of training transfer, it seems that clear objectives and outcomes are required from the outset. Kontoghiorghes (2001) found that

learners are more likely to transfer when they have a clear understanding of what knowledge and behaviours are required for training. This is supported by Burke and Hutchins (2007), who identified that clear learning objectives or goals for learners are needed to maximise transfer to the workplace. This has been found to enable learners to perform to a required criterion, and to regulate learners' behaviour by directing attention, energy, motivation and persistence over time to develop strategies for goal attainment. It therefore seems practical to add Learning Objectives/Outcomes as a component within Training design.

Training Delivery Techniques concern the different training designs that can be used to transfer the learning to the RCW. Clarke (2013) points out that to date there has been little research investigating the effectiveness of social care training under different design configurations. Although Clarke's (2013) study was not directly related to specific dementia care, the analysis of training transfer concerns social care staff from various social care settings, including residential care. The author explains that an analysis of training delivery techniques referred to in several training evaluation studies finds the consistent use of experiential and behaviour modelling methods. For example, Wright & Frazer (1987) incorporated a mix of lecture, video, discussion, case studies and role play exercises. Although not identified by Clarke (2013), it is noteworthy that the Wright & Frazer study involved mini-workshops devoted to specific techniques devised to help workers generalise their learning by providing examples tailored directly to their residents' needs. All levels of the organisation in which the training took place were involved in the planning and delivery of training.

The need to use different learning modelling methods to maximise training transfer has also been proposed by Lindsey et al (1987). They proposed that for training to transfer to the workplace, learners gained knowledge about a skill, observed a skill, practiced a skill, then received feedback on their performance. Taking a slightly different approach, Ford & Weissbein (1997) used the learning principle of 'identical elements'. Using case studies proved to be a helpful learning tool as they provide a way to use practice scenarios that reflect the real work environment (Ford & Weissbein 1997). This is supported by Bates (2003), who has drawn upon 'identical elements', in that training goals and materials should be closely relevant to the transfer task.

Some authors (Bates 2003, Ford & Weissbein 1997, Lindsey et al 1987, Wright & Frazer 1987, Clarke 2013) did not refer to a student-centred approach to learning. In contrast, a study by Thulsius et al (2002) with the objective of producing guidelines for end of life care, found traditional lectures were insufficient. Learner-centred approaches were introduced and focussed on small group work, lectures, seminars, and discussion. It acknowledges the advantages of accessing care worker views on making improvements to daily practice.

It is worth noting that Clarke's (2013) review of in-service training in adult social care did discover that providing positive reinforcement of skills through a series of experiences sequentially leading to more difficult interactions, combined with classroom-based rehearsal of the skills being taught, are all necessary for training transfer. The themes emerging from all the authors identified (Clark 2013, Wright & Frazer 1987, Lindsey et al 1987, Ford & Weissbein 1997, Bates 2003, Thulsius et al, 2002) is that all advocate a mix of teaching/learning strategies that link closely with practice, and that repetition is the pre-eminent technique to maximise training transfer.

Behaviour Modelling provides the learner with the chance to witness and repeat targeted skills and behaviours, thus providing the repetitive element discussed in the previous paragraph. Using Bandura's (1977) social learning theory, the purpose is to provide behaviours to be learned, models that illustrate the appropriate use of the behaviours, chances to practice the learned skills and provision of feedback. Grossman & Salas (2011) noted that

"Of the array of learning strategies to choose from when designing training programs, research suggests that behaviour modelling is of particular importance for the transfer of training." (p111)

The Error Management component in Training Design by Grossman & Salas (2011) was considered relevant as

"Error management promotes the transfer of training by allowing trainees to anticipate potential issues, providing them with knowledge of how to handle such problems, and highlighting the negative outcomes that can occur if training is not transferred." (Grossman and Salas 2011, p107)

However, error management needs to provide a Realistic Training Environment. This is an important component of training transfer. Grossman & Salas (2011) stated that the completion of training and practice in an environment that is like the work environment increases the prospect of training transfer taking place. However, for RCWs, it seems more important for the training environment to be 'safe' so that any errors during training do not have any effect on residents with dementia. This links with the idea of behaviour modelling

The Work Environment

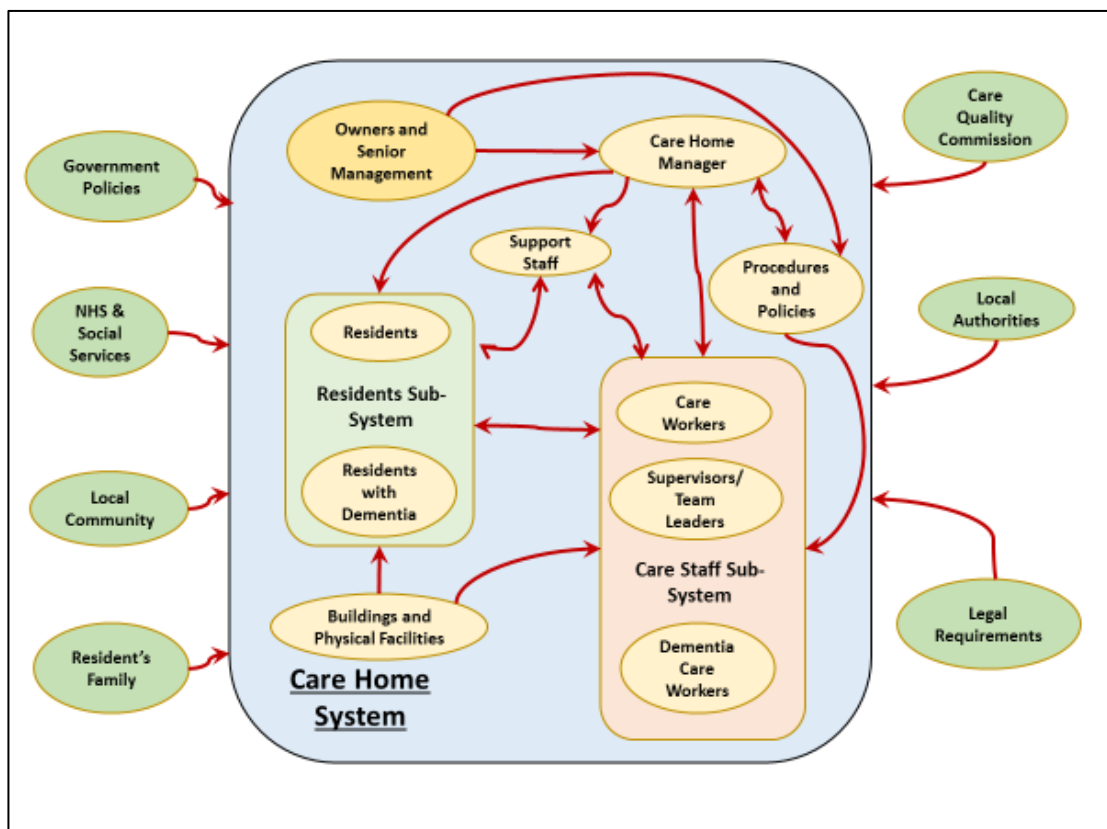
The importance of the setting in which staff receive training to enhance their understanding of dementia should not be underestimated (Hughes et al 2008). If the Transfer Climate is perceived as positive, learners tend to apply learning more readily in their day-to-day activities (Grossman & Salas (2011) According to Noe (1986), organisational support is needed for learning and training transfer to take place. Noe (1986) proposed that maximum behaviour change is likely to result when learners have mastered the course content and are motivated to use their new skills on the job. Learners will be motivated to use these new skills in daily practice when their supervisors and peers support behaviour change with reinforcement and feedback (Noe 1986). Scott-Cawiezell et al (2005) argued that a home culture that supports working relationships based on trust and respect can provide staff with an environment and the necessary resources to create and sustain improvements in standards of care. For example, RCWs may not demonstrate learned skills if they perceive that the necessary organisational support or resources are not available. This is a pertinent point considering the very high demands of a dementia care environment and the economic constraints within residential care that have already been discussed. Support is also seen as an important factor in facilitating training transfer (Grossman & Salas (2011). Cromwell and Kolb's (2004) study focussed on the work environment factor "support" identified by Grossman & Salas's (2011) model. Their findings suggest that both supervisor and peer support is a significant factor in the transfer of training. Trainees who perceived higher levels of peer support indicated that they were

applying, to a higher extent, the newly learned knowledge, and skills (Baldwin & Ford, 1988).

The importance of the work environment has already been illustrated. Scott-Cawiezell et al (2005) indicated that the home culture, for example, is important. A care home is more than just bricks and mortar. Burton (2007) introduced the concept of viewing a care home for older people as a system whose primary function was to care for its residents. This was expanded (Burton 2008) by placing a resident at the centre of this system to illustrate how the concept of person-centred care could be accommodated within a care home in terms of the organisation of work. When considering RCWs and their learning needs, it is possible to create a systems' view of their work environment.

The construction of a systems diagram of a care home (Figure 2.4) has been based on the work of Burton (2007, 2008) and my own professional experience of working for a residential care home organisation.

Figure 2.4 The Care Home System



It is important to explain the difference between those elements that are defined as being part of the care home system and those in the system's environment. This

concept is taken from Checkland (1981). Elements defined as part of the system are those that would cause the system to malfunction, in terms of day-to-day operation, should they be removed. For example, if there were no residents, the 'Care Home System' would become redundant. Those elements defined as being in the system's environment can influence the system but are not necessary for the system to function. For example, CQC is not involved 'hands on' in the day-to-day operation of a care home, but could force corrective action or close the home if it was deemed inadequate when inspected. However, if CQC were abolished or replaced, the Care Home System would continue to operate.

Opportunity to perform links with the previous components of the work environment, in addition to the perceived utility of training. Learners need to be provided with the opportunity to put their learning into practice. Grossman & Salas (2011) note that

"For training to successfully transfer, trainees need the resources and opportunities to apply their new skills and abilities to the workplace." (p114)

Finally, Follow-up is required after formal training has been completed. It gives opportunities for learner reflection on their learning, complete further training and receive feedback on performance to further facilitate training transfer.

2.6.5 Summary

Learning theory has a great deal to offer in understanding the views of RCWs towards their dementia training. Student-centred learning attempts to put students at the centre of their learning. This is particularly pertinent for RCWs for several reasons. It reflects the person-centred care approach that RCWs are expected to implement. Its philosophy demonstrates respect for the views of a group of adult learners who feel undervalued and would acknowledge the specific learning needs of the workforce.

Emotions and adult learning holds relevance for training RCWs. The centrality of emotional labour to care work has been identified as a distinctive demand of the role (King 2012). The specific challenges faced by RCWs can result in emotional responses that impact on the emotional well-being of the RCW and include negative feelings that can impact on the level of care shown to the resident. This perspective also recognizes

past educational experiences and how these emotions might inhibit learning, and educators need to be aware of emotional responses and how to deal with them.

Any training received has a specific purpose: to be implemented in the care home for the benefit of residents. Training transfer is particularly pertinent for RCWs, as it is bringing learning into practice that is important for care. It also seems that the repetitive nature proposed by several authors (Wright & Frazer 1987, Ford & Weissbein 1997, Bates 2003, Clark 2013) is also a good fit for RCWs' training on dementia. This is therefore an area of investigation when seeking care worker views on training – is their training reinforced in the workplace and do they receive the support and feedback necessary to improve their everyday practice? This question forms part of the interviews with the care workers.

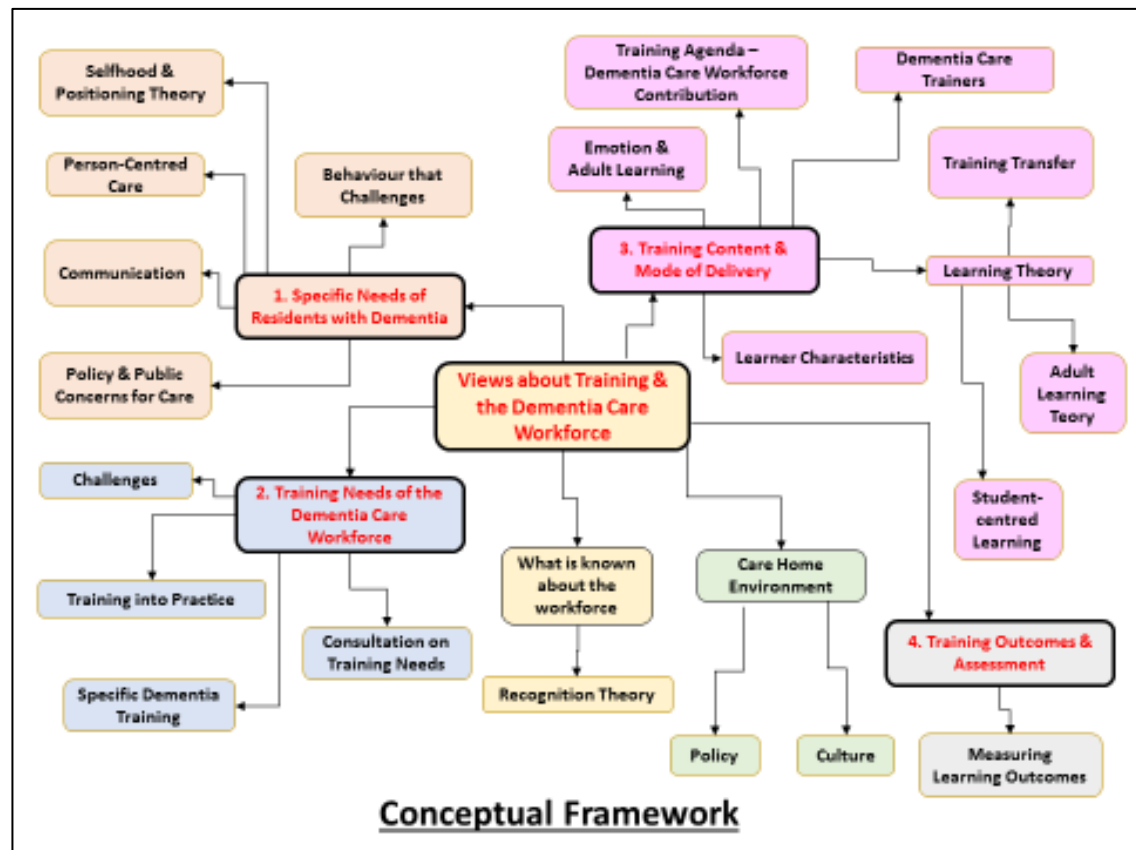
2.7 RCW Views on Training: A Conceptual Framework

The Conceptual Framework (Figure 2.5) represents the research domain in terms of the research questions, the areas for further investigation and the relevant theories that provide a 'lens' through which the findings can be addressed. This brings all the preceding elements that have been explored within this chapter into an integrated conceptual framework that captures how the different elements of the research fit together.

The four main areas of focus are

- 1) The specific needs of residents with dementia;
- 2) Training needs of the dementia care workforce as identified by the workers themselves;
- 3) Training content and mode of delivery;
- 4) Training outcomes and assessment.

Figure 2.5 RCW Views on Training: A Conceptual Framework



2.8 Summary

This literature review identifies the factors that influence RCW training in relation to my research questions. Four areas for investigation were the focus of the literature review with the intention of advancing training for RCWs from the views of RCWs themselves. The literature has identified some of the key challenges confronting RCWs, in circumstances of limited support, and relatively poor pay and working conditions. It has continued to highlight the need for RCWs to have specific dementia training (Kitwood 1998; APPG 2009; Talbot and Brewer 2016), yet this training has remained variable or non-existent. Given that numbers of people with dementia are growing, and the recognition that quality of care is related strongly to RCWs, it is concerning that the training needs of this workforce have remained unmet.

RCWs are at the forefront of caring for residents with dementia and their relationship with them directly impacts the physical and emotional well-being of the resident (APPG 2009). How RCWs feel about their role, and what they feel they need in terms

of training to implement care is therefore of paramount importance. However, literature about RCWs' views on training is limited. With questions outstanding over the quality of dementia care trainers and training (Carter 2015; APPG 2009), there is clearly a need for the dementia care workforce to have a voice in communicating what they feel influences their ability to care and identifying training needs from their perspective.

Residents with dementia have specific and sometimes complex needs associated with the condition. Kitwood (1997) identified the need for a person-centred approach, and it is an approach recognised as needed to meet these specific and complex needs (Martin et al 2002). Accommodating these specific needs requires a workforce able to deliver care in a person-centred way.

The literature has identified the importance of communication, including non-verbal communication in dementia care (Kitwood 1997; Eggenberger et al 2013). One of the many challenges faced by RCWs is behaviour that challenges, thought by Kitwood (1997) to be an expression of not being able to communicate an unmet need. For an RCW to recognise and act on one of Kitwood's (1997) proposed five indicators of personhood that are applicable to communication and associated behaviours would be a considerable accomplishment, given that only 2% of the day is spent in communication with a resident (Ward et al 2005).

In terms of training content and mode of delivery, there are guides as to content, but nothing mandatory or definitive for dementia care. Adult learning theory can be used to support the way in which RCWs receive training. This should include addressing the emotional nature of the role, and the emotional aspect of learning for RCWs. Training transfer must be considered if RCWs are to apply knowledge, competence and confidence gained in training to the job (Broard & Newstrom 1992). Training transfer theory identified the need for a supportive organisation if transfer of learning is to be successful.

The literature review identified a lack of follow-up research on training outcomes. Some articles considered the training of RCWs and discussed post-test results of training. However, none reported empirical measures some 3 or 6 months after, to

test if training had been retained in practice in the work setting, limiting the conclusions that can be drawn about the effectiveness of the training models researched.

Finally, a lack of interest in dementia care work is reflected in the limited amount of research on RCW views, and little consultation with them on their training needs (Smybye and Kirkevald 2013), was apparent. The purpose of the primary research for this thesis was to rectify this.

3 Research Methods

3.1 *Objectives and Scope*

This section will outline the objectives and scope of my research into the views of RCWs about their specific training needs, these objectives, originally defined in Section 1.3, have been included below as a focus for this Chapter and sets the scope of the empirical research

1. Identify the specific needs of residents with dementia as perceived by RCWs
2. Identify the training needs for RCWs in terms of content and mode of delivery, as identified by the RCWs themselves.
3. Provide data from RCWs that could inform the content and mode of delivery towards the development of a dementia care curriculum for RCWs.
4. Identify the training outcomes and how these could be measured reliably

The development of the Dementia Care Training Conceptual Model (Figure 5.1) was the result of three stages, the first being the literature review. This included government guidance and documentation from recognised charities knowledgeable within the field along with current literature. For example, the developing framework had to take into consideration the guidance from the National Institute of Clinical Excellence (NICE), the Dementia Care Standards, and the Alzheimer's Society. The resultant Conceptual Framework (Figure 2.5) was used as input into the interview phase of research.

Stage two drew on the views of the RCWs interviewed. It was envisaged that knowledge gained from the interviews of RCWs themselves would identify what training RCWs were already receiving. It would identify what they found helpful or unhelpful, and what format their training and assessment took. The interviews also addressed what RCWs felt they needed from training sessions.

Stage three was to integrate findings from phase one and phase two. Comparing knowledge of literature, theory and interviews identified gaps in current dementia care training, enabled recommendations for the assessment and delivery of training, and

informed the development of a more comprehensive Dementia Training Conceptual Model. This forms part of the Discussion chapter.

3.2 Social Research Strategies & Design

This section looks at the research strategy, covering the ontological and epistemological positioning of the researcher along with the research design. It continues by discussing the sampling criteria and method, along with the data collection and analysis.

3.2.1 Ontology

Ontology is concerned with the nature of reality. There are those who consider reality is out there waiting to be discovered, and others consider reality is socially constructed (Glassner 2000). A researcher's ontological assumptions inform their epistemological assumptions, which in turn inform methodology, and these all give rise to the methods employed to collect data (Grix 2004). Malloy & Hadjistavropoulos (2004) stated that a person's ontological position forms the way one perceives the self and others. It defines the groundwork for all human contact.

"Who one is and who one can be are defined in the context of authentic relationships." (Malloy & Hadjistavropoulos 2004, p152)

Ontology can be divided into two contrasting ontological perspectives, that of objectivism and constructivism (Bryman 2008). Objectivism is an ontological position that implies social phenomena confront us as external facts that are beyond our reach or influence. Constructivism, on the other hand, implies that social phenomena are not only produced through social interaction, but that they are also in a constant state of revision (Bryman 2008). According to Drisko (2013), the world is understood and related to by the ways in which experiences are organised. These constructs used to understand the world are social artefacts created by groups in specific cultural, political and historical contexts. The ontological perspective of this study is constructivist, focusing on the way RCWs construct their caring role through social interaction and how this shapes ideas about their learning needs.

Historically, dementia has been dominated by the psychiatric or a medical model approach to care (Cheston and Bender 1999). Kitwood's (1997) seminal work in person-centred care provided a way that focused on the person and not the disease, changing the way dementia is viewed, how people with dementia are cared for, and influencing training requirements. Sabat and Harre (1992) have acknowledged that social constructivism has also evolved in respect of the importance of the person and his or her voice in dementia care. However, even with a new philosophy and knowledge gained, the literature review identified that RCWs, like the people they care for, are still marginalised within society, have low status within the care home hierarchy, and their experiences and knowledge about training and learning needs remain unheard and unrecognised. This has the potential to influence the quality of care that is delivered to residents with dementia. Honneth's (2005) recognition theory identified that the self is born out of day-to-day social interaction and claims that rightful identity was the driving force behind societal transformations. My thought therefore was to make this research relevant by using an inclusive approach. Constructivist research provides useful insights into care worker training and learning needs. This approach can be joined with social workers' professional values and purposes in that there is an emphasis on equality and collaboration between researcher and participant (Guba and Lincoln 2005), aligning with that of student-centred learning, and this sits more comfortably with my personal values.

It is important to understand that the experience and behaviour of people with dementia and their carers are continually being socially constructed through the interplay of conversational and social practices undertaken between them (Adams and Gardiner 2005). This interaction between RCWs and residents raises ideas and questions about how RCWs construct care practices (Parker 2005) and training needs. Exploring the constructs used by people to make meaning of experience is a key focus of constructivist qualitative research (Drisko 2013).

3.2.2 Epistemology

Epistemology is concerned with the nature of knowledge, and questions what we 'do know' and 'can know' (Allison and Pomeroy 2000). Epistemology represents the

general set of assumptions about the best ways of inquiring into the nature of the world (Easterby-Smith, Thorpe & Lowe 2002). Epistemological views can be divided into three broad categories: positivism, realism and Interpretivism (Bryman 2008).

Interpretivism, in contrast to the positivist and realist epistemologies, is the idea that reality is determined by people rather than by objective and external factors (Easterby-Smith, Thorpe & Lowe 2002), and that reality is built up by the perceptions and actions of the social actors themselves (Bryman 2008). Burr (2003) identified that constructionist approaches are referred to as interpretivist approaches as they focus on how the world is interpreted by those experiencing it. The interpretivist approach assumes that values of the researcher and participants matter, and that researchers' values are inherent in all phases of the research. Almost all social constructivist research uses qualitative data collection methods (Robson 2011).

For this research, it was the RCWs' views, expressed via semi-structured interviews, that provide the data that can 'construct the reality' of their specific training needs within dementia care. Bryman (2008) noted that this idea of construction within constructivism

"...has also come to include the notion that the researchers' own accounts of the social world are constructions." (p19)

The findings of the data analysis were a construction based upon my interpretation of the data, i.e. the views of RCWs and how they constructed their care role. Parker (2005) suggested that for RCWs, dementia is constructed by their everyday practice and care given. For example, dementia might be conceptualised through the behaviour observed: that of anxiety, restlessness, 'wandering' and aggression. Everyday care practice includes responses made to those behaviours (Parker 2005). As part of the interview process, questions were asked about how RCWs responded to these potentially challenging aspects of their role. RCWs had their own varied backgrounds and experiences that contributed to their ongoing construction of reality that shaped their understanding of dementia and how to respond to residents. Interpretivists believe that as human perspectives and experiences are subjective, social reality may change and can have multiple perspectives (Wahyuni 2012). This approach had important implications for training and reflects Houston's (2015) additional fourth

dimension to Honneth's (2005) recognition theory. This fourth dimension (Table 2.2 earlier) addressed cognition and emotion, specifically an individual's self-belief in terms of what is known and can be known (Allison 2000).

