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Abstract

Objectives: This study explored the experiences of a range of health and social care professionals employed in the role of trainer/coaches to support care home staff to implement a psychosocial intervention for residents living with dementia. It aimed to identify the factors which are pertinent to the success of these roles, in the context of a cascade model of training.

Method: A focus group involving dementia trainer/coaches and supervisors who had worked on the Well-being and Health for People with Dementia (WHELD) randomised control trial in delivering and support of the "WHELD Therapist" role was convened. Twelve participants explored their preparedness for and experiences of the role. They reflected on their perceptions of the resources and support required .The data was transcribed verbatim and subjected to inductive thematic analysis.

 Results: Three main themes emerged from the data. Within the theme of "skills in relationship building" were two subthemes of developing trust and getting to know individual staff and each care home. In the second main theme of "using tangible resources" two subthemes relating to using training manuals and receiving their own supervision arose. The third theme, "being an agent for change", contained three subthemes concerning the use of effective training methods, creating opportunities for care staff who were their coachees to reflect and rewards of the WHELD therapist role .

Conclusion: The findings provide new insights into the trainer/coach role applicable to the practices of services recruiting, training and providing ongoing professional support to practitioners in-reaching into care homes.

Key words: Dementia, care homes, trainers, coaches, psychosocial intervention.

Introduction

The quality of care of people living with dementia in care homes has raised concerns (Care Quality Commission, 2017; Quince, 2013), some of which can be addressed through training and support. Guidance on dementia care recommends that care home staffs are provided with training to enable them to deliver person-centred care and evidenced-based non-pharmacological approaches (Department of Health, 2015; National Institute for Health and Care Excellence, 2016). However, Fossey et al, (2014) found that whilst there is a proliferation of person centred care training programmes available only four have an evidence base of effectiveness in improving behavioural and psychological symptoms for care home residents. Furthermore, this study showed that for training to be incorporated into routine practice a sustained period of joint working and supervision is required.

Previous research has tried to identify the necessary components required to make training in biopsychosocial approaches in dementia care effective. Findings for the What Works study (Surr et al 2017) suggests that for learning to take place, theory needs to be included in the training and any simulation sessions must include an opportunity for debriefing and discussion. Training which focuses on the use of a specific approach and is a combination of face to face sessions with practical activities is most likely to lead to staff changes in behaviours and for attitude change to occur training needs to take place over a minimum of half a day. Spector, Orrell and Goyder (2013) found that staffs' ability to manage behavioural and psychological symptoms of dementia could be improved through training which contains a strong theoretical background, sufficient duration and augmentation of supervision, observations of practice and feedback.

In a systematic review Lawrence, Fossey, Ballard, Moniz-Cook and Murray (2012) identified that attitude change can be fostered through active involvement of staff in implementing new

psychosocial approaches to their work, supported by staff being given the opportunity to reflect on their role and the care they provide. Training in new ways of working may also require trainers to be instrumental in achieving a change in the culture of the care home (Boersma, van Weert, Lakerveld & Droes, 2015). Where a task-based approach predominates in a care home, for example, the challenge of incorporating psychosocial interventions into practice becomes more complex (Dugmore, Orrell & Spector, 2015). To understand factors influencing implementation of new ways of working from a staff perspective, Lawrence, Fossey, Ballard, Ferreira and Murray (2015) conducted interviews with staff prior to their care homes engaging in a research programme which evaluated the effectiveness of person centred and activity based training and implementation support (Ballard et al, 2015). Care staff wanted practitioners to take a whole home perspective and to understand contextual factors relating to their homes, including staff morale and interpersonal relationships within the homes and to identify and communicate clear benefits of participation for staff and residents.

