

**The Impact of SettleIN (an Adjustment Programme for People
with Dementia) on Staff Attitudes, Competence and
Knowledge of Adjustment**

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

Volume one of this thesis is presented in three parts. The first presents a literature review exploring the impact of training interventions in dementia care homes on staff outcomes. The 18 papers are reviewed with regard to training approach, outcomes measured and intensity of programme. Organisational barriers to implementation are noted, and additions to training that maximise improvements in staff domains are discussed.

Part two is an empirical paper that reports a study exploring the effect of SettleIN, a staff-led intervention to support healthy adjustment to residential living for people with dementia, on care home staff knowledge, competence and attitudes. This paper follows a previous feasibility trial for the SettleIN intervention, with enhancements to the programme, training structure and methodology of evaluation. The research was joint with another trainee; the feasibility of the programme and impact on resident outcomes are documented by Caroline Saint.

The third part of this volume presents a critical appraisal of the research project. The experience of the process and barriers to completion are discussed. The appraisal includes a discussion on personal development and learning.

Impact Statement

There are 850,000 people living with dementia in the UK, of which a third live in residential care homes. Transition to residential care is associated with negative outcomes for people with dementia (PwD). The practice of care home staff is vitally implicated in resident outcomes. This paper adds to the knowledge base of effective training for staff working in these settings, as well as addresses the current gap in the research in regard to specific adjustment support.

The systematic review presented explores the outcomes of training interventions for care home staff, taking into consideration the approach, intensity and practicality of delivery. These findings inform the design and delivery of educational programmes to ensure that learning is in an accessible and realistic format. Direct care practice can improve as a result of such training, for example the ability to communicate with PwD. Outcomes specific to staff are discussed with regard to how care home managers can best support staff wellbeing through the provision of such interventions, ultimately with the desired benefit of improved quality of care. The review further adds to the ongoing discussion concerning the barriers of implementation in these settings, with suggestions for future research to ensure training benefits are maximised.

The empirical paper presented discusses the effect of a new programme on staff outcomes. SettleIN is the first intervention focusing specifically on the period of transition into as home, and as a result, the evaluation of this programme adds a novel and much needed intervention to dementia research. This study evaluates the feasibility and potential benefits of SettleIN to ensure the development of an evidence based programme, a title not held by the vast majority of those currently used in care practice. Specifically addressing staff outcomes allows for an understanding of whether improvements are observed in those delivering the programme. The findings indicate that change can be seen in staff knowledge of adjustment even after a relatively short training and intervention period. This is a

promising result in the context of many barriers to delivery, however, further research on SettleIN would need to include further enhancements to the programme and training design.

This study also works to keep the adjustment conversation present in research. Researchers should continue to strive to ameliorate the current situation if the quality of life of PwD is to be maximised in residential care. Any parties attempting to address this process may be assisted by the contents of this paper. Suggestions for further research specifically relating to the SettleIN programme are made, as well as more broadly relating to this particular research demographic and setting.

Table of Contents

Acknowledgements.....	11
Part 1: Literature Review	13
Abstract.....	14
Introduction	15
Method.....	19
Results.....	22
Discussion	47
Conclusion	53
References	54
Part 2: Empirical Paper.....	61
Abstract.....	62
Introduction	63
Methods	68
Results.....	78
Discussion	90
Conclusion	97
References	98
Part 3: Critical Appraisal	105
Introduction	106
Choosing this project	106
Challenges recruiting care homes and participants.....	106
Experience of training	107
Staff and organisational barriers.....	109

Emotional Challenges.....	111
Skill Development.....	112
Conclusion.....	113
References.....	114
Appendices.....	117

Figures and Tables

Figures

Literature Review

Figure 1: Training programme classification21

Figure 2: Flow chart of selection process for new studies.....23

Empirical Paper

Figure 1: SettleIN training structure.....74

Figure 2: Stages of coding and analysis of TA (Braun & Clarke, 2013).....77

Figure 3: Consort diagram of recruitment.....80

Tables

Literature Review

Table 1: Quality ratings criteria and scores part one 24

Table 2: Quality ratings criteria and scores part two 25

Table 3: Summary of studies included in the review 26

Empirical Paper

Table 1: Staff participant demographics 81

Table 2: Mean scores on quantitative measures..... 83

Table 3: Overarching themes, themes and codes..... 84

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Part 1: Literature Review

**The impact of training interventions in dementia care homes on staff specific
outcomes**

Abstract

Aims: This review aimed to explore staff specific outcomes of dementia training programmes in residential settings. The review built on previous work to include most recent findings following increased dementia research funding and interest. The type of approach, intensity of intervention and barriers to implementation were considered, as well as many domains of staff practice and wellbeing.

Method: databases PsycInfo, Medline and PubMed were searched for papers reporting randomized designs and published between September 2013 and December 2017. Eighteen papers representing sixteen studies were included in the review and appraised for quality.

Results: The papers represented a number of training approaches and included measurement of many staff domains. All but three papers showed a positive effect of training in comparison to control conditions. There was no indication of training intensity on outcome, however, all low intensity studies also included an ongoing supervision element to consolidate learning. The included papers were mostly of medium or high quality.

Conclusion: Training approaches in dementia care can prove to positively affect outcomes in a number of staff domains. No training approach was found to be the most effective in improving staff outcomes. There was no observed effect of intensity, however, low intensity interventions did all include a supervision element to consolidate learning. Barriers to implementation continue to present in this setting and should be formally measured to ascertain the most effective strategies to support implementation in care practice.

Introduction

Dementia prevalence

The number of people living with dementia (PwD) is increasing with increased life expectancy, with an estimated 47 million people living with the condition in 2016 (Prince, Comas-Herrera, Knapp, Guerchet & Karagiannidou, 2016). In 2014, 311,730 (39%) of people over 65 years old living with dementia in the UK lived in residential or nursing care homes (Prince et al., 2014) and the proportion of care home residents with dementia increased from 56 percent in 2002 to 70 percent in 2013 (Matthews et al., 2013). Good quality dementia provision is, therefore, essential in residential and nursing homes around the country.

Dementia care staff characteristics

Many staff-related factors are associated with quality of care and, as a result, resident experience; for example, staff communication style affects residents' resistance to care (Williams, Herman, Gajewski & Wilson, 2009; Christenson Buchanan, Houlihan & Wanzek, 2011), and staff person-centeredness is associated with residents' quality of life (Sjögren, Lindkvist, Sandman, Zingmark & Edvardsson, 2013).

Staff supporting people living with dementia in UK residential settings tend to work long hours and often at a minimum wage. Burnout, an emotional state characterised by exhaustion, cynicism and ineffectiveness (Maslach & Leiter, 1997), is an experience to which the caring professions are particularly vulnerable (Barron & West, 2007) and, when "burnt out", healthcare staff provide lower quality care to patients (Spence-Laschinger, Shamian & Thomson, 2001). Staff factors, such as self-efficacy, have been found to predict burnout in nursing home staff (Duffy, Oyebode & Allen, 2009). As well as negatively impacting staff wellbeing, burnout

leads to economic consequences for organisations due to factors such as absenteeism, higher attrition rates and lower productivity (Cordes & Dougherty, 1993).

Dementia care staff training

To support the work of care home staff, specific training is needed (Riesch, Meyer, Lehr & Severin, 2017). Many training programmes have been developed to improve the quality of care provided by those in dementia care homes. The majority of studies and reviews on staff training programmes in long-term settings focus on teaching skills to care staff aimed at reducing the behavioural and psychological symptoms of dementia (BPSD) (Moyle, Hsu, Lieff & Vernooji-Dassen, 2010). There is evidence for the effectiveness of training programmes in reducing challenging behaviour for PwD (Spector, Orrell & Goyder, 2013).

In regard to staff outcomes, Spector, Revolta and Orrell's (2016) systematic review found training interventions to have significant effects on self-efficacy, sense of competence and knowledge. The most common focuses of these beneficial interventions were the management of challenging behaviour and taking a person-centred approach. The majority of studies did not find a significant impact on burnout; however, there was only one high quality study that measured this domain. Despite benefits being recognised, organisational barriers, such as perceived management support, reduced post training. These barriers are important in the understanding of implementation, and therefore the success, of a training programme. Spector et al.'s review is somewhat limited due to the inclusion of variable paper quality, a consequence of the limited research in this area at the time of writing. The cluster randomised control trials (CRCTs) included were also shown to have an inflated chance of type-two error due to a lack of adjustment for clustering effects.

Whether the type and intensity of training affects outcomes has also been

queried. Even interventions focused on the same domain are found to show large levels of heterogeneity (Machiels, Metzelthin, Hamers & Zwakhalen, 2017). Literature in this area points to the methodology of the information transfer. Caregivers needed multiple implementation strategies to improve their knowledge; education alone was not enough (Boersma, van Weert, Lakerveld & Dröes, 2015). It is suggested that the combination of theoretical knowledge and practical exercises helps staff to apply knowledge to daily practice (Riesch et al., 2017). Findings about the impact of training and continued supervision have been found to be inconsistent (Spector et al., 2016).

Uptake of training in clinical practice

Despite research demonstrating the benefits of dementia specific training for those working in care homes, poor care continues to be seen. In a thematic review of the care of PwD in care homes and acute hospitals, it was found that 27% of care homes demonstrated aspects of variable or poor care regarding staff's knowledge and understanding of dementia care, not all staff received training and providers of training did not routinely monitor whether training improved quality of care (Care Quality Commission, 2014). The review summarised that there are not always enough well-supported and trained staff (and with the right values) to care for people with dementia across care homes and acute care settings.

Increased interest in dementia research

The UK has seen a recent increase in political and public interest in dementia, which has been demonstrated in research funding. The UK Government doubled research spending on dementia between 2009/10 and 2013/14 from £28.2m to £60.2m (Department of Health, 2015), an investment that was mirrored by a 96% increase of dementia publications between 2008/2009 and 2014/2015,

thus showing the greatest percentage increase in the number of research publications by disease field (Alzheimer's Research UK, 2017).

The move to enhance funding for research in dementia is echoed in global policy; the G8 nations agreed to develop an action plan to significantly increase the amount spent on dementia research internationally at the 2013 G8 Dementia Summit (World Health Organisation, 2015). In regard to care for people living with dementia, the UK Government aims to see more research being conducted in residential care, as well as a majority of care homes signed up to the NIHR ENRICH 'Research Ready Care Home Network' by 2020 (Department of Health, 2015).

The current review

The current paper updated Spector et al. (2016)'s systematic review in order to incorporate the most recent research into the impact of staff training on staff outcomes in dementia care. Although published in 2016, the searches for the original review were conducted in September 2013; therefore, there was a potential that a number of studies had been published since the searches ended. The aims remained to (1) establish the impact of training on staff domains, (2) compare the impact of different training approaches, (3) explore the influence of training intensity and (4) explore barriers to change. In addition, it explored whether the quality of randomised control trials have improved since the completion of the original review.

Method

This paper is an update of Spector et al.'s (2016) review on the impact of staff training on staff outcomes in dementia care, which included nineteen papers, of which eleven were randomised designs. Due to the increased amount of literature since the completion of the original review, this review solely included randomised designs.

Inclusion criteria

- Randomised designs
- Published in English in peer review journals since September 2013 (the completion of Spector et al.'s (2016) searches)
- Training interventions for staff working in care homes, nursing homes or assisted living residences, with a focus on psychosocial outcomes for staff members

Exclusion criteria

- Studies without a randomised design
- Studies without a control condition
- Staff training in a primary care, inpatient or home setting

Search Strategy

The search terms of Spector et al.'s (2016) paper were replicated, which were:

- staff training interventions ('staff training', 'staff education', 'staff training intervention/s', 'dementia training', 'dementia care training', 'dementia training intervention', 'dementia staff training', 'dementia education')
- delivered to care staff ('nursing staff', 'nursing', 'care', 'caregiver/s', 'staff', 'care assistant/s', 'carer/s')

- supporting people with a diagnosis of dementia ('dementia', 'Alzheimer's disease', 'vascular dementia')
- in a residential setting ('nursing home', 'care home', 'assisted living residence', 'residential care institution', 'long-term care')
- with the inclusion of staff outcomes, rather than solely focus on resident outcomes ('staff behaviour', 'staff psychological wellbeing', 'staff attitudes', 'self-efficacy', 'stress', 'job satisfaction', 'sense of competence', 'burnout', 'knowledge', 'coping behaviour', 'approach to dementia').

The databases PsycInfo, Medline and PubMed were searched in October, November and December 2017. The reference list of each included study was also searched by hand for any further papers.

Classification of training programmes

The same criteria were used to rate the intensity of the training interventions into three categories by the training duration; 1.5–5hours was defined as low, 6–11 hours as medium and 12–24 hours as high. The categories for type of approach used by Spector et al. (2016) have been revised to ensure that the aim of the training approach is the key feature of categorisation (see figure 1).

1. Communication and awareness focused approaches;
Focusing on the improvement of staff's verbal and non-verbal communication skills when interacting with people with dementia. Also includes staff member's awareness and responsiveness to cues from people with dementia that might struggle to communicate verbally.
2. Managing challenging behaviour;
With the aim to improve the staff response to behaviour that challenges, for example restlessness and aggression, and to consider factors that might increase the likelihood of these behaviours
3. Person centred care;
Aiming to promote and improve practice in this approach to care, for example, through dementia care mapping
4. Other;
Training approaches that are not aligned specifically to the above three categories.

Figure 1: Training programme classification

Results

Included studies

Using the updated inclusion/exclusion criteria, eight of the original papers were excluded due to study design. Eleven of the papers included in the original review therefore met the criteria for this update to the review.

428 studies were found through the initial searches, of which 421 were excluded in line with the exclusion criteria. Figure 2 details the selection process. Five studies met the inclusion criteria, which are represented in this review in seven papers (one study is presented in three separate papers). All of these new papers were identified through the database searches.

Study quality

Kmet, Lee and Cook's (2004) appraisal tool was used to assess paper quality. This tool gives each paper an overall value between zero and one based on ratings from fourteen criteria. Although a comprehensive appraisal tool, Kmet et al's framework does not provide guidelines for how to categorise the quality of the papers. For that reason, the quality criteria proposed by the original review's authors was used again, in which <0.6 is rated low, $0.6-0.8$ is rated medium, and >0.8 rated high quality. Only two of the included papers (Davison et al. 2007, Visser et al., 2008) were rated as low quality. Five were rated as medium quality, and the remaining eleven papers were rated as high quality. Tables one and two present the quality ratings for the included papers. Whilst the findings of the low quality papers will be included in this review, there will be reference on the possible impact of quality on validity. Quality of the papers was considered in integrating the findings and drawing conclusions about the efficacy of the current available training interventions. Table three provides a summary of the included studies.

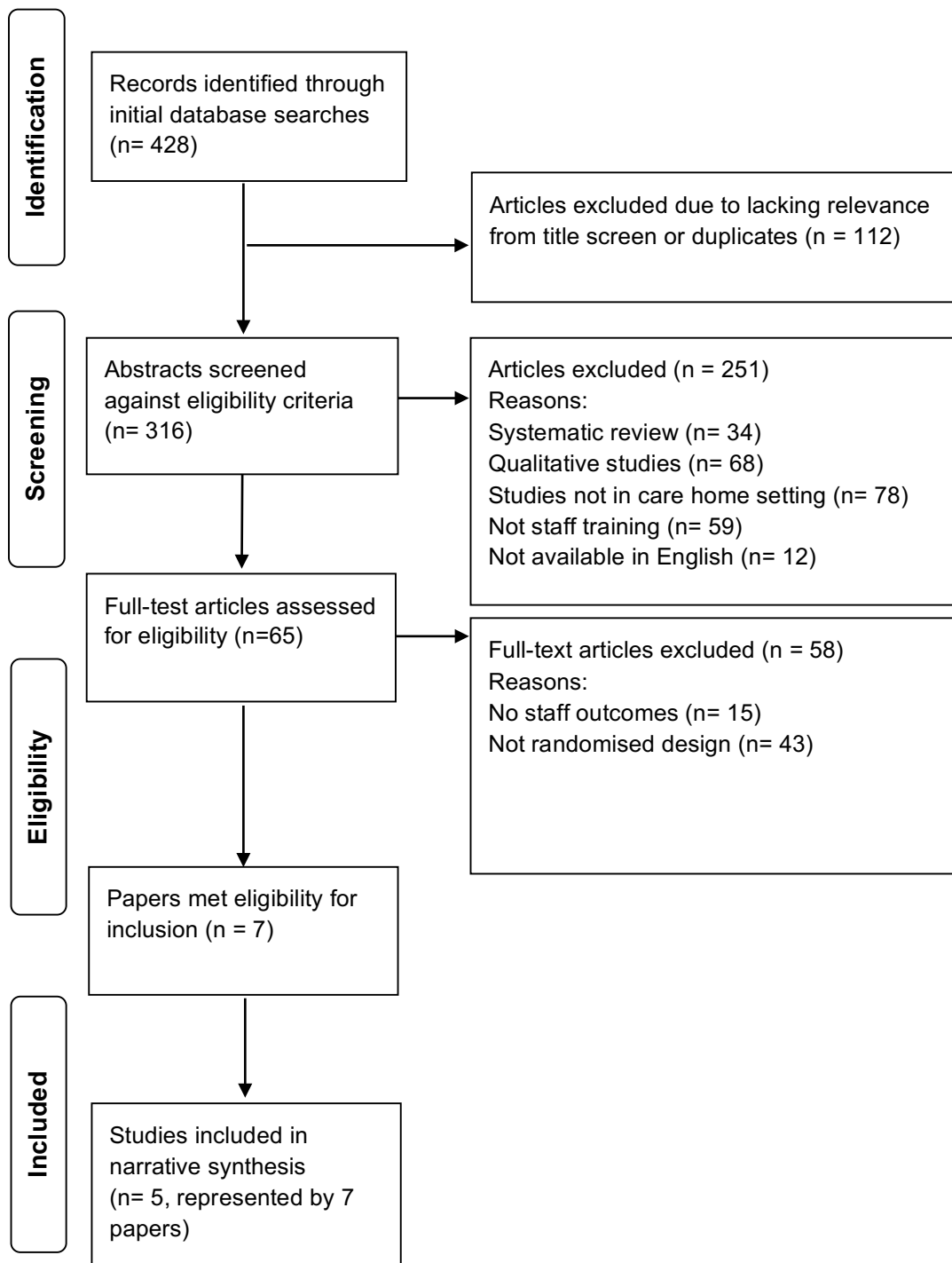


Figure 2: Flow chart of selection process for new studies

Table 1: Quality ratings criteria and scores (Kmet et al., 2004) part one

Study	Question /objective sufficiently described?	Study design evident and appropriate?	Method of subject/comparison group selection described and appropriate?	Subject and comparison group characteristics sufficiently described?	Was random allocation described?	Was blinding of investigators reported?	Was blinding of subjects reported?	Outcome measures well defined and robust?
Barbosa et al., 2015, 2016, 2017	✓✓	✓✓	✓	✓✓	✓✓	X	✓✓	✓✓
Berendonk et al., 2017	✓✓	✓✓	✓✓	✓✓	✓✓	X	--	✓✓
Clare et al., 2013	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	--	✓
Davison et al., 2007	✓✓	✓	✓	X	✓	X	--	✓✓
Finnema et al., 2005	✓✓	✓✓	✓✓	✓✓	✓	✓	--	✓
Jeon et al., 2012	✓✓	✓✓	✓✓	✓✓	✓	✓✓	--	✓✓
Kuske et al., 2009	✓✓	✓	✓✓	✓✓	✓✓	✓✓	--	✓
Magai et al., 2002	✓✓	✓	✓	✓✓	✓	✓✓	--	✓✓
McCabe et al., 2015	✓✓	✓✓	✓	✓✓	✓✓	✓✓	--	✓✓
McCallion et al., 1999	✓✓	✓	✓	✓✓	✓	✓	--	✓✓
Richardson et al., 2004	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Sprangers et al., 2015	✓✓	✓✓	✓	✓✓	✓	X	--	✓
Teri et al., 2005	✓✓	✓✓	✓	✓	✓	✓✓	--	✓
Visser et al., 2008	✓✓	✓✓	✓	✓	✓	X	--	✓
Zimmerman et al., 2010	✓✓	✓✓	✓✓	✓✓	✓	X	--	✓
Zwijzen et al. 2015	✓✓	✓✓	✓	✓✓	✓✓	X	--	✓✓

✓✓ Criteria fulfilled ✓ Criteria partially fulfilled X Criteria not fulfilled --Not applicable for study

Table 2: Quality ratings criteria and scores (Kmet et al., 2004) part two

<0.6 = low, 0.6-0.8 = medium, and >0.8 = high. Maximum score is 1, minimum score is 0

Study	Sample Size appropriate?	Analytic methods described and appropriate?	Some estimate of variance reported for the main results?	Controlled for confounding?	Results reported in sufficient detail?	Conclusions supported by the results?	Quality rating (total sum/total possible sum)
Barbosa et al., 2015, 2016, 2017	✓	✓✓	✓	✓✓	✓✓	✓✓	0.82
Berendonk et al., 2017	✓✓	✓✓	✓✓	✓	✓✓	✓✓	0.88
Clare et al., 2013	✓	✓	✓✓	✓✓	✓✓	✓✓	0.88
Davison et al., 2007	✓	✓	✓	✓	✓✓	✓✓	0.58
Finnema et al., 2005	✓	✓✓	✓✓	✓	✓✓	✓✓	0.80
Jeon et al., 2012	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	0.96
Kuske et al., 2009	✓	✓✓	✓✓	✓	✓✓	✓	0.80
Magai et al., 2002	✓	✓	✓✓	✓✓	✓	✓✓	0.77
McCabe et al., 2015	✓✓	✓✓	✓	✓	✓✓	✓✓	0.88
McCallion et al., 1999	✓	✓	✓	✓	✓✓	✓✓	0.69
Richardson et al., 2004	✓✓	✓✓	✓	✓✓	✓✓	✓✓	0.96
Sprangers et al., 2015	✓	✓✓	✓	✓	✓✓	✓✓	0.69
Teri et al., 2005	✓	✓	✓✓	✓	✓	✓✓	0.69
Visser et al., 2008	X	✓✓	✓✓	✓	✓	✓✓	0.59
Zimmerman et al., 2010	✓	✓✓	✓	✓✓	✓✓	✓✓	0.77
Zwijzen et al. 2015	✓✓	✓✓	✓✓	✓✓	✓	✓✓	0.85