Alongside a constructivist ontology, an interpretivist epistemology underpinned my research approach. The epistemological assumption was that knowledge is derived from daily perceptions, associations, and socially constructed understandings (Blaikie 2003).

3.2.3 Research Design

The research design needed to consider and clarify several key aspects, namely, the type of research, the research paradigm, and the research strategy. My aim for this research was to develop knowledge and understanding of RCWs' views on their training needs, and to address the limited research in this area. I wanted to promote the voice of RCWs and inform understanding about how RCWs construct their training needs. Guba and Lincoln (1989) advocate that the constructivist approach aims to develop understanding and knowledge and promotes action and change. Rodwell (1998) supports this, saying that constructivist inquiry can empower participants and facilitate social change. The nature of the original research objectives therefore dictated the design of the research. Sarantakos (2013) lists no less than 15 types of research. Ritchie et al (2014) identified a wide-ranging classification of the approaches to social research but narrow down the options to four specific types: explanatory, evaluative, generative, and contextual. Taking each in turn, this research was not seen as explanatory. The objectives were not to examine why specific training was delivered to RCWs, or why the RCWs held the views they did on the training they received. As it was also not the purpose of the research to appraise the effectiveness of current dementia care training for RCWs, evaluation research was discounted. Generative research

"...is concerned with producing new ideas as a contribution either to the development of social theory or to the refinement or stimulus of policy solutions." (Ritchie et al 2014, p35)

The purpose of this research is to obtain the views of RCWs on their dementia training, rather than, for example, looking at dementia training with a view to changing policy. Contextual research was considered in part, as this

“...is concerned with identifying what exists in the social world and the way it manifests itself.” (Ritchie et al 2014, p31)

My research, however, goes beyond ‘what exists’, with the desire to determine the views of RCWs about their dementia care training needs. Acknowledged by Ritchie et al (2014) as part of contextual research, my research is more aligned with exploratory research (Robson 2002). The major emphasis for exploratory research is the discovery of ideas and insights (Kothari 2004), to assess a phenomenon in a new light, to ask questions, and to generate ideas and hypotheses for future research (Robson 2011). As research on RCW views about dementia training needs has been so limited (Hughes et al 2008), it is this very exploration of the RCW contribution to the improvement of dementia training that my research is aiming to provide.

Looking at research paradigms, the choice between the quantitative and qualitative paradigms was straight forward. The quantitative paradigm is linked with positivism and post-positivism (Robson 2011). This in turn leads to the idea of the research carrying out measurement and quantification (Robson 2011). Quantitative approaches, for example questionnaires to a large number of RCWs, would not have given me a handle on their experience of caring, and how that affects their construction of their learning needs.

The qualitative paradigm is closely associated with the idea of social constructivism that

“...indicates a view that social properties are constructed through interactions between people, rather than having a separate existence.” (Robson 2011, p24)

Qualitative research is associated with words or images rather than numbers and the volume and richness of qualitative data are highlighted (Ritchie et al 2014). It is the richness of data that is important for my research and qualitative research is more appropriate for this purpose and aligns with my ontological and epistemological positioning discussed earlier in this chapter.

Research strategies are regarded as either deductive or inductive in nature (Bryman 2008, Robson 2011). Bryman (2008) sees these different approaches as exemplifying the nature of the relationship between theory and research, with deductive seen as theory guiding the research, and inductive as theory being the outcome of the research. Ritchie et al (2014) label deduction as a 'top-down' approach and induction as 'bottom-up'. Although qualitative research is often associated with an inductive approach (Ritchie et al 2014), Blaikie (2007) argued that it is not really the case of 'one or the other'. Interpreting data, for example, does not start with a blank sheet – the questions asked by an inductive researcher to generate the data

"...will have been influenced by assumptions deductively derived from previous work in their field." (Ritchie et al 2014, p6)

My research used a mix of deductive and inductive approaches: deductive in designing the semi-structured interview questions and inductive when identifying emergent themes during the analysis, for example.

In summary, my research design encompassed exploratory research using a qualitative approach, and a research strategy using inductive and deductive approaches.

3.2.4 Data Collection and Analysis

The research consists of two distinct phases: the literature review and the qualitative research. Fink (2010) best described the process of a literature review as

"A systematic, explicit, and reproducible method for identifying, evaluating, and synthesizing the existing body of completed and recorded work produced by researchers, scholars, and practitioners." (p3)

The methodology used for the literature review is explained in Chapter Two. This chapter focuses on the methodology adopted for the fieldwork. The literature review and analysis informed the construction of the questions for the semi-structured interviews. For the data collection, interviews were used to address the first two objectives. There were specific questions on which responses were sought, with the interviews themselves focused in a number of ways to ensure that the interviewee is aware of the content and context of the research to improve consistency and the quality of data collected (Bryman & Bell 2003). On this basis, therefore, an

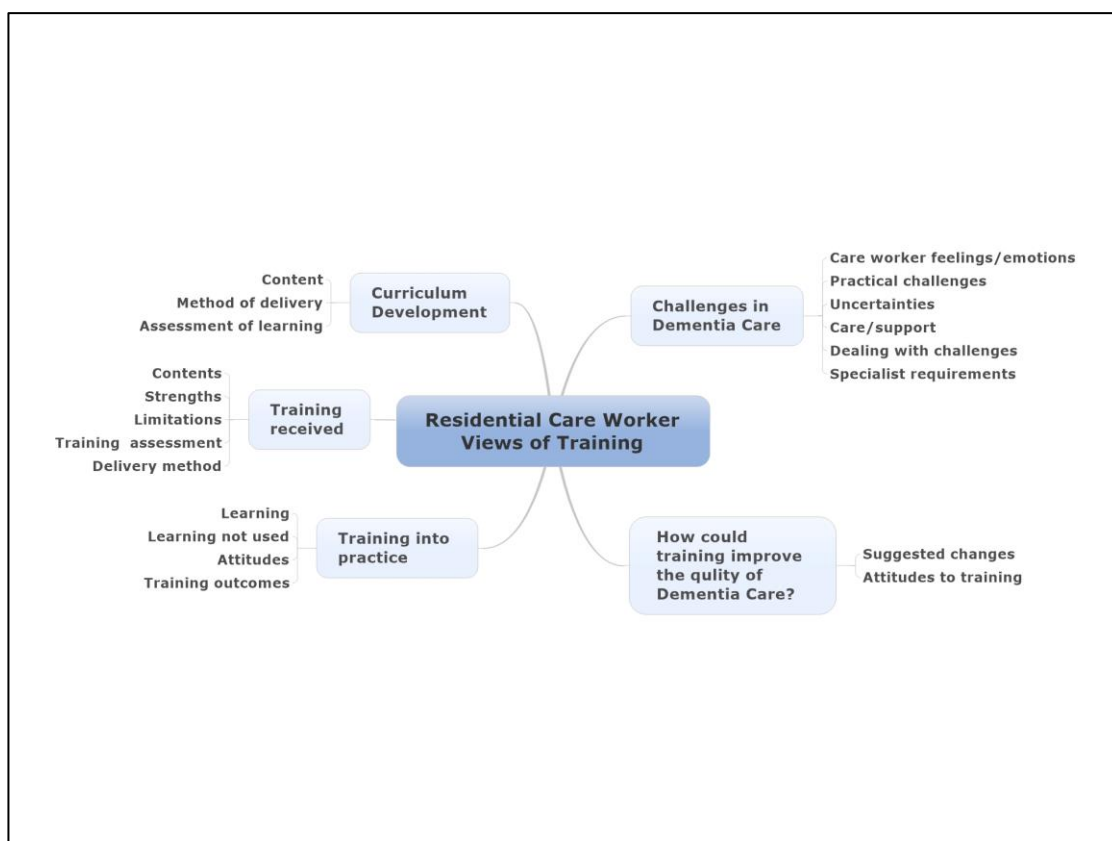
unstructured interview approach appeared inappropriate because of its lack of focus, and that time with each RCW was also limited for care home operational reasons. Fully structured interviews might have provided an alternative, having predetermined questions in a pre-set order, allowing the RCW to elaborate on a specific point of interest (Robson 2002). However, it would not have provided the opportunity for follow up or probing questions (Robson 2002). Semi-structured interviews, on a 'one to one' basis, were the preferred choice for the data collection method. The reasons for this are that although semi-structured interviews have pre-determined questions, the order can be modified based upon the interviewer's perception of what seems more appropriate (Robson 2002). Bryman & Bell (2003) argued that if the investigation has a clear focus, semi-structured interviews are more appropriate as specific issues can be addressed.

Finally, focus groups were considered, but were discarded as unsuitable. Focus groups allow qualitative data collection to be completed in a group context and can be structured, semi-structured or unstructured (Robson 2011). Although focus groups may be an efficient technique for data collection, as involving several people at the same time means that several views can be included in one session (Denscombe 2007), they do have disadvantages. Problems transcribing recordings can occur if multiple interviewees speak at the same time. Dominant personalities may have to be controlled or reticent speakers encouraged to participate (Bryman 2008). Group interviews can discourage people from sharing their views on sensitive topics or revealing too much of themselves in front of colleagues. However, the main disadvantage for this study is the number of participants required in what is judged to be the optimum size. Morgan (1998) believed 6-10. Bryman (2008) noted that, in the comparison of 9 focus group studies, sizes varied from 3-10. For care homes, even three RCWs coming off the floor at the same time would be too many operationally. This was the primary reason focus groups were discarded as a data collection method. Telephone interviews were not appropriate given the nature of the RCW's busy role. If a mobile phone is used, it is not possible that the RCW could give full attention to their responses. Telephone interviews are not conducive to the relationship building necessary for honest construction (Rodwell 1989). In addition, 'face to face' interviews

allow the researcher to read and respond to facial expression and body language to understand further the meaning of verbal responses (Robson 2002). Rodwell (1998) refers to this as *“listening with the eye and ear”* (p126), which is the constructivist interview.

With the research objectives clearly defined, the next stage was to develop sub-categories for which data would be sought from the interviewees, i.e. the areas of interest for the data collection from RCWs. These were synthesised from the Literature Review, reflecting those areas where there seemed to be a lack of clarity in terms of RCWs own views on the training they had received. For example, under the grouping Training into Practice, information was sought on; the learning they received and put into practice, the learning they could not put into practice and possible reasons why, did the learning change the RCWs’ attitude to those under their care, and were the training outcomes measured in any way. Figure 3.1 illustrates the areas of interest and was used as the foundation for the creation of semi-structured interview plan (Appendix 2).

Figure 3.1 Research Objectives – Areas of Interest



3.2.5 Sampling Criteria & Method

My decision to cold call was based on a pre-understanding (Gummeson 2000) of care home environments. Cold calling in this context means that I contacted my chosen care home without them knowing they had been selected or that a call was coming. I was aware of the unique environment, the nature of the caring role and the respect it deserved. Indeed, my previous experience was one reason to explore views of RCWs in my research. I felt able to relate to the care staff, and understood that the well-being of residents, relatives, and staff remain central always (Luff et al 2015). Luff et al (2015) emphasised the importance of the skills and experience of the researcher to engage in home settings, without which the researcher would need additional support. The concept of pre-understanding is discussed further in Section 3.3.4.

In 2012, the ENRICH (Enabling research in care homes) project was established to create a network of care homes that were 'research-ready' (Davies et al 2014). Had I known about ENRICH at the time of my fieldwork (July/August 2013) this may have been a useful resource. However, further investigation of the ENRICH website (ENRICH 2017) has shown that there were no care homes registered with ENRICH within the geographical locations selected for my fieldwork. . These were chosen because travel distance would be manageable.

Initial representations were made to BUPA, Care UK and Barchester⁵, via the Head of Training, to carry out research within homes in the counties selected. One of the organisations refused permission, and the other two did not respond despite follow-up by letter and telephone. An alternative approach was therefore taken to identify care homes where the research could take place. The Care Quality Commission (CQC) are the independent regulator of health and social care in England. Their role is to register care providers, to monitor, inspect and rate services, and to act to protect people who use those services (CQC 2013).

Their website (CQC 2013) was used to create a list of all the care homes within three counties in England. The data were collected through the summer of 2013. The homes

⁵ BUPA, Care UK and Barchester are three of the largest residential care home providers in the UK.

selected had to cover services/specialism for dementia and caring for adults over age 65. The list was sorted by provider name and all entries removed for provider names that had less than five homes. The condition of more than five homes was considered to heighten the chance of a coordinated training programme across the care home provider. That left 26 organisations. Each of these 26 organisations was then contacted via letter and followed-up via telephone conversations. Again, as with the larger organisations, many organisations did not reply (n=17) or declined to participate (n=6). Of the three remaining organisations, all suggested contacting the homes directly to seek participation.

Taking a purposive sampling approach (Bryman 2008), six residential care homes (two from each organisation) in three different counties, were chosen. The selection of all three organisations was to help eliminate any bias that might arise from organisational culture and to ensure diversity, and breadth of experience, of the way workers in different organisations perceive their dementia training. This was the other of the two main aims of purposive sampling (Ritchie et al 2014).

Letters were sent to all the homes requesting permission to interview dementia care staff (Appendix 3). Included with the letter was an information sheet explaining the purpose of the research with my details and the details of the University (Appendix 4). There was also a list of interview questions that participants could look at ahead of the interview. It explained that participants could leave the interview at any point if they chose. There was also a statement about the boundaries of confidentiality. The letter was followed up with telephone calls to arrange a convenient date and time to access care staff. Six care homes agreed to participate, with three interviews in each, and one with four. The care home organisations and care home characteristics are described further in Section 4.1. The participants in this purposive sampling exercise were chosen (by the Care Home Manager out of those available) because they shared specific experiences of dementia training and working with people with dementia. The implications of this are considered later. All the interviews were conducted at the care homes at which the RCWs worked. Confidentiality was maintained using a private room. The time of the interviews was arranged by prior arrangement with the Care

Home Manager and was based on the availability of RCWs without compromising the operation of the home.

There were 19 tape recorded interviews that lasted about 40-50 minutes. However, several participants expressed a wish to speak at the end of the interview when the tape recorder was switched off. These lasted for about an extra 15 minutes and I gained permission from the participants to use these data.

3.2.6 Data Analysis

Ritchie et al (2014) have argued that there are no clearly agreed rules or procedures for analysing qualitative data. The different approaches, they argue, are more about how qualitative data are 'managed' than the intellectual processes involved in generating findings. For this research, thematic analysis was chosen. This involves discovering, interpreting, and reporting clusters of patterns or themes within the data (Ritchie et al 2014). This was a useful way of thinking about and managing the data to gain the meaning from the RCWs' views about their training needs. Braun and Clarke (2006) also suggest that one of the benefits of thematic analysis provides a purely qualitative, detailed, and nuanced account of the data.

Robson (2011) makes the point that while there are several diverse ways of carrying out thematic coding analysis, they all tend to share several recurring features. Miles & Huberman (1994) propose what they see as a classic set of analytic stages. My preference was for the five key steps in data management for thematic analysis proposed by Ritchie et al (2014). These steps were clear and concise and allowed for the analysis to evolve as the individual interviews were scrutinised and provided the flexibility to amend the initial thematic framework as further themes emerged. These steps are summarised in Table 3.1.

Table 3.1 Thematic Analysis (Richie et al 2014)

Step	Description
Familiarisation	What are participants saying that is relevant to the research questions
Constructing an initial thematic framework	Under what headings can participant's views, experiences or behaviour be organised?

Step	Description
Indexing and sorting	What parts of the data are about the same thing and belong together?
Reviewing data extracts	What other ways of organising the data are possible that might produce more coherent groupings?
Data Summary and Display	What is each person saying about a particular theme?

The first stage before following the steps of the analysis was to transcribe the interviews verbatim. This was completed by a third-party service using a professional transcribe who was not given any information about the participants to maintain anonymity. The transcripts were read and re-read along with my hand-written notes of observations of the participants' body language, facial expression, and tone during the interview. I also had permission to use participants' comments made without a tape recorder on. Some RCWs felt more comfortable speaking without a tape recorder. In this way, I was able to immerse myself in the data. A diary was helpful to record my thoughts and feelings about discussion within the interviews. Within the diary, notes and labels were made alongside participants' responses.

Starting with the first stage proposed by Ritchie et al (2014), that of familiarisation, I read each of the interview transcripts and highlighted with a 'theme' or 'label' anything that seemed relevant to my research questions. Ritchie et al (2014) identified that labels can be applied to the data in differing ways, the importance being to achieve a meaningful account of the data that addresses the research question.

The next step, 'constructing an initial thematic framework', was assembled from the questions used under in the semi-structured interview plan and from the initial reading of the transcripts. These labels are defined in Table 3.2. This was deductive label and theme development as described by Fereday & Muir-Cochrane (2008), where fixed, pre-defined labels completed the analysis of the data. and were developed from the semi-structured interview questions

Table 3.2 Thematic Framework

1	Challenges in Dementia Care
1.1	Feelings
1.2	Cognitions
1.3	Practical Challenges
1.4	Methods
1.5	Care support that cannot be provided and why
1.6	Other
2	Experiences of Dementia Training
2.1	Dementia Care training received in the last two years
2.2	How was training assessed?
2.3	Strengths
2.4	Limitations
2.5	Learning most helpful & why
2.6	Putting into practice
2.7	Attitude change towards residents after training
2.8	Other
3	Changes to training
3.1	What training changes would you make
3.2	Attitudes to training
3.3	Outcomes of training
3.4	Other

The third step proposed by Ritchie et al (2014), that of indexing and sorting, was completed to ensure the correct labelling of the data within the thematic framework (Table 3.2) and that the data were assigned to the correct themes and sub-themes. This was completed using CAQDAS (Computer Assisted Qualitative Data Analysis Software), namely NVivo 9. Flick (2009) believed that the use of CAQDAS software makes it easier to demonstrate the quality of the analysis. The structure of the nodes and sub-nodes within NVivo were taken from the Thematic Framework (Figure 3.2); the interview transcripts were then imported, and text assigned to the appropriate sub-node. NVivo 9 was used to assign text to the pre-defined sub-nodes; it was then extracted into an Excel spreadsheet for the next step in the process.

Data reduction, the fourth step, used Excel to group elements (i.e. individual statements) from the interviewees into categories, removing any duplicate statements, and then grouping categories into themes. Moving to non-specialist CAQDAS software, such as Microsoft Excel, facilitated a clearer view of all the individual statements (elements), moving outside of the CAQDAS software to 'gather my thoughts' (Lewin and Silver 2007).

Viewing each of the elements, statements such as ‘people get bored’ and ‘fall asleep during training’ were grouped together under the category ‘not engaging with training’. Once the categories were completed, the final phase of Data Reduction was to group the categories into themes. For example, ‘forgotten training’ and ‘not engaging with training’ categories were considered as part of the theme ‘Experiences of training’. The final stage of data analysis, that of data summary and display, was completed by creating a matrix that summarised the data by category and theme (Appendix 5).

I adopted the combination of both cross sectional and non-cross-sectional analysis for my research, as discussed by Ritchie et al (2014). Cross-sectional analysis is based on interpretations of meaning, by making sense of the findings through the production of descriptive and explanatory accounts (Spencer et al 2003). The advantage of this is that cross-sectional analysis offered the opportunity to compare and contrast RCWs’ views. In addition, cross-sectional analysis is an overall system of labels used across the whole data set (i.e. all interviews). Non-cross-sectional analysis provided the opportunity to look at each interview separately. This meant being able to collect data to compare and combine labels from each interview. A combination of the two allowed me to use a collection of labels to look at the commonalities and to group together themes.

On completion of the data analysis, the Dementia Care Training Conceptual Model (Figure 5.1 later) was a synthesis developed from

- reviewing the literature and theoretical perspectives about adult learning and the transfer of learning,
- identifying the nature of dementia care work and needs of care workers,
- identifying the needs of people with dementia,
- exploring the strengths and weaknesses of dementia training,

and findings from care worker interviews into a coherent framework for understanding how RCWs perspectives can inform the areas of training content and process for dementia care.

3.3 Ethical Considerations and Concerns

Shaw (2003) says the ethics of qualitative research design place distinctive demands on the principles of confidentiality and privacy, informed consent, and practitioner

research. Dementia care is not limited to residential homes and I was aware that RCWs could also have cared for a relative outside of the home environment. Manthorpe et al (2012) identified that decisions to join caring professions may be influenced by personal or family experiences of caring. Because of this and the general nature of the role, sensitivity, and concern for the participants during the interview process were important. Two separate areas where power is involved are also considered: that of the care home manager, in terms of who is available for the interviews, and that of a possible power imbalance between the participant and myself.

The research undertaken conformed to the University of Sussex Standards and Guidelines on Research Ethics (Ref: ER/LE65/1). This included the completion of the Ethics Checklist and Ethics Clearance process. The Ethics Certificate of Approval is in Appendix 6.

3.3.1 Confidentiality and Anonymity

Initially, the University Ethics Committee queried how confidentiality could be protected, given that the interviews were to be completed at the residential care home and place of employment for the participants. According to Lincoln and Guba (1989), confidentiality and anonymity cannot be absolutely guaranteed. For this research, it was not possible to guarantee anonymity, as home managers needed to know who was 'free from the floor' and other care staff needed to 'cover' for the RCW being interviewed. The home manager acted as a 'gatekeeper' (Miller and Bell 2002), i.e. those that can permit access for interviews. This is the first aspect in which the manager's 'power' influenced the conduct of this research. For me, this was an ethical consideration, as the home manager influenced which care worker became a research participant. The home manager would choose RCWs/participants based on who happened to be around on the day I visited. Obviously, the needs of the residents come first, and so I waited until an RCW was 'free from the floor' to participate. There is a possibility of bias in the data due to the managers selection in that they may have screened out those who might have had negative views.

Although the home manager knew who was to be interviewed, the responses given in the interview were not made available to the organisation to which the RCW belonged.

The interview was also conducted in private behind a closed door, thus addressing the confidentiality concerns of the University Ethics Committee. If a participant revealed a safeguarding issue, the ethical framework agreed with the University had identified a need to report it. As a registered social worker also, I am duty-bound to disclose this information. Lincoln and Guba (2003) argue that where this possibility exists, it needs to be discussed with the participant who needs to be made aware of this risk. This was addressed as part of the Participants Information Sheet (Appendix 7) and the Interview Informed Consent Form (Appendix 8).

I adopted an approach identified by Miller and Bell (2002) who point out that ethical considerations should not be forgotten once ethical approval is given but, rather, ethical considerations should form an ongoing part of the research. Miller and Bell (2002) promote the need for 'thinking ethically' and 'behaving ethically' throughout the research process. The Code of Ethics for social work and social care research (Butler 2002) identified how social work researchers have a duty to maintain an active ethical awareness at all stages of the research process. This includes the methodology and the use to which any findings might be put, which should be congruent with the aims and values of social work practice. Research findings must be reported accurately and without distortion and note any conditions that may have affected the interpretation of the data (Butler 2002).

3.3.2 Informed Consent

Informed consent was considered an important area to be addressed. From professional experience, I was aware that some RCWs have limited reading skills. In addition, English is not always their first language. Miller and Bell (2012) identify that it is important for participants to know what they are consenting to. This meant that I felt it necessary to explain the consent form to each participant and ensure that each participant knew they could withdraw at any time. I explained to the participants that the interview was recorded on a digital recording device that only they and I would hear. Once the analysis was complete, the data would be deleted.

I questioned whether RCWs could make a choice to participate. Miller and Bell (2008) point out that there is an assumption that providing consent is voluntary, and that

'coercion' is deemed not to have occurred. However, they contend that such an assumption ignores the power dynamics around access and consent. This seemed pertinent to my research, as I am aware that the culture within residential care homes is particularly hierarchical. Not all RCWs approached by the Care Home Managers were willing to participate when asked. This could have been for several reasons but was not pursued with the individuals, as to do so could have been perceived as attempted coercion. Once an RCW had agreed to be interviewed, I explained to each participant that interviewing was voluntary, and they could withdraw at any time. Fortunately, all RCWs who agreed to participate appeared happy to continue, saying they enjoyed it or found it interesting. One RCW commented that it was nice to be asked how she felt about her work, as she was used to just '*being told*'.