Influencing the care practices of large staff groups can be compounded by the busy environment where staff turnover is high and finances limited, resulting in difficulties for managers in releasing staff to attend training (Beeber, Zimmerman, Fletcher, Mitchell & Gould, 2010; Wild, Nelson & Szczepura, 2010). A frequently used model to deliver training in what is regarded as a cost effective, relevant manner which is grounded in care home practice is a "cascade model" of training (Loveday, 2011) in which designated leaders are trained and given resources and in varying degrees supported to lead dementia practice. It is therefore imperative that trainers and training materials are effective and achieve intended outcomes of improved care and better experiences for people living with dementia. The Fits into Practice study (Brooker et al, 2016) identified the need for care home staff responsible for leading practice improvement to be given dedicated time to fulfil their role. The

qualitative findings from the two trainer/coaches involved in this study suggest that personal knowledge and experience of delivering person centred dementia care and being experienced in coaching others are highly valuable for their role. However, availability of people with experience of dementia care who are also experienced trainer/coaches is limited. It is therefore important to understand the experiences of a broader range of health and social care professionals who might undertake the role, in order to identify how their skills can be optimised to do this.

This qualitative study explores in depth the experiences of dementia trainer/coaches engaged in a cascade model of delivery to implement an optimised psychosocial intervention as part of the Well-being and Health for People with Dementia (WHELD) randomised control trial (Whitaker et al, 2014; Ballard et al, 2017, under review) .

Context of the WHELD study

The WHELD RCT evaluated the effectiveness of an optimised person-centred intervention involving structured activity and medication review based on the outcomes from previous studies (Lawrence et al, 2012; Fossey et al, 2014, Testad et al, 2014; Ballard et al, 2015). A cascade model of delivery suitable for the real world setting was used. WHELD therapists (WTs) who had the role of trainer and coach delivered one day a month of manualised training over four months to groups from participating homes. Attendees were made up of 2-3 care home staff from each home who had been selected by the manager for the role of "Dementia Champions" (DCs). This training took place outside of the care homes and WTs also provided support and coaching either weekly or fortnightly (by negotiation with the care settings) on site in the care home for eight hours per month over a nine month period. Their focus was to support the cascade of the intervention by DCs in sharing their learning and implementing the intervention in collaboration with their care home colleagues.

The WT's supported DCs by providing training to address a knowledge and skills framework (Miller,1990) through didactic sessions, role play and modelling skills as well as joint working to provide observational feedback to DCs as part of coaching and development of reflective practice (Gibbs, 1998).

Prior to this intervention phase of the WHELD study, the WTs attended nine days of training to prepare them for delivering the intervention. This included an overview of the evidence for biopsychosocial approaches, three days addressing generic skills including training skills, supervision skills, working with groups, problem solving and coaching focused on empowering DCs, and five days on the specific content of materials to be shared with DCs - person centred care, providing personalised socially interactive activities, understanding behaviour that challenges and antipsychotic review and methods of sharing this with colleagues. The training was manualised to provide a guide for the WTs to use through the intervention phase. A modified manual was produced for the DCs .

Once the programme started in the care homes the WTs themselves received weekly individual or group supervision provided by WHELD supervisors who were experienced clinicians (occupational therapy, nursing and psychology) who had experience of working with staff and people with dementia in care homes, training, staff supervision and the WT training.

Method

Participants

All thirteen of the WTs and supervisors were invited to take part in a focus group discussion (FGD) to explore the team's experiences of using a cascade training model to implement the

WHELD intervention in the 36 care homes randomly allocated to the intervention arm of the study.

Twelve WTs and supervisors attended the FGD; eight (66.6%) were WTs and the remaining four (33.3%) were supervisors. The professional and academic backgrounds of the participants were occupational therapy (33%), nursing (16%), psychology (16%) and mental health research (33%).

Data collection

Focus groups were considered appropriate to explore the participants' perspectives as they encourage discussion and the group processes can help people to explore and clarify their ideas. Efforts were made to encourage participation across the group and to challenge apparent areas of consensus and clarify areas of disagreement.

A topic guide was developed by the authors, all of whom had prior experience of qualitative research. It was used as the basis of discussion to ensure the areas of relevance were covered but also allowed the participants to raise their own ideas. The group were asked to reflect on the extent to which the WTs were prepared for their role, their perceptions of the role, the usefulness of resources and support made available to them and the need for any further knowledge or skill development which emerged during the intervention phase.

The FGD was facilitated by authors (JF) and (LG). Notes of the discussion were taken by a trainee psychologist who was an independent observer and the group was audiotaped and transcribed verbatim (by LG) and anonymised to prevent identification of the individuals taking part.

