

## **Helping staff to implement psychosocial interventions in care homes: augmenting existing practices and meeting needs for support**

### **Running title**

Implementing psychosocial interventions in care homes

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### **Key words**

Care homes; interventions; implementation; qualitative, dementia; staff

## **Key points**

- Effective training interventions are needed to translate effective nonpharmacological therapies into widespread practice in care homes.
- Contextual factors such as staff morale, interpersonal relationships within the home and the existing use and perceived value of nonpharmacological interventions influence the success of staff training programmes.
- Staff value interventions that promote understanding of their role and ensure that expectations regarding the implementation of psychosocial interventions are shared across the care home.
- Enthusiasm exists for implementing psychosocial interventions within everyday work. Successful implementation requires a collaborative approach that utilises the expertise of staff and engages relatives and the whole care team.

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## **Word count**

3499

## **ABSTRACT**

**Objectives:** To contribute to an optimised training programme for care staff that supports the implementation of evidence based psychosocial interventions in long term care.

**Methods:** Qualitative study involving focus group discussions with 119 care home staff within 16 care homes in the UK. Part of wider clinical trial aimed at developing and evaluating an effective and practical psychosocial intervention and implementation approach for people with dementia in long term care. Inductive thematic analysis was used to identify themes and interpret the data.

**Results:** The findings highlighted that successful training and support interventions must acknowledge and respond to “whole home” issues. Three overarching themes emerged as influential: the importance of contextual factors such as staff morale; interpersonal relationships within the home; and experience and perceived value of the proposed intervention.

**Conclusions:** Priority must be given to obtaining the commitment of all staff, management and relatives to the training programme and ensuring that expectations regarding interaction with residents, participation in activities and the reduction of medication are shared across the care home.

## **Introduction**

Over the past decade dementia care guidelines and consensus statements (Salzman et al., 2008, Alzheimer's Society, 2011) have repeatedly endorsed the use of nonpharmacological interventions for managing behavioural and psychological symptoms of dementia. Despite challenges to conducting large scale, randomised studies in this area (Cohen-Mansfield, 2001), there is now strong evidence that psychosocial interventions such as behavioural management techniques, cognitive stimulation and exercise, can improve key mental health outcomes and/or reduce antipsychotic use among people with dementia (Seitz et al., 2012, Testad, 2014). Through daily contact with residents, care professionals in long-term care facilities are uniquely positioned to deliver psychosocial interventions to improve the quality of care and the ensuing quality of life of people with dementia. Yet, it is well documented that the implementation of evidence based nonpharmacological interventions remains limited and none has achieved widespread implementation in a health or care setting (Fossey, 2014).

A recent review of evidence examining the obstacles to successful implementation underlined the necessity of collaborative training programmes that engage staff and acknowledge their expertise, preferences and concerns from the outset. (Lawrence et al., 2012). However, to date there has been a plethora of non-evidence based training schemes and manuals (Fossey, 2014) and a lack of attention to the variation in care environment and obstacles to effective training and delivery (Lawrence et al., 2012). Person-centred care training interventions have been found to deliver

significant benefits including a reduction in antipsychotic use and improvement in symptoms of agitation, yet further work is needed to optimise these interventions and confer more consistent benefits (Testad, 2014). Qualitative research and process evaluation embedded in trials of training interventions allow a deeper understanding of the context in which interventions will be used and enable us to identify how they can be implemented as part of routine practice in the long term (Vernooij-Dassen, 2014). Here, we present findings from a qualitative study of care home staff perspectives aimed at developing a sustainable optimised nonpharmacological intervention and training programme. The findings have been used to inform a definitive randomised multi-centre trial (Whitaker, 2014).

## **Methods**

### *Design*

This study was part of pilot cluster-randomised trial involving 16 care homes in London, Oxfordshire and Buckinghamshire. Eight care homes represented a convenience sample of local care homes known to be willing to participate in research and eight were identified randomly from all care homes rated as “adequate” or “better” on the UK Care Quality Commission (CQC) register. Half of the locations were in a large city and the others were equally divided between small provincial towns and rural locations. Three of the providers were government funded local authorities, nine were private care companies and four were voluntary organisations / charities in the “not-for profit” sector. Each cluster received training in a random allocation of four key interventions with established efficacy: person centred care,

antipsychotic review, social interaction and pleasant events and exercise (see full trial protocol (Whitaker et al., 2013)). Focus groups were undertaken in each of the 16 participating care homes prior to randomisation to gain insight into the shared beliefs and practices of care home staff.