✓✓ Criteria fulfilled ✓ Criteria partially fulfilled X Criteria not fulfilled --Not applicable for study

Table 3: Summary of studies included in the review

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
Barbosa et al., 2015, 2016, 2017	4 aged care facilities Portugal	CRCT Education + support vs. education only (control) Study: 10 weeks (baseline and 2 weeks after intervention)	Impact of a person-centred care based psycho-educational intervention on staff stress, burnout and job satisfaction, care workers' communicative behaviours and person-centredness Training duration: 12 hours Supervision: Not specific to intervention condition High intensity	Staff: 56	Staff: Burnout, job satisfaction, stress, verbal and nonverbal communicative behaviours and person-centred care	Staff: MBI, MSQ, PSS, frequency and duration of verbal and non-verbal communicative behaviours (ethogram), GBS Time points: baseline, 2 weeks post intervention	Sig positive effect of intervention on EE scores ($F=0.251$, $p=0.029$), verbal behaviour "inform" ($p<0.01$; $\eta^2_{\text{partial}} = 0.09$) and laughs ($p < 0.01$, $\eta^2_{\text{partial}} = 0.18$). Improvements in person-centredness were higher for the experimental group than control group, with values very close to significance ($F=3.906$; $p=0.054$). No sig effect of intervention on perceived stress ($F=0.049$, $p=0.826$), job satisfaction (on either intrinsic ($F=0.757$, $p=0.388$) or extrinsic ($F=2.232$, $p=0.133$) subscales)) or on any other subscales of communication.	0.82

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
Berendonk et al., 2017	20 long term care facilities Germany	CRCT Intervention vs. Treatment as Usual (TAU) control group Study: 8 weeks	Impact of a person-centred nursing intervention on care providers' motivation, work strain and satisfaction Training: 2 days Supervision: additional coaching session, continuous telephone support High intensity	Staff: 147 Res: 80	Staff: satisfaction, motivation, work strain and references made to residents' emotional states in nursing documentation Residents: Well-being, quality of life, behaviour and cognition	Staff: TAA-A, BHD, reference to emotional states in care documentation Time points: Baseline, 8 weeks post intervention	Sig effect of intervention on time pressure ($\beta=0.283$, $p=0.026$). No differences in other TAA subscales (SNR) Higher number of entries to documentation related to emotional wellbeing intervention group compared to control group, close to significance ($\beta=6.189$, $p=0.088$).	0.88
Clare et al., 2013	8 care homes UK	CRCT intervention vs control group Study: 8 weeks	Addressing staff perception of resident awareness to improve staff quality of life Training duration: 3 hours Supervision: Fortnightly Low intensity	Staff: 65 Res: 66	Staff: Attitudes, Well-being, care practices Residents: Well-being, quality of life, behaviour and cognition	Staff: MBI, GHQ-12, ADQ, Quality of care, DCPA Residents: QUALID, PRS, GADS, BASOLL Time points: Baseline, 8 weeks post intervention	No sig differences between intervention and control group in EE ($F=0$, $p=0.99$), depersonalisation ($F=2.55$, $p=0.12$), personal accomplishment ($F=1.87$, $p=1.86$), psychological distress ($F=0.22$, $p=0.64$) or attitudes ($F=0.06$, $p=0.81$). Sig better quality of life of residents (as rated by family) in intervention group than control group ($F=5.88$, $p=0.02$). No other significant differences in resident measures.	0.88

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
Davison et al., 2007	6 care homes Australia	CRCT Training + peer support vs. training vs. control Study: 8 weeks	Training in managing challenging behaviours Study: 8 weeks Training duration: 10 hours Supervision: None High intensity	Staff: 90 Res: 113	Staff: Staff burnout, self-efficacy, nursing performance Residents: Frequency of behaviours	Staff: MBI, SEDC, SNP Residents: CMAI Time points: Baseline, 8 weeks post intervention 6 month follow up	Sig positive effect of intervention on self-efficacy ($F= 23.74$, $p < 0.001$), which was maintained at follow up ($F= 5.07$, $p < 0.05$). No sig differences between training groups and control group on EE, depersonalisation or personal accomplishment ($F=1.80$, $p > 0.05$). No additional effect of peer support (relative to the training only group) on self-efficacy, either at T2 or T3 ($F= 3.01$, $p > 0.05$) Changes in overall ratings of residents' behaviours following training (relative to the control group) approached but did not reach significance ($F= 3.20$, $p = 0.077$). No additional effect of peer support (relative to the training only group) on overall ratings of residents' behaviours, either at T2 or T3, ($F = 1.90$, $p > 0.05$).	0.58

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
Finnema et al., 2005	14 nursing homes The Netherlands	CRCT Emotion orientated care vs. usual care Study: 7 months	Impact of emotion focused care on PwD Training duration: 16 hours Supervision: None High intensity	Staff: 99 Res: 146	Staff: General health, work place stress, job satisfaction Residents: Emotional adaptation, mood, behaviour	Staff: OSS, GHQ, DWSS Residents: ASEP, CSDD, CMAI, GRGS, PGCMS Time points: baseline 7 month follow up	Sig positive effect of intervention on stress reactions in a sub-group of participants ($F= 9.11$, $p=0.03$) No sig effect of training on stress perceptions ($F=1.51$, $p= 0.54$) or competence ($F= 0.09$, $p=0.77$).	0.80
Jeon et al., 2012	15 care homes Australia	CRCT Training Person Centred Care (PCC) vs. training Dementia Care Mapping (DCM) vs. TAU control Study: 8 months	Impact on PCC and DCM in staff outcomes Training duration: 2 days (PCC) and 3 days (DCM). Supervision: None High intensity	Staff: 124	Staff: Staff burnout, general health, attitudes to behavioural disturbances, perceived management support	Staff: MBI, GHQ-12, NPI-NH, QUIS, management support Time points: Baseline, post training, 4 month follow up	Sig positive effect of training on EE ($F=2.77$, $p= 0.028$). Correlation between perceived management support and EE ($r_s =0.26$, $p < 0.01$) and depersonalisation ($r_s =-0.21$, $p < 0.05$). Lower level of support correlated with greater scores on the burnout subscales.	0.96

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
Kuske et al., 2009	6 nursing homes Germany	CRCT Training group vs. relaxation group vs. waitlist control Study: 9 months	Impact of intervention on interactions between staff and residents with dementia Training duration: 13 hours Supervision: None High intensity	Staff: 96 Res: 210	Staff: knowledge, burnout, competence, health complaints Residents: Reduced number of sedatives/restraints	Staff: MHQ, MBI, BL Residents: Use of physical restraints, sedatives and falls Time points: Baseline, post training, 6 month follow up	Sig positive effect of training on knowledge ($F=10.429$, $p=0.002$) Higher level of competence in the intervention group compared to control group following training close to significance ($F=3.773$, $p=0.056$) and significantly higher competence in the intervention group at follow up ($F = 7.93$, $p=0.006$). No sig time effect of intervention on subscales of the MBI-D. No difference between intervention and control groups in all burnout subscales ($p>0.05$, SNR) and in health complaints ($p>0.05$).	0.80

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
Magai et al., 2002	3 nursing homes USA	CRCT Training vs placebo training vs. waitlist control Study: 2 weeks	To assess whether training in non-verbal communication could enhance resident mood Training duration: 10 hours Supervision: None Medium intensity	Staff: 20 Res: 91	Staff: Psychological wellbeing Residents: Mood and behaviour	Staff: BSI Residents: BEHAVE-AD, CMAI, CSDD, MAX Time points: Baseline, 3, 6, 9 and 12 weeks follow up	Sig positive effect of training on anxiety, depression and somatic symptoms ($F=4.9$, $p<0.05$).	0.77

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
McCabe et al., 2015	16 residential care facilities (Australia/New Zealand)	CRCT Training group+ ext. clinical support vs. workshop on BPSD+clinical support vs. training vs. TAU	A programme to assist staff to manage BPSD in residential care. Training duration: 2 hours Supervision: 6 (2 hour) support sessions Low intensity	Staff: 204 Res: 187	Staff: staff stress, general strain, attitudes, self-efficacy Residents: changes in BPSD	Staff: Carer Stress Scale, SDCS, ADQ, SEDC Residents: CMAI Time points: baseline, 3 and 6 months follow up	Training/support condition reported significantly lower stress than staff in the support only condition ($F=4.51$, $p<0.05$). Sig time effects were found for carer stress for the training/support condition ($F=18.07$, $p<0.01$) and the support condition ($F=5.97$, $p<0.05$). No sig time effect was found for either the training only or the care as usual conditions. Sig lower stress in training/support condition than support only condition at follow up ($F=4.51$, $p<0.05$).	0.88

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
McCabe et al., 2015 (continued)							<p>Sig time effects found for staff perceived disruption in the training/support condition (F= 10.79, p <0.01) and the support condition (F=8.11, p <0.01). No sig time effect was found for either the training only or the care as usual conditions. No sig difference between the training/support and support only conditions found in this measure.</p> <p>Sig time effects found in the training/support condition on the total frequency (of strains) scale, (F=9.49, p <0.01). Sig time effects were found in the training/support condition on the total stress (associated with strains) scale (F= 9.91, p <0.01). No sig time effects were found in frequency or stress for the support only or care as usual conditions, or for frequency for the support only condition.</p>	

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
McCabe et al., 2015 (continued)							No sig time effect was found on attitudes (SNR). Sig time effects were found in self-efficacy in the training/support condition, ($F= 6.26, p <0.05$) and the training only condition ($F= 9.14, p <0.01$). No sig time effect was found for the support condition (SNR) or care as usual condition (SNR). No sig difference between the training/support and training only conditions.	
McCallion et al., 1999	2 nursing homes USA	CRCT NASCP training vs. waitlist control Study: 3 months	To develop interaction between staff and residents Training duration: 2.25 Supervision: 4 hours Low intensity	Staff: 88 Res: 105	Staff Knowledge, problem management Residents: Mood, behaviour, disorientation	Staff: KAT, MHQ Residents CSDD, CMAI, MOSES, medication, restraint Time points: baseline, 3 and 6 months follow up	Sig positive effect of training on behavioural management ($F=5.35, p<0.01$). No sig effect of training on knowledge ($F=0.24, p>0.05$).	0.69

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
Richardson et al., 2004	UK	RCT Training vs. printed information Study: 6-8 weeks	Improve knowledge/management of elder abuse Training duration: 6 hours Supervision: None Medium intensity	Staff: 64	Staff: management of abuse, attitude, burnout	Staff: KAMA, MBI, AHCPDP Time points: baseline, post training	Sig positive effect of training on knowledge ($F=23.0$, $p<0.001$).	0.96
Sprangers et al., 2015	1 nursing home The Netherlands	Two group comparison design Intervention vs. control Study: 8 weeks	Improve nursing aide's communication with people with dementia Training duration: Not specified Supervision: None	Staff: 24 Res: 26	Staff: Communication, job satisfaction, level of caregiver distress Residents: agitated behaviours, psychopathology	Staff: CSC, OFGC, UWES, NPI-Q Residents: CMAI, NPI-Q Time points: baseline, post intervention	Sig positive effect of intervention on caregiver distress ($F=5.20$, $p<0.05$) and number of multiple instructions ($F=9.12$, $p<0.01$). No sig effect of intervention on communication skills. ($p>0.05$, SNR), types of instructions ($p>0.05$, SNR) or job satisfaction ($p>0.05$, SNR).	0.69

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
Teri et al., 2005	4 care homes USA	CRCT Intervention vs. control Study: 8 weeks	Reducing distress in residents and enhancing staff skills and job satisfaction Training duration: 10 hours Supervision: 2 hours Medium intensity	Staff: 25 Res: 31	Staff: Job satisfaction and competence Residents: Affective and behavioural distress	Staff: SSQC, job satisfaction Residents: GDS, CAS, RMBPC, ABID, NPI Time points: baseline, 8 week follow up	Staff: No sig group effects on job satisfaction (Z= 1.79, p>0.05) or sense of competence (Z=1.39, p>0.05). Residents: Sig effect of training on agitation (Z=- 6.75, p<0.01), depression (Z= -15.99, p<0.01) and anxiety (Z= -3.06, p=0.02).	0.69
Visser et al., 2008	3 care homes Australia	CRCT Training + peer support vs. training vs. control group Study: 8 weeks	Impact of training on staff attitudes and burnout and resident outcomes. Training duration: 12 hours Supervision: None High intensity	Staff: 52 Res: 76	Staff: Attitudes, burnout Residents: Behaviour, quality of life	Staff: SAQ, MBI. Residents: CMAI, ADRQL, restraint Time points: baseline, 8 weeks, 3 and 6 month follow-up	Education+peer support significantly improved skill and knowledge subset of the SAQ in comparison to education only and control (F=6.10; p<0.001). No sig time, group or interaction effects for each of the MBI subscales at post-intervention (SNR).	0.59

Table 3 Continued

Authors	Setting	Study design	Intervention aim and design	N	Outcome Domains	Outcome measures and time points	Results	Quality Rating
Zimmerman et al., 2010	9 nursing and 7 care homes USA	CRCT Intervention vs. control Study: 4.5 months	Evaluation of a national training curriculum programme Training duration: Not specified Supervision: None	Staff: 491 care staff, 173 supervisors	Staff: knowledge, attitudes, stress, satisfaction, perceptions of training and organisational outcomes	Staff: ADQ, WSI, training perception confidence Organisational: Communication, BLS, supervisory support Time points: baseline post training and 3 month follow up	Sig positive effect of intervention on communication ($F= 31.8$, $p<0.001$) and pain awareness, ($F= 9.1$, $p=0.009$). No group differences in job satisfaction or confidence. Sig reduction of reported supervisory support in the intervention group ($F=4.79$, $p=0.046$).	0.77
Zwijssen et al. 2015	17 dementia special care units The Netherlands	CRCT Intervention vs. control Study: 16 months	Care programme for the challenging behaviour of nursing home residents. Supervision: None Medium intensity	Staff: 380	Staff: burnout, job satisfaction and job demands	Staff: MBI, Leiden Quality of work questionnaire Time points: baseline, midway through implementation, after implementation	Sig effects of intervention on job satisfaction (95% CI 0.48–1.38). No sig differences found in outcomes of EE, personal accomplishment, depersonalisation of job demands (SNR).	0.85

Note: ABID = Agitated Behaviours in Dementia, ADQ = Approaches to Dementia Questionnaire, ADRQL = Alzheimer's Disease Related Quality of Life, AHCPDP = Attitude of Health Care Personnel towards Demented Patients, ASEP = Assessment Scale for Elderly Patients, BASOLL = Behavioural Assessment Scale of Later Life, BEHAVE-AD = Behavioural Pathology in Alzheimer's Disease Rating Scale, BHD= Screening instrument for job strain in human service work, BL = 'Beschwerdeliste' German measure of health complaints, BLS = Baldrige Leadership Scale, BSI = Brief Symptom Inventory, CAS = Clinical Anxiety Scale, CMAI = Cohen-Mansfield Agitation Inventory, CRCT= Cluster randomised controlled trial, CSC= Communication Skills Checklist, CSDD = Cornell Scale for Depression in Dementia, DCPA = Dementia Care Practitioner's Assessment, DWSS = Dutch Work Satisfaction Scale, EE= Emotional Exhaustion, GADS = Guy's Advanced Dementia Schedule, GBS = Global behaviour scale, GDS = Geriatric Depression Scale, GHQ= General Health Questionnaire, GHQ-12 = General Health Questionnaire (12-item version), GRGS = Geriatric Resident Goal Scale, KAMA = Knowledge and Management Questionnaire, KAT = Knowledge of Alzheimer's Test, MAX = Maximally discriminative Facial Movement Coding System, MBI = Maslach Burnout Inventory, MOSES = Multidimensional Observation Scale for Elderly Subjects, MSQ = Minnesota Satisfaction questionnaire- short form, NPI = Neuropsychiatric Inventory, NPI-NH = Neuropsychiatric Inventory for the Nursing Home, NPI-Q = Neuropsychiatric Inventory Questionnaire, OFGC= Observational form of general communication, OSS = Organisation and Stress Scale, P-CAT= Person-Centred Care Assessment tool, PGCMS = Philadelphia Geriatric Centre Moral Scale, PRS = Positive Response Schedule, QUIS = Quality of Interactions Schedule, PSS= Perceived Stress Scale, QUALID = Quality of Life in Late Stage Dementia Scale, RCT= Randomised controlled trial, Res: Residents, RMBPC = Revised Memory and Behavioral Problem Checklist, SAQ = Staff Attitudes Questionnaire, Sig= Significant, SDCS= Strains in Dementia Care Scale, SEDC = Self-Efficacy of Dementia Care, SNP = The Scale of Nursing Performance, SNR: Statistic Not Reported, SSQC = Short Sense of Competency Questionnaire, TAA-A = Task and job analysis tool- residential LTC version, UWES= Utrecht Work Engagement Scale, WSI = Work Stress Inventory.

Training approaches

Communication and awareness focused approaches (n=6)

Findings of communication and awareness focused approaches were variable. Some interventions designed to improve staff communication saw significant positive effects of training on a number of outcomes, including competence (Kuske et al. 2009, high quality), knowledge (Zimmerman et al., 2010) and staff depression and anxiety (Magai, Cohen & Gombert, 2002, medium quality). There were conflicting results on knowledge improvement following this style of training. One paper did not see an effect of training on communication styles; however, it observed a significant reduction on caregiver distress (Sprangers, Dijkstra, & Romijn-Luijten, 2015, medium quality). These findings suggest that communication-focused approaches may have implications for certain staff domains; however, the findings are not conclusive. Zimmerman et al. (2010) observed the only negative significant effect found by any paper in this review, with a significant increase in staff stress following training focused on communication and the awareness and management of pain.

Managing challenging behaviour (n=4)

All four studies evaluating training programmes to manage challenging behaviour saw significant effects of training in at least one staff domain, including self-efficacy (Davison et al., 2007) and job satisfaction (Zwijzen et al., 2015). Visser et al. (2008) found this type of training programme to significant effect of training on attitudes; however, this was a low quality study. Neither of the two studies measuring burnout found training to have a significant impact (of which one study, Zwijzen et al., 2015, was high quality, and the other, Davison et al., 2007 was low quality).

Person-centred care (n=3)

Five papers reported findings on three training interventions. Person-centred interventions had significant positive effects compared to control conditions in regard to time pressure (Berendonk, Kaspar, Bär, & Hoben, 2017) and staff burnout (Jeon et al., 2012). One study (presented by three papers; Barbosa, Nolan, Sousa & Figueiredo, 2015; Barbosa, Marques, Sousa, Nolan & Figueiredo, 2016; and Barbosa, Nolan, Sousa & Figueiredo, 2017) evaluated a person-centred psychoeducation programme with additional emotional support (intervention group), as compared to the same psychoeducation without support (control group). The psychoeducation programme significantly improved person-centredness over time (Barbosa et al., 2017). There was a time and group interaction that indicated significant benefits of the addition of emotional support on emotional exhaustion (Barbosa et al., 2015) and communication (Barbosa et al., 2016), as well as improvements of person-centredness; however, this was only close to significance (Barbosa et al., 2017). This study was limited by the small sample size, the researchers not being blind to the conditions and the lack of follow up. It is, therefore, difficult to understand the impact of the intervention over time.

Other (n=3)

Three papers reported interventions that did not fit into the above categories. One intervention was designed to improve staff knowledge of abuse (Richardson et al., 2004), and found training to significantly increase measures in this domain compared to the control condition. One reported an emotion orientated intervention (Finnema et al., 2005), which, interestingly, found a positive effect of intervention on stress levels in a subgroup of participants. The final paper in this category was focused on a behavioural approach based on person-environment fit (Teri, Huda, Gibbons, Young & van Leynseele, 2005), and did not find any effect of training on staff outcomes.

Outcomes

There were many different outcomes measured across the studies, using a variety of measures. All outcome domains reported in the original review were measured in at least one new paper, with the exception of sense of competence. There was an addition of two outcomes to note, which were measures of person-centred care and communication. This review will also include comment on measures of staff mental health/wellbeing.

Burnout

Seven of the included studies measured staff burnout, all of which used the Maslach Burnout Inventory (MBI, Maslach & Jackson, 1981). Two papers (Barbosa et al. 2015, Jeon et al., 2012) found staff training programmes focusing on person-centred approaches to significantly decrease emotional exhaustion, a subset of the MBI, in comparison to control conditions. For one programme this was maintained at follow up (Jeon et al., 2012). The five other papers exploring burnout did not see a significant effect of training on this measure.

Job satisfaction

Five studies measured staff satisfaction. One study found a significant effect of training on job satisfaction (Zwijssen et al., 2015) as measured by the Leiden Quality of Work Questionnaire, found to be a reliable measure for this outcome (van der Doef & Maes, 1999). Each of these studies used a different measure for job satisfaction with varying psychometric properties.

Attitudes

Five of the nineteen studies measured staff attitudes. Of these papers, only one (Visser et al., 2008) found a significant effect of training on staff attitudes. This paper, however, is low quality and the authors did not use a parametrically tested

measure. The majority of the papers measuring attitude used the Approaches to Dementia Questionnaire (Lintern, 2009), for which previous research has shown adequate internal reliability (Lintern, 2001).