3.3.3 Ethics and Participants

Reducing potential harm to participants within the interview process is a key ethical concern (DiCicco-Bloom and Crabtree 2006). My task as an interviewer was to discover data from the perspective of the interviewee. In my professional experience, RCWs have explained that they bring knowledge of caring for someone with dementia from intimate and personal experience into the workplace, a point noted also by Manthorpe et al. (2012). This makes dementia an emotive topic for RCWs who have had that level of care experience.

When conducting an interview on an emotive topic, Kvale and Brinkman (2009) identified that ethical issues arise in terms of a dichotomy between wishing to collect as much data as possible and the integrity of the interviewer. The risk identified by Brinkman and Kvale (2005) was that whilst being as respectful as possible, I may only have got empirical material that scratched the surface. I decided that I would build a rapport at the start of each interview and explain the research before putting on the tape recorder. I felt this would help maximise the data collected and minimise any discomfort of the interviewee.

3.3.4 Interviewer Bias and Pre-understanding

I had an advantage during the interview process in that I already had knowledge of the way care homes operated, being able to draw on my placement experience in a care home, and five years' experience in a senior management role in an organisation that owned 30+ residential and nursing homes for older people. This knowledge and experience is akin to what Kvale and Brinkman (2009) term as the use of

"Objective perception and experience-based judgement..." (p170)

when completing interviews. The researcher also needs

"...experience-based situational judgement, clear perception and proper attention to the particularities of the situation." (Kvale and Brinkman 2009, p170)

Such judgement and perception on behalf of the interviewer could be provided by what Gummesson (2000) terms pre-understanding:

"Pre-understanding refers to such things as people's knowledge, insights and experience before they engage in a research programme." (Gummesson 2000 p57)

The concept and apparent advantage of pre-understanding does introduce potential disadvantages that must be acknowledged. How directly does it translate to the organisations and workers that participated in the research? Could it potentially lead me to make assumptions or approach interviews with pre-conceived ideas? These risks were considered as part of the formation of the interview questions, the way in which the interviews are carried out and the methods used to analyse the data collected.

Pre-understanding is like the position of an 'insider researcher', where the knowledge of the organisation's day-to-day operation and culture allows an insider researcher to gain a richness of data. Coghlan & Casey (2001), discussing nurses as insider researchers, stated:

"When they are inquiring they can use the internal jargon and draw on their own experience in asking questions and interviewing, and are able to follow up on replies and so obtain richer data." (p676)

For a typical insider researcher, the disadvantages can be substantial (Robson 2011), including the duality of the role (as a researcher and employee) and potential tensions

of interviewing work colleagues. The consideration for the latter was the potential power imbalance between the researcher and those interviewed and that of possible 'employer pressure' during the course of the research (Easterby-Smith et al 2003). However, not being an employee of any of the organisations in which the interviews were carried out avoided these issues.

The second aspect of 'power' stated in the introduction to this section, concerned me as the interviewer. I was mindful of a potential power imbalance as I had held a senior management position and was a qualified social worker and teacher. I was aware of the need to provide a safe and comfortable environment (DiCicco-Bloom and Crabtree 2006). Establishing a rapport and gaining trust was part of providing such an environment. At the start of each interview, I explained to each participant that I had worked 'on the floor' and understood the nature and the demands of care work with dementia, and that my research promoted my personal interest in the voice of the RCW.

As the interviews unfolded, participants showed willingness to share their experiences and openly engaged in explaining examples of practice. They saw their work as a privilege but were forthcoming on the difficulties of their role, their feelings about caring for people with dementia, and their perceptions on training needs. During the interviews, participants chose to share some powerful experiences. For example, one participant shared her feelings of profound sadness at losing a resident she had cared for, and another at how she felt unable to care for a dying person.

On reflection, there can be a vulnerability for participants in interviews. Participants were not asked directly for painful experiences in practice. Rather these were shared voluntarily through discussion around training needs. However, even with a pre-understanding of the topic, it cannot be fully anticipated how questions might reveal powerful feelings or expose what the participant viewed as a 'failure'. Sinding and Aronson (2003) pointed out the danger of exposing self-perceived failures, in that they can threaten participants' identities. As a social worker, I felt it necessary to acknowledge the participants' feelings, and the importance of what they had shared, rather than just move onto the next question. I thanked them for their openness and

honesty and explained that it was these experiences that would help in my research into dementia training. I drew on the principle of continuous consent to ensure participants were willing to continue after sharing a painful experience (Allmark et al 2009).

The extent of power and possible imbalances between the interviewer and interviewee is returned to in Section 5.5 in greater detail when discussing the challenges of completing research in residential care.

3.4 Reliability & Validity in Qualitative Research

There is a need for rigour in research. There is general agreement that research studies must be open to critique and evaluation. Indeed, Long & Johnson (2000) stated that incorrect findings might result in the adoption of inappropriate or harmful practices. It is therefore important to establish how the reliability and validity of my research were established.

The question of reliability and validity in qualitative research has been the subject of much discussion in academic literature (Ritchie et al 2014; Long & Johnson 2000; Aguinaldo 2004; Lietz et al 2006). For example, Winter (2000) argues that the issues surrounding the use and nature of the term validity in qualitative research are controversial and many. It is therefore important to outline what is meant as reliability and validity for my research.

3.4.1 Reliability

Silverman (2006) contends that reliability deals with replicability. This means that at some point researchers could repeat my research project and come up with the same results, interpretations, and claims. However, Ritchie et al (2014) argued that the extent to which replication can occur in qualitative research is questionable on several counts. They note that the constructivist school raised severe objections, explaining that there is no single reality to be captured in the first place, so replication is an artificial goal. Lincoln and Guba (1985) have highlighted that the concept of replication is naïve, given the likely complexity of phenomena. Bond and Corner (2001) stated that

dementia care was a complex phenomenon. At some stage, therefore, the idea of reliability must be recognised as not being absolute.

Onwuegbuzie & Leech (2007) asserted that there is no method in qualitative research guaranteed to produce trustworthy conclusions, stating that it is still necessary to be able to assess the procedures used by a researcher by enabling the ability of a third party to evaluate or increase legitimisation. It is this idea of trustworthiness that I believe best represents the idea of reliability in the context of my research. Establishing trustworthiness can be achieved by maintaining confidentiality (Rodwell 1998), although this is a small part of the process. This research was also approved by the University Ethics process and detailed in the previous sections. Shenton (2004) suggested that researchers in pursuit of a trustworthy study can

*“...ensure tactics to help ensure honesty in informants when contributing data.”
(p66)*

This means that participants in my research were willing to take part and prepared to offer data freely. Possible interviewer bias must be acknowledged and was discussed in Section 3.3.4. A second area suggested by Shenton (2004), and contained within my research design, is that of data triangulation – three separate care organisations were used for the data collection to

“Reduce the effect on the study of particular local factors peculiar to one institution.” (Shenton 2004, p66)

3.4.2 Validity

Validity is described in a wide range of terms in qualitative studies (Golafshani 2003; Cresswell and Miller 2000). Whitmore et al (2001) contend that the interpretivist perspective has struggled to articulate validity criteria in qualitative research. Many authors have proposed alternatives to the concept of validity, which is often associated with quantitative research (Seale 2012). Onwuegbuzie and Leech (2007), who contend that no one definition of validity represents hegemony in qualitative research, support this. Guba and Lincoln (1982) proposed that

“Internal validity should be replaced by that of credibility, external validity by transferability, reliability by dependability and objectivity by confirmability”.
(pp. 3-4)

Seale (2012), has outlined three components of validity that are believed to have salience for qualitative research: measurement validity, internal validity, and external validity. For measurement validity in qualitative research, researchers should

“Seek to exhibit excellent, well-grounded links between the concepts and conclusions they develop, and examples drawn from the data from which these have been derived.” (Ritchie et al 2004, p357)

Seale (2012) defined Internal validity as the extent of ‘cause and effect’ within qualitative research. For example, a causal statement such as ‘I am afraid when a resident becomes violent’ indicated that the aggression caused fear. The extent of measurement validity will be the subject of discussion of the data analysis methods used as part of the Conclusions Chapter (Chapter 6), as will internal validity. External validity is an integral part of whether a finding is applicable to wider settings or the wider population (Seale 2012). In this sense, it is the generalisability of a finding, or group of findings, that goes a long way towards whether it or they are valid (Ritchie et al 2014). The extent of the generalisability of the findings has also been debated in the Discussion chapter.

3.5 Challenges of Research in Residential Care – A Reflection

Luff et al (2011) stated that the care home setting represented a challenging environment for research. As residential care is a hierarchical environment, I encountered questions around power and control.

The invitation to be interviewed was sent with the intent that RCWs across the home could participate if they wished. However, managers approached RCWs to seek participation on the day I arrived. The risk of this was that managers could introduce bias by choosing staff that would give favourable answers, and it meant the interviewees were restricted to those working at the time, and unintentionally excluded night staff. This put me under pressure as I realized that staff were coming ‘off the floor’ to be interviewed, meaning that other staff would have to compensate with being a co- worker down. Luff et al (2011) stated that

"As a visitor to the care home the researcher had to negotiate around the daily routine of residents in order to secure their participation." (p21)

The RCWs approached by the manager to be interviewed may have felt pressure to agree. As the researcher, I too felt the effect of a lack of control as it was unknown if the manager informed all care staff, or if care staff came forward to volunteer or not. On reflection, there might have been RCWs who may have wanted to participate but were unaware of the research. Therefore, in addressing how I could have done things differently, letters could have been sent to each care worker, giving all the opportunity to participate.

I anticipated there might be a perceived power imbalance between the researcher and the interviewee. Hoffmann (2007) identified that in the interview context power is multifaceted and difficult to assess. (Hoffman 2007) argued that the interviewer holds a certain amount of official power as the initiator of the contact, but qualitative researchers must lose a certain amount of power as interviewees possess the knowledge that is required by the interviewer. Anyan (2013) argued that power lies in the hands of the interviewer because they ask the questions and moderate the interview. For example, power may have influenced responses by the way I responded to answers, changed direction, or enquired further about a response. Schwalbe and Wolkomir (2002) identified that interviewees often perceive the interview as both an opportunity and a threat. For RCWs, the opportunity might be a chance for their voice to be heard, the threat might be in how they should answer the questions or if something they say is discovered by management.

Even with all the assurances of confidentiality, there were still interviewees who felt more comfortable talking once the tape recorder had been switched off, i.e. "off the record". Kvale (1996) referred to this stage of the interview as the debriefing and that the interviewee may *"bring up topics he or she did not feel safe raising with the tape recorder switched on."* (p128) One RCW explained there were concerns something 'might get back' to management. I repeated that no information would be accessed by staff or management. The RCW concerned spoke about how staff have differing standards of care. Naturally, this could not get back to any other RCW.

One of the challenges was that many interviewees had not had, or could not remember, having any training in dementia care. The result was that they were unable to answer later questions, such as what training was helpful and why, and what method of training delivery was preferred, etc.

3.6 *Summary*

This chapter discussed the research methods used for my research. The research is exploratory in nature, with the objective to explore the training views of RCWs and use these to inform the development of a dementia care curriculum. The qualitative nature of the research complements the ontological and epistemological views of the researcher, those of constructivism and Interpretivism, and these underpinned the research process from the outset. The methods used for the literature search were detailed at the start of Chapter 2.

Semi-structured interviews were used for data collection, with the thematic framework built from the semi-structured interview schedule used as a basis for the analysis. The next chapter looks at the findings of the primary research after the analysis had been completed.

4 Findings

4.1 Characteristics of the Organisations

Three organisations approved the research, with six care homes agreeing to participate. Three interviews were carried out in each of five of the homes and four interviews completed in the sixth (Organisation 1, Home B, i.e. 1B). Individual interviewees are referred to using the organisation identifier, home identifier and interview number, i.e. 3A#18 refers to Organisation 3, Home A, interview 18.

At the time of the interviews for this research, staff training came under the CQC Comprehensive Inspection Report heading of “Supporting Workers” (CQC 2017). This was the information source for what training RCWs had received from a CQC perspective.

The Appendix 9 summarizes the important characteristics of each of the six care homes in which the interviews took place. For each home, the last completed full Inspection Report was selected and details such as the overall rating and comments on training extracted. Looking at Appendix 9, several interesting common characteristics can be observed. Of the six care homes across three organisations, only one home inspection report mentioned that dementia care training had been delivered, but no details on the extent of the training were given. Two other homes (1A, 1B) were judged to have met the standard “Supporting Workers” even though dementia care training was not mentioned. This lack of dementia care training was not commented on in any of the inspection reports except one (3A); this was marked for follow-up but was not checked as part of the follow-up Inspection. It is interesting that this home was categorised as a ‘care home with nursing’ (Appendix 9) and promoted itself as having a specialist dementia care unit. However, from the findings there was no discernible difference between it and the other homes that did not have nursing care.

Two things emerged from the study of the Inspection Reports. Firstly, there was no overall emphasis on training. One of the inspections (1B) went into detail on Criminal Records Bureau (CRB) and reference checks but did not mention anything about training; others just mentioned the completion of mandatory training (food hygiene, fire safety etc.). Secondly, practice in reporting seemed not to follow any single standard, as the points made in the previous paragraph illustrate when considered together.

4.2 Characteristics of the Interviewees

This section reviews the characteristics of the nineteen interviewees who participated in the research. Table 4.1 uses the variables of age, gender, and ethnicity as a way of shedding some light on the interviewee population and how it compares with national data on this workforce. The NMDS-SC data covers residential care workers with older adults in England and represents around half of the social care sector (NMDS-SC 2017b).

Table 4.1 Interviewee Demographics

		Number of interviewees (N=19)	NMDS-SC Workforce
Age	24 and under	0	15.7%
	25 - 34	0	24.5%
	35 - 44	5 (25%)	18.9%
	45 - 54	11 (58%)	22.4%
	55 - 64	3 (17%)	15.7%
	65 and over	0	2.7%
Gender	Male	0	11.1%
	Female	19 (100%)	88.8%
Ethnicity	White	14 (74%)	70.8%
	Mixed / Multiple Ethnic Group	1 (5%)	1.7%
	Black / African / Caribbean / Black British	2 (10%)	6.2%
	Asian / Asian British	2 (10%)	6.3%
	Other	0	1.0%

Of those interviewed, 17 were RCWs, one was a newly appointed care home manager (2B#14) and one was a team leader (3B#10). All the interviewees were in a direct care

role, although the Care Home Manager and Team Leader spent less time with clients because of other duties.

The invitation by the Care Home Manager to be interviewed was accepted by the researcher as there were no RCWs available at the time. It should also be noted that this interview took place in the home where four interviews were completed. The Care Home Manager stated that she often “...helped out on the floor.” (2B#14) and had only been promoted to the position of Manager a few weeks previously. Although the purpose was to interview RCWs, the newly promoted manager was keen to participate. The manager was interviewed as the home was short-staffed and did not want to disrupt the care team by removing another RCW from the floor.

That all interviewees were female reflects the observation that the dementia care workforce is generally more likely to be female (Hussein and Manthorpe 2012). In terms of age, the interviews did not reflect the workforce as a whole, with a basis that did not include any under the age of 35. The average age of RCWs, at around 50, was slightly older than the age of 42 reported by Hussein and Manthorpe (2012). It is not thought that the slight difference in the average age made any difference in terms of representativeness. However, this sample is close to reflecting the characteristics of the residential care workforce nationally.

As for ethnicity, the division between ethnic groups within the interview population and the figures from the NMDS-SC population were broadly similar given the smaller sample size for the interviewees. The homes were in three different counties with a less diverse population. Had they been in areas of higher minority population, the sample might have been different in terms of ethnicity.

The selection of RCWs to be interviewed was determined by the Care Home Manager based on who was available. As such, it represents an opportunistic sample.

4.3 Demands of Dementia Care

Dementia care has its own specific demands. This section explores RCWs’ views and experiences of working with residents and their families, and the implications for care

worker training and learning. It examines the emotional demands placed on RCWs and how teamwork and communication can impact on practice and inform training needs.

4.3.1 Emotional Demands on RCWs

Working with dementia places many demands upon an RCW (Lee-Treweek 1997, Beck et al 1999, Innes 2009). RCWs need both physical and emotional skills, and those interviewed were asked about their feelings about working with people with dementia, what challenges they felt were presented in their role, and if they felt they could give the care and support needed to support residents.

The majority of RCWs interviewed said they liked working with people with dementia, and it was clear that RCWs had genuine concern for the welfare of the residents and wanted to do their best for them. *"It's a privilege to help."* (1B#03) However, one recurring concern was articulated. This concerned aggression shown by residents with dementia towards RCWs and to other residents. Except for one RCW, who said *"violence doesn't bother me one bit"* (1B#05), the remaining 18 interviewees voiced concern about resident aggression. Of the 19 interviewees, 17 acknowledged experiencing fear of aggression. One said, *"They can hit and beat you - I was hit several times today"* (3A#17). Some workers intimated a certain resentment and some a feeling of acceptance about this recurring subject.

Another RCW (1A#02) explained how a male resident broke everything in the room and took hold of her arm and then her throat, not letting go. There was anxiety in her voice as she explained the experience. The home called the resident's son and the GP to help. She said that *"The gentleman resident wore himself out and fell on the floor"* (1A#02). Fortunately, the gentleman was uninjured. The RCW however, was hurt and bruised. Another RCW explained how she was hit across the back of the head with a walking stick (2A#13). She showed me bruises on both her arms where she said she had been *'grabbed'*.

"You never know when they are going to hit you or what. It's the same with the food situation" (1B#01)

Aggression took the form of physical, verbal, and racial abuse. RCWs identified that residents had made unkind comments about their hair or weight or skin colour. One

resident said, *'I don't want that black one'*. (1A#07) The same care worker said, *"they scream and shout at me."* (1A#07) Another said, *"They use bad language – some of it is shocking what they say."* (2A#13) RCWs commented that little can be done to reduce this, and bad language was possibly part of that person's way of speaking. RCWs said they just ignore it, try not to let it upset you and to carry on. Again, there is an acceptance of it.

One RCW described how she feels affronted when under verbal attack. The RCW (1B#01) said she tried to explain to the resident that the resident had ordered fish and chips. The resident argued that she had not ordered fish and chips and shouted at the RCW *"are you making me out to be a liar"*? The RCW said she found this behaviour *"very, very challenging - I don't know how I do it"* (1B#01).

Several RCWs admitted being afraid of residents or being nervous around them. RCWs talked about their concern for other residents getting injured, or becoming injured themselves when a resident becomes aggressive.

"I do get frightened I'm going to be more seriously hurt – like one RCW here. She was off a while. She didn't want to come back." (2B#15)

"It's pressured - you constantly have to be on your guard and watch for the danger signs." (3A#17)

"There is danger in everyday personal care." (1B#05)

"You have to have an understanding what facial expressions and non-verbal actions mean when a resident doesn't speak – she will kick people up the bum to get them out of the way!" (1B#05)

Two RCWs expressed that *"you are not allowed to hit them back."* (1B#01, 1A#06). Even for RCWs to consider *'hitting back'* (however briefly) illustrates a level of frustration and anger that can be felt towards the resident. This finding suggests that RCWs would benefit from training about the nature of dementia, and appropriate ways to respond. Indeed, all RCWs, except for one, wanted training in responding to aggressive behaviour. Without training about the nature of dementia, the RCWs may not know why people with dementia behave this way.

Coping mechanisms used when facing challenging behaviour were also discussed frequently. There was a strong recognition from most RCWs that when residents became aggressive, it was

"Important to walk away and come back to the resident a bit later when they had calmed down" (1A#06)

and that

"Sometimes you go back, and they are a completely different person." (2A#11)

However, one RCW pointed out, walking away isn't always possible:

"It's very hard to accept being slapped and scratched. Sometimes I have come out of here quite scratched because you are in a position where you can't just walk away. If they've just got out of the shower and they turn on you- you can't just leave them, can you? My way is to walk away. Sometimes you are in a position where you can't just walk away, and you have to get on and have your hair pulled a little bit more." (3B#10)

One care home had sought to give RCWs what was termed as 'breakaway training'. Breakaway techniques were originally imported from the Prison Service in the early 1980s (Mott et al 2009), and defined by the National Institute of Clinical Excellence (2006) as

"...a set of physical skills to help separate or breakaway from an aggressor in a safe manner" (Mott et al 2009, p38)

Mott et al (2009) stated that there were no agreed standards as to when such techniques could be used. Breakaway training did seem to be of benefit to this RCW:

"We have residents who are aggressive, physically aggressive to staff and other residents. We have to know recovery techniques when she's attacking you – you have to move away from the situation.... or ask for assistance - we have breakaway training. For example, if she grabs you. Last week she grabbed one of our staff from behind the neck. So, you need to make sure - hold your hands - try and break away - peel off. Yes, and then you move away without hurting her" (1B#03).

Another coped by

"Keeping calm, talk quietly, and a lot of reassurance" (2A#11).

Several RCWs identified they had some understanding as to why residents become aggressive:

"A memory sometimes triggers a frustration or a challenging behaviour" (3B#08).

"Residents get very confused sometimes and get angry with themselves because they cannot understand what is happening to them. They don't realise they need changing or washing." (2A#11)

Uncertainties and ethical dilemmas were identified by RCWs about knowing what is in the best interests of the resident about challenging behaviour when attempting necessary personal care tasks.

"Should we go ahead and wash and change them if they are soiled and they don't want changing? Other homes have training in this and they are told to change them anyway if they like it or not for their own well-being. If they are left unwashed – it looks bad on the care staff. But some residents won't let you go near them" (3B#08).

"If you leave them unwashed its neglect, and what if management came in and saw it? If we force them its abuse" (1B#03)

Clearly there are uncertainties about how to care for the resident, and pressure and anxiety about how their practice is viewed by management. This was a common concern and places additional strain on what is already a stressful situation. Working with dementia touched emotional buttons for RCWs, identifying feelings of fear, apprehension, resentment, and uncertainty about aggressive behaviour.

Perhaps more positively, RCWs acknowledged feelings of attachment towards residents and talked about sending them birthday cards.

"We all have our favourites, even nurses and management - everyone." (1A#02)

Although it could be considered infantilizing, an RCW spoke of the emotional attachment she felt towards the residents.

"It's because of doing tasks for them every day like you would for a child." (1B#05)

Yet such attachments brought challenges and uncertainties. One RCW commented that she was told not to become attached,

"But it's hard - really, really hard because you work with people day in and day out - it's hard not getting attached." (1A#02)

Handling bereavement was an emotional aspect of their role, and is linked to attachment. One RCW broke down when a resident passed away (2B#16). Having worked closely with the resident for almost four years, the worker knew the resident's family including younger grandchildren. This care worker had drawings from the resident's grandchild they had drawn for her in school. The worker said that she finds it difficult when the room that used to be occupied by a familiar resident has become empty

"With all their little bits and bobs left - then another resident is in the bed and you have to carry on – start over - it's hard, really very hard." (2B#16)

Clearly, this can have an impact on the emotional wellbeing of workers. RCWs identified that they had little choice but to carry on, often with scant opportunity to process the emotions they were experiencing. Attachment and bereavement is an area for training. Several RCWs acknowledged feeling emotional when residents asked about their mothers and spoke about wanting their mums. One said

"In the end she just wanted her mum - you always want your mum don't you." (2A#12)

This triggered her own feelings of loss when her own father had died.

Residents' questions about their mothers caused one RCW to wrestle with an ethical dilemma. The RCW (1B#04) had been told to tell the resident the truth in response to her questions about her mother. The RCW admitted that even after many years of working in residential care with dementia, she could not bring herself to tell the residents the truth about emotionally charged questions. Instead, she chose to redirect the resident's attention with the offer of a cup of tea. The RCW said there was *"uncertainty about playing along with them and there were ethical implications about lying to them."* (2B#14) She reflected on her practice, saying *"maybe it was a good thing to do that?"*

Given these types of questions are frequently asked by residents, and the distress answers can bring, there is an important training need in ways to respond. RCWs need knowledge about why these questions are asked, and the confidence and competence to respond in a sensitive way.