### *Data Collection*

Purposive sampling was conducted in consultation with the care home manager to obtain the perspectives of staff in a variety of roles with a range of experience and expertise. Invitation letters were distributed to potential participants, which emphasised that the focus group discussion (FGD) was an opportunity for staff to share their views on the forthcoming training programme and how it should be delivered. Where possible the focus groups consisted of 8 to 12 members of the care team. Participants included 53 care assistants (45%), 30 senior care assistants (25%), 13 activity therapists (11%), 6 registered nurses (6%), 5 deputy managers (4%), 2 managers (2%) and 10 other staff (8%). The FGDs aimed to explore successful working practices, challenges and priorities within the care home as well as specific attitudes and beliefs surrounding psychosocial interventions and the support that would be required to deliver them. The topic guide was revised iteratively allowing the main concerns of participants to be explored in depth. Differences of opinion were examined and participants were encouraged to express both positive and negative views. The FGDs were recorded and transcribed verbatim; observations and impressions were routinely noted at the end of each group.

## *Data Analysis*

Thematic analysis was undertaken to identify themes and interpret the data. Data were separated into meaningful fragments and labelled with codes. The constant comparison method (Glaser, 1978) was used to delineate similarities and differences between the codes and to develop categories and sub-categories that were verified and refined as the analysis proceeded. Ideas about themes and their relationships were recorded in theoretical memos, regularly discussed in team meetings and critiqued by care professionals, carers and people with dementia during conference presentations of the data. Multiple coding was also conducted on three transcripts to allow researchers to identify and discuss any alternative interpretations. This led to the development of three key themes: “undervalued and understaffed”; “centrality of relationships” and “existing practices and desire for support”. Quotes illustrating these themes are presented in Table 1.

## **Results**

### **Undervalued and understaffed**

A sense of being undervalued and overworked pervaded the FGDs and provided essential information about the context in which the training programme was to be delivered.

### **Lack of recognition**

One of the most salient themes across the focus groups was the lack of recognition that staff experienced in the caregiving role. Participants discussed the negative portrayal of care homes in the media and the stigma and misconceptions that they encountered in social situations. This was thought to reflect the low priority afforded to older people by the government and the limited funds allocated to their care. Yet staff in a number of groups asserted that caring for a person with dementia was a highly skilled and demanding job of which they should feel proud. In some care homes this sense of being undervalued was compounded by the attitudes of managers and relatives who staff felt did not understand the challenges of working with people with dementia on a daily basis. Many participants stated that they hoped that the training programme would raise the status of dementia care. However, others were wary of receiving further criticism from a third party that had insufficient knowledge of the residents or the home. A related concern was dislike of the word “intervention”, used by the research team to denote the training programme, which some considered to imply criticism of existing practices within the home.

### **Lack of resources**

There was a consensus across the focus groups that limited budgets placed constraints on the care that staff could provide. Low staffing numbers and a perceived rise in the proportion of residents with dementia contributed to the view that “physically and mentally it is draining”. Participants explained that being “fully staffed, but understaffed” limited their involvement in activities, the feasibility of spending one-to-one time with residents and their ability to implement person



centred care. Lack of resources was considered an unavoidable reality that threatened to undermine any future intervention. Yet it was also hoped that in demonstrating the effectiveness of psychosocial interventions, the training programme might motivate more sceptical members of staff and encourage managers and care providers to commit greater resources to this type of work.

### **The centrality of relationships**

Staff members were unequivocal that their relationships with residents, relatives and each other constituted a key strength or difficulty within the home that governed existing practices and the type of support required.

### **Relationship with residents**

For many staff their relationship with residents underpinned positive working practices within the care home. These relationships were characterised by mutual respect and a sense of reciprocity. A large proportion of participants stressed that what they enjoyed most about their job was having the opportunity to talk to older people and find out about their lives. Another distinctive feature emerged as the willingness of staff to reveal aspects of their own lives in the working environment. This was also manifested in the informality of some interactions and the readiness of staff to “act a fool” or sing or dance or share jokes with residents. Some staff spoke about the inevitability of forming bonds with people with dementia, arguing that this was a prerequisite for a successful, trusting relationship. At the same time it was suggested that forming attachments was discouraged by “management” and could

lead to distress if residents became unwell. While colleagues often provided support in these circumstances, management typically did not.