Knowledge

Four of the eighteen studies measured staff knowledge, all of which were included in the original review. Three of the four papers (Kuske et al., 2009, Richardson et al., 2004, Zimmerman et al., 2010) found a significant effect of training on knowledge, with increased knowledge in the intervention condition in comparison to the control, of which two saw these maintained at follow up (Richardson et al., 2004, Zimmerman et al., 2010). One study found no impact of training on knowledge (McCallion, Toseland, Lacey & Banks, 1999).

Sense of competence

Sense of competence was measured in two studies, both of which were included in the original review. One communication-focused approach (Kuske et al., 2009) found a significant positive effect of training on the management of challenging behaviour. This result was maintained at follow up. The other study (Teri et al., 2005) did not see a significant effect of training on competence.

Self-efficacy

Two studies measured staff self-efficacy. Both of these studies were evaluating interventions focused on managing challenging behaviour (Davison et al., 2007, McCabe et al., 2015). Davison et al. (2007) found a positive effect of training on self-efficacy, which was maintained at follow up. McCabe et al. (2015) observed significant time effects of training/support and of training alone which were not found in the support only or care as usual conditions. No significant difference was found between the training/support condition and training conditions. The studies used the

Self-Efficacy of Dementia Care self-report instrument to measure this outcome, originally developed by Davison et al. for their study and reporting high internal reliability for the scale. However, these two papers varied in quality (Davison et al., 2007 was rated as low quality and McCabe et al. 2015 as high quality), therefore more high quality research would be needed to support this finding.

Communication

Two of the eighteen papers measured communication. Barbosa et al. (2016) found effects of a psychoeducational intervention focused on person-centredness coupled with emotional support led to a broader impact on communication (e.g. significantly more likely to laugh and inform) than those that received psychoeducation alone. The other paper found a significant post-intervention difference in the use of multistep instructions, with the intervention group using this type of instruction less than the control group (Sprangers et al., 2015).

Person-centred care

Despite three training interventions focusing on person-centredness, only one study measured this concept. This study (Barbosa et al., 2017) found significantly higher scores in person-centredness for both the intervention and control group, with a higher improvement in the intervention group close to significance. It is important to note that both the control and the intervention group in this study received psychoeducational training, with the intervention group receiving additional emotional support.

Staff mental health/wellbeing

Different domains of staff health and wellbeing were measured by a number of the papers and with varied findings. Three papers used versions of the General Health Questionnaire (GHQ, Goldberg & Hillier, 1979) pre- and post- intervention.

One paper (Finnema et al., 2005) found a positive effect of intervention on stress reactions using this measure, however, this was true for only a subgroup of participants. The other two papers did not see an effect on general health (Clare et al., 2013, Jeon et al., 2012). Studies showed a significant decrease in anxiety and depression and somatic symptoms (Magai et al., 2002), as well as stress and strain (McCabe et al., 2015) among care staff following training in comparison to control conditions, whilst others showed no significant impact on health complaints (Kuske et al., 2009) or stress (Barbosa et al. 2015), and even worsened stress as a result of the intervention (Zimmerman et al., 2010).

Influence of training intensity and supervision

The studies varied widely in the number of hours of training and supervision provided. Only three of the intervention training programmes were classed to be 'low intensity' (1.5-5 hours). Six papers evaluated medium intensity programmes (6-11 hours) and six high intensity training programmes (12+ hours). There was no indication of an effect of training intensity on outcomes. All training programmes classed as low intensity, however, did provide supervision sessions or ongoing clinical support to help consolidate learning. Interestingly, McCabe et al. (2015) found staff who received clinical support without training showed reduced carer distress which was not seen in a training alone group. Conversely, the training alone group in this study showed improved self-efficacy which was not observed in the support group. An impact of training alone on self-efficacy was also observed by Visser et al. (2008). These findings suggest that solely providing training may be effective in affecting change in some domains, but ongoing support is more effective in others. Not all medium and high intensity programmes offered ongoing supervision and there was no clear effect of supervision when the training session had been more extensive. Less than half of the studies included a long term follow up to assess whether changes had been maintained.

Inclusion of emotional support

Five papers (evaluating three interventions) explored the effects of including a supportive component for staff within the intervention as opposed to education alone. This included emotional support and peer support. Significant positive effects were found when including emotional support on emotional exhaustion (Barbosa et al., 2015) and communication (Barbosa et al., 2016), as well as trends of improved person-centeredness (Barbosa et al., 2017). The inclusion of peer support alongside education led to staff feeling significantly more satisfied with their knowledge, skill level and confidence when working with PwD after the intervention than staff members who had attended the education alone (Visser et al., 2008). This supports Spector et al.'s (2016) finding of the importance of including factors beyond resident outcomes in training if hoping to maximise outcomes for staff members. The addition of peer support did not, however, improve outcomes related to burnout (Davison et al., 2007). Two of the papers evaluating interventions with additional emotional support were of low quality, however, therefore more research is needed to understand the effect of these components.

Barriers

A number of papers noted the impact of organisational barriers on the implementation of the evaluated interventions. Some of the included studies used quantitative measures to explore this concept. One paper found that supervisor support had significantly decreased at follow up (Zimmerman et al., 2010). Staff perception of being listened to was also found to be significantly correlated with lower burnout and better general wellbeing (Jeon et al., 2012). Interestingly, staff who received education with peer support perceived the presence of organisational barriers to change significantly more than those who received education alone (Visser et al., 2008). The authors noted that this group may have gained the

motivation to change and the improved ability to interact with residents, but the organisational environment made it difficult to implement the desired interventions. The measure used for this concept was developed for this study, however, so information of psychometric properties is unclear.

Conversely, Berendonk et al. (2017) used a measure with a focus on workplace conditions to explore concepts such as task-related resources and job demands. Interestingly, the study found that time pressures were significantly reduced for staff delivering a person-centred programme from pre- to post-intervention, in comparison to the control condition. Also, Zwijsen et al. (2015) did not find job demands to increase with the addition of the training intervention.

Barbosa et al. (2015) used qualitative analysis to explore these concepts and found that outcomes of the intervention can be affected by perceptions of workload and poor leadership support. McCabe et al. (2015) heard from staff members through anecdotal reports that the lack of commitment to the improvement of resident mental health, insufficient knowledge of management about the best practice in mental health, high staff turnover, low staff motivation and ineffective communication are likely to have limited the implementation of the intervention, thus varying the degree to which the protocol of the intervention was adhered to.

Discussion

Summary of findings

All but three training approaches were associated with significant positive effects, in comparison to control conditions, in at least one staff domain. Communication and awareness focused approaches showed significant effects in competence, caregiver distress, depression and anxiety, but had conflicting outcomes on knowledge improvement. Approaches designed to manage challenging behaviour showed significant effects of training in self-efficacy and job satisfaction. Approaches in person-centred care led to positive, significant effects on burnout, emotional exhaustion, person-centredness and communication. Three interventions were unique in approach and had quite varied results in regard to staff outcomes.

Although the majority of papers showed a significant effect of training in a staff domain, there were many domains included, with few measured in more than three papers. The most explored outcome domain was burnout, of which only person-centred approaches saw significant differences in this domain between the intervention and control conditions. Staff satisfaction was the next most frequently measured domain; however, only one of six studies found a significant effect of training. No medium or high quality studies found an improvement in attitudes. Three of the four papers measuring knowledge saw a significant effect of training in this domain. All other reported domains were measured in three papers or fewer. Only one paper saw a significantly worsened outcome as a result of the intervention, which was a higher level of stress (Zimmerman et al., 2010). Interestingly, no new papers measured staff knowledge as a result of receiving training, despite interventions in the original review being most effective for change in this domain. This was also the case for measurement of sense of competence.

The current review revised some of the categories of approach that were included in the original review. This change was made to minimise the overlap between the different groups and to ensure that training approach (rather than outcome) was the basis of the categorisation. This change was made because interventions may have had an aim and/or outcome of improving staff knowledge and improving resident quality of life, both included as categories of the previous review, whilst delivering a communication or person-centred focused training package. Two categories were, therefore, removed and an 'other' category was added for interventions that were unique in approach. The 'communication focused' category was expanded to include training that aimed to improve staff awareness of non-verbal cues in PwD that have limited spoken language. This further aimed to reduce the overlap between categories, because one study that was previously categorised as focusing on improving staff knowledge included a communication module (Zimmerman et al. 2010), and this study has now been included in the 'communication and awareness' group of this review. As a result of broadening the category, this type of approach was associated with the most papers in the review. However; the approach associated with the most new papers was person-centred care, all of which were rated as high quality. It is important to note that three of these papers evaluated different staff outcome measures from the same research study, therefore the increased number of papers did not reflect a greater number of training interventions in this approach than others. In fact, there was not one approach that showed a larger increase in research in comparison to the others.

There was no indication of an impact of training intensity on outcomes. This could possibly be because low intensity interventions all included ongoing supervision support. Previous literature states that additional training features such as follow up or coaching is needed to allow staff to consolidate their learning and thus implement the interventions in practice (Boersma et al., 2013). Therefore, low intensity training with ongoing supervision may have allowed the targeted learning to

be used in practice. The inclusion of emotional support showed benefits to staff levels of emotional exhaustion, an indicator of burnout, and therefore has implications for care provision due to the observed relationship between this domain and quality of care (Spence- Laschinger et al., 2001).

The categories from the original paper were revised to reduce commonalities between the training approaches as much as possible. Despite this revision, some overlap remained unavoidable. For example, McCabe et al.'s (2015) clinical protocol for managing the biological and psychological symptoms of dementia, included in the 'managing challenging behaviour' group of this review, contains teaching on person-centred care strategies. As a result of similarities like this one across the interventions, a direct comparison between the different approaches remains difficult to establish.

That one person-centred intervention (Berendonk et al., 2017) was associated with reduced time pressures is interesting in the context of organisational barriers. This intervention was a high intensity approach and provided ongoing supervision in the form of additional coaching sessions and telephone support, which is labour intensive for staff. This finding suggests that interventions can reduce time pressures, however, organisations need to allow time for staff to implement them for these effects to be possible.

Strengths and limitations

A strength of this review was the sole inclusion of studies that had a randomised design, due to the superior quality of this methodology over other types of design, particularly in relation to internal validity. All of the new papers added to this review were rated as either medium or high quality. As a result, only two of the included papers were low quality, a figure lower than the five included in the original review. This provides support for the exclusive inclusion of randomised controlled designs. Another strength was the use of a highly rigorous framework to assess

quality which included fourteen criteria considering factors such as blinding, sample size and confounding.

There were some notable limitations to this review. Many different outcome measures were included with varying psychometric properties. It, therefore, remains difficult to draw comparisons between the papers. Only one paper (Sprangers et al., 2015) considered staff outcomes prior to training to tailor the intervention length to the needs of the individual staff members, and thus attempt to provide the most time effective training intervention to each individual. A number of papers included also reported on resident outcomes; however, these were not commented on in the main body of this review. Training programmes of care home staff are designed to indirectly improve resident experience; therefore, resident outcomes are hugely informative about the effectiveness of an intervention. Indeed, the approaches that did not see a change in any staff domain did see significant improvements in resident domains including quality of life (Clare et al. 2013) and behavioural problems, depression and anxiety (Teri et al. 2005). Resident outcomes are otherwise missed in this review.

Research shows that influencing care practice in care homes can be confounded by time and financial pressures, resulting in managers struggling to release staff to attend training (Beeber, Zimmerman, Fletcher, Mitchell & Gould, 2010). Further barriers include staff absenteeism, high workload, opposing attitudes, lack of commitment and logistics (Low et al., 2005). Indeed, many studies noted such barriers as possible confounding factors, however few used a quantitative tool to measure the impact of such barriers. Less than half of the included studies included a follow up to explore the extent that learning had been integrated into ongoing practice.

Implications for research

There were many studies evaluating new interventions for staff in dementia care that were not included in the current review due to design. Suggestions for further research would, therefore, be to use randomised designs to provide strength to conclusions and thus provide support for the use of interventions in real world settings. The studies included in this review measured a number of domains using different techniques and instruments. As a result of this, it was difficult to draw direct comparisons and conclusions regarding the most effective interventions. In future reviews of the literature, the use of meta-analyses will allow for the results of randomised control trials to be combined, and thus allow for conclusions to be drawn relating this area of research (Petitti, 1999).

It is known that there is a disconnect between what is implemented in a research trial and care practice, and as noted in Teri et al. (2005), sites are often eager to participate in research which may not be the 'real-world' experience. A number of studies commented on organisational barriers to implementing the interventions that they were evaluating. Few, however, measured this formally and there was little measure of implementation. Further research calls for true measures of implementation, for example using the RE-AIM Framework (Dzewaltowski, Glasgow, Klesges, Estabrooks & Brock, 2004), and more consideration of the barriers to introducing new programmes effectively.

Implications for clinical practice

Alarming, the implementation of an intervention in routine dementia care does not indicate an evidence base for it; Fossey et al. (2014) found there to be a striking difference between the interventions that are routinely available and being commissioned and the evidence base indicating benefit, with only four of 170 training manuals available within the UK found to have efficacy through a

randomised controlled trial. Further research is vital to ensure that the interventions delivered are based on robust research.

The findings of this review hold possible implications for the design of new interventions in dementia care. The addition of emotional/supportive factors are suggested, as improvements in these domains have possible consequences for quality of life for both staff and residents alike. Similarly, the findings related to the organisational barriers to implementation would need to be considered for the managers and commissioners of care homes; there would simply be no justification for the expense of training if staff are unable to implement their learning.

The majority of studies included in this review found significant improvements in care staff outcomes. Paper quality differed across the studies, however, and change over a longer period of time was not always measured or maintained. With regard to these factors, the best available staff training programmes did not all share a training approach. McCabe et al. (2015) evaluated a clinical protocol to manage challenging behaviour, including a training session and a clinical support component. Both of these separate components were shown to impact on staff outcomes in different domains at six month follow up, thus providing support for the inclusion of both over training alone. A person-centred approach, providing no supervision following a high intensity training period, saw a maintained reduction in burnout for staff over time (Jeon et al. 2012). These studies are highlighted due to their maintained improvements and high paper quality.

The impact of supervision was not clear for medium to high intensity programmes; however, it is notable that the low intensity programmes all offered ongoing supervision and, therefore, provided opportunity to consolidate learning. This finding suggests that low intensity training does not necessarily equate to lower cost for management, as ongoing supervision requires resource to facilitate. The effect of additional support that attends to staff's emotional wellbeing is also an interesting addition to training that could further inform best practice to maintain the

staff workforce, and as a result this may have future implications for the staff factors that are known to be related to quality of care. Few papers such support, however, and those that did varied in quality. Before introducing this component to routine practice, it is suggested that more research is conducted to ascertain that it holds true benefits.

Conclusion

This review found that training approaches in dementia care can prove to positively affect outcomes in a number of staff domains. No training approach was found to be the most effective in improving staff outcomes. There was no observed effect of intensity, however, low intensity interventions did all include a supervision element to consolidate learning. The continued evaluation of the impact of staff training interventions on staff outcomes is suggested to ensure effective care. Furthermore, interventions must be feasible in clinical, 'real world' situations. Researchers should continue to explore the organisational factors that provide barriers to the effective application of training outcomes.

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Part 2: Empirical Paper

**The Impact of SettleIN (an Adjustment Programme for People with Dementia)
on Staff Attitudes, Competence and Knowledge of Adjustment**

Abstract

Aims: This study aimed to explore the impact of training and delivery of SettleIN, a manualised programme to support healthy adjustment for people with dementia, on care home staff knowledge, competence and attitudes.

Method: A single blind, multicentre feasibility randomised design was employed, comparing the SettleIN intervention (n=12) to treatment as usual (n=9). A mixed methods design was used for analysis. Outcomes measuring competence and attitudes were collected at baseline and after seven weeks. Staff interviews were completed for those in the SettleIN intervention condition to explore knowledge change.

Results: SettleIN was not shown to have an impact on staff competence or attitudes. Most staff in the intervention condition endorsed learning from the programme, though there was mixed feedback on whether this was recognised as adjustment specific learning by staff.

Conclusion: SettleIN can be associated with change in adjustment specific knowledge for care home staff. If any further research is undertaken on the programme, the format of training and supervision must be developed to ensure accessibility and effective communication of the rationale for the intervention to maximise staff benefits.

Introduction

Residential dementia care

Dementia is a term used to describe a collection of symptoms including memory loss and difficulties with perception and communication, and is a condition associated with the reduction of skills for daily living (Public Health England, 2018). There are 850,000 people living with dementia in the UK, of which one third live in a care home (Alzheimer's Society, 2014) and receive help with personal care (Age UK, 2017). Transition into a care home for people with dementia (PwD) is known to be associated with negative outcomes, including cognitive decline (Wilson, McCann Li, Aggarwal, Gilley & Evans, 2007). In addition, relocation is related to a two-fold increase in mortality risk net of health status (Aneshensel, Pearlin, Levy-Storms & Schuler, 2000). Therefore, supporting healthy adjustment is likely to be crucial to successful transition and positive post relocation health status.

Adjustment

Adjustment is defined as 'the process of adapting or becoming used to a new situation' (Oxford Dictionaries Online, 2016). Examining the needs and effortful activity of PwD after relocation to a care home, Aminzadeh, Molnar, Dalziel and Garcia (2013) identified that three categories were essential in the adjustment process; to settle in, to fit in and to find meaning in this transition. Sury, Burns and Brodaty (2013) identified factors that can influence the adjustment of PwD moving into care homes, including sensitive person-centred care, introduction procedures and continued involvement of families and carers. These named factors indicate that care staff practice is important in the adjustment process.

Dementia training for care home staff

The national dementia strategy (Department of Health, 2009) recommends that continuous professional development, including effective staff training, is required to improve the quality of care for PwD living in care homes. On an organisational level, providing training is useful in reducing staff turnover (Grant, Kane, Potthoff & Ryden, 2016; Zimmerman et al., 2005) and is perceived by staff as good managerial support (Filipova, 2011). Dementia education has been widely researched across a number of domains including staff knowledge, competence and attitudes, as well as outcomes for PwD.

The impact of dementia training on staff knowledge

Many studies have established that education or training improve staff knowledge associated with dementia care in a variety of settings. Galvin et al. (2012) found that a seven-hour training programme led to immediate improvements in staff knowledge and confidence in supporting PwD in hospital, and these were largely maintained after 4 months. Knowledge of communication support was seen to significantly improve for community based aged care staff following a one-hour workshop and three post training feedback sessions, in comparison to a non-training group (Conway & Chenery, 2016). In the care home setting, a literature review found knowledge (in a variety of domains in dementia care) to be the area that changed most frequently following staff training (Spector, Revolva & Orrell, 2016).

The impact of dementia training on staff competence

Increased competence in person-centred dementia care was found following involvement in a dementia educational programme in residential care staff (Roksad et al., 2016). This can translate into practice; Aasgaard, Fagerstrom and Landmark (2014) found that increased competence after dementia training for home care

nurses contributed to greater confidence, which went on to show improved quality of services delivered to PwD. Furthermore, perceived competence in providing dementia care has been associated with dementia sensitive attitudes and job satisfaction (Zimmerman et al., 2005).

The impact of dementia training on staff attitudes

The attitudes to dementia that care staff hold are widely measured in dementia training research. Attitudes correlate with care practices; for example, nursing home staff's perception of safety culture correlates with clinical outcomes (Bonner, Castle, Men & Handler, 2009) and staff with negative attitudes towards PwD displaying aggression reported the use of physical or chemical restraints more than those with positive attitudes (Nakahira, Moyle, Creedy & Hitomi, 2009).

Some findings suggest that receiving dementia-specific education is positive for the attitudes of staff in long term care settings (Fielding et al., 2016; Scerri & Scerri, 2017), aged-care (Jones & Moyle, 2016) and acute hospital sites (Surr, Smith, Crossland & Robins, 2016). More specifically, attitudes to dementia can be improved through programmes to encourage person-centred communication and interaction (O'Connor & McFadden, 2010). A person-centred attitude is related to job satisfaction (Zimmerman et al, 2005), therefore may be beneficial for staff members themselves. However, a positive effect of training on attitudes is not observed consistently (Spector et al., 2016).

The impact of dementia training on outcomes for PwD

Training for care home staff working with PwD is often expensive and time consuming, and it could be argued that it is not justified without a knowledge that positive outcomes are observed in the population they are designed to benefit. There is a body of research on the outcomes of staff training programmes for PwD living in care homes. Evidence shows that staff training interventions can positively

impact behavioural and psychological symptoms of dementia (Spector, Orrell & Goyder, 2013), training in communication skills significantly improved the quality of life and wellbeing of PwD (Eggenberger, Heimerl & Bennett, 2013) and wellbeing values for PwD increased following staff training in Dementia Care-Mapping and person-centred care (Yasuda & Sakakibara, 2016).

The development of SettleIN

One area that has not been explored previously is the knowledge that care home staff hold about adjustment to care, despite the identified need for an intervention supporting this process (Sury et al., 2013). Hayward, Nunez, Ballard and Spector (in press) developed a programme, SettleIN, in line with the principles of facilitating successful adjustment for PwD proposed by Sury et al. (2013). The programme is designed to foster the values of equality with fair and equal person-centred care, as well as support healthy adjustment through tailored plans that are easy for staff to complete.

Hayward et al. (in press) conducted a feasibility study for the SettleIN programme. They found that while SettleIN was acceptable to stakeholders and staff, the programme was limited by the difficulty that staff found in adopting the proposed techniques and attending the required training due to work pressures. The study observed high attrition rates, therefore, lacked data to determine whether the programme was effective in supporting the adjustment process for PwD. Furthermore, staff knowledge of adjustment following programme delivery was not explored.

The current study

The current study was an extension of Hayward et al's (in press) initial feasibility pilot, with a focus on staff outcomes. The SettleIN programme was adapted in line with the learning points from Hayward et al.'s study; the training session was redesigned to ensure standardisation and aimed to maximise learning. In a further extension to Hayward et al., a control group (treatment as usual, TAU) was included to explore how the outcomes of the SettleIN condition compared to staff members who did not receive training or deliver the programme.