Analysis

The data was subjected to inductive thematic analysis (Joffe, 2012). Two authors read the transcript and notes repeatedly to immerse themselves in the data; they then separated the data into meaningful fragments and emerging themes were identified and labelled with codes (Braun & Clarke, 2006). Themes and sub-themes from the transcription were identified, discussed and refined and ideas about the themes were discussed by all the authors, which led to the development of three main themes and associated sub themes.

Ethical considerations

The study was part of the wider WHELD RCT which was reviewed and approved by the Oxford C National Research Ethics Committee (Ref: 13/SC/0281).

Written consent was obtained from the participants taking part in the study. The data was transcribed anonymising individual participant identity and the identity of the speaker of quotations reported here is denoted by a single letter.

Results

Three main themes were identified. Firstly, "Skills in relationship building"; secondly the value and difficulties of "Using tangible resources" and thirdly the experience of "Being an agent for change". These themes are discussed in turn.

Skills in Relationship Building

The relationship building skills which the WTs found themselves developing during the nine month intervention phase centred on two sub-themes:

i.   Developing trust.

ii. Getting to know individual staff and each care home.

Developing trust

Development of trust with the DCs and care home teams was a gradual process. To establish collaborative working relationships all the WTs identified the importance of '*acknowledging the fact that they [the DCs] have a huge amount of knowledge anyway.' (E)*

It helped the care team to know that the WTs were empathetic to the experience of being a care worker. Some of the WTs had previously worked as carers and activity co-ordinators and found it beneficial to openly share this information:

> *... it definitely has helped me to tell them, "I've been in your shoes." (C)*

Trust was also built by listening '*to the good things, and the bad things, you know, and all that you don't necessarily need to know,'* although WTs were instinctively cautious about '*not getting drawn in to the home politics.'(D)*

WTs perceived that the care home staff needed to see that they were genuine in their compassion for the residents' well-being and that they could sometimes demonstrate this by working directly with residents:

> *I think if they could see that you had an emotional attachment to the residents as well that helped them to understand that you were trying to do good. (D)*

By modelling behaviours associated with the intervention, WTs found a way of enabling care home staff to trust in the effectiveness of person-centred care and personalised social interaction:

> *...it is validating the sitting and chatting and seeing that as a valuable activity and it can really make a difference to people. (A)*

If you're there enjoying yourself with the residents they could see the more human

side to you, that you're not there just to get a job done. (E)

WTs also noticed the importance of giving DCs positive feedback about their practice, which they perceived as a boosting confidence and increasing their sense of self-efficacy in implementing the WHELD intervention:

Dementia Champions really enjoyed that someone was being positive about things

that they were doing and I think that enabled them to reflect on their skills and maybe

see their skills in a different light. (G)

Getting to know individual staff and each care home

Dementia Champions had been nominated for the role by their managers and their skills, roles and experience were diverse:

It was really a very mixed bunch of Dementia Champions, people with very different

levels of knowledge, literacy and language and motivation and all of that. (M)

To get know staff individually, including their different needs and motivations took time, but once achieved the WTs were able to adapt their approach to each DC accordingly:

...once I knew everybody well it becomes inherent and you just support them in the

way they need to be. (E)

It became apparent that for some DCs the responsibilities of the role was new and unfamiliar. Recognising this, the WTs provided individual support:

...one Dementia Champion wanted me to practice the training, the workshop, with

her four times before she would deliver it herself and whereas other people were

confident they said, "it's fine [name] we'll do it once and then I'll get on and do it myself,"... (E)

WT s made the most of what individual DCs brought to the role. They agreed that having DCs from a combination of roles worked well:

...a mixture was good because activity co-ordinators have time, they have a bit of time and they did take on a lot, but then they don't do care plans... (B)

As well as adapting to individual needs the WTs needed to familiarise themselves with the individual way in which each home operated:

Each care home was quite different in that way, in the structure, and getting to know that structure and who has influence and who makes the decisions and helps things moving on and can instigate change... (A)

WTs allowed some flexibility in how DC led training within the care home was delivered, for example delivering it in shorter sections to make it more feasible in the time-pressured environment. WTs, DCs and care home managers had to work together to consider how to engage the care home team in training by *'just making it far more personal'* (C) and focusing on practical sessions.