### **Relationships with relatives**

It was not unusual for staff to describe strained relationships with relatives. A common complaint was that families do not always understand or seem able to accept how dementia can affect the individual, causing them to be impatient of other residents and unfairly critical of staff. Around half the groups suggested that it would be mutually beneficial to educate families about dementia as part of the intervention. The majority of these groups indicated that relatives had limited involvement in the life of the care home. However, evidence of more collaborative relationships emerged in which relatives appeared actively involved in meetings and a wide range of activities. This was not only seen to confer practical advantages, in terms of freeing up staff time, but also to contribute to a comfortable and relaxed environment.

### **Relationships within the team**

The cohesiveness of staff within the care home was considered key to the provision of high quality care. Three groups argued that the shared ethos of the team helped to mitigate the challenges posed by time pressures and low staffing numbers. Participants explained that meeting the needs of the residents required them to work collectively rather than as individuals with narrowly defined roles. Yet a recurring issue was the potential disjuncture between carers, who in some instances seemed

to provide the majority of daily care, and nurses who were responsible for writing care plans and daily reports. Divisions also emerged between day staff and night staff, care staff and management, and focus group participants and less “positive” members of staff. A common concern was that it would be difficult for the training programme to motivate and engage the whole team. Participants emphasised that this necessitated full managerial support and clear systems for communicating the purpose and structure of the training.

### **Use of psychosocial interventions: existing practices and desire for support**

Staff members were familiar with the proposed psychosocial interventions and had established views on the desirability and practicality of implementing them in their work.

### **Provision of person centred care**

While participants tended to offer narrow definitions of person centred care, often equating it with individualised care plans or resident choice of food and clothes, many demonstrated considerable knowledge of residents and recognised that this was fundamental to understanding, engaging and reassuring individuals. Staff acknowledged, however, that time pressures constrained their ability to respond to individual preferences and needs. Staff in three groups reflected on the enduring dominance of the medical model and the tendency to prioritise routines. Yet it was striking that all groups appeared receptive to receiving further training around person

centred care. Staff volunteered that there is always more to learn and that it would help to ensure that *all* staff apply the concept successfully.

### **The use of antipsychotic medication**

Participants in roughly half the care homes hoped that the training programme would help to reduce the use of antipsychotics within the home. Reported practices of annual or biannual reviews were considered inadequate, and staff complained that prescribing clinicians did not always take their views into account. Yet staff also expressed apprehension about reducing antipsychotics. There was widespread agreement that aggressive or agitated behaviour among people with dementia represented the most difficult aspect of working within care homes. Staff described a range of skills and psychosocial strategies for managing this behaviour, yet agreed that medication benefited some individuals. Three focus groups confided that medication was sometimes necessary for the care home itself, as it was not always possible to give residents the “positive attention” that was needed to avert aggressive behaviour. Some participants were uncertain how they would have time to attend to residents if antipsychotics were reduced.

### **Promoting interaction and activities**

Almost all the group discussions touched upon the value of spending one-to-one time with residents with the mutual benefits of talking cited with conviction. This was often identified as preferable to group activities, particularly for residents in the more advanced stages of dementia, as it allowed staff to focus on individual needs.

However, there was recognition that spending too long with an individual in the pressurised working environment could be construed as “dossing” and ultimately frowned upon by colleagues and / or management. Some staff identified quiet time with the individual during personal care as an invaluable opportunity to interact, yet others felt distracted by the task in hand and the need to complete it as quickly as possible. In contrast to one-to-one, activities were often considered the domain of the activity coordinator, whose hours varied considerably; here it was implied that the wider care staff neither expected nor knew how to provide these activities themselves. Variation also existed in the rigidity with which activities were defined with some placing greater emphasis on activities of daily living and purposeful rather than social activities.