Aims

This project was a joint project with Caroline Saint (see Appendix A for separate contributions to the project). The primary aim of this study was to establish the feasibility of the enhanced SettleIN programme and ascertain whether a randomised controlled trial (RCT) was merited. Saint aimed to explore feasibility along with the effect of SettleIN training and delivery on outcomes in adjustment, quality of life, depression and anxiety for PwD living in care homes. This part of the study aimed to explore whether training staff in the SettleIN programme, and the experience of delivering the programme, improved staff sense of competence in dementia care and staff attitudes to dementia as compared to TAU. A change in staff knowledge of the adjustment process was also investigated.

Three hypotheses

It was hypothesised that for those staff that completed the SettleIN training and intervention in comparison to those providing TAU there would be a significant improvement in staff 1) attitudes in dementia care and 2) sense of competence. It was also posited that staff would 3) see a change of knowledge of the adjustment process following completion of the training and programme.

Methods

Design

A single blind, multicentre feasibility RCT of an updated SettleIN programme versus TAU for PwD who had recently relocated to a residential care home was employed. The study used a between-subjects randomised experimental design and tested the acceptability of the SettleIN intervention following changes to the programme content and structure.

The SettleIN programme was enhanced following changes to the content and structure as informed by feedback collected by Hayward et al. (in press). Changes included shortening the programme, reducing reliance on family and the addition of a module for residents that struggle to engage. For details on the process of updating the programme, see Saint (2018).

Settings

Care homes were identified through the Enabling Research in Care Homes (ENRICH) database, internet searches of care homes in identified geographical areas (Greater London and the surrounding counties) and opportunity sampling. Care home managers were invited to take part in the research by letter, which detailed the aims and methodology of the study. A researcher visited and provided additional information to all managers who responded registering their interest. Researchers made follow up calls to homes that did not respond to the written invitation. For further details of this process, see Saint (2018).

Participants

The initial visit to care home managers was an opportunity to discuss the study aims and procedure. Following this visit, managers that provided written consent to take part were asked to identify new residents that met the inclusion criteria for the study.

Inclusion criteria

Site

- Managerial assurance of adequate resources allowing staff participation.
- An overall CQC rating of 'requires improvement' (that does not include safety as an improvement factor), 'good' or 'outstanding'. Lower ratings were excluded due to the possible presence of systemic problems that would reduce ability to commit to research.
- Sufficient cover to allow at least one staff member to attend 1.25 hours of training
- Not participating in any other psychological research study.

Staff members

- Working as a nurse (registered nurses of any grade, student nurses), care assistant (health care assistants and nursing assistants), or another role within the care home that included direct contact with PwD in a supporting role (team leaders, activity coordinators).

Residents

- Meet diagnostic criteria for dementia according to the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V, American Psychiatric Association, 2013).
- Score between stage two and six on The Functional Assessment Staging Test (FAST, Reisberg, 1987) representing a range of mild to moderately-severe dementia.
- Be able to communicate in English.
- Has moved into the home within the past month.

Newly relocated residents with capacity to consent were initially informed of the research by managers and asked to indicate if they had an interest in being involved. If interest was indicated, managers contacted researchers who then arranged to visit the care home to take written consent from the resident as appropriate. For residents who lacked capacity to consent, the manager was asked to provide an information sheet to the resident's personal consultee (usually a family caregiver) and asked for permission to pass contact details to the researchers. If permission was granted, a researcher contacted the personal consultee to discuss the study further and obtained written consent. GPs were informed by letter of the resident's involvement in the research if the resident participant/personal consultee granted consent to do so.

Once resident participants had been recruited, managers were asked to identify a staff member that met the inclusion criteria and worked alongside the resident (typically their named keyworker). Managers disseminated study information to the staff member and researchers contacted the staff member to address any questions they had before obtaining written consent. Staff participants were paired with resident participants for randomisation.

Ethics

Ethical approval was obtained from the Health Research Authority Research Ethics Committee Camden and Kings Cross (Appendix B) and the University College London Joint Research Office. Written consent was obtained from all care home managers, staff members, residents and/or family or proxy representatives of each resident participating in the research (see appendix C for all information sheets and consent forms). All participants were informed that they could withdraw from the study at any point without having to state a reason and without usual care being affected.

Power

As this was a feasibility study, it was expected that the study would be insufficiently powered to detect an effect. The target sample size for sufficient power was 24, based on a power value of 0.8, a significance value of 0.05 and an effect size of 0.3 (a conservative effect size of 0.3 was used due to a lack of existing research in this field). The researchers therefore aimed to recruit 30 participants at baseline to account for attrition, which is commonly observed in research within this setting.

Procedure

Outcome measures were collected at baseline (week zero, recruitment week) and time two (week seven). The data collection and training were completed by different researchers. The researcher completing data collection was blinded to the condition of each participant to reduce researcher bias. Randomisation into the intervention or control group was facilitated by an independent researcher using Research Randomizer, a randomisation software available online. Pairings were randomised in groups of four. For pairings in the intervention group, the researcher that completed training contacted the manager and/or staff member to inform of the randomisation outcome, and the training was arranged. Training took place at the first convenient time for the staff member to ensure that the programme could begin as quickly as possible. Managers and/or staff members in the TAU were informed of their condition assignment. All resident participants' personal consultees that had indicated that they would like to be informed of the study progression were contacted to be informed of the randomisation outcome.

The SettleIN programme

SettleIN is a staff led, manualised programme designed to be implemented for PwD who have recently relocated to a care home. The programme consists of

modules that each list activities for staff to complete a number of times with a resident. The SettleIN workbook (appendix D) provides information on each activity along with space to record a short description of completion and information learnt about the resident through completing the activities. For details of how the programme is designed to support adjustment, see Hayward et al. (in press). Although the workbook presents a four week programme structure, it allows for activities to take up to six weeks due to shift patterns or other obstacles that might delay completion.

The management manual is designed for use alongside the workbook and provides further information to staff members about the aims of the intervention, the adjustment research and more in-depth information and suggestions about some of the activities in the workbook. Due to the time constraints of this project, the management manual was not updated for this second feasibility study and therefore Hayward et al.'s (in press) original manual was used. Staff were informed of this verbally in the training process.

SettleIN training

The SettleIN training session was designed to teach staff participants in the SettleIN intervention condition about the purpose of the research and how to use the SettleIN programme. SettleIN training was provided to staff participants individually by the researcher. The training was completed in one session and designed to last 1.25 hours. It was formed mostly of didactic teaching, with opportunity for participants to ask questions throughout. Participants were given a copy of the SettleIN workbook, the SettleIN management manual, slides (appendix E) and a summary fact sheet (appendix F) following the training session for their reference. See figure 1 for an overview of the training structure.

To ensure training consistency across participants, the training session was trialled on a layperson known personally to the researcher and recorded. A detailed

script was then developed from the transcript, which provided a structure for the researcher to follow in each training session (appendix G). This was tailored, however, to each participant's needs. One of the SettleIN activities involved creation of a life book. If this process was unfamiliar to staff they were directed to an online resource that provides guidelines for life story work (Dementia UK Online, 2017).

1. Information about the research study (15 minutes total)
 - 1.1 Purpose of the training
 - 1.2 Brief information on adjustment research
 - 1.3 The research study procedure

2. The SettleIN programme (60 minutes total)
 - 2.1 Overview of workbook
 - 2.2 Orientation module
 - 2.3 Recording progress for each module
 - 2.4 Lifestyle module
 - 2.5 Friends and family module
 - 2.6 Identity module
 - 2.7 Optional module and when appropriate to use
 - 2.8 Future planning conversation
 - 2.9 Supervision call structure

Figure 1: SettleIN training structure

SettleIN supervision

Following the training session, staff participants were offered weekly supervision calls to discuss progress and ask any questions/raise any concerns or queries from implementing the programme. The first call was scheduled for around one week after the training session at a time convenient for the staff participant.

Forty-one supervision calls were scheduled in total by the researcher and staff participants in the SettleIN intervention condition (one per week for four weeks to each staff participant completing the intervention). One staff participant was not offered any calls due to the resident participant being in hospital for the entirety of

the intervention period. One staff participant was offered one call, and after this call they dropped out of the research due to lack of time to complete programme. At the end of each call, the next call was scheduled for the next week.

Measures

Quantitative outcomes

Two questionnaires were administered to all staff participants at baseline (week zero) and time two (week seven). The Approaches to Dementia Questionnaire (ADQ, Lintern, 2009) is a validated nineteen item self-report measure designed to examine staff attitudes to PwD from two subscales of 'hopefulness' and 'person-centredness'. Staff participants rated on a five point Likert scale the level to which they agreed with certain statements from 'strongly disagree' to 'strongly agree'. Higher scores are indicative of more positive attitudes to dementia. Previous research has shown adequate internal reliability (Lintern, 2001).

The Sense of Competence in Dementia Care Staff (SCIDS, Schepers, Orrell, Shanahan & Spector, 2012) is a validated seventeen item self-report measure of sense of competence in dementia care across four subscales; professionalism, building relationships, care challenges and sustaining personhood. Staff participants rated their response to questions asking how well they can perform different aspects of their role as 'not at all', 'a little bit', 'quite a lot' and 'very much'. The scores for each response are one, two, three and four respectively, and higher scores are indicative of a greater sense of confidence in working with PwD. The SCIDS has accrued evidence of moderate to substantial test-retest reliability and acceptable to good internal consistency (Schepers et al., 2012).

Resident measures indicating quality of life, levels of anxiety and depression and relocation adjustment were also collected at baseline and time two. Resident outcomes are discussed by Saint (2018).

Qualitative outcomes

There is currently no established and psychometrically tested measure for knowledge of adjustment in relocation to dementia care homes. Qualitative data was therefore collected to explore this construct following completion of the SettleIN training and intervention. At time two, staff participants from the SettleIN intervention condition took part in a 30-minute semi-structured interview designed by the researchers (see appendix H for interview schedule). The aims of the interview were to:

- 1) Collect information on the feasibility of the intervention (see Saint (2018) for more information on feasibility)
- 2) Explore whether completing the SettleIN training and intervention changed participants' knowledge of adjustment, including understanding of the adjustment process and how to support somebody to adjust to living in a care home.

Analysis

Statistical Package for Social Sciences (version 24) was used to analyse the questionnaire data. Intention to treat analysis was used, which involves analysing the data for all participants that were randomised, to control for non-compliance and missing data. For both quantitative measures, baseline scores were compared between the two conditions to determine whether any statistical differences were present between the two groups.

The ADQ data met all assumptions for the use of a parametric test. An independent samples T-Test was used to compare the baseline scores between the conditions and then the change scores for the SettleIN intervention condition and the TAU condition.

The SCIDS data did not meet assumptions of normality, therefore a non-parametric test was used. A Mann-Whitney U test was used to compare the

baseline scores between the conditions and then the change scores for the SettleIN intervention condition and the TAU condition.

The interview data was analysed using thematic analysis (TA). TA is a method for the identification, analysis and report of patterns (themes) within data, and as an approach holds theoretical freedom (Braun & Clarke, 2006). TA was chosen as an approach because it is a flexible methodology and allows analysis to be data driven (Braun & Clarke, 2013). The steps of TA (outlined in Figure 2 below) were followed in the analysis. Two researchers independently coded each of the transcripts. See appendix I for an example transcript with initial codes and appendix J for an example map of codes related to a theme.

1. Reading and familiarisation
2. Coding – complete; across entire dataset
3. Searching for themes
4. Reviewing themes- producing the ‘thematic map’
5. Defining and naming themes
6. Writing- finalising analysis

Figure 2: Stages of coding and analysis of TA (Braun & Clarke, 2013)

Results

Sample

In total, seventeen sites consented to take part in the research, of which twelve had resident and staff participants included. Five sites did not identify participants that met the inclusion criteria in the research period. 21 staff participants consented to the study and were assessed at baseline (twelve SettleIN intervention, nine TAU) and follow-up. On two occasions, the care home manager identified two members of staff to support one participant. On these occasions, both staff members were included as participants in the study. The majority of staff participants held roles of Health Care Assistants/Support Workers. Their age ranged from 21-61 years old and their number of years of working in dementia care ranged from nine months to 32 years. For details of the resident population demographics, see Saint (2018). Between baseline and time two, two staff members dropped out due to resident participant death (one SettleIN, one TAU) and one dropped out of the SettleIN condition due to lack of time limiting their ability to complete the programme. Follow up measures included the three staff members who dropped out as intention to treat. Figure 3 is a consort diagram detailing the recruitment process.

SettleIN training and supervision

The training sessions provided typically averaged 1.25 hours. The longest session was 1.5 hours, and the shortest was one hour. Of the 41 supervision calls offered, 22 were used by the staff participants and lasted for an average of ten minutes. The calls were predominantly used to review challenges and problem solve any obstacles to delivering the programme, for example not being allocated to the resident participant's floor. The calls that were offered and not used were due to the staff participant not being available at the agreed time (for example due to sickness,

being too busy on shift, last minute rota changes/not being on shift as previously expected). Two staff members at the same site preferred supervision visits to calls (n=3, lasting around 30 minutes each). One staff member did not use the calls originally due to sickness, however sent an email to the researcher midway through the intervention phase detailing that they did not have any queries with the programme therefore did not feel that calls were necessary.

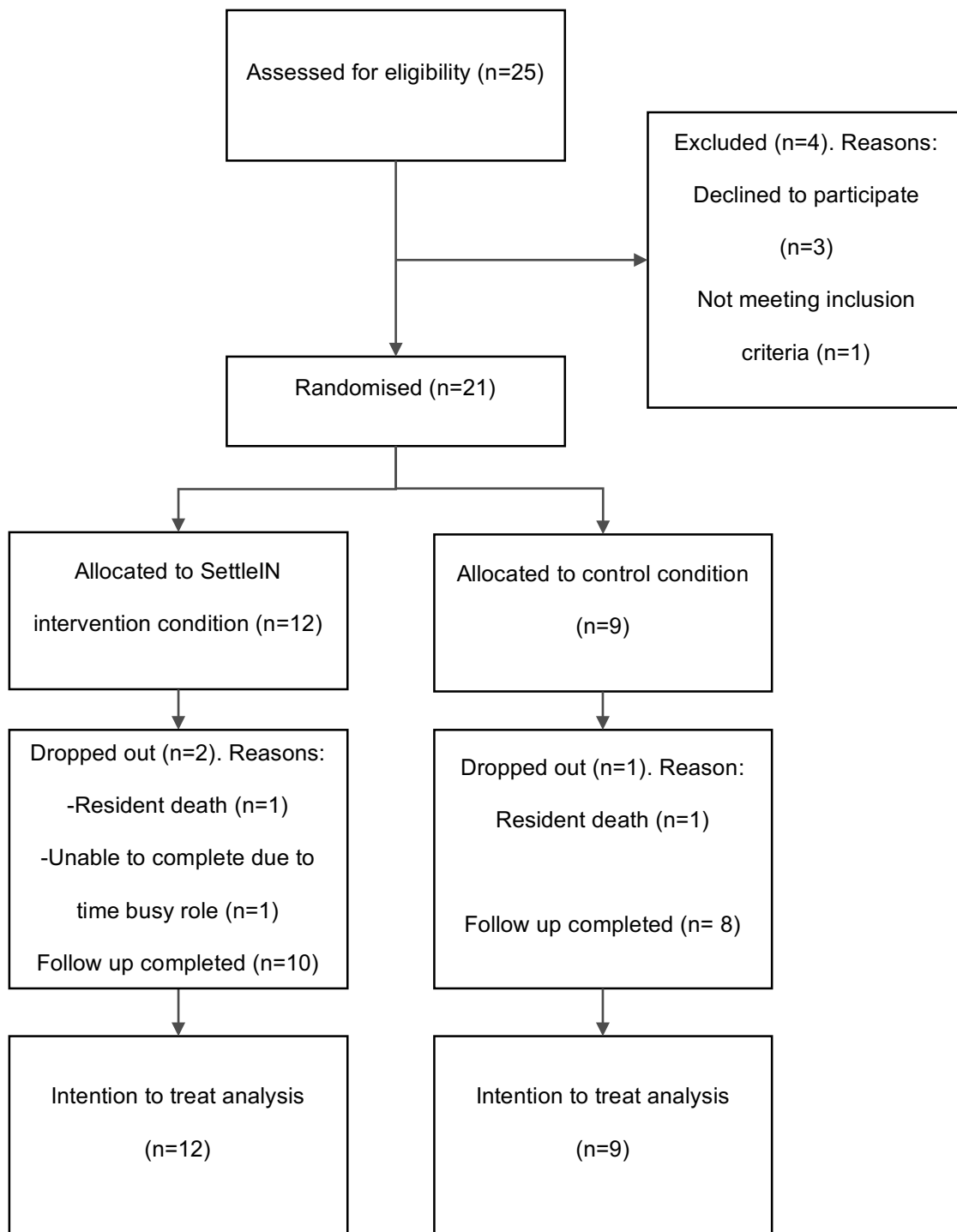


Figure 3: Consort diagram of recruitment

Descriptive statistics

The demographic details of participants are shown in Table 1. The average age of staff participants was 43 years old, and the average length of time working in dementia care was just under ten years. At baseline, there were no significant differences in age, gender, years working in dementia or job title between the two conditions.

Table 1: Staff participant demographics

	SettleIN Intervention (N=12)	Control (N=9)	Total (N=21)
Gender			
Female N (%)	11 (91.67)	7 (77.78)	18 (85.71)
Male N (%)	1 (8.33)	2 (22.22)	3 (14.27)
Age (years)			
Mean (SD)	43.17 (13.72)	38.78 (12.85)	41.29 (13.21)
Range	21-61	22-60	21-61
Time working in dementia care (years)			
Mean (SD)	9.88 (9.59)	7.97 (6.77)	9.06 (8.36)
Range	2-32	0.75-20	0.75-32
Job Title N			
Care Assistant/ Support Worker	8	5	13
Senior Care Assistant	1	2	3
Team leader	1	2	3
Activities Coordinator	1	0	1
Care Manager	1	0	1

Quantitative analysis

Data preparation

Each variable was tested to explore whether the data met assumptions of normality. No outliers were identified in the data. ADQ scores met all assumptions for the use of a parametric test. Scores on the SCIDS did not meet assumptions of normality, therefore a non-parametric statistical test was used to analyse the results. Table 2 reports the mean scores on the quantitative measures.

Attitudes

The ADQ scores at baseline were not significantly different between the SettleIN intervention group and the TAU condition in an independent samples T-Test ($t(19) = -0.64, p = 0.53$). There was no significant difference between change score on the ADQ between the SettleIN ($M = 1.42, SD = 4.38$) and the TAU ($M = 0.22, SD = 5.61$) conditions; $t(19) = 0.22, p = 0.83$.

Sense of competence

The mean score for the SCIDS measure at baseline across the two conditions was 59.1, which was a relatively high score (the total possible score for the questionnaire is 68). At baseline, 54.6% of answers given were rated as four, the highest value for each question.

The SCIDS scores were not significantly different at baseline in the SettleIN intervention group and the TAU condition in a Mann-Whitney U test ($U = 50.50, p = 0.80$). There was no significant difference between the SCIDS change scores for the two conditions ($U = 54, p = 1.00$).

Table 2: Mean scores on quantitative measures

		Intervention baseline	TAU baseline	Intervention time two	TAU time two	Intervention change score	TAU change score
ADQ	Mean total (SD)	75.67 (10.45)	78.22 (6.92)	76.17 (11.10)	78.00 (5.45)	0.67 (3.68)	0.22 (5.61)
	t score		0.64		----		0.22
	p value		0.53		----		0.83
SCIDS	Mean total (SD)	58.83 (5.67)	59.44 (5.96)	60.75 (3.89)	61.22 (3.23)	1.92 (5.71)	1.78 (4.71)
	U score		50.5		----		54
	p value		0.8		-----		1.00

Table 3: Overarching themes, themes and codes identified in the interview responses

Overarching themes	Themes	Codes
Learning specific to adjustment was achieved through the SettleIN programme	Conversation and building relationships	Building relationships between staff and residents (a process connected to adjustment, discussed below).
		Got to know more about the residents
		Learnt questions to ask to support adjustment
	New learning about the complexity of the adjustment process	Gave staff member time to focus on residents
		Developed opinion that staff/environment more important in adjustment process
		Reconsidered the difficulty of adjustment for residents with dementia
Applying a protocol to adjustment is helpful	Previously no formal way to aid adjustment	
	Completing activities that they would not have completed before	
Using SettleIN will change future practice	Standardised steps helpful	
	Improved knowledge of how to help someone adjust	
	Expectation that practice will be different since completing training/programme	
Training and delivery of SettleIN did not add to staff knowledge of adjustment	SettleIN did not add any new knowledge about the adjustment process	Noticed a change in self/some learning since completing the programme
		Already has knowledge of how to help residents adjust
		Knowledge of how to help somebody adjust has not changed
		Care home already practices the activities
		Expectation of adjustment time hasn't changed

Qualitative analysis: Theme definitions from the interview data

Twelve participants completed interviews at time two. There were two seemingly conflicting main themes that were identified in the data, therefore the response was varied. One was an overarching theme from the qualitative feedback that the process of training and delivery of SettleIN facilitated self-reported learning about the adjustment process and how to support adjustment. The other was that training and delivery of SettleIN did not add to staff knowledge of adjustment. Table 3 details the overarching themes, themes and codes identified.

Learning specific to adjustment was achieved through the SettleIN programme

1. New learning about the complexity of the adjustment process

There was a sense from around half of the participants that completing the training and delivering the intervention changed their perspective of the adjustment process in some way. This included a sense of reconsidering the difficulty of relocation for PwD, for example commenting on the emotions that a new resident might experience with relocation (*“Just understanding that it’s such a big change... coming somewhere completely strange to them with strange people” (Participant 15), “I have learnt that, like, for example there are people [who are] anxious” (Participant 2), “it’s just so confusing for them and scary you know?” (Participant 16)*).