Another RCW said it was *"distressing not being able to help them understand their reality."* Residents with dementia are often not aware of who and where they are (1B#05). *"They don't understand; it's distressing on both sides."* (1B#05) One RCW recognized that she felt a range of emotions during her daily practice with residents. She identified feeling *"very sad because the resident couldn't look in the mirror because she knew how bad she looked."* (2A#12) She felt sadness when she saw other RCWs *"just getting the job done without any talking to the residents."* (2A#12)

However, it was clear that caring for people with dementia does have its positive moments, *"Sometimes, there are funny things that help you out."* (2A#12) The RCW explained that two ladies always sit together at lunchtime and insist on having the same meal, even if it's something one of them doesn't like. Addressing happiness in working with dementia is reported as job or work satisfaction (Manthorpe 2014). This view seems to reflect Manthorpe's (2014) recommendation that RCWs should be consulted about what makes them happy in their work. Training could address the importance of positive aspects to the role, where views of RCWs can be used to boost morale and share knowledge.

A recurring theme highlighted the importance of working relationships and teamwork, and how workers felt teamwork impacted on the level of care. There were mixed responses from RCWs about how they felt the staff worked together as a team for the benefit of all. At its best, teamwork enabled workers to manage challenging situations they could not handle on their own, and to learn from each other. At other times, however, teamwork posed challenges of its own.

One RCW referred to an incident where a resident was behaving in an aggressive way towards her.

"Another RCW came and spoke with the resident to help calm the situation down. She knew the resident - there are times when you have to rely on other staff." (1B#03)

Similar responses were given by other RCWs where staff had intervened in order to protect residents or staff members. One RCW said that

"We have a good team here - you can always shout for help from someone. Or there's management you can call" (3B#09)

However, this was not always the view from all RCWs interviewed. Another RCW said,

“Working with other staff members is a challenge and an uncertainty. It’s difficult to work as a team. It’s very difficult. It’s more difficult to manage the person I am working with than the person with dementia.” (2B#16)

The RCW did not want to elaborate on this point whilst the tape recorder was still recording. Later, she explained, once the recording had been stopped, that she found some staff did not have the same standards of care that she felt she had:

“They are just getting the job done and to them it’s more important getting them washed and dressed” (2B#16)

The RCW explained how teamwork can influence care. This centred-on tension between sub-groups among the staff and communication difficulty with workers for whom English was a second language.

“There are cultural differences between the care staff. The African girls won’t talk to the Asian girls. The Asian girls won’t talk to the African girls - or they just insult each other when they should be getting on with caring for the residents. It makes it very difficult to work with. The language for one thing. Communication is important when you work with dementia. Some of them [care staff] cannot speak English properly – not so that you can understand them. If I can’t understand them, how can the residents understand them?” (2B#16)

Another RCW raised a similar point

“You need to rely on staff members and who you are working with. I collapsed with anxiety with needing help but the RCW misunderstood English and went away. It was harrowing. It’s hard to break away when they are biting your hands.” (1A#02)

Another RCW identified that she felt teamwork had a direct impact on care given to residents with dementia.

“It (i.e. care) depends who you are working with. We are supposed to work as a team. You can spend ages working with a resident to make them happy then someone else comes along and spoils it.” (2B#16)

Another RCW said

“Staff have to work as a team. Communication has to be good - you need information just to go into a certain room.” (2A#11)

One RCW identified her concern and sense of responsibility about tasks that needed doing at shift change over. She said, *"If you don't do it - it won't get done by the next shift."* (1A#07)

These responses indicated that teamwork is very much a training needs necessity. In certain situations, it is imperative for team members to be able to rely on one another. RCWs expressed the importance of good communication between team members, and of being able to speak and understand English to ensure the needs of residents are made clear. RCWs would benefit from team building exercises. English lessons are needed for some RCWs. However, this would take time to learn enough to be understood and is an additional cost to the care home.

4.3.2 Working with Residents' Families

RCWs acknowledged they needed training to work with families and that what they had been told was not working well in practice. Several RCWs acknowledged feelings of sadness and some of anger when working with families of residents (1B#05, 1A#06, 1A#07, 3B#09, 2A#13, 2B#14). Responses from RCWs showed the difficulties families experience as the disease progresses and their loved one loses the ability to recognise them. RCWs had their own perceptions and expectations of how families should show care for the family member with dementia, and be part of, and contribute to, the person's wellbeing.

One RCW explained how upsetting it was when a family won't become involved: *"It's very hard"* (1B#05). She gave the example of one family who would not pay for their mother's hair to be done as *"she has dementia and doesn't know anyway - it's a waste of money"* (1B#05). *"But it's her [the resident's] money!"* exclaimed the RCW to me. *"Everyone feels better when they've had their hair done"* (1B#05). Another explained that a family would not buy everyday toiletries like soap or shampoo, saying that the home should provide it (2A#13). If the family did provide soap or shampoo, it was the very cheapest they could find: *"cheap soap is not good for her skin - it's so dry"* (2A#13). A sense of injustice, sadness, and anger came through from RCWs. This was especially so when they felt that residents were neglected or treated without warmth or kindness by family.

Two RCWs (1A#06, 3B#09) commented that staff themselves bring in toiletries for the residents for those whose families are inattentive in those areas. One RCW commented that the home buys a few bits like talc from petty cash. (1A#07)

"Everyone likes a bit of smelly. We just have to get on with it. You know the family has money to provide toiletries, but they won't give it. Ladies with dementia really like their nails being done. Self-esteem is linked to this. Little touches can make a difference." (1B#05)

Another said she found it

"Upsetting when the family doesn't visit or take them out regularly. It's hard getting families involved - especially at Christmas time - that's what I don't like. (1A#07)"

The RCWs said that they try and make up for what they feel is missing from family support. They highlighted the importance of appearance and comfort for residents with dementia, and of trying to retain a sense of doing the things they were used to doing, like having their hair and nails done.

At the same time, the same care worker felt that families should receive more support. She said she felt a

"Strong feeling of needing to comfort the family that does visit - especially during changes in behaviour. The family find that difficult" (1B#05).

One RCW said she felt sad for the family when the resident doesn't recognize them anymore, *"I can't imagine my mum not recognizing me"* (2A#12). She explained about one difficult family visit. A gentleman resident was holding hands with a female resident. The gentleman's wife came to visit him and was taken aback seeing her husband holding hands with another woman:

"It was upsetting for her - but luckily she understood. She was all right about it. We should have training in working with families" (2A#12).

An ethical concern was raised about working with families.

"Family want different to what's taught. We are told to tell the truth when the resident is confused. The family just want us workers to go along with it - it's not what they deserve." (1B#04)

There is a discrepancy between what RCW are told is good practice by management, and what the family sometimes wants, or thinks is best. RCWs see value in working

with families, but get upset when residents do not receive the attention or kindness they feel is due to them. RCWs also understand that families face emotional difficulties in coming to terms with witnessing the deterioration of their loved one or when there are changes in behaviour. The comments imply that there is a strong feeling of injustice, but nothing is done to address their concerns. The implication is that RCWs feel they are not able to challenge given there is little opportunity to voice concerns, or they have not been listened to in the past.

The interaction between RCWs and families has been identified as an important area for training by RCWs themselves. RCWs want enough knowledge to be able to explain about the nature of dementia and about care home policy, so they are confident to do what they feel they should be doing, and that is to help the families, as well as wanting the best for the resident. They felt inadequately supported with this aspect of their role.

4.3.3 Barriers to Implementing Person-Centred Care

An important theme that emerged from the analysis is the concern over the level of care received by residents, particularly those with higher level dementia care needs. One RCW asked *“where is person-centred care? Like we are trained to do - there isn’t time.”* Training in delivering person-centred care needs to consider the necessary time such care requires. For example, from a person-centred perspective, it is more important to ensure that a resident enjoys a bath rather than it being a task to be completed. Person-centred care means maximising opportunities for respect and building caring relationships, or, as one RCW said: *“Time to sit and hold their hand.”* (1B#05)

RCWs felt very strongly about this. They identified that very heavy workloads and insufficient staff often meant there was little time to spend with residents, leaving them without the level of care that workers believe they should have (1B#03, 1A#07, 3A#18). Although measuring care is beyond the remit of this study, it is important to point out that RCWs identified concerns for care and what this means for training and practice. One RCW felt very strongly and stated that *‘dementia is different to a normal unit. They need more concern from us. You have to spend more time because of their*

limitations’. The RCW reiterated this statement, *“they need more concern from us.”* (1B#01) Several RCWs indicated that person-centred care was simply not possible:

“More time. Time with them is very limited. There is not enough staff to give them time. With high dependency residents you need more staff. It’s upsetting for staff because you can’t provide everything you should. We are not just there to wash and dress, we need to talk to them – they need reassurance.” (1B#01)

“We can’t talk to them like we are trained to do. We can’t do person-centred care.” (1A#02)

“The main issue is time- nobody gets the quality of time they need. If you spend more time with one- another will get less.” (1A#06)

This was also acknowledged by a team leader who said,

“Because you are concentrating on their toileting needs, they rely on you for the diet and their fluids, so you are constantly going from one to the other – we are missing out on the social side of things” (3B#10)

It was clear that the RCWs were aware of the concept of person-centred care, even if practicalities and the demands of the role prevented its implementation. RCWs’ understanding of person-centred care largely related to dignity, individuality and promoting choice. This came mostly from working alongside others, or what some may have remembered from previous training.

One RCW identified a resource concern. The care home didn’t have the right equipment. (1B#01) A shower was required for a female resident who did not like having a bath. It took two or three RCWs to reassure her and help her at bath time, which meant that no other resident was being attended to. *‘Staffing is a problem, especially in a high dependency unit’* (1B#01).

Another RCW identified the size of the home and how that impacts on person-centred care. She says,

“It’s such a big home there is no time to talk to the residents like we are supposed to do. Residents need time to be explained to. They get confused and agitated. We have one lady who kicks off really quickly and it’s because there isn’t time for her. If you spend time with her and talk to her, she doesn’t get angry or hit out.” (1A#02) - *“Because of the limited number of staff there is little time to get to know the residents like we should”.* (1A#02)

The RCW explained that some of the residents ask why they have not seen them. She said that

"We get pushed around from unit to unit to cover wherever - that you have to go back in your break to say hello to residents that have been asking about you. They need to know you. We need time interacting with them... even if you are around you are not actually with them, rubbing their hands and interacting with them." (1A#02)

One RCW (1B#03) gave an example that illustrated how limited staff numbers can impact on the delivery of even basic personal care.

"There are three staff to twenty residents. We need more people to give people what they need. They need to be washed more - they are lacking in personal care. We need more carers. We can't take them out. What should happen doesn't happen." (1B#03)

Several RCWs believed that many residents in the home had dementia, but had not been diagnosed. This led to these residents not being cared for in the dementia unit. This can have an impact on staff and the level of care delivered, as has already been illustrated by care worker responses.

"In a home like this not a lot of residents are diagnosed with it (dementia). They probably are, but not to the extent that they are on the dementia unit - so everyone thinks that everyone with dementia is on unit 4 (dementia unit). People don't realize how severe it is in here not just in this home, but in general... their needs are not provided for. We have 29 residents to care for downstairs - to get five minutes is a miracle." (1B#05)

It was clear most RCWs verbalized feelings about a level of injustice and how that made them feel about their ability to care and how they perceived their job role. One said

"You want to give them so much more. They deserve more... The real thing is here you have to wash twenty residents- people don't realize how hard it is in here when there's only three of you- it's hard work. It just breaks your heart." (1B#04)

"I know we have human rights, but some haven't got quality of life.... And some of them do suffer." (1B#05)

She continued....

" They can't get up when they like - it's too time consuming. There just aren't enough staff. They deserve more. They deserve better" (1B#05)

RCWs identified a level of injustice in terms of the lack of meaningful activities for the residents.

"We have one man in here – he was a caddy and worked on a golf course. There's nothing to stimulate them here. There is nothing for them here, honestly". (1B#05)

This RCW explained that for this gentleman, there ought to be activities that reflect his interest and is meaningful to him as an individual. Another said

"We need things they would do if they were in their home – I asked the resident's niece to bring in her crochet." (1A#02)

Two RCWs commented similarly on the inappropriate nature of activities available. One said *"there are a few activities here- we do the best we can with what we've got. We have skittles and balls - but they are not five years old!" (1A#02)*. Another said, *"we were meant to have an activity coordinator, but they can't get anybody."* (2A#12) When I asked why she thought that was, she shrugged her shoulders and said *"don't know - they don't stay. The pay is so bad here. It's such a big home - she can't do the whole building."* (2A#12)

RCWs identified how limited staff and the environment had an impact on person-centred care they felt they should be able to deliver. One very experienced care worker of over twenty years, said that

"the dementia unit is on the first floor. It means we can't take them out into the garden. Residents do enjoy going out" (2B#16).

Another said

"Ok, I feel I can't care for them... I would like to take them out into the community but can't because they might start shouting. There are not enough of us to deal with that." (2B#15)

A team leader summarised the barriers to person-centred care.

"We are not giving them the care they deserve. You are not giving them the person and social side of things like you are supposed to. There's no interaction. We are unable to put training into practice - it's like a conveyor belt. They have lovely gardens here, and no one to bring them down - we have a higher level of dementia but the same measure of staff. Your time with a person is very limited." (3B#10)

It is reasonable to ask why residents with dementia reside on the first, as opposed to the ground, floor when the care home had a purposefully designed sensory garden. As RCWs pointed out, limited numbers of staff meant that residents did not get to go downstairs to the garden, and it was therefore wasted as a valuable resource.

Several RCWs related to their care role in terms of the care they would like to deliver to their own family. *“I treat them like they were my mum and dad”* (2B#16). Three RCWs had previous experience of caring for a parent with dementia before working in a care home. (1A#02, 1A#06, 2A#11)

Quality of care within the care homes as provided to the residents is beyond the remit for this study. That said, RCWs identified what they thought their job role should entail to provide what some termed as ‘proper care’. The term ‘proper care’ was frequently used by RCWs, and refers to having enough time and staff to implement person-centred care.

The barriers to person-centred care cannot be resolved by training alone. Training can only be useful if there is opportunity and time to put it into practice. Training needs to take account of the realities of practice and how care is organised. This requires a change in the way organisations operate, and is a key dimension in facilitating learning and training transfer.

4.3.4 Summary

This section has addressed the many demands on RCWs as viewed by RCWs themselves, and what this means for specific dementia care training. RCWs have identified that they want the best for the residents, but that there are significant gaps in training. RCWs identified a need for training to work with families, challenging behaviour, attachment, bereavement, and teamwork. Within these identified areas of learning needs, emergent concerns included ethical considerations, lack of confidence, limited knowledge, fear and uncertainty about what to do in certain situations that would result in the best for the resident.

There was an expressed requirement for training that increased knowledge about the nature of dementia and provided RCWs with the competence and confidence to transfer their learning into practice to deliver person centred care.

4.4 Experiences of Dementia Training

This section will identify the views about specific dementia training from the RCWs' perspective. It will address mandatory training, a compulsory and a more generic form of training, largely in areas of safety and hygiene. It identifies views on the limited experiences of previous dementia training and that of the only manager to be interviewed. RCWs gave views on the strengths of 'on the job' training and their preference for practical training experiences. Learning needs were identified in terms of the learning environment, and having knowledgeable trainers that address the learning needs of the group. Learning needs identified by RCWs included course content on working with families, teamwork, addressing the emotional demands of their role, challenging behaviour, person-centred care, diagnosing dementia, and medication.

4.4.1 Mandatory training

Mandatory training is training that must be given and must be updated every year, forming part of the CQC (Care Quality Commission) home inspection procedure (see Section 2.4.1). Most care staff interviewed said that they had had mandatory training but little else. Staff explained that mandatory training consists of manual handling, food safety, fire safety, first aid, and infection control. This does not include specific dementia care training.

When asked what specific dementia training had been received, one RCW said *"Very little. The only training, they do is for stuff you can sue them for."* (3B#09) Another said, *"only mandatory training - mainly on the job training."* (2A#13} One said, *"we never really get training apart from safeguarding."* (3B#10) Another said she could not remember any training she had had except for something on diversity (1A#07).

These findings identify that care home organisations are not committed to dementia care training and will only provide mandatory training. One RCW identified that her

safeguarding training had lapsed, implying that even mandatory training slips. The RCWs identified that very little, if any, specific dementia care training had taken place. There was no mention from any RCWs of the 'Common Induction Standards', training that has to be completed by a new care worker within their first 12 weeks of employment. This training includes the subjects covered by mandatory training, so it is possible that RCWs were not aware that the Common Induction Standards cover the same subject matter.

4.4.2 Previous Dementia Care Training

RCWs were asked what training they had received in the previous two years, a timeframe I deemed short enough that it was reasonably likely to be still within recall, but long enough to capture training that would still be relevant in terms of retained knowledge.

Four RCWs (1B#01, 1B#03, 1B#04, 1B#05) had received an Alzheimer's Society three-day training course called '*Yesterday, Today, Tomorrow*'. All four were from the same care home and reported that they had taken the course more than two years ago. One of the four RCWs said that she thought it was about four years ago (1B#05). Another of the four RCWs said she "*couldn't remember much of it, but that it was more than two years ago.*" (1B#03) None of the four RCWs that took the '*Yesterday, Today, Tomorrow*' course could remember how the training was assessed (1B#01, 1B#03, 1B#04, 1B#05). Another RCW identified she had had previous training, but more than two years ago.

"I did a course on challenging behaviour – but it was over two years ago. I haven't done dementia in the last two years. I've done a DOLS Mental Capacity and I think my safeguarding has been updated but it's hard to remember in two years." (2A#12)

Most RCWs expressed that they had not received any dementia care training. One said she "*hadn't had dementia training in the last two years.*" She said she "*did a little with another company for about three or four hours*" (2A#11). The same care worker said she had done "*in depth mandatory training but nothing dementia specific*" (2A#11). Another RCW said she could not remember any training specific to dementia (3B#09). She thought she had done a dementia course when she was a house keeper, but not

since she had been a care assistant, and that was more than two years ago (3B#09). One RCW said she had done half a day, once a year, on ‘behaviour that challenges’ – *“about how to approach and how to talk to them”* (2B#15).

Three RCWs who said they had had little or no training were unable to answer about training strengths (1A#07, 3B#08, 3B#09). They were from the same organisation, which suggests that this organisation did not invest or commit to dementia care training. The same point of concern was voiced by three other RCWs (1A#02, 3B#09, 3A#18). However, these RCWs came from different care organisations, illustrating that the lack of training was not limited to just one organisation. All three had also been in post for at least a year.

There was some confusion, and conflicting responses, from some RCWs as to what specific dementia care training they had been given. For example, One RCW said she could *“not remember any training specific to dementia”* (1A#07). However, later during the interview, the same care worker said she *“has training every month and thousands [sic] of eLearning off the computer”* (1A#07). When asked, the RCW could not identify any of this training. The RCW said that she thought she had done a course in rarer cases of dementia, but again could not tell me anything about it. A more senior care worker (3B#10) said she had covered just the basics on eLearning for dementia, but that she found eLearning confusing. The only thing from the course that she could remember was *“to try and put yourself in their shoes.”* The RCW said she thought she had done a National Vocational Qualification but was unable to tell me anything about it or if it, or part of it, was specific to dementia care. This same care worker said, *“I haven’t had enough dementia training to answer your questions* (3B#10). Another RCW said she had done an NVQ but, again, could not tell me anything about it or if it was dementia specific (1A#07). Neither care worker could tell me if the NVQ was health and social care, or at what level they had studied.

One RCW appeared hesitant about answering questions about training (3B#09). The same care worker said, *“we have training here or at other homes or on the website-you forget the basics.”* She said she could not remember what training she had at other homes or what training she had done on a website. These responses could be for many

reasons, including that the RCWs did not want it to appear that they had not had training. If RCWs are genuinely forgetting training, it is possible that training was not engaging, or perhaps not understood as other RCWs had explained, or just too long ago to remember. This suggests that there is a need to look at how training is delivered, the environment in which it is delivered, to have refresher courses, and to measure training outcomes a few months after training has been completed as literature has identified (Burke & Hutchins 2008).

When asked about what training the manager had received, she replied that she had done a course for a couple of hours. It was a Best Interests Assessor course, but that she hadn't quite finished it. (2B#14). The same manager was doing a Deprivation of Liberty Safeguards (DOLS) course that she had paid for herself. The manager said she needed safeguarding training. When asked about managers needing specific dementia care training, the manager replied

"On dementia care. No, I don't think so. Not dementia care. I don't think so. You have got to have NVQ management, which I'm waiting to be put on." (2B#14)

The comments from the manager raise many concerns about the lack of support for her from the care home organisation. The organisation appointed the manager without the management qualification needed or even working towards it, as required by CQC. The manager had to pay for the necessary courses herself, and that dementia care training had not been provided for her as manager of a care home with a high needs dementia unit. This finding is reflective of the lack of importance shown to dementia care by a care home organisation, and is well documented in the literature. The manager came across as a genuinely warm, caring and gently spoken person. However, she is governed by the boundaries set in place by the hierarchy of the organisation. If the care home organisation does not feel it is important for a manager to have dementia care training, it would seem there is little chance of them implementing it for RCWs.

Most RCWs identified that 'on the job' generic training was most useful to them. This training meant they were working with people with dementia, but without formal specific dementia training. This was most of training they received and had

remembered. This meant fully engaging with everyday practical tasks, i.e. *'hands on-learning by doing'* alongside more experienced RCWs.

Several RCWs believed that a strength of their 'on the job' generic training was to understand the importance of being able to leave and come back a few moments later when dealing with a difficult potentially aggressive situation (1B#01, 1A#06, 2B#15, 2B#16). This, and knowing when to 'back off', was the most prevalent answer. There was a strong understanding that a person with dementia can present differently a little while later. A view from several RCWs was the understanding that each resident is an individual with their own needs (1B#01, 1B#03, 2B#15). One said, *"It's important to keep calm and play music – some like music and dance."* (3A#18). One RCW said that a strength of 'on the job' training was knowing about the environment: *"It's important not to crowd the person"* (1B#01).

It would seem from RCW responses that 'on the job' generic training has greater potential for RCWs to recall their learning than a previous isolated training session. This suggests that RCWs need opportunity to put learning from training sessions into practice. A training session would provide the RCW with knowledge and then 'on the job' training, with peer and supervisor support, can provide the confidence and competence to transfer the knowledge into practice.

An RCW spoke of the learning environment being inappropriate. The RCW said

"They use the lounge and residents come in and out all the time - it's their lounge. This is their home. It's disruptive and there is no confidentiality." (1B#03)

RCWs identified that there is a need to change the learning environment (1B#03, 2A#11). Inappropriate learning conditions would seem to interfere with the learning process.

"Residents come into the lounge. Of course – it's their home - it's their lounge. Training is interrupted and then we can't ask questions about residents. But you can't say anything -it's their home and they should be able to come in." (1B#03)

One of the views that came across strongly was the lack of understanding of the training provided. One RCW that had completed the Alzheimer's Society course thought that the specific dementia training she received should have had the

opportunity for more questions (1B#05). This care worker did not understand the training:

“Training either goes over your head or it just doesn’t register. We are getting all this training and not putting it to use – there is no time to involve yourself with residents. It’s the same for other care workers.” (1B#05)

Two RCWs expressed a view of not fully understanding training: *“I wouldn’t say training wasn’t useful, but I couldn’t get my head around it.” (3B#10)* One said,

“I just fall asleep in training sessions. Sometimes the training is not at our level, sometimes it can go above your head. We need separate training for carers... especially new carers.” (2A#11)

Clearly this training did not meet the learning needs of this care worker. I tried to discuss the reasons for her comments. The RCW just reiterated that she felt it was not aimed at care worker level, but did not want to elaborate on what or why she felt that way about training. A different care worker had told me similar, that trainers would tell the RCWs to read books at home. This is not useful given what is known about how RCWs learn. (1B#05) the RCW also commented that she felt annoyed that

“People walk out of courses and I don’t understand. They only go because their name is on the board - they don’t like being in the limelight. They say what was that all about? They have taken up a space and at the end of the day you have done nothing with it.” (1B#05)

I asked the RCW why she thought RCWs walked out of training. The RCW commented without the tape recorder on, that she thought some RCWs might have had a fear of training. Her view was that some RCWs felt

“it was a waste of time because you can’t do any of it anyway - you can’t do any person-centred care – you can’t do what they tell you should be done.” (1B#05)

One RCW (2A#11) stated that other RCWs had said they felt uncomfortable about training; they weren’t sure if they were going to be asked questions they couldn’t answer. *“It’s no wonder some of us don’t turn up at all.”* This last point becomes more understandable when I was told that RCWs had to attend training on their days off and were not compensated for it. This was not an isolated incident; in my professional experience, I am aware of many organisations that operate the same policy. This has

implications for learning and implies that the employer does not see training as important enough to compensate workers for its completion.