Participation was considered dependent on residents’ mood and energy levels and as such required a flexible, but persistent approach. Participants were keen to point out that individual’s decision to take part was theirs to make. A related fear was that the training programme might impose activities, in a prescriptive way, on individuals who did not wish to be involved. However, most participants appeared hopeful that they may learn fresh ideas that would help to stimulate and engage residents. Many of the groups were clear that they hoped the training programme would increase the focus of management, residents and staff on activities within the care home and promote an interest and expectation among *all* staff to get involved.

## **Discussion**

The study confirms that successful training and support interventions for care home staff must acknowledge and respond to “whole home” issues such as environmental, care practice and attitudinal factors (Fossey et al., 2006). Three overarching themes emerged as influential: the importance of contextual factors such as staff morale and low staffing numbers; interpersonal relationships within the home; and the existing use and perceived value of the proposed interventions. The findings have important implications for developing an optimised psychosocial intervention and implementation approach (see Table 2) that will now be considered.

Evidence of commitment and expertise among care home staff contrasted sharply with the lack of value experienced in the role. Lack of recognition and low status among care staff (Innes, 2002) contributes to high turnover and psychological distress (Pitfield et al., 2011) and is reflected in the 2013 World Alzheimer’s Report mandate to value and develop the dementia care workforce. Recognising the essential, difficult and demanding work that they carry out must form the basis of any intervention. A collaborative approach that seeks the views of staff from the outset, provides positive feedback, and does not judge past or present care practices offers an effective method of engagement (Lawrence and Banerjee, 2010). Use of the term “intervention” should perhaps be avoided in this context given the critical connotations identified. Our study revealed optimism among staff that the training programme might, firstly, enhance their status among relatives, managers and care commissions and, secondly, encourage these parties to commit greater resources to delivering psychosocial care. This places a responsibility on training teams to promote the visibility of staff achievements within the care home. It also highlights the need to support the implementation of the training programme through involving

a wide range of stakeholders in its design and development. Examples of this include holding regular meetings, workshops, and events with family members, home owners, managers and policy makers to enable participation and feedback (Social Care Institute for Excellence, 2009).

A recent review of nonpharmacological interventions in long term care concluded that the time required to train staff and for staff to implement the interventions limited their feasibility (Seitz et al., 2012). In our study insufficient resources were similarly presented as an enduring barrier to implementing person centred care, reducing antipsychotic medication and undertaking activities within the workplace. Increasing the number of care staff and the amount of time available for psychosocial interactions may increase staff engagement in activities (Seitz et al., 2012). In the first instance, however, these data underline the necessity of minimising additional demands on staff time and of identifying and persuading staff of the potential for incorporating psychosocial interventions into routine clinical care (Lawrence et al., 2012). Examples of this include broadening definitions of activities to include those of daily living and reinforcing the value of one to one interaction during everyday care tasks. In some cases it may also be beneficial to challenge the perception that pharmacological interventions offer the most efficient and reliable means of managing behaviour and promoting a calm environment in nursing homes (Kolanowski et al., 2010). Finally, concerns around work pressures reinforce the importance of reaching a consensus with managers and staff at the outset regarding the time commitments of training and implementation. Research suggests that the active participation of leadership teams is vital in sustaining quality improvements in nursing homes (Rantz et al., 2013). Training programmes require the support of

managers, both in allocating resources and in communicating expectations that help to legitimise time spent talking with residents and engaging in group activities.

The expressed enthusiasm for one-to-one time with residents is a positive outcome of the study that could be fostered to promote person-centred care and job satisfaction (Zimmerman et al., 2005). Research indicates that the more staff relate to residents as individuals, as suggested here in participants' accounts of learning about residents' experiences and sharing aspects of their lives, the less they perceive difficult behaviour as challenging (Moniz-Cook et al., 2000). Training and support interventions need to acknowledge, however, that empathising with residents and becoming involved in their lives can contribute to burnout if not accompanied by appropriate support (Brodaty et al., 2003). Participants cited the value of peer support in this respect, reflecting the wider value placed on the cohesiveness of the staff team within the care home, but also felt that management should play a role in encouraging rather than discouraging these attachments. More generally, participants concurred that successfully implementing psychosocial interventions in care homes required commitment from staff at all levels. The importance of teamwork in improving quality of care is well-documented (Berlowitz et al., 2003), as is the role of leadership in promoting communication and relationships among staff (Scott-Cawiezell et al., 2004). Training and support programmes need to recognise the impact of these dynamics and assist managers in promoting information flow among staff, facilitating inclusive discussions about care delivery, incorporating diverse points of view and building positive relationships among all those living and working in the care home (Rantz et al., 2013). This should extend to family members who were frequently criticised for being unduly critical of staff.