Of the eleven participants that reported learning from the process, around half said that their understanding of the adjustment process and/or how to support somebody to adjust had changed. Of those who elaborated further on this, features of the learning included more understanding of resident needs for adjustment, such as the importance of PwD keeping their close connections and routine following

relocation (*"I think I understand now more everything, not everything, because I don't think you can ever understand everything, but there is more to it, the personal side, the family, just maintaining that connection with your past life"* (Participant 15), *"you can help them live their life here like they would at home rather than it more like, so a lot of care homes have their own rules and routines but I think it's important to make sure they have their own routine as soon as they come in so they feel that it's free, it's like a free place you know, they don't have to do what we do"* (Participant 16)).

Some of the participants reflected on how they had more of an appreciation of the role of care home staff in adjustment from completing this process (*"in some of the cases that I thought we were going to make the person settle in, maybe we [failed] a little bit"* (Participant 9), *"I think, I thought adjustment, it was basically to do with, family plays a very big role rather than the staff, but I think we have much more to do rather than the family, because in the end they are going to live with us and we are going to see them every day [instead of] the family"* (Participant 13), *"it makes you think as well we should do more things like family trees and just asking them little questions a day you know, it could really help their relationship and how they feel here"* (Participant 15)).

2. Conversation and building relationships

One of the most recognised learning points from using the SettleIN programme was the ability to expand on conversations with PwD. Ten participants provided feedback that endorsed this theme. Social connection is a crucial factor in adjustment to residential care for PwD (Aminzadeh et al., 2013). Learning was reported at different levels; direct learning of questions to ask from the programme structure (*"I never [asked] what is your favourite colour [to] others, I [asked] (resident's name) 'what is your favourite colour?'"* (Participant 3), *"When somebody*

moves in you know we obviously ask about their family and everything else but we don't go into as much depth" (Participant 15), "I never really knew what to say, much, to residents in there, but the programme gave good guidelines, so I have learnt a bit from it" (Participant 21)) and also learning more about PwD by implementing the programme ("to know [their] likes and dislikes" (Participant 3), "[I learnt] a lot about the new resident, and the others as well" (Participant 10), "I just found out from doing this programme that she played piano" (Participant 9), "[it] gives you a lot of, so much to know about that person and how to support that person" (Participant 19)). Furthermore, the conversations proposed in the programme were considered by staff to support them to build relationships with PwD, as well as encourage them to want to find out more about the resident ("I want to know the person, the person, what she's like" (Participant 11)). One participant, who had attended the training but was unable to complete the intervention, noted that they expected the programme to facilitate a connection with residents ("I know that the training would have been good, would have been perfect for one of our dementia residents, well any of them, umm I think, because that resident would get to know me, I'd get to know them" (Participant 7)).

3. Steps and structure helpful for adjustment

A number of the participants spoke about the benefits of the standardised steps of a programme with a protocol in aiding adjustment ("*it is like a chronology of the things [we] can do for the person to settle in" (Participant 9), "I think I've broken it down more, sort of you know, understanding finding your way around a bit, we can find our way around. Piece of cake. But it's not that easy, you know break it down into smaller things" (Participant 15)). Having the protocol to review gave new ideas ("I would have never thought about having a board, because I was given a board" (Participant 13)) and acted as a reminder to consider a new resident's adjustment*

needs (*"I keep remembering the word settling in so I keep going back to check what can I do better"* (Participant 19)).

4. *Influence on future practice*

Seven of the participants spoke about an expectation that their practice would change following learning from the programme, due to learning about how to approach PwD (*"It [changes] us, like the way you can deal with the new resident and old resident"* (Participant 10)) and also through noticing a change in themselves (*"I think [I have] more understanding, massively, more, I think I've got more patience, I thought I was quite a patient person before but I've got more"* (Participant 15), *"it makes you, err, think wider"* (Participant 19)) and through skill development (*"it has probably increased my skill set for the early stage [of dementia]"* (Participant 21)).

The programme did not change knowledge of adjustment

No new learning in regard to the adjustment process

As mentioned, the results were varied in regard to self-reported knowledge change of adjustment. Converse to the above findings, one participant did not find the programme led to changed knowledge in any domain (*"I didn't feel it's done anything else for me that needed to be done"* (Participant 4)). Five participants did not feel that their knowledge of adjustment had changed, typically due to a sense that they already had an understanding of adjustment (*"we always [understood] adjustment"* (Participant 2), *"it would be second nature to me, I'm like that anyway"* (Participant 4)). Some said that their care home already implemented some or most of the activities on the programme (*"we don't have [a] particular programme like this, but we are doing the same"* (Participant 10), *"most of it is what (Care Company)*

actually do” (Participant 19)). Around half of the participants had a continued expectation following the programme that PwD adjust well and/or quickly to relocation (“*[residents] settle in well here (Participant 11)*”). A similar number of participants felt that their expectations of adjustment time had not changed since completing the programme.

Discussion

Summary of results

The main aim of this project was to explore the feasibility of the updated SettleIN programme. Saint (2018) found that the updated programme was feasible in regard to retention and was acceptable to staff. However, it was not feasible in terms of the recruitment procedure, practicality or wider organisational acceptability. In regard to resident outcomes, there was no significant effect of intervention on adjustment, psychological wellbeing or quality of life.

In this study, which focused on staff outcomes, there were no observed significant differences between the conditions in measures of attitude or competence, thus, the null hypotheses for these domains cannot be rejected. The results of this study, therefore, do not suggest that training on SettleIN and delivering the programme leads to a significant improvement in attitude or competence.

In analysing the qualitative data, there was an overriding sense from participants that there had been some learning from using the programme, however there were mixed findings on whether knowledge of adjustment had changed in the process.

Interpretation of findings

It has been suggested in previous literature that it is easier to change knowledge than behaviour, including attitudes and skills, of caregivers (Boersma, van Weert, Lakerveld & Dröes, 2015). This is supported in the outcomes of this research, yet this could be due to the measures used. The high average for the SCIDS at baseline may indeed represent a pre-existing high level of competence in dementia care, but the use of a self-report measure does raise the question of whether these results were affected by the social desirability of appearing competent in the role. Although the ADQ uses a scale of agreement rather than self-

report on ability, again this could be affected by what participants feel “should” be reported by a person in their position rather than a true response. That there was no significant change on the ADQ score could also be an indication that the training session was not long enough, as staff need time engaging with sessions to affect attitude change (Surr et al., 2017).

One encouraging theme that was identified through the collection of interview data was new learning about the complexity of the adjustment process. This included a deeper understanding of a staff member’s role in supporting healthy adjustment and more consideration for the difficult emotions that a new resident might experience on relocation. Some participants spoke about how they benefited from using steps to support adjustment and felt that their practice would change in the future. These findings suggest that adjustment specific learning can be gained through the process of training and delivery of SettleIN, thus, providing support for the hypothesis of changed knowledge through the introduction of this intervention.

Over 80% of participants reported that the training and delivery of SettleIN led to learning about how to have in-depth conversations and build relationships with PwD. This is in line with previous research that beneficial psychosocial interventions are perceived by staff to support them to ‘know the person’ and to facilitate PwD connecting with others (Lawrence, Fossey, Ballard, Moniz-Cook & Murray, 2012). Developing skills in conversation and building relationships with PwD certainly promotes person-centred practice, which is a positive factor in adjustment (Sury et al, 2013). To ‘fit in’ to a care home through social connections is an important step in this process (Aminzadeh et al., 2013), therefore, skills to foster relationships are important. Interestingly, not all of the participants that endorsed this theme reported that they had learnt more about the adjustment process or how to support somebody to adjust. This raises the question of whether the rationale for these conversation-based activities was made clear enough in the training.

To further promote positive adjustment, many of the suggested conversation topics in the programme are designed to inform action. A number of these activities relate to the initial, crucial process of 'settling in', which includes creating a personalised and private space (Aminzadeh et al., 2013). The activities are also designed in line with the findings of Sury et al.'s (2013) review, for example tuning a radio to a favourite station in order to help maintain a familiar lifestyle, or ensuring access to the means to celebrate religious holidays and thus reducing cultural dissonance. The aim of these activities is to put information gained through conversations with PwD into practice. Many participants did talk about learning tangible activities from the programme (for example, providing a whiteboard for visitors to write messages, putting together a life book), yet not all that reported this learning felt that they had learnt skills to help adjustment. Again, whether the rationale was communicated effectively in training may be queried.

Strengths and limitations

The study had a number of strengths, including the use of a control condition to facilitate comparison with the usual adjustment process as well as blinding of the researcher for data collection. The study used a standardised training structure that allowed for the session to be tailored to the staff participant. The use of face to face training was consistent with the literature around the benefits of active approaches compared to passive learning styles in dementia education (Surr et al., 2017). Introducing a qualitative component allowed the researcher to capture information about a domain that could not have been found with any existing quantitative measures. Randomising resident-staff member pairs individually reduced the chance of confounding and type-two error as is possible with cluster randomisation.

There were also a number of limitations to the study. The chosen statistical test changed between protocol and analysis stage, therefore, the power calculation originally used to provide a target number for participants was no longer applicable.

Although feasibility studies are not expected to be fully powered, the researchers did not recruit as many participants as planned and therefore caution is needed when drawing conclusions from the quantitative analysis. Although some staff demographics were collected, information about language and previous educational level was not recorded and therefore it is not known whether the two conditions differed on these factors. The sample was certainly diverse in terms of nationalities, however, this is not formally explored in the data. Implementation was also not measured, therefore, there is no way of knowing how much of the programme was completed by staff. A follow up measure or interview was unfortunately outside of the scope of this project, however, this could have given important information about change in practice over time.

Due to the time pressures observed from working in this setting, there was limited time to elaborate on the concept of adjustment and learning in regard to this domain in the interviews (see critical appraisal for reflection on time pressures). Therefore, the information gathered may not give a full understanding of the change in adjustment knowledge. Staff competence and attitudes are regularly analysed in the research of new interventions in dementia care, however, there may have been other domains that were affected but were not captured in the measures used.

The methodology used for qualitative analysis was TA. Despite the many benefits of TA, it does hold weaknesses as an approach, including limited interpretative power if not used within an existing theoretical framework (Braun & Clarke, 2013). Alternative approaches may have been adopted in the analysis of the interview data, for example Interpretative Phenomenological Analysis (IPA). IPA is an approach that implicates the researcher's interpretations in the analysis of data derived from in-depth interviews (Finlay, 2011), with particular concern given to how people make sense of their lived experience (Braun & Clarke, 2013). Grounded Theory, an approach that aims to generate theory from research data (Glaser & Strauss, 1973), is another approach that could have been adopted in exploring

knowledge of adjustment. The use of either IPA or Grounded Theory may have provided opportunity to generate more in-depth data in response to the research question. However, it was observed during the data collection phase that participants often struggled to elaborate on short answers they provided to questions posed by the interviewer. It is possible, therefore, that the data, and as a result the conclusions, may have remained limited even if a different analysis method had been adopted.

Implications for future research

This study suggests that changes to knowledge of adjustment can be made through the training and delivery of the SettleIN programme. However, the programme was found to be unfeasible in a number of areas. An RCT would, therefore, not be advised at this stage. A conflict presents here as to whether a further feasibility study would be suggested in the current climate of care provision; whilst there is a recognised need for adjustment support, the inability for staff to complete the programme as it is currently designed was apparent. To justify any further research on SettleIN, changes to the programme such as reduced documentation, a more flexible structure, training staff members in pairs and a longer recruitment period would be vital (see Saint (2018) for rationale for these changes). The training session would need to be developed to maximise learning and truly promote the rationale for the programme. The design of a measure specific to staff knowledge of adjustment would further add to the evidence base. Researchers exploring staff factors would need to consider possible confounding factors such as desirability in selection of outcome measures. A formal measure of implementation following the RE-AIM framework (Dzewaltowski, Glasgow, Klesges, Estabrooks & Brock, 2004) would provide more information on the level of compliance to the programme. It is suggested that any further research on SettleIN

is not attempted within the confines of a Clinical Psychology Doctorate thesis project, due to the size of the task.

Due to the scope of this study, time two measures were taken at week seven rather than directly after the training session. To evaluate training alone in future research would provide information on whether a one-off training session focused on techniques to support healthy adjustment is enough to affect change in staff domains. It has been found, however, that multiple implementation strategies such as follow up meetings, observations and consultations are important elements in caregivers putting the knowledge of dementia training into practice (Boersma et al., 2013; Eggenberger et al., 2013). Furthermore, benefits seen immediately after training in staff knowledge are not sustained with time or reflected in resident outcomes (Kukse et al., 2007). Techniques to provide ongoing supervisory support to staff following training should, therefore, continue to be considered.

Implications in care practice

There are no current interventions to support resident transition from home care to residential care (Müller, Lautenschläger, Meyera & Stephana, 2017), thus an intervention like SettleIN is called for. There were mixed findings in terms of feasibility of the programme. Care home staff found the intervention acceptable and on the most part reported learning from the process, but organisational barriers were recognised as are frequently found in research of this nature (Low et al., 2015). Careful consideration of these barriers and strategies to overcome their effects would need to be incorporated into all new interventions to ensure effective implementation in residential care settings. Furthermore, training sessions need to be designed to provide the necessary learning in the most time efficient way to allow for staff attendance, as care home managers can struggle to find the resources to release staff for training (Beeber, Zimmerman, Fletcher, Mitchell, & Gould, 2010).

The training session was designed to be conducted in 1.25 hours. This duration was agreed to ensure enough time to cover the training objectives, whilst being a manageable amount of time for managers to facilitate. Time pressures were present for some staff members during the training session, which resulted in one being shortened to one hour, and others being interrupted by other staff or residents. The teaching was mostly didactic to cover the programme in detail, with little to no time to use other techniques such as role plays and vignettes, despite these being shown to be effective teaching methods to realise a change in practice in this setting (Kontos, Mitchell, Mistry & Ballon, 2010). A dilemma presents here between the extension of training to include more techniques and the time efficiency of the training session; the former may be more effective in regard to affecting change, however, this is unlikely to be acceptable in the current climate of care provision. Furthermore, beneficial interventions foster critical reflection in staff around how their own approach may influence resident behaviour, and such practice has an impact on domains such as attitude (Lawrence et al. 2012). Reflection can be supported in supervision; however, the supervision of this study was typically very brief with little opportunity to foster reflective practice.

Conclusion

This study explored staff outcomes following training and delivery of SettleIN, a manualised, staff led programme designed to support adjustment. The quantitative results did not show attitudes or sense of competence to improve through using the programme in comparison to TAU. Staff members did endorse that they had learnt different approaches from the process that had been helpful in skill development, however not all connected this with specific knowledge of adjustment support for PwD. If any further research is conducted into the SettleIN programme, it is suggested that enhancements are made to the programme and training schedule to reduce the role of organisational barriers to implementation.

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Part 3: Critical Appraisal

Introduction

Completing this research allowed me to explore the staff outcomes associated with a manualised programme designed to support adjustment for people with dementia (PwD). I was also able to conduct this study in residential care homes, which is a novel setting to me. In this critical appraisal I will discuss my experiences of completing this piece of research, including reflections on the recruitment process, providing the training, barriers that presented and a discussion on the findings in the context of these areas.

Choosing this project

The perception of care homes in Britain to the average person seems to be negative. This is a message that is also reflected in the media. Throughout my life I have heard anecdotally that people fear needing residential care as they get older. It is quite striking that relocation to care homes is associated with decline for PwD when they are moving in order to receive round the clock care not available to them at home. I was keen to work on this project to contribute to positive change for outcomes for PwD. I am also passionate about equality in care, a value that the SettleIN programme aims to foster.

It is striking in an age of evidence based practice in Psychology that so few psychosocial interventions are based on evidence (Fossey et al., 2014). Evaluation of interventions is an important contribution of Psychology to care, and I was keen to use this opportunity to enhance my research skills as a scientist-practitioner. I am also interested in staff training due to the positive affect that changes in practice can have on the wellbeing of the people they support. This project encompassed all of these areas of interest for me.

Challenges recruiting care homes and participants

Recruiting care homes for this research was more difficult than first anticipated. Care home managers were rarely available to talk, and did not tend to

get back to the researchers following letters, e-mails and telephone calls. As a result, many more care homes were contacted than visited. Arranging these initial meetings alone was, therefore, incredibly time consuming. Once able to speak to managers, they were mostly very keen to work with researchers on this project. This process highlighted to me just how busy and pressured their role was. This was also endorsed anecdotally by many managers in conversation.

Once we had obtained consent from the care home manager, the process of recruiting new resident participants was equally challenging. There were many crucial steps before randomisation into one of the two groups where potential new participants were lost; this included no consent from personal consultees, no available staff member to participate and too much time lapsing from relocation to consent (and as a result, being unable to take the resident into the research). The researchers developed practices to try to minimise the possibility of these barriers arising; however, this meant increased input such as regular update calls with managers and more frequent visits to the home than first expected. This project could have been improved with more time to recruit participants to increase the power. Also, there were simply not as many new admissions that met our inclusion criteria as we expected in the recruitment period. The researchers were told by staff that many new residents were displaying symptoms of dementia without a formal diagnosis.

Experience of training

As noted, I had a great interest when starting this project in working with PwD, however with limited professional experience. Before I provided any training to staff, I was keen to consider my role as the 'trainer'. Although I was there in the knowledgeable position in terms of the programme, I was not the most experienced in residential dementia care in the room. To be knowledgeable about the topic is an important trait of a dementia educator (Surr et al., 2017). In addition, it is important

to recognise and build upon the life experience, skills and strengths that staff bring to their position (Coates & Fossey, 2016).

I was keen to balance the approach of being knowledgeable about the SettleIN programme with calling on care staff's experience. For this reason, I would often comment on the importance of the staff member's skills and professional judgement in completing the programme, for example, finding the best time to complete the activities by reading the feedback from the residents. Throughout this process, I also considered the 'expert position', which I would typically try to avoid in my clinical practice as a Trainee Psychologist. The training session was designed to impart a standardised message in an individualised way and I attempted to honour this by using my skills of monitoring feedback. It was challenging at times to get the balance right, particularly under time pressures. I provided face to face supervision rather than telephone supervision for two staff members as this was their preference. I noticed at the time that I felt obliged to offer support to staff in the most accessible way to help them to implement the programme. On reflection, this would not be a feasible model if the intervention was more widely used and I think the decision to do this was a reflection of the pressure the researchers felt to keep participants interested in the study.

Trainers report that it takes time to become familiar with the individual needs of those that they provide training for, and trust must be developed before real progress can be made in changing practice (Fossey, Garrod, Guzman & Testad, 2018). These ideas support previous work which suggests effective training programmes need to involve a sustained period of joint working to change ways of working (Fossey et al., 2014). This approach was unfortunately not possible under the constraints of this project, therefore the structure of the SettleIN training may have missed some helpful elements in influencing care practice.

Through qualitative research, care home staff have expressed that they want researchers that introduce psychosocial interventions to communicate the benefits

for staff and residents (Lawrence, Fossey, Ballard, Ferreira & Murray, 2015). To ensure sustained benefits after the research period, interventions need to fit into day-to-day care, avoid extensive record-keeping and should save more time than they take (Rapaport, Livingston, Murray, Mulla & Cooper, 2017). The qualitative results from my paper certainly did raise the question of whether the rationale for the programme and potential benefits were communicated effectively in training, and if not, this may have affected delivery of the intervention, as it would have simply been seen to add time pressures with no benefit.

Staff and organisational barriers

The barriers to working in this setting are widely documented. Influencing care practice in care homes can be compounded by the busy environment where staff turnover is high along with increased time and financial pressures, resulting in managers struggling to release staff to attend training (Beeber, Zimmerman, Fletcher, Mitchell & Gould, 2010). Further barriers include staff absenteeism, high workload, opposing attitudes/lack of commitment and logistics (Low et al, 2015). It has been found that frustration over varying managerial support restricts the implementation of new learning (Spector, Revolta & Orrell, 2016), and senior leadership resistance was ranked as one of the most significant barriers to culture change by LTC specialists (Miller et al., 2010).

Many of these barriers presented in the current research, some a large number of times. The programme structure was challenging for staff to deliver over the four- to six-week period, for example due to changing shift patterns or being positioned on another floor from the resident on a working day. As the researcher offering the training sessions and supervision calls, I was able to provide flexibility to contact at less busy times such as the evenings; however, this was not always successful in ensuring contact, as staff often made last minute shift changes and as

such were no longer available when agreed. Logistics alone, therefore, proved a barrier to completing this research as intended.

High workload and time pressures further compounded the work, and it was common feedback from participants that they struggled to find time alongside their day to day role to complete the intervention. In the current 'changing landscape' of care of lower staff to resident ratios, a focus on 'priority needs' can emerge among care staff whereby managing behaviour takes precedence (Lawrence et al., 2015). This did seem to be the case in many of the homes that we worked with, and the intervention was viewed as an 'add on' that staff did not have time for. This belief may have been compounded by the fact that many did not seem to connect the intervention with adjustment support as reported in the qualitative feedback.

Staffing levels proved problematic for the training phase. At times, I felt conflicted about whether I was using staff time at the detriment of all of the residents in the home. This was particularly apparent when the only available time for the training was when the staff member was one of a small number on shift (for example the evening), and by being absent from the floor, their colleagues' workload was increased. This felt particularly uncomfortable when the home seemed understaffed before I had even started the session.

Beyond training, it often felt impossible to problem-solve barriers to the programme with staff members when the organisational blocks were many. It was interesting to observe the difference in the manager's expectations and a staff member's expectations of what could be achieved in a shift, in that manager's tended to seem more optimistic about the amount that could be completed. I did wonder whether this was due to a disconnect between managers and their staff in regard to the nature of the work, or whether lack of time was being presented by staff as a more comfortable excuse to give when there was a reluctance to engage in training. My hypothesis is that both factors were present. To receive feedback that there were blocks to completing the intervention was crucial information for this

feasibility study, however, at the time of collecting data this did make me feel very powerless and conflicted about how to proceed.