Making use of tangible resources

Two subthemes emerged under the theme of making use of tangible resources;

i.   Using the WHELD manuals.

ii.   Supervision of WHELD Therapists.

Using the WHELD manuals

The value and use of the manuals, which had been developed from evidence based resources and adapted to be user friendly following feedback from staff and WTs in a previous proof of concept study (Ballard et al, 2015) was discussed .These were regarded as useful to the WTs in organising their own work:

> *...we obviously covered a lot of stuff in training so it was nice to have all those slides and stuff in there. (G)*

The WT's felt that having a specifically adapted set of materials to use with Dementia Champions was also beneficial. As intended, these manuals provided a reference point that WTs could remind DCs of during periods of implementation after training. These were used in a flexible order to respond to the circumstances in each home and were a useful resource for the cascade training which the DC's subsequently delivered:

> *....they actually liked it and, but then after the four days were completed they kind of forgot [laughs] the content. It wasn't until we were preparing and organising the workshops when Champions were like, "Oh, this is, this is good, this is something I want to deliver in the home." (F)*

The manuals contained structured templates designed to enable the WTs to help staff understand and implement the WHELD intervention in a systematic way. They also enabled staff to refine and personalise existing practice:

> *... like from the NEST manual* [referring to the activity part of the DC manual]*we'd go through, "Ok, you're already doing a singing group", but, "Oh, you don't use* [printed] *words. If you use words that will make it more inclusive."(C)*

However, the WT's perceptions were that some of the DCs were ambivalent about their manual:

...some of them found their manual a bit overwhelming, but in the same breath they said it was useful to have that information. (G)

The DCs responses shaped the WTs way of working, introducing smaller sections of the manuals per session to avoid them being 'overloaded' with information. They recognised that some of the approaches were entirely new to the DC's and that the time needed to develop skills varied along with individual DCs' learning preferences and literacy skills:

..one of my Dementia Champions was very academic and really liked having it all there, which she could refer to and go back to and she would always bring it in with her when we had meetings and, and really enjoyed having it, whereas the others were completely put off by the whole thing.(E)

One home had *'English teachers come in' (E)* and they included the DC manual in their sessions to support non-native speakers.

Supervision of WHELD Therapists

The FGD drew attention to the WTs own support needs in working across a diverse range of settings. Many of the therapists commented on both the emotional and practical challenges faced in developing flexible ways of supporting DC's who had competing demands on their time such as meeting residents' immediate needs, supporting colleagues and undertaking other training . Occasionally agreed meetings got cancelled due to workload and this sometimes challenged the WTs' ability to facilitate structured and goal-orientated sessions. Managing this was a learning experience for the WTs:

It wasn't because they didn't try. Umm, but then some of them were working sixty hour weeks, and doing an NVQ and trying to be a Dementia Champion. They were just overwhelmed. (C)

Supervision enabled the WTs to reflect on the appropriateness of the balance they achieved between being flexible to the competing needs of the care homes and with setting boundaries to ensure implementation of the WHELD intervention was being given sufficient priority. Having group supervision helped the WTs to recognise challenges as shared experiences and to find solutions:

> *We just all solved each other's problems really, so we would say what was bothering us and then they'd give us a solution that we could try. (E)*

One WT reflected on the benefit of having individual supervision in providing a safe space for managing the fluctuating emotions she experienced whilst working in the care homes:

> *I mean* [supervisor] *had a lot experience of my highs and lows (A)*

Having their own support away from the care homes was described as '*a luxury*' (D) which enabled WTs to return to the care homes feeling reassured and with renewed positivity. Some reported that it enabled them to better support the DCs, who themselves sometimes expressed their frustration with the perceived pressures on their time, constraints on their roles and their working terms and conditions.

Being an agent for change

The FGD participants spoke about their role in bringing about change in the care homes. Three sub themes were identified:

   i.   Effective training methods

  ii.   Creating opportunities for Dementia Champions to reflect

 iii.   Rewards of the WHELD Therapists role.