Inviting relatives to participate in training sessions and promoting an inclusive ethos within the home has been found to enhance communication skills and empathy for the other group (Robison et al., 2007).

Before drawing final conclusions it is important to consider the limitations of this study. Firstly, participating care homes, although heterogeneous in ownership, management and location, were all rated as adequate or better on the CQC register. Similarly, although efforts were made to minimise selection bias through recruiting staff with varied roles and experience, it is possible that participating care staff were not representative of the homes as whole e.g. managers may have encouraged more “positive” members of the team to participate. In particular, the small number of registered nurses is notable, as this group of staff may face particular challenges and hold particular views on implementing psychosocial interventions alongside their other nursing duties. That said, the sample is large for a qualitative study and a range of positive and negative views were expressed. Participants spoke extensively about divisions within care homes and the challenge posed by “negative” staff that did not share their commitment to nonpharmacological interventions.

## **Conclusion**

We found cautious enthusiasm for training interventions that promise to help staff implement psychosocial interventions within their everyday work. The data is clear that this must take the form of a collaborative approach that acknowledges the expertise of staff and listens to their concerns, particularly around time pressures and the reduction of medication. Staff members were explicit that training

programmes must acquire the cooperation of all staff, management and relatives if interventions are to succeed. While participants were receptive to acquiring new skills, priority was placed on promoting understanding of their role and ensuring that expectations regarding interaction with residents, participation in activities and the reduction of medication were shared across the care home. There was a strong sense that many staff desired the authority to implement these interventions more widely.

### **Conflict of interest**

None declared.

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**Table 1: Quotes illustrating the three main themes: “Undervalued and understaffed”, “Centrality of relationships”, and “Existing practices and desire for support”.**

Themes	Quotes
<b>(1) Undervalued and understaffed</b>	<p data-bbox="421 384 568 443"><b>(1a) Lack of recognition</b></p> <p data-bbox="658 384 1335 413"><b>Lack of recognition from society, managers, relatives</b></p> <p data-bbox="658 416 2007 568">So they [the government] really have to recognise that the care workers are doing a highly skilled, professional job, they don't take it seriously. Even when I am out there and somebody asks me, “what are you doing?” you know a care job and the way people, even the way that the relatives look at you because you are doing this job, you can't win. And they can't do it. So really I feel that they don't recognise the care job is a good thing, they think we just come here to wash somebody, but that is not what we do. (2004)</p> <p data-bbox="658 571 1104 600"><b>Fear of criticism from training team</b></p> <p data-bbox="658 603 2024 724">I'm a little bit concerned now because obviously somebody's going to be coming in and you know again it goes back to the active living team when we had them in and they, the way that they spoke to us and the way it was sort of didn't they, we weren't good enough and they were sort of telling us how to do our job and that's what I'm a little bit concerned about that someone's going to come in and say do this do that and we think 'hang on'. (1004)</p> <p data-bbox="658 727 1032 756"><b>Dislike of word “intervention”</b></p> <p data-bbox="658 759 1980 880">As soon as you say we are having an intervention, it's like what you have done wrong needs to be assessed and then we are going to better it through our intervention and we are going to intervene in activities, we are going to intervene in this and this. And to me it's more of an association with us, working with us to do these things and helping to guide whereas intervention sounds like we have done something wrong. (2004)</p> <p data-bbox="421 884 568 943"><b>(1b) Lack of resources</b></p> <p data-bbox="658 887 981 916"><b>Pressurised environment</b></p> <p data-bbox="658 919 1211 948">You feel like you're not doing your job properly.</p> <p data-bbox="658 951 1308 979">You actually feel that you're letting the residents down.</p> <p data-bbox="658 983 1944 1042">Yeah that you're letting them down. You say, “I'll be with you in a minute, I'll be back”...and you're not, you're running off for something else. (3003)</p> <p data-bbox="658 1045 1279 1074"><b>Time constraints likely to undermine intervention</b></p> <p data-bbox="658 1077 2024 1190">There has been so much focus on it recently, dealing with challenging behaviour, creating different activities, etc. Every nursing home in the country would be more than happy to do that, but what people need to realise is that to do that costs a lot more money. To give one to one intervention is very expensive. Whereas it's dead easy isn't it if you give them a few tablets? (2002)</p> <p data-bbox="658 1193 1615 1222"><b>Hope that intervention will encourage investment in psychosocial therapies</b></p> <p data-bbox="658 1225 2002 1307">If this were to prove to the government and the NHS and stuff that we do need these extra things and it does work and it forces them to put more money into care or allow us to do more of these things...then that's a good thing. (2004)</p>