There are also staff led factors such as reluctance to participate in dementia care training (Lawrence et al., 2015). I had to take time to reflect on my feeling of frustration to ensure that it did not affect my approach with staff members, who were of course able to decide not to participate. I drew on the therapeutic skills I have gained through the Clinical Psychology doctorate to allow myself to remain curious with the hope to allow honest responses about their reservations and thus the possible overcoming of the obstacles when appropriate.

Despite the many challenges listed above, I was struck by the commitment of staff members to engage in the research and to be flexible in their delivery to work towards completion. Appreciating the long hours care staff work for low pay, so many were fiercely committed to improving the quality of life of their residents and were keen to enhance their practice to contribute to this. It was enjoyable to provide the training and supervision support for the staff, particularly when the I felt I could contribute with practical and possible solutions to the challenges faced. It was also very rewarding to review the feedback of the participants and the skills they had gained through being part of this research.

Emotional Challenges

The transition to residential care is also extremely difficult for family caregivers (Gaugler, Pearlin, Leitsch & Davey, 2001) where feelings of grief and shame can present (Afram, Verbeek, Bleijlevens & Hamers, 2015). To be contacting family members at this early stage of moving was vital to ensure participation in the study as we were focusing on the weeks prior to admission. However, this did sometimes feel intrusive and emotions were understandably running high for many. Family members might have called on us for support with home matters and it felt dismissive yet necessary to redirect them to the home, particularly if they had

concerns related to care. The sheer nature of working in this setting means that you will observe attrition due to frailty and the instability of the residents' condition (Cohen-Mansfield, 2002). To be in contact with the family of a person who was unwell or sadly died was a particularly difficult part of this project.

At times I felt that the boundaries of my role became slightly blurred in my mind and in that of staff, for example, whilst waiting in a communal living room for a meeting, where I could be waiting for some time. I was keen to help staff, particularly when they were immensely busy, however, there was very little that I could appropriately support with as I am not a trained carer. I would, therefore, call on the staff to attend to a resident who needed assistance. I wondered whether for me to then step into the trainer position was confusing for participants. Despite being unable to provide much support with care tasks, I enjoyed the opportunity to engage in conversation with residents as typically my contribution to the method was more staff facing.

Skill Development

Reflecting on this process has allowed me to notice the truly enjoyable aspects of the project, as well as the strengths that I have built on the way. I was privileged to work with the managers, care staff and residents that participated in this research. My ability to adapt my practice to suit the needs of individuals was improved through this process. Empathy was a vital skill in connecting with all involved, be that a resident struggling with transition or a staff member overwhelmed with work demands. I felt that my ability to adapt the training to suit individual needs was strengthened as I became more practised.

The inclusion of qualitative analysis alongside the quantitative allowed researchers to gain a detailed description of events or experiences (Braun & Clarke, 2013) about a concept that would have not been captured otherwise. Using both questionnaire and interview data allowed me to develop research skills in

quantitative and qualitative analysis. This was a challenge to balance along with the other demands of the research and the rest of the requirements of the Clinical Psychology Doctorate.

Conclusion

There is no doubt a need for continued research into the best practice in dementia care. In the current climate, however, researchers need to be prepared to face obstacles to implementation such as low staffing levels, competing demands and resistance. This research was incredibly challenging and the provision of an intervention at the very early stages of transition was certainly a huge task in the context of a Clinical Psychology doctorate. Despite these challenges, the process was highly rewarding and I have gained many skills that will be essential in my career as a Psychologist in NHS settings that will undoubtedly present similar challenges. I would be keen to complete further research in this field to contribute towards widespread practice that is evidence based, as so little is currently grounded in empirical findings.

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and social care workforce: A systematic review of the literature. *Review of Educational Research*, 87 (5), 966-1002.

Appendices

Appendix A – Table of Contributions	118
Appendix B – Ethical Approval	120
Appendix C – Information Sheets and Consent Forms	125
Appendix D - [REDACTED]	164
Appendix E – SettleIN Training Slides	166
Appendix F – SettleIN Fact Sheet	171
Appendix G – [REDACTED]	174
Appendix H – Interview Schedule	176
Appendix I – Excerpt of coded transcript.....	178
Appendix J – Picture of Theme Map	180

Appendix A – Table of Contributions

Contribution	Judy Murrill	Caroline Saint	Janine Hayward
Enhancement of programme	✓	✓	✓
Consultation on enhanced programme	✓	✓	
Recruitment of care homes	✓	✓	
Data collection baseline		✓	
SettleIN training	✓		
SettleIN supervision	✓		
Data collection time two (including interviews)		✓	
Data Analysis	✓	✓	

Appendix B – Ethical Approval

Ethical Approval



Health Research Authority

London - Camden & Kings Cross Research Ethics Committee

Jarrow Business Centre

Rolling Mill Road

Jarrow

NE32 3DT

Tel: 0207 104 8087

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

22 February 2017

Judy Murrill

Trainee Clinical Psychologist

University College London

Dear Judy

Study title: An Adjustment to Care Intervention for People with Dementia: A Feasibility Pilot Study in Care Homes
REC reference: 15/LO/0611
Amendment number: SA1
Amendment date: 12 December 2016
IRAS project ID: 173126

The above amendment was reviewed by the Sub-Committee in correspondence.

Summary of amendment

This amendment was submitted to seek approval for the addition of a control group, who would receive care as usual, and would require a larger sample of participants to be recruited of around 30 participants and 30 staff members.

Two additional researchers would be included in the research, Caroline Saint and Judy

Murrill, who would act as lead researchers, and Janine Hayward would now act as an External Supervisor. Furthermore, Clive Ballard would no longer be involved in the research.

A new measure, the Approaches to Dementia Questionnaire, was added for use in the study, which sought to explore staff attitudes towards dementia.

Additionally, training time was reduced from half a day to one hour and fifteen minutes, as the existing length of time was not feasible in a care home setting.

Ethical opinion

The members of the Committee taking part in the review gave a **favourable ethical opinion** of the amendment on the basis described in the notice of amendment form and supporting documentation.

The Sub-Committee did not raise any ethical issues.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
GP/consultant information sheets or letters [GP Information Letter - Highlighted Changes]	0.4	10 December 2016
Notice of Substantial Amendment (non-CTIMP)	SA1	12 December 2016
Other [Site-Specific Agreement Letter - Highlighted Changes]	0.4	11 December 2016
Other [UCL Insurance Registration Form - Highlighted Changes]	15	12 December 2016
Other [UCL Student Study Registration Form - Highlighted Changes]	11	31 January 2017
Other [Letter to Nominated Consultee - Highlighted Changes]	0.4	13 December 2016
Other [Personal Consultee Invitation - Highlighted Changes]	0.4	13 December 2016
Other [Letter to Personal Consultee - Highlighted Changes]	0.4	13 December 2016
Other [Nominated Consultee Invitation - Highlighted Changes]	0.3	13 December 2016
Other [Caroline Saint CV]		
Other [Judy Murrill CV]		

Participant consent form [Nominated Consultee Declaration - Highlighted Changes]	0.3	13 December 2016
Participant consent form [Personal Consultee Declaration - Highlighted Changes]	0.4	13 December 2016
Participant consent form [Resident Participant Assent and Witness Form - Highlighted Changes]	0.6	13 December 2016
Participant consent form [Resident Participant Consent Form - Highlighted Changes]	0.4	13 December 2106
Participant consent form [Care Home Manager Consent Form - Highlighted Changes]	0.3	13 December 2016
Participant consent form [Staff Consent Form - Highlighted Changes]	0.3	13 December 2016
Participant information sheet (PIS) [Care Home Manager Invitation and Information Sheet - Highlighted Changes]	0.6	10 December 2016
Participant information sheet (PIS) [Nominated Consultee Information Sheet - Highlighted Changes]	0.6	10 December 2016
Participant information sheet (PIS) [Personal Consultee Information Sheet - Highlighted Changes]	0.3	11 December 2016
Participant information sheet (PIS) [Resident Participant Information Sheet - Highlighted Changes]	0.5	12 December 2016
Participant information sheet (PIS) [Staff Information Sheet - Highlighted Changes]	0.6	11 December 2016
Research protocol or project proposal [Study Protocol - Highlighted Changes]	4.0	12 December 2016
Validated questionnaire [ADQ]	N/A	

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/LO/0611:

Please quote this number on all correspondence

Yours sincerely

Mrs Rosie Glazebrook Chair

E-mail: nrescommittee.london-camdenandkingscross@nhs.net


Enclosures: List of names and professions of members who took part in the review

Copy to: Mr Dave Wilson, UCL

*Dr Aimee Spector, Department of Clinical, Educational and Health
Psychology, UCL*

Appendix C – Information Sheets and Consent Forms

Care home manager information sheet and consent form

<p>RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY</p> <p>University College London Gower Street London WC1E 6BT General Enquiries Tel: +44 (0)20 7679 1897 Fax: +44 (0)20 7916 1989 http://www.ucl.ac.uk/clinical-psychology/</p>	
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SettleIN: Exploring adjustment to care homes for people with dementia. A feasibility pilot study (Doctoral Student Study)

Version ...**0.6**....., Date**10th December 2016**

Information for Care Home Manager about the research

You are invited to grant approval for the care home you currently manage to participate in a research project to help develop and test an intervention that aims to, support healthy adjustment to new accommodation for people with dementia, who have recently relocated from independent or family based care. The intervention is based on best practice identified in research to date for supporting relocation based adjustment and minimising negative factors influencing adjustment. It attempts to provide staff and carers with a process tool; a manualised, standardised yet flexible, person centred approach to supporting healthy adjustment in people with dementia. The study will be conducted by Caroline Saint and Judy Murrill as part of their training at University College London and will be submitted as a thesis in partial fulfilment of the requirements for the postgraduate degree of Doctor of Clinical Psychology. Before you decide if you want to join, it's important to understand why the research is being done and what it would involve for you. So please consider this leaflet carefully and ask the researcher any questions you may have.

Why are we doing this research?

Research shows that admission into a residential care home for people with dementia (PwD) has been linked with both positive and negative psychological outcomes for both the resident and their carers. Whilst some PwD adjust spontaneously to care home placement (adjustment commonly taking between two to four weeks or as long as six months) many never adjust at all or adjustment is complex and linked to cognitive and behavioural decline. Therefore, support for healthy adjustment is needed. This study is developing and testing a new intervention to help support successful and healthy adjustment in people with dementia when they relocate from independent or family care into a care home.

The intervention is an easy to use, person centred tool (and manual) that outlines a framework and structure for considering the adjustment needs of newly admitted residents. It covers a range of fifteen positive and negative factors condensed into a

small number of modules that are helpful to consider when supporting a person to adapt quickly and successfully to their new home. The tool provides a standardised approach to selecting and implementing components of a tailored adjustment support (settling in) programme for a new resident. The SettleIn tool has been developed with feedback from care home managers, staff, service users, families and carers of people with dementia and professionals working in dementia care.

Why have I been invited to take part?

You have been invited to join the study because you currently manage one of the care homes that admit people with dementia and are in a position to grant approval for the care home to be denoted as a research site for this project.

Do I have to take part?

No: it's up to you. Please read through this information sheet and think carefully about whether you want to take part. We invite you to attend a meeting with a researcher at your workplace about the study. If you have any questions about the study, you can ask the researcher then. If you are willing to take part in the study, we will ask you to sign a consent form to show you have agreed for the care home to take part.

What will happen if I take part?

If you were to take part in this study, the residents of your care home (and therefore their assigned key workers) will be randomised into one of two groups; one group receiving the SettleIN intervention, and the other receiving care as usual. This will allow us to make comparisons between the impact of the SettleIN programme and natural adjustment.

If you agree for the care home to be a research site for this project you will be asked to do the following:

1. Disseminate information sheets about the study (these will be provided to you) to your staff and make them aware of the opportunity to participate in the study at team meetings.
2. Provide support to staff members that wish to participate in the study by approving their attendance to the half-day on-site training and supporting their lead and involvement in intervention delivery.
3. Attend the training programme, which will be held at the care home where you work and involve one training workshop of approximately half a day in length.
4. Identify potential participants considering the inclusion and exclusion criteria provided (i.e. new admissions of people with dementia) and contact them or ask a member of the care team to contact the potential participant about the study and seek permission for the researcher to directly contact the potential participant.
5. Support the staff participants to be available to complete the measures, to take part in interviews (approximately 30 minutes each) and for those in the

SettleIN condition to apply the healthy adjustment intervention and in particular support the assessments needs phase which is anticipated as a 30 minute meeting involving the resident, carer if there is one, direct care team representative and principal researcher. The purpose of the meeting is to assess the adjustment needs of the person with dementia (participant) and identify the intervention programme modules most appropriate for the participant.

6. Over the intervention period (currently planned for one month) support staff with and facilitate the completion of the intervention modules with the participant, as relevant (i.e. if the module involves talking with the participant about their move it may involve organising for a psychologist to attend to do this or if the module involves creating a life book it may involve the staff member interviewing the participant and their family to gather information to create a life book and ask the participant and family to contribute photographs. Please note that there is separate guide on how to go about this activity). Activities may range from 30 minutes to one hour. Also remind and support participating staff in the SettleIN group to complete field notes (simple templates will be provided in order to make this no more than a 5 minute task).
7. At the end of the intervention we will invite you to discuss your thoughts and ideas about the practicality, feasibility and impact of the intervention. This will involve you taking part in a face-to-face or telephone based interview lasting approximately 30 minutes. If face-to-face, it will be held at the care home where you work and take place within a month of all resident participants completing the intervention.

What are the possible benefits of taking part?

The potential benefits for you are improvement of skills and/or knowledge about healthy, positive adjustment and prevention of adverse reactions in residents with dementia. We hope that the intervention will help you to provide the best care possible for your residents, potentially leading to a consistent, standardised yet flexible admission support process, which may enhance their quality of life.

It is also hoped that this study will help us to improve relocation and transitions for people with dementia in general and make staff delivery of effective admission and adjustment support easier for staff, families and residents.

What are the risks of taking part?

We do not expect there to be any risks of taking part in this study over and above those that would be part of your normal job. However if being involved in this research really does not suit you, for example if you find it distressing, you are free to withdraw at any point.

Although it is not anticipated that the face-to-face interactions will cause any stress or distress, this is a possibility. If, for any reason you do become distressed the

researcher, who is a clinician with appropriate training, will be available to help you manage this in the most appropriate way.

What happens if I don't want to carry on with the study?

You can withdraw approval for the care home to be used for the study at any time, without giving a reason. If you choose to withdraw the care home from the study this will not affect your employment in any way.

Will our taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. It will be shared with associated university researchers who have a duty to you as research participants. However, if you or another member of staff were to disclose issues related to protection of vulnerable adults during the research, we might have to share this information with an appropriate person. We would discuss this with you before we notified anyone else.

What will happen to the information I give?

One of the requirements for taking part in the study is that you plan to be working at the care home throughout the study (until [date]). If you plan to leave your job before this date and so decide not to take part in the study we will not share this information with your manager.

The results of the research study will be published in a report that will be available to you and your workplace and in journals for medical professionals and other scientists. Your name or the name of your workplace will not appear in any report or publication.

Who is organising and funding the research?

The research is being organised and funded by the Research Department of Clinical, Educational and Health Psychology, part of University College London.

Who has reviewed this study?

The study has been reviewed by UCL Research Department of Clinical, Educational and Health Psychology/ Reviewer Dr Georgina Charlesworth, Clinical Psychologist and specialist in research for people with dementia and family carers of people with dementia. The study has also been reviewed by the Camden and Kings Cross Research Ethics Committee.

What if there is a problem?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, UCL complaints mechanisms are available to you. Please report the complaint through research-incident@ucl.ac.uk at the Joint Research Office, UCL, Gower Street, London WC1E 6BT. Telephone: 020 3447 5199.

In the unlikely event that you are harmed by taking part in this study, compensation may be available. If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to

claim compensation. Please make the claim in writing to Dr Aimee Spector who is the Chief Investigator for the research and is based at University College London. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

Contact details

If you would like to know more, please contact the Researchers, Caroline Saint and Judy Murrill, or the Chief Investigator Dr Aimee Spector, on 020 7679 1897, or by writing to the address on the letterhead.

Thank you for reading this – please ask any questions you may have.


Yours Sincerely

Caroline Saint
Trainee Clinical Psychologist

Judy Murrill
Trainee Clinical Psychologist

Dr Aimee Spector
Senior Lecturer in Clinical Psychology
Psychologist
University College London

Dr Janine Hayward
Chartered Clinical
External Supervisor

<p>RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY University College London Gower Street London WC1E 6BT General Enquiries Tel: +44 (0)20 7679 1897 Fax: +44 (0)20 7916 1989 http://www.ucl.ac.uk/clinical-psychology/</p>	
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Participant identification Number (Office Use Only):
Name of Researchers: Judy Murrill and Caroline Saint
Title of project: SettleIN: Exploring adjustment to care homes for people with dementia. A feasibility pilot study
CARE HOME MANAGER CONSENT FORM

Please **initial**

box


1. I confirm that I have read and understand the information sheet dated () for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I confirm that I have had sufficient time to consider whether the care home I manage and/or I want to be included in the study
3. I understand that my participation is voluntary and that I am free to withdraw the care home and/or my participation at any time, without giving any reason, without my occupational status or legal rights being affected.
4. I understand that data collected during the study may be looked at by members of the research team from University College London or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
5. I agree to take part in the above study.

Name of Participant	Date	Signature
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Name of Person taking consent	Date	Signature
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When completed, 1 for care home manager; 1 for researcher as part of the study documentation; 1 (original) for researcher site file

Participant information sheet and consent forms

<p style="text-align: center; margin: 0;">RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY</p> <p style="margin: 0;">University College London Gower Street London WC1E 6BT</p> <p style="margin: 0;">General Enquiries Tel: +44 (0)20 7679 1897</p> <p style="margin: 0;">Fax: +44 (0)20 7916 1989</p> <p style="margin: 0;">http://www.ucl.ac.uk/clinical-psychology/</p>	
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PARTICIPANT INFORMATION SHEET

Version ...0.6..... Date

Study Title: SettleIN: Exploring adjustment to care homes for people with memory and/or communication problems (student study).

Invitation to participate in a research study

You are being invited to take part in a research study. The study will be conducted by Caroline Saint and Judy Murrill, and will form part of a postgraduate degree in Clinical Psychology at University College London.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?

This study is testing out a programme called SettleIN, designed for people with memory and communication problems to adjust and adapt to living in new accommodation. This programme involves helping these people, their carers and staff who look after them, to choose the best activities to support their sense of wellbeing while they become familiar with their new surroundings and make them feel at home.

Why have I been invited?

You have been invited to take part because you are considered to be experiencing memory problems and/or communication difficulties.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you can change your mind and withdraw at any time without giving a reason. If you decide not to take part, at any time, this will not affect the standard of care you receive.

What will happen to me if I take part?

If you decide to take part, you will receive your usual care, or your usual care plus the SettleIN programme. Assignment to the SettleIN programme is random, so there is a 50% chance that you will receive the programme.

A psychologist/researcher will spend time with you to complete short questionnaires to ask about your wellbeing. This will happen on three occasions spread out over two months.

In the SettleIN group, a member of staff and/or your carer will spend time with you to complete specifically designed activities that are tailored to you. The activities may include things like talking about the decision to move and how you feel about it, identifying a goal you would like to achieve or helping you to do an activity you have always done and enjoyed but don't know how to do in your new home.

What are the possible disadvantages and risks of taking part?

We believe that the risks involved in taking part in the research are minimal. However, you may find some of the talking activities, as part of staff, carers and psychologists supporting your adjustment, upsetting or distressing. If you do find any part of being in the research distressing, you are free to withdraw at any point.

What are the possible benefits of taking part?

Hopefully you will find our 3 discussions with you over 10 weeks to be engaging and friendly. We would certainly look forward to having this time with you. If you are in the group that receives the SettleIN programme, we hope that you will find the activities helpful, interesting and fun.

For all participants, the information we get from this study may help us to better support people with memory problems and/or communication difficulties in the future in situations when they relocate to new homes.

Will my taking part in the study be kept confidential?

All information collected about you will be kept private unless there is a concern about risk; if we are concerned about your or another person's safety we may need to break confidentiality and share any relevant information.

All documents that leave the care home will have your name removed, with the exception of a consent form, which will be kept in a locked cabinet. Once the study has finished University College London will keep the study data in a secure location. We will ask for your permission to inform your GP about your participation in the study so that they can be up to date in all matters of your care. If you decide not to have your GP informed you may still participate in the study.

What happens when the study stops?

The workbooks from the SettleIN programme will be available for all participants once the study has finished. This includes those who did not receive the SettleIN programme during the research study. This means that people can access parts of the programme should they want to once the study has finished.

What will happen if I don't want to carry on with the study?

You will be free to withdraw from the study at any time, without giving a reason. Withdrawing from the study will not affect the standard of care you receive. We will need to use all data collected in the study, up to the point of withdrawal.

What if something goes wrong?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, UCL complaints mechanisms are available to you. Please report the complaint through research-incident@ucl.ac.uk at the Joint Research Office, UCL, Gower Street, London WC1E 6BT. Telephone: 020 3447 5199.

In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. Please make the claim in writing to Dr Aimee Spector who is the Chief Investigator for the research and is based at University College London. The Chief Investigator will then

pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

Who is organising and funding the research?

The research is being organised and funded by University College London. The study will be conducted by Caroline Saint and Judy Murrill, Trainee Clinical Psychologists who are being supervised by Dr. Aimee Spector, who is a Clinical Psychologist.

What will happen to the results of the research?

The results will be published in journals for health care professionals and other scientists. No-one who takes part will be identified in any publication. Once the study has ended you will be invited to hear the researcher present the study findings at your care home. If you would prefer to have a written report this is also possible.

Who has reviewed the study?

The study has been reviewed by UCL Research Department of Clinical, Educational and Health Psychology / Reviewer Dr Georgina Charlesworth, Clinical Psychologist and specialist in research for people with dementia and family carers of people with dementia. The study has also been reviewed by the Camden and Kings Cross Research Ethics Committee.