One RCW felt that once the tape was not running she could open up more about her feelings about training (2A#11). She said that RCWs have been taken out of training sessions to cover if staff are off sick. The RCW said that in one training session, she left briefly to go to the toilet. On the way back from the toilet, the Care Home Manager caught her and told her not to bother going back in as she was needed on the floor (2A#11). This incident is interesting and goes to the heart of whether training is seen as important by the Care Home Manager or the organisation as a whole.

Motivation to engage in training was seen by RCWs as non-existent. One RCW commented that there were *"no incentives to do dementia training!"* (3B#10). The RCW conveyed that RCWs want recognition, preferably financial reward, as an incentive to complete dementia training. This is understandable, given what is known about their pay and the nature of their work. The RCW felt that there was injustice if two carers are working alongside one another but are on the same pay when one has completed relevant training. This would have financial implications for the organisation and, as has already been noted, staffing is one of a care home's biggest financial outlays. In the current financial climate, paying RCWs additional salary may not be considered a viable proposition.

RCWs believed training was unsuitable as they could not provide person centred care as they were told to do, or they didn't understand it, and therefore was not transferable into practice. As RCWs were expected to come in for training on their days off, they believed it to be a waste of their leave. The logical implication is that training should be run on different days to accommodate different shifts. Having a fear of training and not wanting to be in the *'limelight'* supports what has been found in literature about the learning needs of RCWs. It implies that there is discomfort and insecurity in being in a learning environment and in the *'role'* of a student. The above care worker responses imply little motivation to attend training.

Two of the four RCWs who had received the *'Yesterday, Today, Tomorrow'* course identified that a strength of the training was learning about independence and person-

centred care. Helping with choices of everyday life, like choosing what clothes to wear and what food to eat (1B#01, 1B#03), with one stating that *“having photos of the family to help them remember”*, was a strength of this training. (1B#01) One of the four had the view that training with families was a strength as was using different approaches towards residents with dementia.

“I know what dementia is and how they present and how we can manage - so it helped me a lot. Training helped with day-to-day care as I had no experience.”
(1B#01)

One of the four thought the ‘Yesterday, Today, Tomorrow’ course was good but couldn’t remember much of it. (1B#01) This would seem to suggest that learning should be measured a few weeks after training has been completed, as found in the Literature Review.

Practical exercises seemed popular with a couple of RCWs who had completed the ‘Yesterday, Today, Tomorrow’ course (1B#01, 1B#04) One said, *“practical exercises were best- I like the exercise with the T shirts”* (1B#04). Another said, *“I liked the blindfolding exercise.”* Clearly it was something they have been able to learn from and remember, as this care worker has identified.

“Practical exercises that show how the person with dementia can find simple tasks confusing.” (1B#01)

Practical exercises were a valuable learning tool for RCWs. Several RCWs concurred with the need for more practical exercises (1A#06, 1A#07, 3A#17, 3A#18). One RCW’s view was to have training that uses real examples of who they were working with (1A#06). This style of learning may be more within the RCW comfort zone given that practical tasks are a strong feature of their job role. Practical exercises may provide a more supportive way to learn, and provides an element of fun to help engage fully in their learning experience.

One of the delivery methods identified as being useful was that of eLearning. One RCW said, *“I like eLearning because you can go back to it.”* (3B#08) This view was shared by another RCW who liked being able to go back and revisit certain parts of the training. This care worker liked doing her own training, and sometimes training with another RCW.

“The internet is helpful to talk through things. Going on the internet sort of helps if you just type in the things, it helps you understand why they are that way. You can go at your own pace. I like the internet and doing it through eLearning because I feel I am in control of my learning on the computer. It tends to stay longer in my brain if I go on the computer.” (3B#08)

In summary, the findings from care worker views indicate that all RCWs had limited formal dementia care training or none. RCWs who said they thought they had had dementia training couldn't remember it. Even a Care Home Manager couldn't remember if she had completed any specific dementia care training. Those that had completed the 'Yesterday, Today, Tomorrow' course said it was much longer than two years ago and that they felt they needed more dementia training. The most useful training was generic 'on the job' training alongside another RCW. RCWs pointed out that there was no motivation to train or that training was not understood. The training environment (not necessarily for dementia care, but for mandatory training) was inappropriate, being cramped or did not allow for confidentiality. Care worker experiences identified that training needs to be delivered in an appropriate learning environment that supports learning needs. Learning can then be transferred in the work place with peer and supervisor support. As RCWs identified they had forgotten training, learning needs to be assessed a few months later to ensure knowledge is retained.

4.4.3 Areas for Further Training

It was clear from the responses of RCWs that more training specific to dementia was needed and requested, mostly in areas around challenging behaviour and safeguarding residents and staff. One RCW who had completed the 'Yesterday, Today, Tomorrow' course said

“I need more dementia care training. I would say the 'Yesterday, Today, Tomorrow' training has been longer [ago]. I think three years since I did that.” (1B#05)

Another who had completed the same training course said similar.

“The 'Yesterday, Today, Tomorrow' course was very eye opening. I think we need training on it all - there are so many stages in dementia” (1B#04)

Another RCW felt very strongly about having training on challenging behaviour. *"We need more. We had all that six-week course, but I think we need more with dementia."* (1B#04) When asked about what specific training she felt she needed, her response was

"You don't know what goes on do you, either? Only when, like, the – we get violent ones... they get very violent with me. And there's been quite a few -they grab you and that. I'm not here to take this! ... I think more training on that." (1B#04)

Others responded similarly

"Definitely more dementia training!" (3A#17)

"Dementia training is lacking and gets pushed aside." (3B#08)

"I would like any dementia training!" (2B#16)

The view from the majority of RCWs was that there was not enough specific training on dementia and the predominant view was that there should be more training on behaviour that challenges.

One RCW identified a need to know about the Mental Capacity Act (3A#17). The RCW felt this legislation was needed in relation to advanced care planning. The RCW had been involved in caring for someone at the end of life. This made her feel *"very uncertain"* as she was inexperienced in this area and had received no end of life training. This feeling was exacerbated when she discovered that little was known by the care home about the resident's wishes.

Another concern was raised about needing to know what to tell families and how to answer their questions. This response might suggest that there were difficulties in seeking advice from more senior workers. A similar comment was made by another RCW who identified that *"training does not meet needs"* (1B#01). As an example, the same care worker said that she too needed training on working with families (1B#01). Another RCW shared this view

"We need more training with the family. That training is helpful. Family members came into the training session. We are able to explain things to the family." (1B#03)

"We talk to the families as well... they will correspond with us... and sometimes that's all it is - that narrow window with you and the family." (1B#05)

RCWs find that training with family is helpful for many reasons. RCWs use this session to learn more about the resident from family, perhaps identifying a way to meet a need. RCWs can explain to family members what care has been put in place to support the resident and reassure the family that they understand the needs of their loved one. *"Some families don't understand."* (1B#05) Another said, *"I see some family members here and it's just heart-breaking."* (3B#10)

Having families engaging with training provided family members with an opportunity to ask questions and to raise concerns they have about changes in behaviour they found distressing. An example is when residents no longer recognised their family members. When this happens, families sometimes stop visiting. An RCW said, *"the family don't like it when they are not recognized, and they stop coming."* (1A#02) Families being in training sessions informed them of the importance of continuing to visit even if not recognised, thus, helping to facilitate continued relationships with the resident.

Families being involved in training provides an opportunity to share experiences with other residents' families. It has the bonus of families helping and supporting each other once the session has finished.

"This was a very, very emotional training session. There are lots of tears in this session" (03)

Dementia is a very emotive subject and most RCWs interviewed identified this and requested a need for training on the emotional side of caring for a person with dementia. Three RCWs asked specifically for training on dealing with death and bereavement. (3B#09, 2A#12, 14)

"Yeah, coping with death has to be something in your training. Definitely." (3B#09)

"End of life training... It was talked about, because we don't do any kind of bereavement or counselling type. Because some people it affects quite highly, doesn't it?" (2A#12)

An RCW thought there was a need to have more training on medical treatments *“to help them and make their lives better”* (1B#03). This comment about medication was echoed by other RCWs and largely related to concern about the comfort levels of the residents. It was explained that because only certain care staff can administer ‘over the counter’ medicines like paracetamol or Gaviscon (for indigestion), it sometimes meant that residents had to wait a long time for pain relief if a qualified staff member was not around. RCWs commented on residents not getting pain relief as soon as possible after requesting it. *“It’s wrong they have to wait a long time for pain relief - “Sometimes it can be hours”* (1B#03). RCWs believe that if they had training they could administer pain relief to residents.

Another RCW identified that having training in diagnosing dementia amongst residents within the home would allow specific needs to be addressed (2B#16). From the comment, the RCW meant recognising the signs of dementia in residents thought to be free of the disease. The response from this care worker has a strong link with a previous comment about training, as advanced care planning would require early diagnosis of dementia so there is time for a resident to make choices about care while capacity to be fully involved remains. This care worker believed that there were residents undiagnosed who needed additional care but, without additional staff to attend to dementia specific needs, they went unattended. This means additional strain on workload and reflects literature findings that there are undiagnosed residents in residential homes.

One RCW felt that training should be tailored to the residents being cared for, and wanted training on recognizing signs of dementia (2B#16). This can have significant consequences for the resident with dementia in meeting their needs. The RCW felt that the training she had was not helpful because it didn’t address what she was hoping to learn about, meaning the direct questions concerning residents she was caring for. The RCW wanted training to address specific concerns so that she was *“able to do something about it.”* (2B#16) There was an overriding sense of frustration in wanting to, but not being able to, address these specific concerns. It is possible that this concern identified by the RCW can be addressed by support from the organisation. A consultant

can build a relationship with the home and can provide training that suggests ways of working with specific residents

Training was requested on how to approach the resident with dementia (1B#04), although this seemed to be one of the areas that most RCWs who had had training, remembered, and found a strength. RCWs' views were that they needed to know more about all aspects of the condition,

"We need – really, it's about everything! More on everything to do with dementia." (1B#04)

RCWs expressed concerns about the quality of dementia care trainers, in terms of trainers' knowledge, course content and delivery of training. Clearly there was room for improvement in many areas.

"I like trainers to be well prepared - not just tell you what books to read later at home." (2B#16)

"If they could focus more on into practice, so we could be fed with practical information that we could use on our daily basis - daily basic work... trainers that have been training for first or second time, they don't know what they talk about." (2B#16)

Training was "too rushed" and there was "not enough time." (1A#02) RCWs' comments referred to trainers not providing the answers or support for learning that they had hoped for from training. "They don't help us for a very long time." (2B#16) These comments suggest that little attention has been given to the specific learning needs of this group and that RCWs feel that trainers are not helpful in their delivery of training.

"People get too bored or too tired or hungry. People train, but they still don't know -we need to learn – seriously." (2B#16)

This comment to some extent reflects the comment above about training being "too rushed." The organisation of training and the environment where training takes place are paramount. Training needs to allow for the comfort of the learners. For example, when training is rushed there has not been enough time to eat. RCWs must go straight from training back to their work, often missing lunch breaks. RCWs that have come straight from a night shift to attend training are too tired to engage in learning.

RCWs were asked questions around whether they could put training received into practice and how that had helped them during their day-to-day activities. Several RCWs were unable to answer this question, as they had not received any training, or couldn't remember it. One RCW acknowledged that since training she altered the way she communicated with residents.

"I'm quite a loud person. But I do now remember to step back and let them talk to me rather than me talk over them and – not so much tell them what they want - but to give them option to tell me what they want." (1B#05)

Another RCW said

"I feel it has changed – as I explained to you that I know how to approach them, how to communicate with them, build a rapport. How to calm them down when they are high or when they are anxious, how to reassure them when they are agitated and anxious." (1A#06)

From the above two statements, it seems that RCWs felt that training can be, and has been, transferred into practice from their own perspective. However, with no assessment of training into practice completed, this could not be confirmed.

4.4.4 Learning Outcomes and Assessment

RCWs were unable to identify training outcomes as so little, if any, formal dementia care training had taken place. RCWs could not remember if training had taken place, so therefore there was no recollection of assessment of knowledge gained or retained in practice. RCWs referred to 'on the job' training where a more experienced worker was paired with a new care worker. Here they 'helped each other out' From care worker perspectives, working alongside one another in pairs meant just getting through the tasks with what knowledge they had shared about each resident. This relies heavily on a good working relationship, and on the knowledge and competency of the person demonstrating care. There is no formal assessment, 'it's just about getting the job done'. Clearly there is a need to deliver training that has clear learning outcomes, so RCWs know what is expected of them. Assessment of practice (with support) is needed to ensure that learning is retained and is transferred into practice.

4.5 Summary

This chapter addressed the findings from interviews with RCWs about their views on the challenges of their role as paid carers for residents with dementia, their experiences of dementia care training, and what training they feel is needed to provide for the specific and individual needs of residents with dementia. Although RCWs were asked about their training in the last two years, it soon became clear all RCWs interviewed had either been trained longer ago than two years, or had very limited or no specific dementia training that they could remember. Findings revealed many negative experiences with training. These included a lack of knowledge from dementia care trainers and insensitive teaching methods that contributed to a fear of training sessions. The quality of training and teaching methods will be discussed further in the next chapter.

RCWs identified their views on the many challenges specific to caring for people with dementia. For example, the difficulties around challenging behaviour, staff and time limitations, communication and teamwork, and lack of training and organisational support. All inhibit RCWs from delivering person-centred care. This is linked to care worker stress and a strong sense of injustice for the person with dementia. RCWs identified the highly emotional nature of their work, including attachment and bereavement, sharing the sadness of family members, feelings of fear from injury and uncertainty from management. These areas provide input into dementia training that they themselves have identified as desperately needed.

5 Discussion

5.1 Introduction

The aim of this research was to determine the views of RCWs about their specific training needs, with a view to providing input into training content, mode of delivery, and ways to assess learning into a curriculum for RCWs. This discussion draws on these views and uses relevant literature and theory as a lens through which to examine, understand and put them into theoretical context.

In moving beyond training identified by RCWs, the challenges of putting learning into practice and the assessment of training outcomes came through as an important theme. As such, training transfer emerged as a central element. Assessing training outcomes is discussed in this Chapter to assess the transfer of training through the elements of a learner's knowledge, confidence, and competence. These elements emerged as important in the implementation of training into practice during the interview process from the RCWs themselves.

The chapter then continues with the contents of training identified by RCWs and compares what RCWs believe to be important in their training with what is thought by Skills for Health (2015) to be important for dementia care training. The chapter continues by discussing RCWs' experiences of training. Building on Baldwin and Ford's (1988) training transfer model, Grossman & Salas (2011) showed the importance of learner characteristics of cognitive ability, motivation, self-efficacy and perceived utility of training in transferring training and learning into practice. The model suggests that organisations can significantly impact on training design in terms of behaviour modelling, and the work environment. Both shape learners training experiences and are critical to transfer of training.

The chapter brings together this training transfer model, a student-centred learning approach, and Honneth's recognition theory (2005) to propose a way forward for dementia training, mode of delivery, and assessment derived from the views of RCWs

themselves. This proposed conceptual model can be used to augment what has been identified by Skills for Health (2015).

The research questions proposed in the Introduction chapter were:

1. Identify the specific needs of residents with dementia as perceived by RCWs;
2. Identify the training needs for RCWs in terms of content and mode of delivery, as identified by the RCWs themselves;
3. Provide data from RCWs that could inform the content and mode of delivery towards the development of a dementia care curriculum for RCWs;
4. Identify the training outcomes and how these could be measured reliably.

In relation to the first two questions, during the interviews RCWs would often identify a resident's needs and continue by identifying it as a training requirement. Within the discussion, therefore, rather than dealing with the two questions separately, they will be combined by subject matter.

Limited information was gathered about training content and mode of delivery because so few RCWs reported having recent training. However, RCWs did identify preferences and comments on what was not helpful, providing useful insights for this discussion.

Due to the lack of training received by the RCWs interviewed, the subject of outcome and assessment was scarcely addressed. However, the desire of RCWs to have further training in specific areas and put learning into practice came through compellingly. How this could be achieved is the subject of further discussion in the section on training content and delivery.

Finally, putting together all the areas identified in this Discussion chapter, the Dementia Care Training Conceptual Model (Figure 5.1) proposes a framework for potential use in the development, delivery and assessment of dementia care training. The model consists of four distinct phases: Training Objectives, Class-based learning, Learning into practice and Assessment. This model would need to be tested empirically to be verified.

5.2 Challenges for RCWs

When considering the challenges faced by RCWs, several areas were identified by the RCWs: the specific needs of residents with dementia, barriers to implementing person-centred care, teamwork and the emotional characteristics of dementia care work will each be discussed in turn.

5.2.1 Specific Needs of Residents with Dementia

In identifying specific needs of residents with dementia, a person-centred approach is now a fundamental principle of dementia care and is embedded in the language of multidisciplinary practice (McCormack 2003). Therefore, any training for RCWs needs to address person-centred care. The interviews showed that RCWs held a strong belief that providing person-centred care is vital to their care work and is necessary to provide what they have identified as *“good quality care”* (although I acknowledge there are other ways to measure quality of care).

It appears that various models identify that person-centred care is multi-faceted but share some common threads. Brownie & Nancarrow (2013) identified that person-centred care typically consists of many different elements: environment enhancement, social stimulation and interaction, staff empowerment and individualized care. Although the definition of person-centred care is still vague, as discussed above, it is still considered by many as being synonymous with best quality care for older people with dementia (Edvardsson and Fetherstonhaugh 2010). RCWs interviewed perceived person-centred care to indeed contain many of the elements research suggests. For example, RCWs' views were very clear that person-centred care could only be provided through having enough staff and time. This means being able to build relationships, understanding the individual to provide meaningful activities, and giving explanations and reassurance. As one RCW put it *“sometimes it's just holding and rubbing their hand.”* This illustrates Honneth's (2005) first dimension of Recognition Theory in understanding the nature of the caring role, the importance of recognising individual needs, and the necessity of building relationships between the RCW and the resident. Here, the action of the RCW is a 'demonstration of emotional care' and underlines the residents' need for security. The RCW wants to respond to the

emotional need of the resident, and the emotional need of the RCW as a result is to provide comfort to the resident. This aligns with two of Kitwood's (1997) psychological needs, those of attachment and comfort. Positive interactions, such as nurturing and meeting psychological need must occur continually in the care environment if residents with dementia are to receive high quality care (Kitwood 1997). RCWs identified that reassurance was key in alleviating resident anxiety and fear and, in turn, prevents aggressive behaviour.

5.2.2 Barriers to Implementing Person-Centred Care

Barriers to implementing person-centred care were identified as a key theme from care worker interviews. There is nothing in legislation that specifies what the ratio of staff to residents with dementia should be. This remains unchanged over the years, despite research highlighting the concern about staffing levels in care homes and its relationship to care practice (Innes et al 2006, Harrington et al 2011, Popham & Orrell 2012). Since staffing is a care home's greatest cost – at least 60% of the costs for a care home - it seems reasonable from the homes' business perspective to try and limit the number of staff (Shaunak 2015).

Limited staff means limited time with each resident. This means that person centred care, and the building of relationships that comes with understanding a resident's individuality, needs and preferences, cannot always be provided (Ward et al 2008). The need for human contact for people with dementia has been identified in the literature (Morgan and Stewart 1997). Lack of time and staff means residents wait a lot longer than they should for personal needs such as toileting, social and personal care, and pain relief. It was alarming to hear that lack of time goes beyond residents having to wait for a need to be met; as one RCW stated "... *they do suffer.*" The concept of personhood is clearly not being maintained and is a status that can only be provided within the context of mutual recognition and respect (Kitwood and Bredin 1992). This is detrimental to the well-being of the resident, as these negative images of self are what Honneth (2005) calls the '*abyss of failed sociality*' (p155), and Kitwood's (1997) '*malignant social psychology*' (p8). The three domains of Honneth's (2005) Recognition Theory, 'primary relations of love', 'legal relations involving rights' and 'community

relations that value strength and build solidarity', shed light on a level of care that, through no fault of the RCW, is neglectful, removes dignity and a sense of worth, and is a shocking denial of rights for residents. In terms of Honneth's Recognition Theory, disrespect is synonymous with the denial of these spheres of interactional validation (Honneth 2005). Honneth believed that misrecognition provides the justificatory impetus for contest and social change. In terms of what has been identified here, there is a very definite need for social change.

Residents with dementia are powerless in situations where an RCW is not immediately available, meaning they wait for extended periods of time until an RCW becomes available. RCWs were also in a powerless position in that they were trying to balance organisational requirements and provide the level of care they felt is residents deserved but were often unable to do so. Requests for training and changes in practice by RCWs were largely ignored by senior management – *"they don't listen to us."* This, again, points to a form of disrespect towards RCWs by senior management (Honneth 2005). According to Honneth (2005) the experience of struggling for recognition will be even stronger if all group members share the feeling of not being recognised. RCWs want recognition for residents. However, RCWs themselves have no recognition, frequently referring to themselves as *"I'm just a carer."*

Their working environment is such that although RCWs are the backbone of care, they remain unrecognised. This feeling is exacerbated by the strong sense of hierarchy within care home culture. Honneth (2005) argues that the idea of self is a social product born out of day-to-day social interaction, and that this is a process where social actors imagine through an inner conversation how others might react to them. In doing so, this internalises social norms and shapes social behaviour (Houston 2015). This may explain why RCWs identified they had become complacent about how senior management undervalued their role, to a point where it was felt that it was not worth raising complaints or making suggestions for improvement. There was even an element of fear in discussing areas around the lack of recognition afforded them, which might explain why interviewees asked for the tape recorder to be switched off. However, staff and resident well-being are inextricably linked (Spector et al 2016), in that the lack of recognition afforded to RCWs reflects a lack of recognition for residents

and becomes a barrier to care. These findings from care worker perspectives are supported by a recent Canadian study by Bannerjee et al (2015), which identifies that heavy workloads and limited staff are barriers to care and that hierarchies of knowledge contribute to the devaluation of RCWs. Bannerjee et al (2015) says RCWs perceive themselves as not having a voice, suggesting these findings may be understood in terms of 'epistemological violence'. This concept identifies the harmful effects of a 'taken for granted' dominance of a reductionist worldview and results in several exclusions. These exclusions are apparent in the experience of RCWs, for example, not having time to see to the needs of residents (ontological), and their exclusion from decision making (epistemological) (Banerjee et al 2015). This is unlike physical or verbal violence in that it is an impersonal form of violence akin to structural violence but can result in very real harm. There is a desperate need for organisational change in caring practices, and in the way organisations respond to the needs of RCWs in supporting residents. In a systematic review of staff training, most studies point to the importance of addressing the barrier to change posed by organisational factors (Spector et al 2016). In addressing these concerns, Moser (2010) promotes the idea of building on quality already at work in care practices, to include and listen to RCWs who have knowledge worth hearing.

Genuine concern and affection came through during interviews. A strong sense of injustice came through from all RCWs, that the ability to provide person-centred care should be a '*right*' for the person with dementia. Residents with dementia do have a right to be cared for in a person-centred way. Person-centred care is related to a broad overarching ethical idea that residents with dementia should be treated as persons (Entwistle and Watt 2013). The term 'person' is often equated with the term 'human' that has valued characteristics and certain ethical privileges. (Entwistle and Watt 2013). These may include abilities to communicate, and interests in developing self and identity, and that 'persons' have a different ethical standing than non-persons (Entwistle and Watt 2013). This raises important concerns when thinking about how human beings should be treated. If a resident with dementia does not demonstrate the characteristics associated with a 'person', they could be excluded from the protection of requirements that they will be treated as persons (Chappell 2011).

Care staff identified differences in care standards, that some RCWs just perform hygiene tasks without interaction so that it becomes routine task. This might be for several reasons. It is possible that these are the RCWs that have been told not to become attached. Possibly, RCWs feel work load and time interfere with interaction, or that the tasks themselves are being used as a barrier for communication due to care worker anxiety about intimate contact. This type of anxiety is common within caring professions, to protect themselves, RCWs use socially structured defence techniques, often unconsciously (Menzies 1970). De-personalising the relationship prevents having to engage on an individual level (Cooper et al 2013). If care staff engage in a more individualised way, they would need to dismantle these defences which could mean the return of anxieties (Dennis and Armstrong 2007). This is an understandable coping mechanism given the emotional nature of their role and their limited support. Implications for training means clarity of care standards and care delivery. This can be addressed by assessing how training is transferred into practice. A student-centred learning approach that offers mutual respect can identify concerns that might need organisational input for further training or changes in procedures.