Effective training methods

WTs felt that combining didactic and experiential training methods helped care teams to think about providing opportunities for residents to participate in activities in a more natural, meaningful and inclusive way:

> *...maybe they understand more about what activity, what that word means... (D)*

Modelling good practice formed a substantial part of the multi-modal training they provided:

> *...there was a lot of modelling, especially just language and how to, yeah, how to do activities and simple things like placing food down and just talking to the resident and stuff like that that (D)*

Their perception was that it was effective in influencing positive changes in practice within the care homes. Through spending time with residents the WTs demonstrated both their credibility and that of the intervention, and over time they observed the same behaviours they were modelling, being repeated by the staff:

> *...the modelling definitely the spending time with residents that were more impaired, umm, that seemed to kind of creep through that they were including them more… (C)*

The benefit of modelling was observed by one care home manager, who attributed it to supporting staff to move away from a task-based focus:

> *...she* [manager] *felt that through the programme* [staff] *are more comfortable just sitting and chatting with residents, she feels it might have been because I've been on the floor doing that…(G)*

Creating opportunities for DCs to reflect

It was recognised that the care home staff usually had limited opportunity to talk about their work. The WT's role in providing space for them to reflect on their practice, be listened to and ask questions was generally appreciated and was seen to promote staff development:

I think you're right they don't often have the time when they can just talk about how it's all going – it's so busy. (G)

Giving the DCs a safe space to express themselves was seen to build their knowledge and confidence:

...that's really key as well that realisation on the behalf of the DCs that they've got something to say and um, what they say is of value...(A)

The fresh perspective WTs brought to the homes was seen as conducive to stimulating thought and discussion, providing:

...space to have a conversation about things and different things and different ways, different approaches, different perspectives (F)

The WTs were able to ask questions based on their observations, which challenged current practices in the care homes:

...it was like, "Oh, when I'm measuring how much activity they are doing there is a quite an imbalance. Oh, could you maybe swop your time around?"(C)

One WT noted that this opportunity to reflect had also impacted on the care home manager's attitudes in relation to developing and recognising staff skills:

...the manager actually said this programme has helped her to actually realise that carers can think, they're not machines who come in to wash, dress, feed, they can actually think about activities to do... (B)

Rewards of the WHELD therapist role

In terms of sustaining their own motivation in practice, WTs expressed particular satisfaction in seeing the personalised social activities element of the WHELD intervention being put into practice:

> ...*they* [residents] *are really enjoying life, they are going out on trips, they're going into town, they're going shopping, they're going to the pubs, they're going swimming and they're really enjoying life.....(B)*

In some care homes WTs reported seeing changes in the skills of staff facilitating personalised social activities with residents, including being able to involve people with more advanced dementia and loss of verbal skills:

> *……and in some homes they sort of developed activity schedules to their floor that are independent from activity co-ordinators and that's been something they have been really proud of and they sort of do activities now twice a day which is something they weren't doing before and so that's something you can really see and relatives see it when they go in (G)*

The positive experience of some dementia champions enabled them to apply their learning to their interactions with families. They recognised the benefits of the communication training they received and they offered this to residents' relatives as well as to their colleagues. This was seen by both DCs and WTs to result in an improved relationship between staff and families:

> *...that really helped and relatives, you know, meeting them now, some of them who attended go, "That was really helpful."(B)*

WTs also reported receiving complimentary feedback from care home managers and relatives on their observations of changes in staff skills:

One of the successes, one of my managers said, feedback from visitors and relatives about the changes in terms of communication and interaction from staff and carers, that was something that she recognised had been improving, that had changed in the last nine months. (H)

Discussion

The FGD explored the experiences of WHELD therapists working in care homes to support the implementation of psychosocial interventions using a cascade training model. The findings identified the essential skills of relationship building, the utility of having a manualised intervention which is responsive to learner style, and the necessity of supervision for WTs to enable them to be instrumental in affecting changes in care practices.

These important findings provide new insights into the trainer/coach role related to both the methods of support delivered to others and also in respect of the trainer/coach's own support and development needs to sustain their own practice. This is particularly pertinent in the current health and social care climate in which services are increasingly developing care home support roles and in-reach models of care (James & Jackman, 2017; Fossey, Broad, Coates & Tsiachristas, 2016; Naylor, Das, Ross, Honeyman, Thompson, & Gilburt, 2016).