Who can I contact for further information?

For more information about this research, please contact:
Caroline Saint or Judy Murrill
Department of Clinical, Educational and Health Psychology
UCL

Gower Street
WC1E 6BT
Email: [REDACTED]

Or if you have any complaints about this study please contact:

Dr Aimee Spector
Department of Clinical, Educational and Health Psychology
UCL
Gower Street
WC1E 6BT
Email: [REDACTED]
Tel: [REDACTED]

Thank you for thinking about taking part in this research study

Yours

Caroline Saint
Trainee Clinical Psychologist

Judy Murrill
Trainee Clinical Psychologist

Dr Aimee Spector
Senior Lecturer in Clinical Psychology
Psychologist
University College London

Dr Janine Hayward
Chartered Clinical
External Supervisor

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

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PARTICIPANT CONSENT FORM

Study Title: SettleIN: Exploring adjustment to care homes for people with memory and/or communication problems. An intervention development and feasibility pilot (student study).

Name of Researchers: Caroline Saint and Judy Murrill

Participant Number:

Please initial
boxes

<p>1. I confirm that I have read and understand the information sheet dated [], version [] for the above study and have had the opportunity to ask questions and have had these answered acceptably.</p>	
<p>2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.</p>	
<p>3. I understand that relevant sections of my medical notes (including my Medication Administration Records) and data collected during the study, may be looked at by individuals from University College London or from regulatory authorities- where it is relevant to my taking part in this research. I give my permission for these individuals to have access to my records.</p>	
<p>4. I understand that all information given by me or about me will be treated as confidential by the research team.</p>	
<p>5. I understand my GP will be informed of my participation in this study unless 'Do not Inform' is indicated here</p>	<p>Circle if preferred:</p> <p>DO NOT INFORM GP</p>

6. I agree to take part in the above study.	
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Name of participant	Date	Signature
Name of person taking consent (if different from the principal researcher)	Date	Signature
Principal researcher	Date	Signature

When completed, 1 for resident (file at site); 1 for researcher as part of the study documentation; 1 (original) for researcher site file

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PARTICIPANT ASSENT AND WITNESS FORM

Version ...0.6..... Date

Study Title: SettleIN: Exploring adjustment to care homes for people with memory and/or communication problems. An intervention development and feasibility pilot (student study).

Invitation to participate in a research study

You are being invited to take part in a research study.

What is the purpose of the study?

This study is testing out a programme called SettleIN, designed for people with memory and communication problems to adjust and adapt to living in new accommodation. This programme involves helping these people, their carers and staff who look after them, to choose the best activities to support their sense of wellbeing while they become familiar with their new surroundings and make them a feel at home.

What will happen if I take part?

If you decide to take part, you will receive your usual care, or your usual care plus the SettleIN programme. Assignment to the SettleIN programme is random, so there is a 50% chance that you will receive the programme.

A psychologist/researcher will spend time with you to complete short questionnaires to ask about your wellbeing. This will happen on three occasions spread out over two months.

In the SettleIN group, a member of staff and/or your carer will spend time with you to complete specifically designed activities that are tailored to you. The activities may include things like talking about the decision to move and how you feel about it, identifying a goal you would like to achieve or helping you to do an activity you have always done and enjoyed but don't know how to do in your new home.

A researcher will also speak to a member of staff who knows you well and look through your medical notes to get information about you and your care.

Do I have to take part?

You do not have to take part in this study. If you do decide to take part you will be free to stop the study at any time, without giving a reason. Stopping the study will not affect the care you receive.

Will my taking part in the study be kept confidential?

The researcher will not tell other people (i.e. people not involved in your care) that you are taking part in the study or share any information about you unless we are concerned about your or another person's safety. We will keep some written information about you but this will be kept securely. We will ask for your permission to inform your GP about your participation in the study so that they can be up to date in all matters of your care. If you decide not to have your GP informed you may still participate in the study

What if there is a problem?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, UCL complaints mechanisms are available to you. Please report the complaint through research-incident@ucl.ac.uk at the Joint Research Office, UCL, Gower Street, London WC1E 6BT. Telephone: 020 3447 5199.

In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. Please make the claim in writing to Dr Aimee Spector who is the Chief Investigator for the research and is based at University College London. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

If you sign below:

If you sign below, this means that you have read this form, or have had it read to you, and that you are willing to be in this study. A researcher will then speak to someone who will think about your best interests and advise whether they think it is ok for you to take part in this study.

Name of Participant

Date

Signature

Consent to Inform GP

Granted / Not Granted (please cross out one)

Name of person who has discussed the study and provided me with information

Date


Signature

If you are unable to sign your name, a member of staff can witness you telling the researcher that you are willing to be in this study.

Name of staff member witness	Date	I have witnessed that the participant has told the researcher they are willing to be in this study Signature to confirm the above
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You will keep a copy of this form. One copy with also be kept in your care records and one copy will be kept by the researcher.

Family member information sheet and consent form

<p>RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY</p> <p>University College London Gower Street London WC1E 6BT General Enquiries Tel: +44 (0)20 7679 1897 Fax: +44 (0)20 7916 1989 http://www.ucl.ac.uk/clinical-psychology/</p>	
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INVITATION TO ACT AS PERSONAL CONSULTEE

Study Title: SettleIN: Exploring adjustment to care homes for people with dementia. A feasibility pilot study (Doctoral Student Study)

Patient Number:

Researcher: Caroline Saint and Judy Murrill

<p>I think that my partner, friend or relative may NOT like to take part in the project.</p>	<p>I agree with this statement</p> <p>Signed</p>
<p>I think that my partner, friend or relative may be interested in taking part and I would like to discuss this with the researcher. I have provided a contact number and the times I can be contacted below.</p>	<p>I agree to being contacted further about the study</p> <p>Signed</p>
<p>I think that my partner, friend or relative may like to take part in the project – but I do not wish to be consulted. I have provided information about an alternative contact person below (if possible).</p>	<p>I do not agree to being contacted further about the study</p> <p>Signed</p>

Contact details:

Name:

Contact number:

Most convenient time(s) to be contacted:

Thank you for completing the form. Please return it in the stamped addressed envelope or leave it F.A.O Caroline Saint/ Judy Murrill at care home.

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

University College London Gower Street London WC1E 6BT

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Fax: +44 (0)20 7916 1989

<http://www.ucl.ac.uk/clinical-psychology/>



Study Title: SettleIN: Exploring adjustment to care homes for people with dementia. A feasibility pilot study

PERSONAL CONSULTEE INFORMATION SHEET

Version ...0.6..... Date

Introduction

We feel your relative/friend is unable to decide for himself/herself whether to participate in this research.

To help decide if he/she should join the study, we'd like to ask your opinion whether or not they would want to be involved. We'd ask you to consider what you know of their wishes and feelings, and to consider their interests. Please let us know of any advance decisions they may have made about participating in research. These should take precedence.

If you decide your relative/friend would have no objection to taking part we will ask you to read and sign the consultee declaration on the last page of this information leaflet. We'll then give you a copy to keep. We will keep you fully informed during the study so you can let us know if you have any concerns or you think your relative/friend should be withdrawn.

If you decide that your friend/relative would not wish to take part it will not affect the standard of care they receive in any way.

If you are unsure about taking the role of consultee you may seek independent advice. We will understand if you do not want to take on this responsibility.

The following information is the same as would have been provided to your relative/friend (though their information sheets refer to 'memory problems and/or communication difficulties rather than dementia).

Study Title: SettleIN: Exploring adjustment to care homes for people with dementia. A feasibility pilot study

What is the purpose of the study?

Research shows that admission into a residential care home for people with dementia (PwD) has been linked with both positive (e.g. Bekhet et al, 2008) and negative psychological outcomes for both the resident and their carers (Sury, Burns & Brodaty, 2013). Whilst some PwD adjust spontaneously to care home placement (adjustment commonly taking between two to four weeks or as long as six months (Ellis 2010; Hodgson et al, 2004) many never adjust at all or adjustment is complex and linked to cognitive and behavioural decline (e.g. Kydd 2001; Wilson et al, 2007). Therefore, support for healthy adjustment is needed. This study is developing and testing a new

intervention to help support successful and healthy adjustment in people with dementia when they relocate from independent or family care into a care home. The project has been approved by the Camden and Kings Cross Research Ethics Committee. We shall make sure that the project is safe for each participant and does not cause them undue distress. To help with this, the researchers need information from people who have known the participant for some time or those who have agreed to be consulted on such matters.

Why have I been contacted?

We are intending to recruit participants to this project who may not have the capacity to consent to their participation. This means that they may not be able to judge for themselves whether they would like to take part or refuse. The project includes such participants because we are studying the impact of an intervention for people with dementia, an illness which limits a person's ability to give consent.

If you do know the prospective participant, you may be able to advise us about any possible difficulties they may have in taking part. You also may be able to tell us how they may communicate that they wanted to cease being involved with the project.

To help decide if the prospective participant should join the study, we'd like to ask your opinion whether or not they would want to be involved. We would ask you to consider what you know of their wishes and feelings, and to consider their interests. Please let us know of any advance decisions they may have made about participating in research. These should take precedence.

When thinking about the wishes and interests of the prospective participant, it is important that you should set aside any of your own views about the project.

What is required of each participant?

Participants of the study will be randomised into one of two groups; one group receiving a SettleIN intervention, designed to promote healthy adjustment, the other group will receive care as usual. This will allow us to make comparisons between the impact of the SettleIN programme and natural adjustment.

The SettleIN intervention provided in this study directly involves dementia care staff, carers and residents of care homes so that a wide range of views can be gathered regarding the feasibility of the intervention and whether a positive impact on adjustment was indicated. In order to explore adjustment in all participating residents, we would do the following:

- 1) The principal researcher will look at all participant's medical records to obtain details about any relevant diagnoses, medication, health complexities and pre-admission care planning.
- 2) Residents (and/or their carer) and staff will be asked to complete standardised and individualised goal oriented assessments before and after the intervention and at one month following the completion of the intervention. Assessments will take no more than 1.5 hours and be predominantly completed with the carer or staff member.

This will help the researchers to assess whether any impact on healthy adjustment has occurred over time and whether the intervention was practical and feasible to deliver.

Taking part in the study does not involve any lifestyle restrictions. Participants will carry on with their everyday activities as normal though may be offered additional tailored activities while participating in the study.

What are the possible disadvantages and risks of taking part?

As support for adjustment to care should be carried out as part of routine relocation to a care home the risk is seen to be minimal and equivalent to that encountered as part of daily care. However if participants find observations significantly distressing they may be withdrawn from the study. A decision to withdraw will be made where the participation is no longer judged to be in the person's best interests. Decisions will be made by the principal researcher through discussion with the Chief Investigator and the person's direct care team. We will need to use all data collected in the study, up to the point of withdrawal.

We will keep you fully informed during the study so you can let us know if you have any concerns or you think that the participant should be withdrawn.

What are the possible benefits of taking part?

Each participating resident will receive three one to one interactions with a researcher for up to 30 minutes each over a period of 10 weeks. We aim for these interactions to be stimulating and engaging discussions for the resident in which they talk about their life and in which we complete the questionnaires. There is also a 50% chance that each participating resident will receive a programme designed to support adjustment to residential living. Previous research has found that when patients with dementia receive person centred adjustment support, adverse reactions to relocation are prevented and patients can thrive in care home settings.

We hope that research of this kind will result in improved dementia care, particularly at the adjustment phase of relocation. There is a lack of evidence-based intervention for this phase of care for people with dementia i.e. post independent living and before end of life care in dementia; therefore this study may also lead to changes in the way that care is provided in this population.

Who is organising and funding the research?

The research is being organised and funded by the Research Department of Clinical, Educational and Health Psychology, part of University College London. This project will be submitted by the researcher as a thesis in partial fulfilment of the requirements for the postgraduate degree of Doctor of Clinical Psychology.

Who has reviewed the study?

The study has been reviewed by UCL Research Department of Clinical, Educational and Health Psychology / Reviewer Dr Georgina Charlesworth, Clinical Psychologist and specialist in research for people with dementia and family carers of people with dementia. The study has also been reviewed by the Camden and Kings Cross Research Ethics Committee.

Will participant's information be kept confidential?

All information collected about participants over the course of the study will be kept private unless there is a concern about risk. All documents that leave the care home will have participant's name removed with the exception of a consent form. This form will be kept securely. After the study has finished study data will be kept by UCL in a secure location.

No participants will be identified in any publication arising from the study. The results of the research study will be published in a report that will be available to you and in journals for medical professionals and other scientists. Your name or the name of your workplace will not appear in any report or publication. The researchers will also present the study findings to staff and interested parties at each care home. You are welcome to attend this presentation.

All participants will be asked to grant consent for their GP to be advised that they are participating in the study so that their GP can remain up to date with all matters to do with their care.

Will information that I give be kept confidential?

Information about yourself (name, address and telephone number) will be held by the Care organisation. Information that you disclose about the prospective participant will be held by the researcher.

What do I have to do now?

If you think that the prospective participant would be interested and you are able to discuss this with the researchers, please fill in the attached 'Invitation to Act as Personal Consultee' form and include your name, contact number and a convenient time when the researchers can contact you. We would be grateful if you could return the 'Invitation to Act as Personal Consultee' within two weeks of the date of our letter. Please also retain the 'Personal Consultee Declaration' form and the spare stamped addressed envelope as we may ask you to complete this once you have spoken to the researchers.

If you think that the prospective participant would be interested but you are not sure about whether you would like to talk about this with the researchers, then please suggest who else could be approached.

If you think that the prospective participant would **not** be interested in taking part, then it is important that you still complete the accompanying form entitled 'Invitation to Act as Personal Consultee'. A stamped addressed envelope is provided. We would be grateful if you could return the 'Invitation to Act as Personal Consultee' form no later than two weeks from the date of our letter.

What if there is a problem?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, UCL complaints mechanisms are available to you. Please report the complaint through research-incident@ucl.ac.uk at the Joint Research Office, UCL, Gower Street, London WC1E 6BT. Telephone: 020 3447 5199.

In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. Please make the claim in writing to Dr Aimee Spector who is the Chief Investigator for the research and is based at University College London. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

For more information about this research, please contact:

If you would like to know more, please contact the Researchers, Caroline Saint at [REDACTED] or Judy Murrill at [REDACTED]. Alternatively you can contact the Chief Investigator Dr.Aimee Spector, on [REDACTED], or by writing to the address on the letterhead.

If you are unsure about taking the role of consultee and would like seek advice from an independent person who is not associated with the project, please contact:

Dr Chris Barker
Department of Clinical, Educational and Health Psychology
UCL
Gower Street
WC1E 6BT
Email: [REDACTED]


Thank you for thinking about helping us with this research study

Caroline Saint
Researcher/Trainee Clinical Psychologist

Judy Murrill
Researcher/Trainee Clinical Psychologist

Dr Aimee Spector
Chief Investigator/Senior Lecturer in
Clinical Psychology
University College London

Dr Janine Hayward
Chartered Clinical
Psychologist

<p>RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY</p> <p>University College London Gower Street London WC1E 6BT General Enquiries Tel: +44 (0)20 7679 1897 Fax: +44 (0)20 7916 1989 http://www.ucl.ac.uk/clinical-psychology/</p>	
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PERSONAL CONSULTEE DECLARATION

Study Title: SettleIN: Exploring adjustment to care homes for people with dementia.
A feasibility pilot study (Doctoral Student Study)
Patient Number:
Researchers: Caroline Saint and Judy Murrill

Please
initial

1. I confirm that I have read and understood the Information for Personal Consultees (version , dated) for the study	
2. I confirm that I have had time and opportunity to ask questions about the study or my role as a Personal Consultee	
3. I understand the purpose of the project and what the participant's (my partner, friend or relative's) involvement would be. In my opinion, they would not object to taking part in the study	
4. I understand that participation in the project is voluntary and that the participant would be withdrawn if they do not wish to continue participating and the participant would not have to give a reason.	
5. I understand that if the participant were withdrawn from the project, this would not affect in any way the care or treatment they receive, or affect their legal rights.	
6. Please also indicate if in your opinion, the participant would consent to inform their GP of their participation in the study. If consent is not granted, the GP will not be informed however the participant may still be involved in the study.	<p>Please circle one option:</p> <p>Inform GP / Do not Inform GP</p>

Name of Consultee	Date	Signature
Name of person who has discussed the study and provided me with information (usually principal researcher)	Date	Signature
Principal Researcher	Date	Signature

Please complete *both* copies of this form and keep one for yourself. Please send the other copy in the stamped addressed envelope provided, thank you.

Staff information sheets and consent forms

Staff information sheet and consent form

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

University College London Gower Street London WC1E 6BT

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<http://www.ucl.ac.uk/clinical-psychology/>



SettleIN: Exploring adjustment to care homes for people with dementia. A feasibility pilot study

(Doctoral Student Study)

Information for staff about the research

Version ...**0.7**....., Date

You are invited to participate in a research project to help develop and test an intervention that aims to support healthy adjustment to new accommodation for people with dementia who have recently relocated from independent or family based care. The intervention is based on best practice identified in research to date for supporting positive adjustment and minimising negative factors influencing adjustment. It attempts to provide staff and carers with a process tool; a manualised, standardised yet flexible, person centred approach to supporting healthy adjustment in people with dementia. The study will be conducted by Caroline Saint and Judy Murrill, as part of their training at University College London and will be submitted as a thesis in partial fulfilment of the requirements for the postgraduate degree of Doctor of Clinical Psychology. Before you decide if you want to join, it's important to understand why the research is being done and what it would involve for you. So please consider this leaflet carefully and ask the researchers any questions you may have.

Why are we doing this research?

Research shows that admission into a residential care home for people with dementia (PwD) has been linked with both positive and negative psychological outcomes for both the resident and their carers. Whilst some PwD adjust spontaneously to care home placement (adjustment commonly taking between two to four weeks or as long as six months) many never adjust at all or adjustment is complex and linked to cognitive and behavioural decline. Therefore, support for healthy adjustment is needed. This study is developing and testing a new intervention to help support successful and healthy adjustment in people with dementia when they relocate from independent or family care into a care home

Why have I been invited to take part?

You have been invited to join the study because you currently work at one of the care homes that have agreed to take part. Your manager has given permission for you to attend the training and to take part in other activities related to the research if you choose to do so.

Do I have to take part?

No: it's up to you. Please read through this information sheet and think carefully about whether you want to take part. We invite you to attend a meeting with a researcher at your workplace about the study. If you have any questions about the study, you can ask the researcher then. If you are willing to take part in the study, we will ask you to sign a consent form to show you have agreed to take part.

If you decide that you do not want to take part or you decide to withdraw from the study you do not have to tell us why, and any reason you do give will not be shared with your manager.

What will happen if I take part?

As a key worker for a resident participating in this study, you will be randomised into one of two groups. One group will be asked to deliver the SettleIN programme, with your manager's support. The other group will provide care as usual. This means that, depending on the group the resident you support is assigned to, you will be assigned to either the SettleIN group or the care as usual group.

If you agree to take part you will be asked to do the following, regardless of the group you are assigned to:

1. Complete some questionnaires about yourself (demographic information, qualifications, job details etc.) and your knowledge and attitudes towards dementia. These will take approximately 15 minutes and will be paper and pen based.
2. Complete some questionnaires about the participant/s you are caring for and who are involved in the research (demographic information, goal attainment, mood, adjustment). These will take approximately 20-70 minutes (considerably less, depending on availability of relevant family carer) and will be paper and pen based.

If you agree to take part and you are assigned to the SettleIN group you will also be asked to do the following:

3. Attend the one to one training programme, which will be held at the care home where you work and will be approximately 1 hour and 15 minutes long. You may also be asked to attend one or two group supervision sessions of approximately an hour, to support you in applying what was learned at the workshop to your clinical work with patients.

There will not be any test or quiz at the end of the training programme.

4. Apply the adjustment tool; with colleagues and/or the researcher assess the adjustment needs of the person with dementia (participant) and identify the intervention programme modules most appropriate for the participant. Each assessment should take a maximum of 30 minutes to complete.
5. Over the intervention period (currently planned for one month) complete and / or facilitate the completion of the intervention modules with the participant as relevant (i.e. if the module involves talking with the participant about their move it may involve organising for a psychologist to attend to do this or if the module involves creating a life book it may involve the staff member interviewing the

participant and their family to gather information to create a life book and ask the participant and family to contribute photographs. Please note that there is separate guide on how to go about this activity). Activities may range from 30 minutes to one hour.

6. Complete field notes (using quick, simple templates that are provided) to provide information about what was done and how practical and feasible it was to do it, and its impact. This is expected to take no more than 5 minutes.
7. At the end of the intervention we will invite you to discuss your thoughts and ideas about the practicality, feasibility and impact of the intervention. This will involve you taking part in a face-to-face or telephone based interview lasting approximately 30 minutes. If face-to-face it will be held at the care home where you work and take place within a month of completing the intervention.

What are the possible benefits of taking part?

All participating staff will receive experience of participating in research and a certificate to add to their employment portfolio.

There is a 50% chance that you will be allocated to the SettleIN group. We hope that engaging in the SettleIN intervention, will mean that those within this group could potentially benefit from an improvement of skills and/or knowledge about healthy, positive adjustment and prevention of adverse reactions in patients with dementia. We hope that the intervention will help staff provide the best care possible for their patients, potentially leading to a consistent, standardised yet flexible admission support process, which may enhance their quality of life.

It is also hoped that this study will help us to improve relocation and transitions for people with dementia in general and make staff delivery of effective admission and adjustment support easier for staff, families and patients.

What are the risks of taking part?

We do not expect there to be any risks of taking part in this study over and above those which would be part of your normal job. However if being involved in this research really does not suit you, for example if you find it distressing, you are free to withdraw at any point.