Finally, RCWs identified a lack of consistency in allowing them to get to know residents. This was a result of staff shortages and having to cover, which meant RCWs were placed wherever cover was needed. With RCWs unable to form relationships with residents with dementia, one of Kitwood's (1997) five fundamental psychological needs for all humans is not being met, i.e. that of attachment. This would also be reflected in the task-centred approach to care that is the result of management of care practices within the organisation, and not what RCWs feel is working to person-centred care principles. Other possible reasons for RCWs adopting a task-centred approach to caring are discussed in the next section.

5.2.3 Teamwork

Teamwork was identified as a key theme from care worker interviews. RCWs identified that specific needs for dementia care required a supportive team to provide continuity of person-centred care.

“Having staff work together as a team was perceived to be the factor that would make the greatest positive change in dementia care. This finding suggests that practice expectations regarding the care of complex patients with dementia necessitates a collaborative model with good communication patterns among staff.” (Kovach & Krejci 1998, p24)

Teams can be defined as individuals who work together to achieve specified and shared goals, have specific competencies and work roles, use shared resources, and communicate to coordinate and adapt to change (Manser 2009). Areas where teamwork is key within the residential care setting were identified by RCWs, specifically the negative impact on the wellbeing of residents triggered by dysfunctional staff dynamics, differing care standards between team members, and communication and language difficulties. One way forward is to address these identified difficulties through teamwork training using an agreed set of teamwork values. Salas et al (2008) proposes eight principles (Table 5.1) for team training that seem equally applicable to RCWs. Each of these principles have been adapted and used to illustrate how each can resolve specific teamwork difficulties identified by RCWs.

Table 5.1 Eight principles for Team Training (Salas et al (2008))

Principle	Description
1	Identify teamwork competencies that are used for training content
2	Emphasize teamwork over task work
3	Let the team based learning outcomes desired and organisational resources guide the process
4	Provide guided hands on practice
5	Ensure training is relevant to transfer environment
6	Feedback matters
7	Evaluate learning outcomes and behaviours on the job
8	Sustain through coaching and performance evaluation

In relation to my research, the first principle would give RCWs a voice in setting the teamwork values and training that they all share and agree on. Mickan and Rodger (2005) said that internal aspects of teamwork are described in terms of shared objectives and agreed responsibilities. Training that can utilise a student-centred approach recognises the emotions associated with dementia care to enable RCWs to identify teamwork training objectives themselves (Robertson 1990). This would reflect the acknowledgement and validation of feelings that would be delivered elsewhere in

training (within the responses to attachment and parental fixation). RCWs identified that training needs to be clear on professional levels of conduct, and clarity on '*what to do*' was needed for training to be successful in practice. This principle addresses the difficulties with differing standards of care, and that there is a sense of expectation from RCWs as to what good team work is, or should be.

The emphasis on teamwork over task work (Principle 2) may go some way towards addressing a barrier to implementing person-centred care identified in Section 5.2.2. Salas et al (2008) reflects the approach of adult learning identified earlier: of didactic training sessions where principles are explained through lecture and discussion and then practice of newly learned teamwork competencies in a safe environment through role play. This can be useful in addressing dysfunctional staff dynamics that can impact on the wellbeing of the resident.

Principle 3, in relation to my research, highlights the necessity for organisational support in learning. Mickan and Rodger (2005) agree that the institutions in which teams exist need supportive organisational structures. Salas et al (2005) identify that teamwork is more than just imparting knowledge, it is about behaviour and attitudes. By adhering to agreed teamwork values in training, trust and respect can be built that are important in the working environment to create and sustain improvements in standards of care (Scott-Cawiezell 2005). It is important in overcoming what Wilson et al (2012) identify as a lack of recognition for the *care working group* that results in a barrier to team working, and reflects Honneth's (2005) third dimension of recognition theory. This dimension highlights the importance of appreciating a person's strengths and their contribution to a community (i.e. the team), and that the negative connotation is that of disrespect and insult – an illustration of a dysfunctional team as was described by RCWs.

The findings from RCWs identified strong feelings about communication difficulties. One RCW stated, "*you need information just to go into a room.*" The RCW was referring to the need for knowledge about any specific needs the person might have. The importance of clear communication and sharing of necessary information that can

impact directly on the wellbeing of the resident can be included in team values (Salas et al 2008).

Communication concerns were raised about some RCWs speaking very little English, and not understanding what was being said. This reflects findings from a report on the role of migrant RCWs in ageing societies (Walsh and O'Shea 2010). This report identified that employers felt that language difficulties posed the greatest challenge to employing migrant workers in elder care. One employer identified that residents complain a lot about language difficulties. This has critical implications for health care, and in developing relationships (Walsh and O'Shea 2010). The organisation for which I worked offered English lessons to their overseas staff. The report by Walsh and O'Shea 2010 suggested that with access to English training, relationships with residents improved, but did not give any measure of how relationships improved or how long RCWs received training. It is therefore difficult to know to what extent training will impact on this concern and is therefore an area for further research.

Teamwork training is fundamental to ensure training transfer is successful, as training needs to be assessed in the workplace and relies heavily on both peer and supervisor support.

5.2.4 Emotions & Dementia Care Work

The emotional demands of dementia care work were another key theme for the specific needs of residents with dementia. Caring for those with dementia is emotionally challenging (Spector et al 2016). King (2012) has identified that care work is unique and is a form of labour in which the use of emotions is central. This section will address significant findings around the powerful emotions that RCWs have identified around aggressive behaviour, parental fixation and ethics, bereavement, and lack of management support. Each will be discussed in turn.

All RCWs interviewed identified with a range of varying emotions about their caring role. They clearly identified feelings of fear, apprehension, resentment, and uncertainty in terms of aggressive behaviour. One RCW described her feelings from when she first began working in residential dementia care. She explained she was shocked and very unprepared for what she would face and what was expected of her.

Managing aggressive behaviour was identified as an important area for more training by 18 out of 19 RCWs interviewed.

The significance RCWs accorded to their emotions is a particularly meaningful finding, as these emotions can all have an impact on how an RCW responds in given situations, and on their continuing feelings about the specific nature of their caring role. Aston et al (2002) identify that more attention should be paid to care worker responses to aggression, as this can reduce quality of care. This is illustrated by the feeling of resentment expressed by one RCW (3A#17) that led to an admission of not wanting to help a resident because of the resident's previous behaviour towards her, although fear of injury could have driven this. Two RCWs interviewed were clearly angry at being exposed to aggressive acts from residents, with the view that aggression was done deliberately. The two RCWs in question had both asked the resident, "*Why did you do that*"? Both RCWs said that residents never give an explanation. Both RCWs also explained that they were not allowed to hit back. This suggests that for some RCWs there are serious limitations on their knowledge of dementia and/or that they are not supported to process difficult emotional reactions in more positive ways. When this is combined with what literature has identified about the stressful nature of the job, it is not surprising that concerns for the safety and care for residents with dementia have been raised (CQC 2017). Staff stress is thought to be associated with resident abuse and neglect (Goergen 2001). This finding identifies a need for training that includes understanding the relationship between negative emotional responses and their impact on care, and how to respond appropriately.

RCWs identified that an extremely emotional part of the job was when residents spoke about wanting their mums, when their mothers had passed away many years ago. RCWs explained that they knew very little about why this happens or what to do. They identified that they found great difficulty in answering emotionally charged questions. RCWs were told to tell the truth, which can be difficult for the resident to hear repeatedly, and difficult for the RCW who knows it will cause distress to the resident, the family, and the RCW. Even an RCW with twenty years' experience explained she didn't know why this happens, lacked confidence about telling the truth, and could only bring herself to try and distract the resident with a cup of tea. However, this does

not always distract the resident or resolve their anxiety. This is another illustration where it is imperative to know the person to understand how best to approach difficult questions.

An RCW explained how very sad it made her feel that residents talk as if their parents are still living. The RCW said that a resident was having her hair done and said to the hair stylist

“Don’t cut it too short my dad won’t like it - and he will be cross with you!”
(3B#10)

This is known as ‘parent fixation’ and is a common occurrence in people with dementia (Miesen 1992). They will talk as if their parents are still alive and will ask to see them and want to return to their parental home. For people with dementia, this is often an expression of attachment need (Mitchell and O’Donnell 2013).

Bowlby’s Attachment theory (1969) is relevant to caregiving relationships with older persons (Phibbs & Woods, 2004). Although Bowlby believed attachment behaviour was particularly evident and critical in infancy, he also believed that it has a continuing role into adulthood (Bowlby 1969). This is supported by the first dimension of recognition theory (Honneth 2005), ‘primary relationships of love’, that was believed to be rooted in early human development but continued throughout the life cycle. A young child whose emotional needs are met develops a confident identity but returns to the protection of the attachment figure when faced with an emotional threat (Honneth 2005). Parent fixation in dementia erodes feelings of safety and security and activates attachment behaviours (Miesen 1992, 1993).

Troll (1994) has found that older people, even when their parents are no longer alive, feel the bonds between themselves and their parents to be important to their well-being and sense of self. Troll (1994) suggests that bonds to parents are the most powerful. Honneth (2005) drew upon Buckley (1999) when stating that even a confident self retains a deep sense of indelible union with the key attachment figure – the mother. From this we can understand that older people with dementia feel more attached to parents (even though no longer living) than to living husbands or wives. RCWs identified that the families of people with dementia found this distressing and

recognised it as an area for training so they could understand themselves what is happening and help the family to understand.

Mills et al (1999) incorporated attachment theory into training for dementia care staff in residential homes. This consisted of the awareness of attachment relationships across the life span and resident well-being, resulting in improvements in communication, understanding of behaviour. Both literature and care worker experiences point to the need for training in attachment theory, helping care staff to understand, and respond to, behaviours related to parent fixation. For example, if a resident is exhibiting behaviour about going home, or calling out for their mother, RCWs could be alerted to a need for security and help them to respond accordingly. One way is validating feelings that accompany parental fixation and is likely to be more beneficial to the person with dementia than continually telling them their parents have died (Browne and Shlosberg 2006). For Kitwood (1997) validation is identified as providing a high degree of empathy to understand a person's reality and acceptance of feelings and is part of the person-centred approach.

RCWs acknowledged feelings of bereavement when a resident died and identified strongly with a need for training around coping with these feelings. McGilton and Boscart (2007) recognised that RCWs build strong relationships with residents and often see them as a surrogate family. Seeing personal items in a resident's room after they had passed away can be distressing for RCWs. One RCW (1B#05) explained that when another person fills the bed, you must start all over again. This implies that there is a cycle of grief as residents are cared for and, inevitably pass away.

Senior staff told the RCW, and other RCWs, not to become attached. This is an unrealistic prospect given that RCWs often care for a resident for a few years, and that part of delivering person-centred care is about building trusting relationships. Indeed, one of the principles of personhood is about the need to create opportunities for the resident with dementia to experience attachment (Kitwood 1997). The maintenance of attachment relationships with continued contact with attachment figures is imperative to well-being, as without the reassurance that attachments provide, it is difficult for any person of whatever age to function well (Kitwood 1997).

With senior staff providing guidance that is contrary to a person-centred care model, it seems that it is not just RCWs whose training needs improvement, but that more senior staff also need training in dementia care. It also raises the question of where the advice from senior staff came from. Does this originate from care home policy or personal views? Either way, it directly contradicts the person-centred care model.

Care work needs to be conceptualised in a way that recognises the importance of the relational ties that are inherent in the work, and which inform much of RCWs' orientation to care work and their satisfaction with it (King 2012). In relation to dementia training, the literature review found that workplace educators can play a significant role in emotion learning, and training may be provided to teach appropriate emotional responses than can be transferred into practice (Bierema 2008).

Another emotional element and a common challenge in daily practice was the feeling of fear of management, rather than support. For example, where there are potential ethical concerns about hygiene, it is inappropriate to force a resident to be washed and inappropriate to leave them in soiled clothing. During the time taken to calm the resident and attend to their needs, RCWs expressed fear that management would accuse them of being negligent. This appeared to be a classic case of *'damned if you do, damned if you don't'*. There was a very real fear among the RCWs that they would be in trouble if it was thought that a resident had been left in soiled clothing. From the way in which RCWs described their concern, it seemed that there had been instances in the past where this had happened. Training needs to impart the knowledge of what policy expects, and the confidence and competence to meet the needs of the situation. Training would provide the opportunity to voice concerns about practice in the supportive environment of a classroom. Understanding what, why and how something is done is key to good practice.

This research identified a lack of clarity about the organisation's policy and protocol in relation to practice, with RCWs having little confidence in or trust from management. RCWs identified a 'them' and 'us' culture. Russell et al (1984) argued that it is the supportiveness in the work environment that provided the key to transfer. In relation to training, RCWs need to be clear about what is expected of them in terms of policy

and practice. A student-centred approach in training would enable and empower RCWs to identify learning needs directly from practice, so that the concerns they have voiced can be addressed for the well-being of both the residents and RCWs. This can then be reinforced during assessment in the care home. RCWs will then have the knowledge to deliver care competently, and with confidence that they will be supported in their workplace. This also reinforces the recommendation that for care staff to deliver person-centred care there should be person-centred management as identified in the literature review by Ryan (2005). The ability to provide person-centred care is dependent upon characteristics of the system in which care is provided (White et al 2008). Organisations can contribute directly to the quality of dementia care by including management practices that empower and support RCWs, provide training and support for resident care, supervision, adequate staffing and appropriate workload (Barry et al, 2005; Castle & Engberg, 2006), all areas that have been identified in this research by RCWs themselves.

According to Harr and Kasayka (2000),

“When management and staff respect each other as persons and honour the dignity of personhood that implies, high quality of care will be a natural by-product” (p. 42).

The welfare of staff and the provision of good support structures are essential components of person-centred care (Perks et al 2001). As Kitwood (1997) noted, if employees are supported and encouraged they will take their own sense of well-being into their day-to-day work.

Ward et al (2008) have said

“...the emotional dimension of dementia care is typically overlooked, and receives little in the way of formal support, but the emotion work of care staff is crucial to what they do....” (p647)

A significant finding, and one way forward to address RCWs’ concerns about how emotions of the job directly impact on care, is for management to adopt a person-centred approach to staff, and a student-centred approach to staff training. Training and learning cannot focus on just a task based or cognitive approach. The dementia

care role has a strong emotional aspect for RCWs own emotions, and in caring for the emotional needs of the residents.

5.2.5 Summary

This section has discussed the highly emotional nature of the dementia care role where several key points of concern have been identified. RCWs experience sadness and grief when residents pass away, distress when residents ask about long dead relatives, and feelings of inadequacy due to not having enough knowledge or confidence to answer questions from residents' family members. There is fear and frustration around aggressive behaviour and potential ethical dilemmas over policy and limited management support. These emotions can impact on care worker responses and on the well-being of both care worker and resident. There are the emotional needs of residents with dementia, and their need for attachment figures when feeling insecure, or becoming distressed when told the reality of their situation. The contributions of Honneth's (2005) recognition theory, Kitwood's (1997) person-centred care and training transfer theory can help to understand ways through training and organisational support to respond to these emotional needs.

5.3 Training Content and Delivery

This section focuses on the discussion of the main themes of experiences of training, the extent of training content and delivery received by the RCWs, and how the findings and literature can be used to influence dementia care training going forward. Overall, the responses from RCWs on the training they had received indicated that it was limited or non-existent. Participants in the research suggested several areas where training was required.

5.3.1 Requested Training and Existing Curricula

Apart from the requests for dementia training in general, are these specific subject areas recognised in other dementia care curricula? A way to substantiate this is to look at the recently created Dementia Core Skills Education and Training Framework (Skills for Health 2015). As mentioned in the literature review ([Figure 2.7](#)), RCWs are in the Health Education England (HEE) Tier 2 for people working in social care working with

people with dementia. RCWs would be expected to complete 13 of the 24 subjects included in the framework and within the subject areas are a series of learning outcomes. These were used as a comparison between what RCWs had requested for training and what was contained in the new curriculum. Table 5.2 shows the comparison.

Table 5.2 Subjects Requested by RCWs

Subject requested by RCWs	Included in Training Framework?	Comments
Responding to aggressive behaviour	No	Communication and behaviour but not how to respond when aggressive behaviour is shown
Teamwork	No	
Bereavement in terms of care worker	No	Only bereavement for family
Emotional context of the role	No	
Attachment theory/ Parental fixation	No	
Diagnosis	Yes	
Knowledge of dementia (dementia awareness)	Yes	
Ethical dilemmas	No	
Mental Capacity Act /DoLS	Yes	
Working with families	Yes	
Administering of pain relief medication	Yes	
Person-centred care	Yes	
End of life	Yes	
Professional conduct	No	

There are several subjects requested by RCWs as part of this research that have not been included in the Dementia Core Skills Education and Training Framework (Skills for Health 2015). Thus there are some fundamental differences in what RCWs feel is important for their training and what has been included for RCW training in the Framework.

RCWs thought that there was a very definite need for training on, and recognition of, the emotional context of their role. Although they expressed the enjoyment of caring for residents, they also experienced adverse emotions around caring, for example fear. The majority of RCWs requested training in managing aggressive behaviour, particularly when it is happening and the measures to prevent it have failed. The usual

term is 'challenging' behaviour. However, the RCWs were specific that it was the difficulties around the aggressive incidents that they felt they needed training. RCWs were aware of the potential triggers of aggressive behaviour, in that it often happens around intimate personal care, or if a person with dementia feels too crowded, or doesn't understand what is going on around them. In such scenarios, RCWs identified that the aggressive behaviour could be prevented with additional staff and time. However, RCWs thought that they needed more knowledge about how to respond when a person with dementia is becoming very angry or has hold of the RCW and there is potential for serious injury. There was also a fear of lack of support from management when an ethical dilemma occurred, for example when residents had soiled themselves but refused help in being cleaned and changed. RCWs requested training in ethical dilemmas, but this is not included in the Framework (Skills for Health 2015). RCWs identified that not knowing what to do causes feelings of incompetence and anxiety and can mean care needs are not met.

Another emotional context of the role is the challenge of dealing with bereavement. Bereavement is addressed within the Framework (Skills for Health 2015) as part of end of life care. However, the learning outcomes centre around the bereaved family and friends. It does not acknowledge the bereavement felt by the RCW, something that RCWs have identified in this research as a training need. For the RCW, the death of a resident they have cared for can be devastating. However, RCWs receive no training on how to cope with grief and have no access to counselling. Given that dementia is a terminal illness, RCWs are exposed to resident death repeatedly. A study on health care assistants in hospitals has shown that persistent exposure to patient death can increase the daily work strain experienced and lead to a profound sense of grief, particularly where there was interpersonal closeness (Redinbaugh et al 2001). It would not be unreasonable to assume that RCWs are affected in a very similar way.

The Framework (Skills for Health 2015) addresses working with families. Most learning outcomes reflected what RCWs have worked out for themselves: that they need to communicate with families compassionately, that families need support, along with understanding the impact having a person with dementia in the family has on relationships. The Framework (Skills for Health 2015) does not address the training

concerns about families as identified by RCWs. Working with families carries an emotional element to their role. RCWs explained they wanted to understand more about dementia themselves, so they can feel knowledgeable and confident to answer questions from the family. For example, RCWs need to know about attachment theory and parental fixation. There is also the nature of how memory is retained as dementia progresses. For residents with mild to moderate dementia, recent autobiographical memories are more affected than memory for remote events (Hou et al 2005). RCWs believe training should prepare them to be able to explain to family members why the person with dementia wants long dead parents more than their living partner, or adult children or grandchildren.

RCWs want to know how to explain to family members why the person with dementia keeps asking to go home to a house that no longer exists or was a childhood home and how to respond to emotionally charged questions, so that the person with dementia is not distressed by what might be told them (i.e. constantly told that their parents are dead). It is particularly important to support the family, as RCWs have expressed that family often stop visiting when the person with dementia fails to recognise them anymore. There is an ethical dilemma when the family want their loved one to be told something different to what RCWs have been told to tell them. This would suggest that inviting family members to a training session, as identified by the RCWs, might be beneficial for all concerned.

RCWs requested training on professional conduct and teamwork, neither of which are included in the Framework (Skills for Health 2015). There were feelings of concern and dissatisfaction among RCWs as there were times when it was felt that disharmony, differing care standards, and difficulties in communication between staff could compromise resident care. RCWs expressed that attending to the specific care needs of residents with dementia relies heavily on staff working together.

RCWs asked for training on mental capacity. For example, it was explained that an RCW was left alone to care for a resident at end of life and did not know if the resident had made any final wishes or decisions, or if so, how to implement them, or even if they had been recorded. The RCW wanted to act within the spirit of the Mental Capacity

Act, but their knowledge was poor. This seems to reflect findings from Manthorpe et al (2011)

“Although managers and care workers might be working within the spirit of the MCA, their level of knowledge about it may be poor and their ability to inform others about its provisions will therefore be limited.” (p294)

Both the Alzheimer’s Society and SCIE are calling for training on the Mental Capacity Act 2005 due to fears that RCWs are not currently able to apply its principles to involve residents in decision making, and that many care staff feel that their knowledge and competence on end of life care is poor. This could mean that residents with dementia do not receive person-centred care or are deprived of their legal rights (Alzheimer’s Society 2015). Training was requested in administering pain relief medication as shortages of more senior staff qualified in administering medicine meant that residents with dementia had to wait too long for pain relief. This might be better addressed by having more senior staff available.

Finally, those RCWs that could remember some training expressed a strong dissatisfaction with the quality of dementia care trainers. RCWs identified that trainers were unprepared, unhelpful, and told them to read books at home. Telling RCWs to read books at home indicates that the trainers had little knowledge of the dementia care workforce as learners. Trainers need to understand the unique learning needs of RCWs.

RCWs identified that trainers rushed through, were not helpful in answering questions and *“didn’t know what they were talking about.”* Clearly, RCWs were not getting what they needed from training, and consequently, residents with dementia were not gaining any benefit. These findings are supported by the OPM (2009) report that highlighted that there are dementia trainers who remain unaccredited, and questions have been raised over their suitability to train. Care home organisations need to ensure they are recruiting competent trainers who can address the unique learning needs for this group. Carter (2015) has identified that in the current economic climate, it is possible that the trainers chosen are the cheapest or training is not delivered at all. However, until CQC start looking at the standard of trainers, and the standard of training that care staff are receiving these concerns will continue.

In summary, there was an overwhelming request for training around the management of aggressive behaviour, teamwork, working with families, attachment, bereavement, and administration of pain relief (over the counter medication). Having established that several training areas have been identified by the RCWs that are either not covered by the Framework (Skills for Health 2015) or that are only partially covered, it is important to discuss the learner characteristics. These provide an important input into training design as will be explained in the next section

5.3.2 Learner Characteristics

The Training Transfer Model, proposed by Baldwin & Ford (1988) and subsequently adapted by Grossman & Salas (2011), provides a lens through which the training needs of RCWs can be viewed. In reviewing the learner characteristics, several areas were highlighted in the research. Each of these - cognitive ability, self-efficacy, motivation, and perceived utility of training - will be covered in turn.

The cognitive ability of RCWs appears to reflect what is known about the general levels of education of the dementia care workforce (see Section 2.2.1). Although it is accepted that levels of education are not a proxy for cognitive ability, it is not possible to test each individual care worker to determine ability more precisely. Only two interviewees had any post-compulsory education qualifications, although both said they had completed an NVQ but could not provide any details or even a course name (1A#07, 3B#10). RCWs often commented that the dementia care training content was either “*boring*” (2B#16) or “*went over their heads*” (1B#05), both comments suggesting that the training did not match their cognitive ability.

Self-efficacy, the second learner characteristic, also seems to be confirmed by the research. Grossman & Salas (2011) comment that

“Trainees higher in self-efficacy have more confidence in their ability to learn and apply trained competencies and are more likely to persist when performing difficult tasks.” (p107)

Findings from the research showed the lack of confidence RCWs felt in certain care situations. The need to promote self-efficacy should be built into any dementia care training to boost care worker confidence, supported by supervisor and peer support.