In relation to the training materials, this study highlights the importance of having high quality evidenced-based manuals with clear goals and objectives which can facilitate cascade training and implementation of new ways of working. The FGD indicated that having the manual as a resource was helpful for the WTs in providing s systematic approach. It also highlighted the importance of designing manuals that are user-friendly and relevant to the setting and the audience they are intended for.

The principles of person-centred approaches to residents needs to be mirrored in the approach to training staff, thereby reinforcing experiential learning. This fits with cognitive load theory

(Sweller, Van Merrienboer & Paas, 1998) that recommends giving consideration to the manner in which information is presented, attending to individuals' different capabilities and levels of familiarity with new concepts. The WTs experience was that it took time to get to know the individual needs of DCs and to develop trust before real progress could be made in introducing new ways of working. This supports previous work which suggests effective training programmes need to involve a sustained period of joint working to embed practice (Fossey et al, 2014). This experience of supporting DCs by promoting reflective practice and seeing the benefits for residents is also highlighted in the recent systematic review of effective components of psychosocial interventions in care homes (Rapaport, Livingstone, Murray, Mulla and Cooper, 2017).

The value of trainer/coaches providing care home staff with opportunities for reflection supports findings by Coates and Fossey (2016) that care home staff bring their own life experience, skills and strengths to their roles, which are important to recognise and build upon. The skills required to do this: genuine interest in others, integrity, active listening, observation, questioning, challenge, feedback and reflection are those used generically in coaching (De Souza and Viney, 2014). The value of this in workforce development within the NHS has been identified in recent years (National Improvement and Leadership Development Board, 2016) and our findings suggest that they are important in care home settings too.

The FGD indicated that while the dementia trainer/ coaches clearly need a sound knowledge of training content, attention must equally be paid to supporting their own professional development to bring about change in the care practices of care home teams. It is likely that whatever preparatory training is given to people in similar roles to WTs, that some on the job learning and skill development will need to occur. The WTs found their roles challenging at times, which reflects the experience of an earlier study (Brooker et al, 2015). The FGD highlighted the restorative and practical role that both individual and group supervision

played for the WTs in developing their own practice, emphasising the need for trainer/coaches to be supported by a robust supervision framework to promote their ability to fulfil their professional roles. As more services adopt an in reach model to care homes we need to ensure that staff do not become isolated when working across wide geographical areas with diverse settings and care practices to support. The themes identified in this work strongly highlight the value of both individual and group supervision for trainer/coaches alongside people in similar roles.

The FGD provided an opportunity to explore ways to overcome hurdles to being agents of change. The experience of seeing observable positive benefits to care practice and resident well-being that resulted from their work appeared to generate a sense of reward for WTs. It reflects findings that residents well-being can reciprocally influence the emotions of the people providing care (Coates and Fossey, 2016). Exposure to resident well-being may have acted as a protective factor to WT well-being over-riding some of the challenges they experienced and reflected upon in their own supervision.

Strengths and limitations of the study

A strength of the study is the number of participants who contributed to the FGD. They represented a varied sample from a range of professional backgrounds and had different levels of experience of work in care homes prior to taking up their role. Their experience working across 36 care homes of varying sizes and organisations also provides useful information about the requirements in supporting this type of role in day to day practice.

However, working on the study provided the WTs with a focus on outcomes and opportunities for peer discussions. These opportunities are less available in routine practice, which could lead to coach/trainers in more isolated roles to form a different view from our participants and further exploration of their views would be valuable.

Conclusions

This study outlines the experience of dementia trainer/coaches. It raises the importance of developing cultural awareness of care homes and the time required to adapt processes from task -focused to individual-centred care. The value of having evidence based, user friendly manuals and resources for trainer/coaches and care home staff to draw on is highlighted, as is the need for resources to be designed so that they can be used flexibly to respond to learner needs. Finally, the importance of ongoing supervision, not only for care home staff in DC roles, but also for trainer/coaches to help develop and sustain practice is a key feature to embed in practice.

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