(2) Centrality of relationships	(2a) Relationships with residents	<p><b>Mutual respect and reciprocity key to good care</b>          People bring their dogs in, bring their family in, pictures, we all send postcards if we go on holiday...it's a lot like life as a general is all shared.(1001)          And they like a laugh, a joke, rather than treating them like, you treat them like you treat your Nan... because obviously they were born and bred in Dagenham, so they talk like we do...there's no need for airs and graces or anything like that. (3004)</p> <p><b>Implications of attachments</b>          I think that's what made me cry more than anything was that they didn't even think, 'oh well, we will ring around and let people know.' And then I just came in and heard that at handover [that the resident had passed away] and that really did piss me off to be honest. But yeah going back to what I was saying, I don't think we do get supported enough with things like that, I think they just think that it's part of the job but again it's people's emotions, we are human. (1004)</p>
	(2b) Relationships with relatives	<p><b>Relationships strained with relatives critical of staff</b>          I think they just don't understand what dementia is, they try to blame the staff for whatever has happened. I think this is frustrating because when we are trying our best and then somebody will come in and tell you 'no, no, no.' It's like we have a lady who goes in her room and messes all her clothes up and her daughter comes in and then they think she thinks it's the care staff that have to put it away properly, when it isn't. (1002)</p> <p><b>Collaborative relationships benefit staff and residents</b>          It's always fun when they [family members] join in because they know them better, do you know what I mean? They know their own mum or dad.          They know how to tease them and that sort of thing.          And it probably helps to make them feel normal for 5 minutes. (1006)</p>
(2) Centrality of relationships	(2c) Relationships within the team	<p><b>Educate families about dementia as part of the training programme</b>          I think you never know if the family is involved in this research it might encourage them to take their relatives home for an hour because if you give them helpful hints on how to deal with things.... getting them involved will open a few doors for them to understanding their relatives' illness. (2004)</p> <p><b>Collective responsibility enables staff to meet resident needs</b>          We all work as a cog in a wheel and if one of those cogs breaks then the wheel doesn't turn does it? So what we do is we all work together it's like they work upstairs with the carers and if something is wrong they report here and then it gets reported to the doctor...That is the heart of the person centred care because if we don't have that we won't know the person's needs. It won't be met without us knowing. (3001)</p> <p><b>Divisions between staff groups</b>          What, hang on, what if you've got staff which you get in every home with a really negative attitude or say are just very negative, 'oh no that's not going to work'.          Yeah and very narrow minded and it's going to be a case of trying, as well as trying to implement this with the residents, it's going to be difficult trying to get the staff to act on this as well. (1004)</p> <p><b>Concern about engaging all staff in intervention</b>          What will happen is they will talk, smile and pretend to understand and then after it will be a different thing.</p>



Some of them have the attitude, 'It's not my job, I am just here to clean him, feed him, that's it, I don't need to do anything else, it's not my job'. (2002)

**(3) Existing practices and desire for support**

**(3a) Provision of Person Centred Care**

**Receptive to training regardless of perceived expertise in area**

You try your best to be as person centred as possible, but it's hard.

You know this person likes XYZ, so you lay this here and that there for her. So it's almost like done in a rush and not really, so you get it all done for them because it just makes it easier for you than the residents. So you try to be, but I don't think it works as well as it could work or people aren't even aware of what they should be doing that is person centred sort of thing. (3005)

**(3b) The use of antipsychotic medicine**

**Hope that intervention will encourage more frequent medication reviews**

It will really help to raise awareness among them [the prescribing GP] because they would never change the medication if it weren't for this.