Houston (2015) identifies such '*facilitative relations encouraging personal change*' (p6) as a form of recognition that can boost self-belief and self-confidence. The purpose would be to instil the '*belief in one's capacity to change oneself*' (Houston 2015, p6), i.e. for the RCW to complete training and put the learning into practice confident that it can improve practice and the lives of the residents being cared for.

Care worker motivation for training gave mixed results, ranging from a number of RCWs keen to receive further training and desiring the opportunity to put the training into practice, to those who had very little motivation for training. One RCW identified that there are RCWs who "*do not like being in the limelight*" (41B#05), acknowledging a definite level of anxiety and discomfort around training. Anxiety is linked to reduced training motivation that can affect training transfer (Webster and Martocchio (1993). Houston's (2015) extension of recognition theory of instilling hope and belief in change could reduce RCWs anxiety about training.

One factor that had a negative impact on training expectations was the view that interviewees felt they could not put the training into practice due to lack of time and staffing ratios. Returning to Houston's (2015) fourth dimension of change (see Figure 2.2) – RCWs have to believe that change is possible and that the effort to learn will change their performance and lead to valid outcomes (Facteau et al 1995). What would RCWs consider as a valid outcome of training? Training transfer theory suggests the importance of perceived utility, i.e. that the training received should be of use in a learners' everyday practice. The majority of RCWs identified a desire to improve the lives of the residents with dementia; they wanted to know more and feel confident in providing person-centred care. If RCWs can see that training can have a positive impact on quality of care, and have confidence about their knowledge and ability, it is more likely they will view training as a positive experience, and learning is more likely to be transferred competently into practice. In terms of learner characteristics within the training transfer model, RCWs as learners will have perceived utility, a belief that training is useful (Grossman and Salas 2011). Here the power of a constructivist position is that we have the capacity to change our constructions of the world and create new possibilities for our own action although difficult or challenging (Burr 2003). Learning from the constructivist perspective involves both the perception of

constructed realities and the encouragement to develop new knowledge through adapted experience. Experiences are interpreted and received, constructing ideas of reality (Shuck et al 2007). RCW training therefore needs to be relevant and reflect identified challenges. This underlines the importance of content and delivery being at the correct level for the RCWs.

Pay and its relationship to dementia training was identified by RCWs, who believed strongly that if an RCW has completed dementia training it should be recognised with higher pay.

Given the characteristics of RCWs, how training is delivered will be critical to the success of training being transferred into practice. Support from peers and supervisors is very much a part of a student-centred learning approach. This approach acknowledges mutual respect between the learner and trainer where the RCW's experience is recognised. This approach for RCWs has been successful. Beer (2012) has identified that there is a link between student-centred training and delivering person-centred care that increases job satisfaction and a sense of competence. This approach can be seen to reflect elements of Honneth's work on Recognition Theory, where recognition and respect are associated with a person's identity. Honneth (2005) says identity conditions our perceptions of self and others. Desired attributes such as self-respect, self-confidence, self-efficacy and self-esteem are based on a flourishing identity. This approach would add value to the support of RCWs and to the nature of dementia care.

Innes (2001) and Beer et al (2012) both support the idea that student-centred learning is important for RCWs practising person-centred care. Designing training for RCWs to include student-centred learning and to facilitate training into practice requires a major change within care organisations. From the research findings, what little training was completed by RCWs was not followed through by the organisation(s) to ensure the learning was transferred into practice.

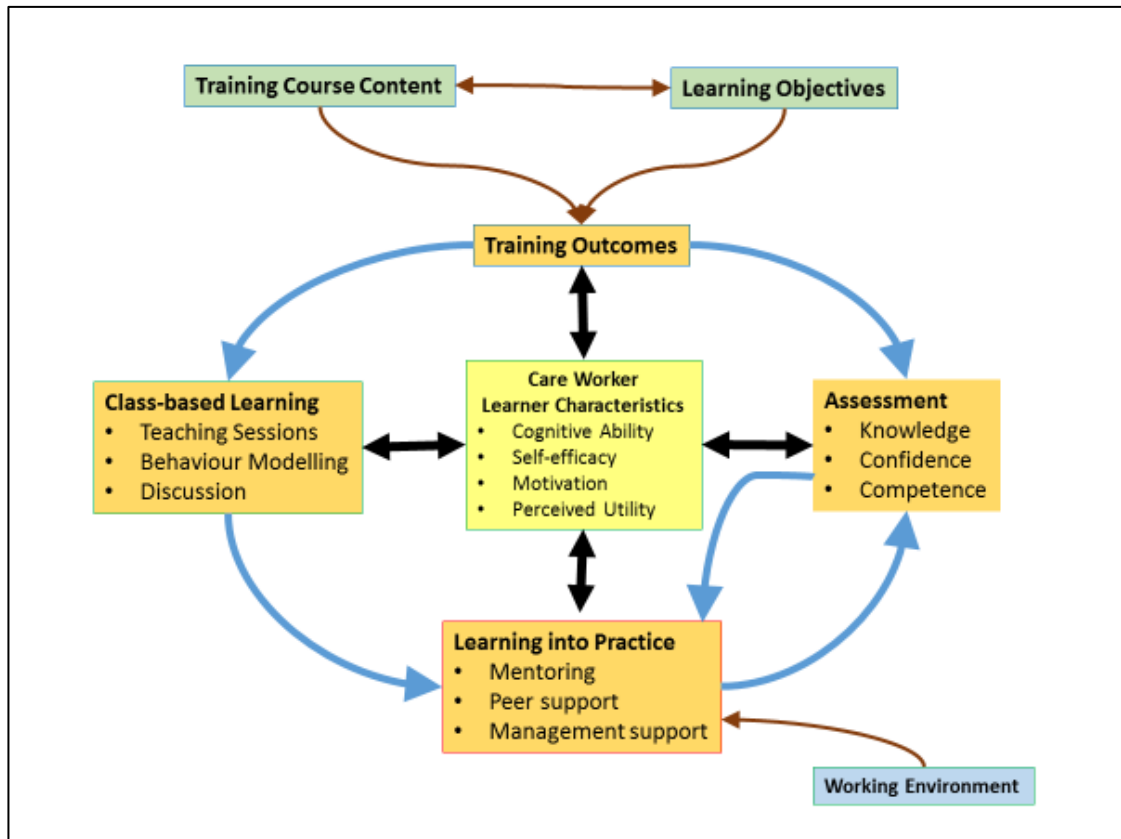
5.4 The Dementia Care Training Conceptual Model

It is clear from this research that the training needs for RCWs in Dementia care go beyond what is being provided. This section proposes a Conceptual Model for training that provides an integrated approach.

The Conceptual Model has proposed a way forward for dementia training (Figure 5.1). The model has emerged from a reconceptualization of Training Transfer Theory (Grossman & Salas 2010), using a synthesis of Recognition Theory, Emotion and Adult Learning, Adult Learning Theory, and Student-centred Learning. This has introduced new attributes consistent with the findings from the research that have taken us beyond the existing literature.

The Conceptual Model supports a student-centred learning approach, where RCWs are encouraged to draw upon their own experiences, reflect on their own practice and put the newly acquired knowledge into everyday practice (Innes 2010). The knowledge gained and practised in the classroom is transferred into the work environment with support from a mentor/assessor, from peers and management. The emphasis is on the RCW participating in active learning, an important characteristic of student-centred learning (Lee et al 2003). Assessment can be measured in terms of care worker knowledge, confidence, and competence in practice. The Conceptual Model consists of four main domains: training outcomes, class-based learning, learning into practice, and assessment (Figure 5.1). The model has emerged with the potential to be used generically for all dementia care content. The content includes training needs identified by RCWs and could be used to augment the Framework (Skills for Health 2015) by taking the learning outcomes for a course or learning module within the Framework and extending them, so that the training is transferred into practice.

Figure 5.1 The Dementia Care Learning Conceptual Model



5.4.1 The Need for a Dementia Care Training Model

Dementia care training for RCWs has been found to be disjointed and lacking a process that maps the learning from inception to completion (i.e. from setting course objectives to confirmed implementation of knowledge into everyday practice). RCWs had not been consulted on their training needs, leaving gaps in knowledge that RCWs felt was needed.

RCWs could remember very little training and were unable to comment on what they had learnt or the types of assessment that was useful to them or otherwise. However, RCWs identified the need to be provided with training that addressed everyday practice, including areas that may have had limited attention in training previously.

Whilst course objectives and learning outcomes are important, one supposition drawn from the analysis was the importance of effective facilitation of training transfer, so that the knowledge gained in courses could be put into practice with confidence and competence. If learners had both class based learning and practical application in the

work environment, it could accommodate different learning styles, reaffirm knowledge taught in the classroom, and provide opportunities for building confidence and competence through support in practice. RCWs identified that 'on the job' training had been useful and requested input about the care of residents they were directly working with. 'On the job' training interventions have been found to be effective in securing skill maintenance (Clarke 2013).

A supervisor/mentor using a student-centred approach that supports learning in the work environment could address some of the emotional elements of their work, the emotional questions from residents about family, for example. RCWs within this research identified that there was confusion over what was appropriate practice in given situations. This direct input and practical application can address individual learning needs and reassure RCWs that they are confidently working to the care homes' guidelines. Clarke (2013) found that the role of the supervisor was particularly important, not only for training transfer but also in terms of the alignment of the organisations policies and procedures.

The conceptual model that emerges from the synthesis of Training Transfer Theory, Recognition Theory, Emotion and Adult Learning, Adult Learning Theory and Student-centred Learning is embedded in the theoretical perspectives that have informed this study. Honneth's (2005) recognition theory and person-centred care (Kitwood 1997) were essential components that support the model from training content through to assessment. The core idea of theory of recognition is that people's (residents' and RCWs') personhood in a philosophical sense may only be sustained when it is recognised by other people (Honneth 2005). For residents to exist as individuals with their own skills and contributions, it is necessary to be recognised as persons and be treated as such. Both RCWs and residents with dementia have been identified as groups with low status and have little recognition (Innes 2006). Both the literature and the research interviews have identified that this can have a dramatic impact on the quality of care provided, and on the well-being of both groups. It impacts how RCWs feel about their role and how they might approach training. If person-centred care is to be delivered successfully to residents, it makes sense that RCWs are treated in training in a person-centred way that will reflect the service they provide.

Both Honneth (2005), and Kitwood (1997), recognised the importance of having a 'positive relation to self'. This includes both residents and RCWs; in receiving love, care and positive regard, dignity, attachment, demonstrating self-esteem, security, confidence and competence, and emotional care. Recognition theory and person-centred care approaches have facilitated understanding of the research findings and informed all areas of the conceptual model for care worker training and transferring learning into practice. Extending on the emotional aspect from Honneth (2005) and Kitwood (1997), adult learning theory has been useful in recognizing how emotions can play an influential role in training the dementia care workforce. There is a strong need for the conceptual model to recognise that emotions play a prominent role in dementia care, in terms of how care worker emotions can impact on care responses and therefore the way care is provided. Emotions around how workers have constructed their role within the hierarchy of the care home can impact upon worker responses to training and how successfully it is implemented in practice. A student-centred approach to learning complements and supports a person-centred approach and Honneth's (2005) work, in that it recognises the RCW as a person with their own contributions, placing the RCW at the heart of the learning process. An important feature of this approach is it allows for self and peer/mentor assessment. This gives some control and responsibility back to the student, giving '*an increased sense of autonomy in the learner*'. There is a more equal partnership between assessor/mentor and learner, where learning is negotiated and mutually agreed (O'Neill and McMahon 2005).

A student-centred approach adds the advantage of addressing individual learning need and in doing so can identify with the specific learning needs of the dementia care workforce. This would address the emotional anxiety around previous experiences to learning in the classroom and the need for ongoing support from a mentor and peers.

Each of these domains will be now be discussed further.

5.4.2 Training Outcomes

Training outcomes, the first domain, is important because the progress made by the learner will be measured against them. The evidence for this domain is reflected by

RCWs, who identified the need for clarity on what is expected of them (2B#16). Training outcomes need to be clear and measurable, so that RCW learning can be assessed in practice (Burke and Hutchins 2007, Kontoghiorghes 2001).

The learning characteristics of RCWs could influence training outcomes by ensuring that training is created for the right level of understanding (cognitive ability), and how training is perceived as useful (perceived utility) (Grossman and Salas 2011). Pre-training motivation (Fecteau et al 1995) could be encouraged by RCWs being involved in the learning process, i.e. during the setting of training outcomes. Grossman and Salas (2011) maintained that knowledge transfer is facilitated when trainees are motivated to learn.

In terms of the overall learning process, the training outcomes are the first domain to be completed and are determined by the learning objectives and the training content. The learning outcomes are specific to the topic being addressed and would form the basis of the assessment instrument used throughout the learning process.

5.4.3 Class-based Learning

The second domain of the model is class-based learning that uses a student-centred philosophy, where learning is delivered in a way that recognises the value and contribution of the RCW.

The classroom setting must be 'fit-for-purpose' (1B#03, 2A#11). RCWs identified that past learning experiences with trainers had been largely negative, with trainers being unprepared and telling the learners to go home and read books. Therefore, it is vital to have a trainer that is suitably qualified, experienced in dementia care, and understands the learning needs of the workforce to produce an environment that is supportive, comfortable, and confidential.

The organisation of training, and the environment where training takes place are of paramount importance. RCWs identified that using a lounge or a bedroom was inappropriate for learning, as it means there can be no discussion of real cases (1B#03, 2A#11). It offers no opportunity for practical exercises and gives the impression that training is unimportant. As one RCW said *"we just get put anywhere for training. We've*

even used a resident's bedroom before now - it was very cramped." Training needs to allow for the comfort of the learners, both physically and emotionally. The training environment/classroom must reflect the aim of care worker training, to gain knowledge on person-centred care and be able to deliver that care with confidence in a competent way. A way of reflecting person-centred care through the delivery of training in the classroom is to use a student-centred approach to learning. This approach advocates the appreciation of the RCW as a learner by demonstrating respect and aligns with Honneth's (2005) second dimension '*legal relations involving rights*' by '*Showing respect*'.

These approaches can be complemented and supported by applying emotional concepts within adult learning theory. This has significance as it reflects the emotional nature of the dementia care role, and the learning needs of the workforce. For example, RCWs identified that there was a fear of classroom training and being put in the "*limelight*." RCWs felt under threat of being asked questions by the trainer they could not answer. Again, we can see how emotional aspects of adult learning reinforce Honneth's work (2005), by recognising '*needs and emotions*' and '*demonstrating emotional care*'. This complements adult learning theory and the role emotion plays in learning.

"Emotions are important in adult learning because they can either impede or motivate learning." (Dirkx, 2001, p. 63).

Serving as motivation to pursue desires, emotion creates purpose and shapes the context of learning experiences (Merriam & Caffarella, 1999).

It is imperative to address care worker feelings of insecurity in the classroom, as this would have a bearing on ability to learn and would determine how much training would be transferred to practice. The model therefore proposes a mix of training strategies, to include discussion, behaviour modelling (which includes RCWs choosing real case scenarios), clearly defined explanations, opportunities for learners to observe and practise learned skills in a safe and supportive environment prior to being transferred into practice. Student-centred learning supports the learner characteristics of the care workforce by building self-confidence in the classroom. This is strengthened

by Honneth's (2005) first dimension of recognition, where self-confidence is '*primary relations of love*'.

5.4.4 Learning into Practice

This is enhanced by using a student-centred approach to learning. This proposes that student-centred learning is focused on the student 'doing', and where learning is 'active' (Lee et al 2003). The knowledge and confidence gained and practised in the classroom can be transferred into the work environment as part of the Learning into Practice domain, with support from a mentor/assessor, from peers and management. Support from peers has also been shown to lead to a higher application of newly learned knowledge and skills (Baldwin and Ford 1988). The increased interaction between peers has the additional advantage of helping to build good working relationships between workers as they share similar learning experiences, where all are valued under a student-centred approach

The success of learning into practice is predicated on the work environment, as it is here where confidence and competence are gained through a learning enabled setting. Organisational support is vital for training transfer to take place (Noe 1986). It is clear from this research that time and staff limitations restrict the implementation of person-centred care. The introduction of learning into practice has the potential to put a further strain on staff resourcing, so an increase in staff numbers or changes in working practices would need to be considered. Senior management would need to amend any policies and procedures to reflect any changes to working practices. There may need to be changes to practices identified by RCWs during this phase. Here, RCWs will be supported to feel confident in feeding back practice issues, and discuss potential improvements to care or input to classroom training with their assessor/mentor. This identifies with Honneth's (2005) first dimension '*primary relations of love*' in building '*self-confidence*'. Learning into practice provides opportunities to address directly the emotional nature of the caring role, and has significance in supporting RCWs in managing responses, for example, alleviating feelings of fear and uncertainty around ethical issues, managing emotional responses to an aggressive incident, or explaining difficult emotional concerns with family.

Addressing emotional needs identifies with Honneth's (2005) first dimension of recognition, '*primary relations of love*', '*needs and emotions*', and '*demonstrating emotional care*.'

Houston's (2015) creation of a fourth dimension to Honneth's (2005) recognition theory is relevant here, '*facilitating relations encouraging personal change*', as it is important that the RCW commits to the change in practice brought about by the training in the classroom and the working environment, with supervisor/mentor support. From a RCW's perspective, such a commitment would result in increased self-belief and self-efficacy, improving confidence and competence when applying their learning to daily practice.

5.4.5 Assessment

The final domain within the Conceptual Model (Figure 5.1) is assessment. Even those RCWs who had received some, albeit minimal and not recent, training recalled no details of assessment or attempts to measure how they put learning into practice. There was no training structure in place for RCWs. However, one way to move forward with assessment of dementia care training came through from the research findings. It emerged that training was not just about gaining knowledge, but also about how confident and competent RCWs felt using that knowledge in everyday practice.

Within the proposed conceptual model, RCWs will be given opportunities to put the learning into practice after class-based training has been completed. This would use assessment based on three dimensions: knowledge, confidence, and competence. Assessment of learning can take place a few weeks later using observation to ensure that learning has been transferred into practice. This would rely on peer and assessor/supervisor support (Grossman and Salas 2011).

The assessment domain is the point at which the learning into practice can be measured in terms of RCW knowledge, confidence, and competence in practice. As all training and assessment has a student-centred approach, the assessment process involves both the assessor and the RCW's discussion of their own practice. A dialogue then follows where the learning and observation can be discussed (Grossman and Salas 2011) in a mutually supportive way.

Observation may prove a more valuable technique given what is known about the dementia care workforce (Elliott et al 2012). To alleviate feelings of anxiety about being observed, RCWs would be given reassurance that the assessment is a mutually supportive one that focuses on the positive, with the assessor knowing when it might be necessary to step in or give guidance to the RCW if a difficult situation arises. This would acknowledge the emotional aspects of adult learning theory and reflect Honneth's (2005) first dimension of recognition theory.

The input into the discussion between the RCW and the assessor would be a training outcomes list. Each of the outcomes would be rated in terms of knowledge, confidence, and competence of the RCW. Appendix 10 is an example of an assessment instrument. The assessment can then be repeated in three months to ensure learning is still transferred to practice. Learning from discussions and questions raised within discussions can be taken back into the classroom for shared learning in revision sessions

5.4.6 Summary

Positive transfer of training is defined as the degree to which RCWs effectively apply their knowledge, skills, and attitudes to the job (Newstrom, 1986). For transfer to have occurred, learned behaviour must be generalised to the job context and maintained over a period of time (Broad & Newstrom, 1992). One way to move dementia training forward is to provide training, then to measure (with peer and supervisor support) that the RCW has retained the knowledge about appropriate responses, and feels confident to respond in a competent way. This can be repeated three months later (as literature has identified), to ensure knowledge has been retained.

This section presented the Dementia Care Training Conceptual Model generated by this research - a proposed model of dementia care training for care consisting of four domains: training outcomes, class-based learning, learning into practice and assessment. This conceptual model emphasised the necessity for training given to RCWs to be transferable into their everyday practice and for the assessment of that training transfer to be completed. For the learning to be of value it must be transferred

to the care home environment for the benefit of the RCWs and to improve levels of care for residents.

The conceptual model re-conceptualized the Training Transfer Model (Grossman & Salas 2011), moving from an emphasis on the learning inputs to one that focuses more on learning into practice and assessment. The influence of the work environment is also acknowledged as more than a learning input by moving it to be a contributing factor to the success of the learning into practice domain.

Student-centred learning theory, training transfer theory, learning and emotion, and recognition theory complement one another to promote one way of enabling care worker learning to be transferred into the workplace. Placing the RCW at the centre of the learning experience (as defined by the conceptual model) potentially results in a more confident care worker whose challenges are addressed, and skills are recognised. In so doing, the care workforce as a whole is in a stronger, more sustained position to support the needs of residents with dementia. The next stage for the conceptual model is that of empirical testing, embedding the model into a care home dementia care training programme, following it from course inception through to reviewing outcomes.

5.5 Summary

This chapter discussed the findings of the research in the light of current literature and theoretical interrogation. Student-centred learning has been used to identify an approach that would accommodate the characteristics of the dementia care workforce and what has been identified as their specific learning needs. Training transfer theory has provided a foundation for how care worker learning can be retained and transferred to the workplace, whilst recognition theory has aided the identification of the relations of power, recognition and respect of residents with dementia and RCWs, both as separate groups and in terms of the relationship between each group.

The challenges for RCWs were discussed, with recommendations for requested training. It was clear that little training had been received and was not assessed or followed up in practice. Topics for training suggested by RCWs were compared with

the current Dementia Care Training Framework (Skills for Health 2015) and gaps identified. Honneth (2005) and Houston (2015) have been integral to my research findings and in answering theoretical questions with reference to the dementia care workforce, their working and learning environment, and the application of training design and delivery. For training transfer to be successful, it is necessary for RCWs to believe that training will change practice, that organisations recognise that person-centred care is a right for residents, and to recognise the value of their workforce by supporting care worker learning and feelings of confidence and competence in the classroom and work environment.

A Dementia Care Training Conceptual Model was then proposed, adapting the Training Transfer Model of Grossman & Salas (2011), and discussed recommending the assessment of training on the basis of a learners' knowledge, confidence and competence when putting the learning into practice. It is clear from the discussion and subsequent conceptual model that RCW training cannot be seen in isolation. Just because an RCW has completed a course on dementia care, it does not mean that training will be transferred into practice. Ongoing support of learning into practice and assessment becomes important in ensuring that the newly acquired knowledge is embedded in the daily care of the resident. It also has the added advantage of ensuring that the class-based learning is relevant and delivers the anticipated benefits.

6 Conclusions

6.1 *Reviewing the Research Objectives*

The aim of the research was to gain the views of RCWs in identifying their training needs and using their views to develop a conceptual model for dementia care training content, delivery, and assessment in practice. This section discusses how the research objectives were met and identifies the specific conclusions that have been developed; each of these objectives will be reviewed in turn, identifying what was done in the research to address the question and at what stage, the conclusions, and anything that may have been left unanswered, why this was unanswered, and what might correct it.

Research Objective 1:

Identify the specific needs of residents with dementia as perceived by RCWs.

The specific needs of older people with dementia align closely with the challenges faced by RCWs. RCWs identified that residents with dementia need person-centred care; RCWs need to build relationships, to discover the person and their individual needs and interests, to understand the person's history to help retain their identity, and to discover their wishes on decisions for when the resident no longer has the ability to communicate. To accomplish these specific needs, there must be enough staff and time spent with each person with dementia. RCWs identified that the amount of time and staff had an impact in all areas of specific need for people with dementia and is a main factor in providing what RCWs termed as 'good quality' care.

Effective teamwork and communication were identified as vitally important in working with dementia. This is especially so when there are incidents where there is a real danger of serious injury to residents and RCWs. It also emerged through discussion that all RCWs should have training that reflects a professional and competent approach through professional conduct training (Table 5.2).

Recognition of the emotional demands of the role was identified as a specific need for residents with dementia. Emotions directly impact on care worker responses to

residents and this emerged repeatedly. RCWs perceived that they could not always meet a need appropriately when answering emotionally charged questions, particularly around parental fixation. RCWs were unsure of how to answer such questions and were concerned how their answers might upset or bring distress to the resident. These views from RCWs reflect what was found in literature.