Although it is not anticipated that the questionnaires or face-to-face will cause any stress or distress, this is a possibility. If, for any reason you do become distressed the researcher, who is a clinician with appropriate training, will be available to help you manage this in the most appropriate way (i.e. accompanying you to a private room).

Participating in the research involves a time commitment and you may experience some minimal inconvenience from attending training and answering questionnaire/completing observational measures. As a small token of appreciation for the time and effort involved in taking part we will provide you with a £10 high-street shopping voucher.

What happens if I don't want to carry on with the study?

You can withdraw from the study at any time, without giving a reason. If you choose to withdraw from the study this will not affect your employment in any way.

Contact details

If you would like to know more, please contact the Researchers, Caroline Saint and Judy Murrill or the Chief Investigator Dr. Aimee Spector, on [REDACTED], or by writing to the address on the letterhead.

Thank you for reading this – please ask any questions you may have.


Yours

Caroline Saint
Trainee Clinical Psychologist

Judy Murrill
Trainee Clinical Psychologist

Dr Aimee Spector
Senior Lecturer in Clinical Psychology
University College London

Dr Janine Hayward
Chartered Clinical Psychologist
External Supervisor

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Participant identification Number:
 Name of Researcher:
Title of project: SettleIN: Exploring adjustment to care homes for people with dementia. A feasibility pilot study

CONSENT FORM

Please *initial* box

1. I confirm that I have read and understand the information sheet dated
 (version 0.6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I confirm that I have had sufficient time to consider whether or not want to be included in the study

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my occupational status or legal rights being affected.

4. I understand that data collected during the study may be looked at by members of the research team from University College London or from regulatory authorities—where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

5. I agree to take part in the above study.

Name of Participant	Date	Signature

Name of Person	Date	Signature

taking consent

When completed, 1 for staff member; 1 for researcher as part of the study documentation; 1 (original) for researcher site file

Nominated Consultee information and consent forms



NOMINATED CONSULTEE INFORMATION SHEET

Version ...0.6....., Date[to be entered].....

Study Title: SettleIN: Exploring adjustment to care homes for people with dementia: A feasibility pilot study

What is the purpose of the study?

Research shows that admission into a residential care home for people with dementia (PwD) has been linked with both positive (e.g. Bekhet et al, 2008) and negative psychological outcomes for both the resident and their carers (Sury, Burns & Brodaty, 2013). Whilst some PwD adjust spontaneously to care home placement (adjustment commonly taking between two to four weeks or as long as six months (Ellis 2010; Hodgson et al, 2004) many never adjust at all or adjustment is complex and linked to cognitive and behavioural decline (e.g. Kydd 2001; Wilson et al, 2007). Therefore, support for healthy adjustment is needed. This study is developing and testing a new intervention to help support successful and healthy adjustment in people with dementia when they relocate from independent or family care into a care home.

The project has been approved by Camden and Kings Cross Research Ethics Committee. We shall make sure that the project is safe for each participant and does not cause them undue distress. To help with this, the researchers need information from people who have known the participant for some time or those who have agreed to be consulted on such matters.

Why have I been contacted?

We are intending to recruit participants to this project who may not have the capacity to consent to their participation. This means that they may not be able to judge for themselves whether they would like to take part or refuse. The project includes such participants because we are studying the impact of an intervention for people with dementia, an illness which limits a person's ability to give consent.

If you do know the prospective participant, you may be able to advise us about any possible difficulties they may have in taking part. You also may be able to tell us how they may communicate that they wanted to cease being involved with the project.

To help decide if the prospective participant should join the study, we'd like to ask your opinion whether or not they would want to be involved. We would ask you to consider what you know of their wishes and feelings, and to consider their interests. Please let us know of any advance decisions they may have made about participating in research. These should take precedence.

When thinking about the wishes and interests of the prospective participant, it is important that you should set aside any of your own views about the project.

What is required of each participant?

Participants of the study will be randomised into one of two groups; one group receiving a SettleIN intervention, designed to promote healthy adjustment, the other group will receive care as usual. This will allow us to make comparisons between the impact of the SettleIN programme and natural adjustment.

The SettleIN intervention provided in this study directly involves dementia care staff, carers and residents of care homes so that a wide range of views can be gathered regarding the feasibility of the intervention and whether a positive impact on adjustment was indicated. In order to explore adjustment in all participating residents, we would do the following:

- 1) The principal researcher will look at all participant's medical records to obtain details about any relevant diagnoses, medication, health complexities and pre-admission care planning.
- 2) Residents (and/or their carer) and staff will be asked to complete standardised and individualised goal oriented assessments before and after the intervention and at one month following the completion of the intervention. Assessments will take no more than 1.5 hours and be predominantly completed with the carer or staff member.

This will help the researchers to assess whether any impact on healthy adjustment has occurred over time and whether the intervention was practical and feasible to deliver.

Taking part in the study does not involve any lifestyle restrictions. Participants will carry on with their everyday activities as normal though may be offered additional tailored activities while participating in the study.

What are the possible disadvantages and risks of taking part?

As support for adjustment to care should be carried out as part of routine relocation to a care home the risk is seen to be minimal and equivalent to that encountered as part of daily care. However if participants find observations significantly distressing they may be withdrawn from the study. A decision to withdraw will be made where the participation is no longer judged to be in the person's best interests. Decisions will be made by the principal researcher through discussion with the Chief Investigator and the person's direct care team. We will need to use all data collected in the study, up to the point of withdrawal.

We will keep you fully informed during the study so you can let us know if you have any concerns or you think that the participant should be withdrawn.

What are the possible benefits of taking part?

We hope that research of this kind will result in improved dementia care, particularly at the adjustment phase of relocation. There is a lack of evidence-based intervention for this phase of care for people with dementia i.e. post independent living and before end of life care in dementia; therefore this study may also lead to changes in the way that care is provided in this population.

There is a 50% chance that each participating resident will receive a programme designed to support adjustment to residential living. Previous research has found that

when patients with dementia receive person centred adjustment support, adverse reactions to relocation are prevented and patients can thrive in care home settings.

Who is organising and funding the research?

The research is being organised and funded by the Research Department of Clinical, Educational and Health Psychology, part of University College London. This project will be submitted by the researcher as a thesis in partial fulfilment of the requirements for the postgraduate degree of Doctor of Clinical Psychology.

Who has reviewed the study?

The study has been reviewed by UCL Research Department of Clinical, Educational and Health Psychology / Reviewer Dr Georgina Charlesworth, Clinical Psychologist and specialist in research for people with dementia and family carers of people with dementia. The study has also been reviewed by the Camden and Kings Cross Research Ethics Committee.

Will participant's information be kept confidential?

All information collected about participants over the course of the study will be kept private unless there is a concern about risk. All documents that leave the care home will have participant's name removed with the exception of a consent form. This form will be kept securely. After the study has finished study data will be kept by UCL in a secure location.

No participants will be identified in any publication arising from the study. The results of the research study will be published in a report that will be available to you and in journals for medical professionals and other scientists. Your name or the name of your workplace will not appear in any report or publication. The researchers will also present the study findings to staff and interested parties at each care home. You are welcome to attend this presentation.

Will information that I give be kept confidential?

Information about yourself (name, address and telephone number) will be held by the Care organisation. Information that you disclose about the prospective participant will be held by the researcher.

What do I have to do now?

If you think that the prospective participant would be interested and you are able to discuss this with the researchers, please fill in the attached 'Invitation to Act as Nominated Consultee' form and include your name, contact number and a convenient time when the researcher can contact you. We would be grateful if you could return the 'Invitation to Act as Nominated Consultee' within two weeks of the date of our letter. Please also retain the 'Nominated Consultee Declaration' form and the spare stamped addressed envelope as we may ask you to complete this once you have spoken to the researchers.

If you think that the prospective participant would be interested but you are not sure about whether you would like to talk about this with the researchers, then please suggest who else could be approached.

If you think that the prospective participant would **not** be interested in taking part, then it is important that you still complete the accompanying form entitled 'Invitation to Act as Nominated Consultee'. A stamped addressed envelope is provided. We would be grateful if you could return the 'Invitation to Act as Nominated Consultee' form no later than two weeks from the date of our letter.

What if there is a problem?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, UCL complaints mechanisms are available to you. Please report the complaint through research-incident@ucl.ac.uk at the Joint Research Office, UCL, Gower Street, London WC1E 6BT. Telephone: 020 3447 5199.

In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. Please make the claim in writing to Dr Aimee Spector who is the Chief Investigator for the research and is based at University College London. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

For more information about this research, please contact:

If you would like to know more, please contact the Researcher, Caroline Saint at [REDACTED] or Judy Murrill at [REDACTED]. Alternatively you can contact the Chief Investigator Dr.Aimee Spector, on [REDACTED], or by writing to the address on the letterhead.

If you are unsure about taking the role of consultee and would like seek advice from an independent person who is not associated with the project, please contact:

Dr Chris Barker
Department of Clinical, Educational and Health Psychology
UCL
Gower Street
WC1E 6BT
Email: [REDACTED]

Thank you for thinking about helping us with this research study

Caroline Saint
Researcher/Trainee Clinical Psychologist
Clinical Psychologist

Judy Murrill
Researcher/Trainee

Dr Aimee Spector
Senior Lecturer in Clinical Psychology
Psychologist
University College London

Dr Janine Hayward
Chartered Clinical
External Supervisor

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 Fax: +44 (0)20 7916 1989
<http://www.ucl.ac.uk/clinical-psychology/>



NOMINATED CONSULTEE DECLARATION

Study Title: SettleIN: Exploring adjustment to care homes for people with dementia: A feasibility pilot study (Doctoral Student Study)

Patient Number:

Researchers: Caroline Saint and Judy Murrill

Please initial

1. I confirm that I have read and understood the Information for Nominated Consultees (version 0.4, dated) for the study	
2. I confirm that I have had time and opportunity to ask questions about the study or my role as a Nominated Consultee	
3. I understand the purpose of the project and what the participant's involvement would be. In my opinion, they would not object to taking part in the study.	
4. I understand that participation in the project is voluntary and that the participant would be withdrawn if they do not wish to continue participating and the participant would not have to give a reason.	
5. I understand that if the participant were to be withdrawn from the project, this would not affect in any way the care or treatment they receive, or affect their legal rights.	
6. Please also indicate if in your opinion, the participant would consent to inform their GP of their participation in the study. If consent is not granted, the GP will not be informed however the participant may still be involved in the study.	Please circle one option: Inform GP / Do not Inform GP

Name of Consultee	Date	Signature
-------------------	------	-----------

Name of person who has discussed the study and provided me with information (usually principal researcher)	Date	Signature
Principal Researcher	Date	Signature

Please keep a copy of this form for yourself. Please send the original copy in the stamped addressed envelope provided, thank you.

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

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Fax: +44 (0)20 7916 1989
<http://www.ucl.ac.uk/clinical-psychology/>



INVITATION TO ACT AS NOMINATED CONSULTEE

Study Title: SettleIN: Exploring adjustment to care homes for people with dementia.
A feasibility pilot study (Doctoral Student Study)

Patient Number:

Researchers: Caroline Saint and Judy Murrill

I think that the prospective participant may NOT like to take part in the project.	I agree with this statement Signed
I think that the prospective participant may be interested in taking part and I would like to discuss this with the researcher. I have provided a contact number at the times I can be contacted below.	I agree to being contacted further about the study Signed
I think that the prospective participant may like to take part in the project – but I do not wish to be consulted. I have provided information about an alternative contact person below (if possible).	I do not agree to being contacted further about the study Signed

Contact details:

Name:

Contact number:

Most convenient time(s) to be contacted:

Thank you for completing the form. Please return it in the stamped addressed envelope or leave it F.A.O Caroline Saint or Judy Murrill at care home.

GP information sheet



Department of Clinical, Educational and Health Psychology
University College London
Gower Street London WC1E 6BT
Phone: [REDACTED]
Email: [REDACTED]

GENERAL PRACTITIONER INFORMATION SHEET

Study Title: SettleIN: Exploring adjustment to care homes for people with dementia. A feasibility pilot study (Doctoral Student Study)

Your patient, [REDACTED], is taking part in a research study. Please find enclosed a copy of the 'Participant Information Sheet', which they have received.

The study will be conducted by Caroline Saint and Judy Murrill, Trainee Clinical Psychologists, as part of their training at University College London. They are being supervised by Dr. Aimee Spector, academic staff member at University College London and Professor Clive Ballard, academic staff at Kings College London, both of whom are Clinical Psychologists.

This study is a pilot of a new intervention designed to support healthy adjustment of people with dementia who relocate from independent or family supported living into a care home.

Participants of the study will be randomised into one of two groups; one group receiving a SettleIN intervention, designed to promote healthy adjustment, the other group will receive care as usual. This will allow us to make comparisons between the impact of the SettleIN programme and natural adjustment.

The SettleIN intervention is for the residents of care homes and will involve staff and/or carers facilitation of activities within the intervention programme collaboratively

with the resident. In order to study the effects of the intervention on adjustment, the following will be undertaken:

- 1) The principal researcher will look at all participants' medical records to obtain details about any relevant diagnoses, medication, health complexities and pre-admission care planning.
- 2) All residents (or their carer) and participating staff will be asked to complete standardised and individualised goal oriented assessments before and after the intervention and at one month following the completion of the intervention.

This will help the researchers to assess whether any impact on healthy adjustment has occurred over time and whether the intervention was practical and feasible to deliver.

Taking part in the study does not involve any lifestyle restrictions. Participants will carry on with their everyday activities as normal though may be offered additional tailored activities while participating in the study.

The study will **not** affect your patient's current or future treatment.

The results of this study are expected to be published in relevant journals. The information collected in the study will be anonymous and patients will not be identified in any report/publication. All information is confidential and will not be disclosed to anyone else unless there is a concern about risk to the participant or someone around them. If this is the case the researcher will discuss their concerns with the participant's care team.

The local Ethics Committee reviews all proposals for research using human subjects before they can proceed. The Camden and Kings Cross Research Ethics Committee has granted the appropriate permission for this study.

Thank you for reading this information sheet. Please do not hesitate to contact me at the above address or email if you feel there is anything that is not clear, or if you would like more information.

Kind regards

Caroline Saint
Trainee Clinical Psychologist

Judy Murrill
Trainee Clinical Psychologist

Appendix E – SettleIN Training Slides

SettleIN Training

Part of the SettleIN Feasibility Research
By Judy Murrill and Caroline Saint, Trainee Clinical Psychologists, University College London
SettleIN programme Developed by Dr Janine Hayward, Chartered Clinical Psychologist



Agenda

- ◆ What is SettleIN?
- ◆ SettleIN Research and your role
- ◆ What do we mean by Adjustment and Healthy Adjustment?
- ◆ How to use SettleIN?

What is SettleIN?

- ◆ A programme for care home staff to help new residents with dementia, quickly and successfully adjust to their new home
- ◆ Manualised programme
- ◆ Aims to promote healthy, positive adjustment

SettleIN Research

- ◆ Your Care Home is trialling SettleIN which is part of a Major Research Project at University College London
- ◆ **HOW THE RESEARCH WORKS**
 - ◆ Residents will be randomly allocated to the **SettleIN group** (involves care staff and new residents with dementia testing the SettleIN programme) or the **care as usual group** (new residents receive the standard care from care staff in their new care home)
 - ◆ Before starting the programme we complete questionnaires with the resident, you, and if possible the resident's family
 - ◆ You run SettleIN
 - ◆ We repeat the questionnaires at the end of four weeks once SettleIN is finished
 - ◆ We repeat the questionnaires again four weeks later
 - ◆ We interview you (a 30 minute chat) about how easy (or not!) SettleIN was to use and your find out more about your opinions
 - ◆ We use the questionnaires and your interview feedback to see what impact SettleIN has on residents and staff

SettleIN Programme Structure and How to do it

- ◆ Modules (a series of activities)
 - ◆ 4 week programme of activities
 - ◆ do each activity (combine SettleIN activities with usual care as well as separately)
 - ◆ record progress and resident's response
- ◆ Future Planning Conversation
 - ◆ review of progress on module activities after four weeks
 - ◆ Think about how activities can be continued

SettleIN Modules

- ◆ **Orientation** – getting to know their way around and feel safe
- ◆ **Lifestyle** – routines and stimulation
- ◆ **Family and Friends** – staying connected and keeping family informed
- ◆ **Identity** – being known, respected and understood

Optional module:

- ◆ **Struggling to Engage**- Supporting residents who seem disengaged or isolated

For each activity write down the information gathered on the forms provided

Module and Activities Monitoring & Recording

When delivering the modules:

- ◆ Each time an activity is done:
 - ◆ Use *SettleIN Recording Progress Sheets* to record brief notes about what was done, by whom and how the resident responded. Also note how you felt.
 - ◆ These should be brief and similar to recording care plan progress notes/end of shift notes
- ◆ Tick off when an activity has been done on the *SettleIN Module Tracker*. Use the *SettleIN Module Tracker* to assess how much of a module has been completed and how much is yet to be done.

Questions

??????????

Appendix F – Settlement Fact Sheet

SettleIN Training: Factsheet

What is SettleIN?

- ◆ A programme for care home staff to help new residents with dementia quickly and successfully adjust to their new home
- ◆ Manualised programme
- ◆ Aims to promote healthy, positive adjustment

How the research works:

- ◆ Residents will be randomly allocated to **the SettleIN group** (involves care staff and new residents with dementia testing the SettleIN programme) or **the care as usual group** (new residents receive standard care from care staff in their new care home)
- ◆ Before starting the programme we complete questionnaires with the resident, you, and if possible the resident's family
- ◆ You run SettleIN
- ◆ We repeat the questionnaires at the end of four weeks once SettleIN is finished
- ◆ We repeat the questionnaires again four weeks later (follow-up)
- ◆ We interview you (a 30 minute chat) about how easy (or not!) SettleIN was to use and find out more about your opinions
- ◆ We use the questionnaires and your interview feedback to see what impact SettleIN has on residents and staff

The benefits of taking part:

- ◆ Free training
- ◆ High street vouchers
- ◆ Certificates for your professional development
- ◆ Experience being involved in research and working with University College London (UCL).
- ◆ You will have made a major contribution to a programme to improve the lives of care home staff and new care home residents with dementia.

What do we mean by healthy adjustment?

- ◆ Adjustment is the process of adapting or becoming used to a new situation (Oxford Dictionaries Online, 2010).
- ◆ Healthy adjustment is the process of adapting or becoming used to a new situation in a positive way without negative side effects such as depression or rapid cognitive and physical decline

What does research says about adjustment?

- ◆ There are positive factors that can help adjustment: new residents being in a home-like environment, having a buddy system, working with families where possible, doing activities that are meaningful to the resident.
- ◆ There are also negative factors which are detrimental to adjustment: loss of familiar surroundings, lifestyle and people, feeling abandoned by family.
- ◆ SettleIN aims to incorporate the positive factors into resident's experience of moving in as well as protecting against the negative factors that may occur.

Support

- ◆ Contact Judy Murrill or Caroline Saint:

[REDACTED]

[REDACTED]

Appendix G – [REDACTED]

Appendix H – Interview Schedule

Staff Interview Schedule

Feasibility Questions (analysed by Saint)

What has your experience been of delivering the programme?

What worked? What didn't work?

What challenges have you experienced?

How easy or difficult has the programme been to do alongside your day to day work?

How easy or difficult has it been to finish the programme in the 4-6 weeks?

What do you think other care home staff would think of this programme?

Would you suggest any particular changes to the programme?

Adjustment Questions

What is your understanding of adjustment?

Has completing SettleIN changed your understanding of the adjustment process? If so, in what ways?

Has your knowledge of how to support somebody to adjust changed?

What do you think needs to happen for a new resident to adjust well?

What can you as care home staff do to support adjustment? What needs to happen within the care home to support adjustment?

Before doing this programme what were your expectations of how well a new resident would adjust? Have these expectations changed since completing the programme?

Was any part of this process helpful for your professional development?

Appendix I – Excerpt of coded transcript

Interviewer: I say these questions so quickly. Has your knowledge of how to support a new resident to adjust changed?

Participant: I've got my knowledge now (laughing). I didn't have before, now I've got my knowledge.

I: Can you tell me a bit more about that?

P: Yes, the life book, for me the life history, the life book, the family tree, the whiteboard is excellent. Signs, wasn't in my mind before to put signs, all this things which I learn.

I: And how do you think those things help someone adjust?

P: (Pause) if you are going to apply, and do it for them, then I believe that it will help. Maybe not everybody, because the type of dementia is difference from one to another one, but we have to try, then we are going to now if it is helpful or not. If we do not try, then we never.

I: And doing the life story, how is that helpful, do you think?

P: To find out about (resident) things, and to have a conversation about it, we didn't know that she played piano before, I just found out from doing this programme that she played piano.

I: Amazing

P: And...

I: Right. Final set. What do you think needs to happen for a new resident to adjust well?


P: Needs to happen for a new resident. We need to find out about a new resident, everything that we can, to be able to provide according to their needs. I think we are going back all the time to the life history, it is very important. Because, every question, we are going back to the life history, and I think this is key to provide very good care.


I: So we've got getting to know the new resident. Getting to know life history


P: The family, also, the family is playing a very big role supporting us carers to know more about the resident, to collaborate, we need help, or we ask them for something, can be anything from clothes to life history to a picture, to memory book, anything.


I: So for a new resident to adjust we need to get to know more about them, get to know their life history, and work with the family


P: Yes, work with the family. And also, in the same time, not forget the GP to find out about the medical condition, to be able to provide the food, the right food for them, to provide the care, the right physical care.


 Judy gained knowledge through the programme


 Judy specific activities of the programme help adjustment

 Judy expectation that the activities help adjustment


 Judy individual differences in residents might make more/less successful


 Judy responsibility to try to support adjustment


 Judy gained knowledge about the resident had not known before

 Judy information about resident important to support adjustment

 Judy knowing life history important to good care

 Judy family key in providing knowledge/resources for resident

 Judy adjustment includes working with family

 Judy consider physical health

Appendix J – Picture of Theme Map