The side effects, at times you see them drowsy. So with the involvement of the GP with this programme I think they will have the awareness...Most of them you see them drowsy at times, at times it is a sedative, I wouldn't like antipsychotics or wish...so they need to review and do something about it. (2003)

**Concern about reducing medication wholesale and extra work this will cause**

Some of them can be quite aggressive if they won't take that medication, and it's how to deal with the aggression from them because we can all do 'Yesterday, Today and Tomorrow', which is a lovely course, it is brilliant, but we never actually had training where I worked of how to deal with the aggression side of it. (1002).

**(3c) Promoting interaction and activities**

**Enthusiasm for talking with residents, but colleagues can criticise**

Unfortunately I think it's that if our proprietor feels that the carers aren't constantly on the move doing a job then we're not doing a job and then she's not getting her money's worth out of us.

Even if we're sitting there talking you can't do that you've got to keep going.

No talking to a resident is skiving...

Yeah, it's very frustrating at times. Because sometimes sitting down and having a cup of tea with a resident just for 10 minutes can make a lot of difference. (3003)

**Reliance on activity coordinators**

Well, nothing happens when we [activity coordinators] are not here.

They all sit around reading the 'Daily Mirror' because they don't do activities at weekends.

Or they just sit and write their reports on the weekend. 'So and so is asleep so who cares.' (2002)

**Table 2: Themes arising from the focus group discussions**

<b>Themes</b>	<b>Related attitudes towards training programme</b>	<b>Implications for training</b>
<b>(1) Undervalued and understaffed</b>		
<b>(1a) Lack of recognition</b>		
Lack of recognition within society	Hope that intervention will raise status of job	Reinforce value of caregiver role
Undervalued by managers and relatives	Fear of criticism from training team Dislike of word “intervention”	Avoid critical approach Promote visibility of staff achievements Avoid term “intervention”
<b>(1b) Lack of resources</b>		
Pressurised environment Time constraints barrier to activities, one-to-one, PCC and reduction of medication	Time constraints likely to undermine intervention Hope that intervention will encourage investment in psychosocial therapies	Acknowledge time pressures Incorporate activities into existing care as much as possible Consensus with managers about time commitments at outset
<b>(2) Centrality of relationships</b>		
<b>(2a) Relationships with residents</b>		
Mutual respect and reciprocity key to good care Implications of attachments		Utilise enthusiasm for one-to-one time with residents Attachments necessitate support
<b>(2b) Relationships with relatives</b>		
Often strained with relatives critical of staff Collaborative relationships benefit staff and residents	Agreement that it would help to educate families about dementia as part of the training programme	Facilitate family education Invite families to take part in daily activities
<b>(2c) Relationships within the team</b>		
Collective responsibility enables staff to meet resident needs Divisions exist between staff groups	Concern about engaging <i>all</i> staff in intervention Intervention requires full managerial backing and clear communication	Stress that role distinctions are unhelpful Provide clear information to all staff at outset
<b>(3) Existing practices and desire for support</b>		
<b>(3a) Provision of PCC</b>		
Evidence of person centred practice, despite narrow definitions of PCC	Receptive to training in PCC regardless of perceived expertise in area	Help staff to relate principles to practices
<b>(3b) The use of antipsychotic medication</b>		
Managing aggression most demanding element of work Evidence of considerable expertise in this area Medications benefits some Alternatives may not be viable	Hope that intervention will encourage more frequent medication reviews Concern about reducing medication wholesale and extra work this will cause	Recognition of demands Reinforcement of positive approaches Reassurance that medication will not be withdrawn wholesale

**(3c) Promoting interaction and activities**

Reliance on activity

coordinators; narrow  
definitions of activities

Enthusiasm for talking with  
residents, but colleagues  
can criticise

Concern that intervention  
may impose activities in  
a prescriptive way

Interest in learning ideas  
Hope that intervention will  
increase focus on  
activities within the home

Interacting with residents to be  
promoted as key role for all  
Broaden definitions of activities  
Meet staff hopes for higher  
focus on activities  
Acknowledgment that  
interaction during everyday  
care tasks is valuable

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