Research Objective 2:

Identify the training needs for RCWs in terms of content and mode of delivery, as identified by the RCWs themselves.

RCWs identified their training needs through interviews to include knowledge about aggressive behaviour. This was a particularly important topic. RCWs overwhelmingly identified that one reason for aggressive incidents from residents with dementia was that the organisation and working environment was not conducive to person-centred care. Person-centred care was an area that all RCWs identified as important to their training needs.

RCWs were very keen to have a knowledge about dementia and about working with families so that they could help inform the family and be able to answer their questions and support their anxieties. A lot of concern was raised about needing training on attachment, particularly parental fixation, and bereavement. Training was requested on the emotional nature of the role. These areas are particularly pertinent when RCWs are trying to work effectively with the resident's family. Other areas for training identified by RCWs included professional conduct and teamwork, as these factors impact greatly upon the quality of care delivered to residents. Training is needed around ethical dilemmas and how RCWs want to be supported by the organisation. RCWs wanted to understand how they should deal with ethical dilemmas in the best interests of the resident, family member or the care home organisation. RCWs expressed the need for training in administering pain relief as they felt that residents should have this as soon as possible, whereas residents were having to wait hours to receive pain relief due to limitations in the number of trained staff. There was an expressed need to know about the Mental Capacity Act and End of Life Care. RCWs identified that they had limited knowledge of these areas and were unable to

accommodate resident preferences at end of life. Obtaining direct views from RCWs identified specific areas of training that directly impact the level of care received by residents. The main preference for modes of delivery identified by RCWs were class-based training and discussion (using practical and sometimes, real examples).

Research Objective 3:

Provide data from RCWs that could inform the content and mode of delivery towards the development of a dementia care curriculum for RCWs.

RCWs identified many subjects where training was required, and these were stated in response to questions in the semi-structured interviews. Many RCWs could not recall the specific contents of training they had received, so it was not possible to inform a detailed curriculum or mode of delivery based on their views of previous training.

However, the publication of the Dementia Care Work Training Framework (Skills for Health 2015) allowed comparison with the topics identified by the RCWs. This comparison identified areas not accounted for in the Framework (Skills for Health 2015). These are summarised in Figure 5.2. The topics identified by RCWs could be considered for a revised version of the framework (Skills for Health 2015).

Research Objective 4:

Identify the training outcomes and how these could be measured reliably.

Specific dementia training outcomes for RCWs were not identified as part of the research, as RCWs had not received sufficient training to enable them to give their perspective. What did emerge, however, was the need to clearly define training outcomes for DSWs and facilitate training transfer by using these outcomes as a focus for putting the learning into practice.

The Dementia Care Learning Conceptual Model (Figure 5.1) incorporates training outcomes being set at course inception (i.e. in the first domain). It emerged through literature that training for dementia care was more than just knowledge but also how confident and competent RCWs felt about using that knowledge in practice. The training outcomes therefore can be used for assessing knowledge, confidence, and competence of the RCW (Appendix 10). Using a student-centred approach, an

assessment sheet can be completed by both the learner and the assessor (as part of the fourth domain), a meeting between the two would result in mutually agreed ratings for each outcome that can be used to highlight areas of strength and areas for improvement.

The strongest conclusion that can be drawn from the research is the lack of dementia training to transfer or any process to follow. As a result, it was not possible to collect any significant data on the measurement of training outcomes. Building on Grossman & Salas' (2011) adaptation of the Training Transfer Model, the Dementia Care Learning Conceptual Model (Figure 5.1) proposes a training process from course inception through to confirmation that an RCW has been able to transfer their learning into practice, using the concepts of knowledge, confidence and competence.

6.2 Contribution to Knowledge

This research has contributed to knowledge in the following areas.

It is one of the few studies that has asked RCWs their views on the challenges they face in day-to-day practice, and the training they require to deal with those challenges in pursuit of implementing person-centred care for residents. Topics for training not included in the Dementia Care Training Framework (Skills for Health 2015) were identified.

It was clear that the training received (which was limited or non-existent) was not followed up in terms of transfer into practice. The second contribution, therefore, was the creation of the Dementia Care Learning Conceptual Model. Based on the evidence from this research, this model proposes a framework for the training process, from course creation through to satisfactory completion of putting the learning into practice, based on the findings of this research. The Conceptual Model's assessment phase measures RCWs' knowledge, confidence and competence. This assessment is a two-way process between the learner and the mentor. It is important to note that this model is an exploratory proposal and has yet to be trialled empirically. Future study is needed to test out and develop it further, but its value is as a first step towards devising

a more integrated framework for research into dementia care training. As the literature review (Chapter 2) showed, this is currently lacking.

However, it must be noted that building training that responds to RCWs' own perceptions of the challenges in the job is only one contribution to a number of potential remedies to the problems facing residential dementia care. Although the effectiveness of its implementation is likely to be affected by a range of structural factors, it remains an important contribution. This is another argument for empirical testing of the approach.

6.3 Limitations of the Research

It is important to illustrate the potential limitations of the research and how things might have been done differently.

Originally, I had planned to share the findings with the RCWs who participated. However, as valuable as this might have been, follow-up was not completed. Due to work demands and an extended period of illness, the analysis and findings were completed only 18 months after the interviews. With a care worker turnover rate of 32.6% ((NMDS-SC 2017a), one in three might have left post, i.e. six of the 19 interviewed, and the lapse of time between the interviews and completion of the analysis would have created a further barrier. Such a follow-up, therefore, could have been of limited value, and time and resource constraints on tracing the individuals concerned meant it was unrealistic. I recognise this as not being congruent with the ethos of the study, despite the practical difficulties I would have encountered and the impact of the elapse of time.

In terms of reflecting on ethical limitations and data collection, most wanted to share views without the tape. As data was not being recorded, I asked the RCWs if I could take notes and use the data, which they agreed I could do. I also clarified this with my supervisors.

I considered whether 19 RCWs amounted to enough interviews. However, the same or similar concerns were being given by the RCWs. This could mean having reached saturation point. This is a small sample, because of the access difficulties and the

availability of RCWs to interview. The number of interviews was also constrained due to time and travel limitations of the researcher. Although the similar responses were over six care homes in three different care home organisations, it is not reasonable to consider them as generalisable – further research is indicated. However, it is possible that had I interviewed another care home organization that had provided training in the last two years, there would have been an alternative set of data.

Care staff from all three care home organisations had difficulty in answering questions about training experiences as they had received little or no training, certainly not in the last two years. However, this is a finding in itself. Some RCWs couldn't remember training. It is possible that training had occurred, but a long time ago. There were one or two RCWs that claimed not to remember, but later in the interview did remember a little.

Reflecting on my interview plan, I would ask more questions about company policies and procedures, and about how RCWs perceived the organisation in terms of support for care staff. For example, are opportunities provided for care staff to raise concerns or ask for training.

6.4 Areas for Further Research

Although the research was enlightening, there are areas that could be developed further. One way forward would be to take the components of the model that have emerged from this qualitative approach and incorporate them into a survey, so that it is possible to test whether similar results are obtained from a wider RCW population.

RCWs gave rich accounts about the perceptions of their role, and how they constructed their views on training needs. These views added considerable insight into their working lives and gave accounts of how this impacts directly on the wellbeing of residents with dementia. Their views highlight the training and ongoing support needs of RCWs that enable the provision of person centred care. Future research needs to ensure RCWs' views are prioritized as their voices are worth listening to.

Having established there is no clear format for assessment or training into practice, it would seem important for further research to build on the foundations of this research

and apply the conceptual model in a residential care setting. This further research would aid the validation of the conceptual model and provide a framework for the model's application in a working environment.

Dissemination of the research in this thesis would enable me to present at a relevant conference. This could encourage discussion with academics and professionals on how the conceptual model could be improved, prior to deployment in a care home environment.

My journey began with a desire to know more about the learning needs of residential care workers working with dementia. This prompted me to find out directly from care workers themselves and provided an opportunity to voice their learning needs. Indeed, care workers commented that they appreciated being asked as this was not usual for them. There was also a desire to develop and grow in my learning so that I would have more to offer my students. The doctorate was a challenging learning curve. I feel I have learnt most from the vast amount of literature and from the depth of care worker explanations about their specific learning needs.

The conceptual model implicitly requires residential care organisations to make investments in people, providing the necessary training and follow-up to facilitate care worker learning and improve the care for residents with dementia. Given the current political and economic climate, where survival seems to be the name of the game for many residential care organisations, the necessity for a fully trained and supported workforce remains imperative.

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8 Appendices

Appendix 1 – Curricula Content

Source	Course	Curriculum Contents
Alzheimer's Society (2009)	<ul style="list-style-type: none"> •Yesterday today tomorrow (Induction programme) 	<ul style="list-style-type: none"> •Based on Kitwood (1997) Person First Principles & the work of Bere Miesen •Life histories •Behaviour that challenges •Communication •Personal care •Maintaining relationships •Team work
Skills for Care (2010)	<ul style="list-style-type: none"> •Common Induction Standards (June 2010) •Two Level 2 awards in dementia •Two Level 3 awards in Dementia <p>Dementia knowledge sets linked with common induction standards and Health and Social Care NOS at levels 2, 3 and 4</p>	<ul style="list-style-type: none"> •Person-centred Care •Person-centred values •Life histories •Needs and future wellbeing •Person-centred approach •Types of dementia •Theoretical models of dementia •Factors that relate to the experience of dementia •Roles of carers and others. •Communication •Equality Diversity and Inclusion. •Person-centred care •Communication •Life history •Assistive technologies •Value base (dignity respect) •Emotional and spiritual needs •Environment •Risk of falls •Personal hygiene

Source	Course	Curriculum Contents
		<ul style="list-style-type: none"> •Activities therapies and medication •Team working with professionals and other roles •Appropriate language focussing on abilities •Types of dementia •Importance of diagnosis •Common signs of dementia
Fazio et al (1999)	•Activity Based Alzheimer's Care	<ul style="list-style-type: none"> •Everyday activities that reflect the interests, strengths, skills, and beliefs of the person with dementia •Teamwork •The need for activity •Knowing the person with dementia in assessment and care planning
Miesen B (2010)	•Towards a Dementia Care Curriculum	<ul style="list-style-type: none"> •Relationship between the RCW and the person with dementia. •Aggressive behaviour •Intimacy and sexuality •Power and powerlessness •Truth and honesty •The paradox of normality •Adoption and (counter) transfer
Teri et al (2005)	•STAR Training	<ul style="list-style-type: none"> •Recognising own behaviour •ABC •Non-verbal and practical communication •Knowledge of dementia •Dignity and respect •Staff responses to resident needs •Pleasant events •Work with families •Getting active and the environment
Peterson et al (2002)	•Basic Care 1	<ul style="list-style-type: none"> •Knowledge of dementia •Challenging behaviour •Communication

Source	Course	Curriculum Contents
Bradford Dementia Group	<ul style="list-style-type: none"> •One three day course for direct RCWs including managers and nurses 	<ul style="list-style-type: none"> •Kitwood 1997 Person first principles - person-centred care which contains an enriched model of dementia therapies and interventions, and an ethical framework.
Social Care Institute for Excellence	<ul style="list-style-type: none"> •Uses Alzheimer's society and NICE guidance to produce 7 on line modules. The Open Dementia Programme 	<ul style="list-style-type: none"> •Views of dementia •Facts •Common symptoms •Image of dementia •Individuality •What happens to the brain •Life history •Types of dementia •Process of diagnosis and impact •Non pharmacological treatments •Emotional dimensions of dementia •Effective strategies to deal with difficult emotions •Looking at your own actions •Communications - helping person with dementia get across their views •Communication to help understanding •Non-verbal communication •Common difficulties – dealing with everyday tasks •Short term memory loss •Recognition perception and visual.

Appendix 2 – Semi-structured Interview Plan

Sub questions	Interview questions
What are the challenges of working with older people with dementia in a residential care home?	1) How do you feel about working with residents with dementia?
	2) What is the most difficult problem in providing care?
	3) How do you deal with it?
	4) What care/support would you like to provide to the residents but can't and why (time limitations/policy/physical issues)
How has dementia care training helped RCWs to feel better prepared to respond to the needs of the residents with dementia.	5) What have you learnt from dementia care training that you have used when working with residents with dementia?
	6) What have you put into practice that you perceive to be most helpful and why? Please give examples
	7) Has there been part of your dementia care training that you would like to put into practice but don't feel you are able to? Please explain.
	8) What session or part of a session (perhaps a practical exercise) that you perceive to be most helpful and why?
	9) What has not been so helpful and why?
	10) In what ways do you feel that your attitude towards residents with dementia have changed with dementia care training?
	11) In what ways is your learning connected to what you do?
How could training support RCWs to improve the quality of dementia care for older people/residents	12) What do you think about the current dementia care training that you are receiving? What are its strengths and weaknesses?
	13) What change would you like to see regarding dementia care training for you as an RCW? What would you add? What would you remove?

Appendix 3 – Organisation Invitation Letter

Organisation Invitation Letter.

I am writing to request your organisations' help with a project forming part of my Doctor of Social Work research programme. The aim of the research is to gather the views of workers within the Social Care sector who care for people with dementia. I realise that your organisation may get many requests of this nature, but I hope that you will agree to participate in this research. Please find the enclosed information sheet that describes the purpose of the research in more detail.

If you wish to participate, please contact me via email (lellames@sussex.ac.uk).

Thank you in advance for your participation in this project. If you have any questions about the administration of the research, please contact Lorraine Ellames via e-mail (lellames@sussex.ac.uk).

Appendix 4 – Organisation Information Sheet

Organisation Information Sheet

I am interested in the specific training needs needed to care for older residents with dementia and the views of direct RCWs in relation to their dementia care training.

Who is conducting this study? My name is Lorraine Ellames. I am a Lecturer in Social Work at Havering College and this research project forms the part of the study for the qualification of Doctor in Social Work. This research is being supervised by Professor Suzy Braye and Dr David Orr, School of Education and Social Work, Sussex University.

What is this study all about? RCWs have responsibility for much of the daily contact with older residents with dementia. RCWs have a significant role to play in the care and comfort of older people with dementia. The aim of this study is to gain some further understanding of what RCWs' views are on the special training needs required in order to work with, and care for, this group of older people. In turn, this may help residential care organisations in their design of dementia care courses and current practice that will influence the quality of service residential social RCWs deliver to residents with dementia.

How will this be done? This study will be carried out in the form of a number of individual interviews with dementia RCWs and managers within the residential care setting and will be conducted in a private room to ensure confidentiality. The proposal is to interview the Home Care Manager and two RCWs in one Residential Care Home within your organisation, located in [REDACTED], [REDACTED] or [REDACTED].

I will be asking about views on training for dementia care. All interviews will be semi-structured in nature. This will involve questions that will act as a prompts for discussion. Each interview will last for approximately 1 hour.

The interviews will be recorded via a digital voice recorder. The recorded data will be stored securely at my home office for safekeeping away from the care home environment.

Will the information collected be treated as confidential? All information collected in this study will be treated in strictest confidence and stored anonymously and participants will not be identified in the final report. Information given by RCWs will not be disclosed and will remain with the researcher. The care home will know who is participating in the interview but not the responses given. At the end of the research

the files containing the information will be deleted. The raw data will not be made available to anybody in the organisation including any control information (years of service, amount of training received etc.). It is important, however, to note that any information shared that has implications for the health and safety of a vulnerable third party will be reported to the home manager.

Will I be told about the results of this study? A written summary of the findings will be prepared for anyone who has contributed to this study if they wish to receive it.

If you have any queries, or would like to discuss any aspect of the project, please contact either Ms Lorraine Ellames L.Ellames@sussex.ac.uk 07966 279299 or

Professor Suzy Braye S.Braye@sussex.ac.uk 01273 678252

Appendix 5 Analysis Categories and Themes

CATEGORY	THEME
Communication with residents	Specific Dementia Challenges
Enjoying care work	
Family concerns	
Family needs	
Frustration	
High Needs	
Residents individuality	
Working with Families	
Acceptance of challenging behaviour	Emotional demands on RCWs
Attachment to residents	
Awareness of own behaviour	
Building relationships	
Care worker fear for themselves	
Care Worker feelings linked with own family/values	
Coping mechanisms	
Emotional demands	
Empathy with resident	
Expectations about job role	
Physical aggression	
Stress of the job	
Verbal aggression	
Admin Work	Teamwork
Management	
Teamwork	
Forgotten Training	Experiences of Training
Lack of basic knowledge	
Learning Environment	
Not engaging with Training	
Training Assessment	
Training Methods	

CATEGORY	THEME
Barriers to Practice	Barriers to Implementing Person-centred Care
Limited staff for number of residents	
Limited time	
Person-centred care	
Resources	
Key Learning	Care Worker Views on Training Needs
Mandatory Training	
Personal Development	
Training received	
Training Requirements	
Training subjects	

Appendix 6 – UoS Ethics Certificate of Approval



University of Sussex

Social Sciences & Arts Cross-School Research Ethics Committee CERTIFICATE OF APPROVAL	
Reference Number:	1213/10/05
School:	ESW
Title of Project	What Are The Factors That Might Be Taken Into Account In The Development And Evaluation Of A Dementia Care Curriculum For Dementia Care Workers?"
Principal Investigator: (Supervisor)	Lorraine Ellames (Braye)
Expected Start Date:*	25/07/2013
<p>*NB. If the actual project start date is delayed beyond 12 months of the expected start date, this Certificate of Approval will lapse and the project will need to be reviewed again to take account of changed circumstances such as legislation, sponsor requirements and University procedures</p>	
<p>This project has been given ethical approval by the Social Sciences/Arts Research Ethics Committee (C-REC). Please note the following requirements for approved submissions:</p> <p>Amendments to research proposal - Any changes or amendments to the approved proposal, which have ethical implications, must be submitted to the committee for authorisation prior to implementation.</p> <p>Feedback regarding any adverse and unexpected events - Any adverse (undesirable and unintended) and unexpected events that occur during the implementation of the project must be reported to the Chair of the Social Sciences C-REC. In the event of a serious adverse event, research must be stopped immediately and the Chair alerted within 24 hours of the occurrence.</p>	
Authorised Signature	
Name of Authorised Signatory (C-REC Chair or nominated deputy)	Professor Stephen Shute 22/07/2013

Appendix 7 – Participants Information Sheet

What are the specific training needs within dementia care: the views of RCWs

Participant's Information Sheet

I am interested in the specific training needs to care for older residents with dementia and the views of direct RCWs towards their dementia care training.

Who is conducting this study? My name is Lorraine Ellames. I am a Lecturer in Social Work at Havering College and this research project forms the part of the study for the qualification of Doctor in Social work. This research is being supervised by Professor Suzy Braye and Dr David Orr, School of Education and Social Work, Sussex University.

What is this study all about? RCWs have responsibility for much of the daily contact with older residents with dementia. RCWs have a significant role to play in the care and comfort of older people with dementia. The aim of this study is to gain some further understanding of what care worker's views are on the special training needs in order to work with, and care for, this vulnerable group of older people. In turn, this may help the organisation in their design of dementia care courses and current practice that will influence the quality of service we deliver to the residents.

How will this be done? This study will be carried out in the form of a number of interviews within the residential care setting and will be conducted in a private room to ensure confidentiality. All interviews will be semi-structured in nature. This will involve interviews that will act as a prompts for discussion. Each interview will last for approximately 1 hour.

The interviews will be recorded via a digital voice recorder. The recorded data will be stored at my home office for safekeeping away from the care home environment. Participants will be given the option to see the transcript of the interview as part of the consent process. The interviews will be on a one to one basis in a room with a closed door.

How long will the fieldwork take? This should take about three weeks in all to complete depending on the interviewee's availability.

Will the information collected be treated as confidential? All information collected in this study will be treated in strictest confidence and stored anonymously and participants will not be identified in the final report. At the end of the research the files

containing the information will be deleted. The raw data will not be made available to anybody in the organisation including any control information (years of service, amount of training received etc). It is important to note that any information shared that has implications for the health and safety of a resident or care worker, must be reported to the home manager.

Will I be told about the results of this study? A written summary of the findings will be prepared for anyone who has contributed to this study if they wish to receive it.

If you have any queries, or would like to discuss any aspect of the project, please contact either Ms Lorraine Ellames L.Ellames@sussex.ac.uk 07966 279299 or

Professor Suzy Braye S.Braye@sussex.ac.uk 01273 678252

Appendix 8 – Informed Consent Form

INTERVIEW INFORMED CONSENT FORM

What are the specific training needs within dementia care: the views of RCWs.

Research Approval

Reference: _____

I agree to take part in the above University of Sussex research project. I have had the purpose and details of the project explained to me and I have read and understood the Explanatory Statement, which I may keep for records. I understand that agreeing to take part means that I am willing to

I Agree

I Disagree

Be interviewed by the researcher

Allow the interview to be recorded

Make myself available for a further
interview should that be required

I understand that any information I provide is confidential, and that no information that I disclose will lead to the identification of any individual in the reports on the research, either by the researcher or by any other party. I understand that the final report may include quotes selected from my interview, but that every effort will be made to avoid including information that could identify me.

I understand that any information shared that may have implications for the health and safety of a vulnerable third party is reported to the care home manager.

I do/do not wish to see a transcript of the interview (delete as appropriate)

I understand that my participation is voluntary, that I can choose not to participate in part or all of the research, and that I can withdraw at any stage of the research without being penalised or disadvantaged in any way.

Your Name: _____

Your Signature _____

Signature of researcher _____

Date: _____

Appendix 9 – Care Organisation and Home Characteristics

Org	Home/ Interviewee No.	Type of Service	Max No. of Residents	Overall Rating at Last Inspection	Training Comments on CQC Inspection prior to Interviews	Rating for Supporting Workers	Dementia care training?
1	A 1A#02 1A#06 1A#07	Care home without nursing	29	Met standards	"Members of staff said they received the training they needed to care for people with conditions such as diabetes, Parkinson's disease, stroke and dementia."	Met Standards	Yes but no details
1	B 1B#01 1B#03 1B#04 1B#05	Care home without nursing	62	Action needed	"We looked at the training spreadsheet that showed that all the care workers had received training on the safeguarding of vulnerable adults within the last two months."	Met standard	No mention of dementia care training.
2	A 2A#11 2A#12 2A#13	Care home without nursing	36	Action needed	"17 staff had not received training in the protection of vulnerable adults. We also noted that not all staff had completed an induction."	Action needed	No mention of dementia care training.
2	B 2B#14	Care home	24	Action needed	"Many staff required	Action needed	No mention of

Org	Home/ Interviewee No.	Type of Service	Max No. of Residents	Overall Rating at Last Inspection	Training Comments on CQC Inspection prior to Interviews	Rating for Supporting Workers	Dementia care training?
	2B#15 2B#16	without nursing			update training on fire safety and food hygiene."		dementia care training.
3	A 3A#17 3A#18 3A#19	Care home with nursing	60	Action needed	"Staff said training had been given. However, the records showed us that no training had taken place during 2012 so it was not clear how staff's skills were kept up to date."	Action needed	No dementia training given but scheduled after the inspection. Subsequent inspection did not mention dementia care training
3	B 3B#08 3B#09 3B#10	Care home without nursing	26	Met standards	Report said the standard was met, personnel files were checked for CRB check & references.	Met Standards	No mention of dementia care training.

Appendix 10 - Training Assessment Person-centred dementia care

Outcomes	Knowledge					Confidence					Competence				
Score	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
a) understand the principles of person-centred dementia care i.e.															
• the human value of people with dementia, regardless of age or cognitive impairment, and those who care for them															
• the individuality of people with dementia, with their unique personality and life experiences among the influences on their response to the dementia															
• the importance of the perspective of the person with dementia															
• the importance of relationships and interactions with others to the person with dementia, and their potential for promoting well-being															
b) understand how person-centred care can provide insights into the experiences of the person with dementia and support care approaches and solutions to meet individual needs															
c) understand the role of family and carers in person-centred care and support of people with dementia															
d) understand how a person-centred approach can be implemented, including the use of advance planning and life story work															
e) understand that a person's needs may change as the disease progresses															
f) know how to adapt the physical environment to meet the changing needs of people with dementia															
g) understand the significance of a person's background, culture and experiences when providing their care															
h) understand the importance of clear documentation to communicate the care needs of the person with dementia															

Please rate your knowledge, confidence and confidence levels for each of the training outcomes above from low (1) to high (5)