Evaluation of the *My* Home Life Admiral Nurse Role in the Orders of St John Care Trust

Final Report

January 2015

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Summary: The *My* Home Life Admiral Nurse role and its impacts

Background

This report presents the findings from an evaluation of the '*My* Home Life Admiral Nurse' (MHLAN) role in care homes run by the Orders of St John Care Trust (OSJCT), a charity that provides care in some 70 care homes as well as a domiciliary care service in seven independent living (extra care housing) schemes. The evaluation aimed to add to a very sparse research literature concerning the Admiral Nurse role in general and its implementation in care homes in particular.

The first Admiral Nurse specialist dementia service was launched in 1990 and Dementia UK, the national dementia charity, was established in 1994. The traditional role of the Admiral Nurse provides support to family carers and people with dementia living in the community. Admiral Nurses are specialist dementia nurses who give much-needed practical and emotional support to family carers, as well as the person with dementia. They offer support to families throughout their experience of dementia that is tailored to their individual needs and challenges. They provide families with the knowledge to understand the condition and its effects, the skills and tools to improve communication, and provide emotional and psychological support to help family carers carry on caring for their family member. They are able to take on complex cases and provide specialist support and advice. The care home model of Admiral Nursing is relatively new, with 15 Admiral Nurses working in the sector at the time of writing.

OSJCT was one of the first care home provider organisations to employ an Admiral Nurse to provide in-house dementia specialist consultancy, training, advice and support. The role was created as part of OSJCT's clinical governance strategy to ensure excellence in care and nursing practice across its services. Working in collaboration with Dementia UK (DUK) and *My* Home Life (MHL), the role aimed to combine the expertise of dementia specialist nursing with the evidence-base of best practice in improving the quality of life for those living, working and dying in care homes.

The Evaluation

The evaluation of the My Home Life Admiral Nurse role was commissioned by Orders of St John Care Trust and carried out by the Association for Dementia Studies (ADS), a

research centre at the University of Worcester, between November 2013 and September 2014.

The evaluation sought to address four main questions:

- What impact has the MHLAN role had on the care homes within OSJCT, their staff and the work they do?

- What impact has the MHLAN had on the individuals who attend dementia cafes, some of whom are living with dementia or caring for someone living with dementia in the community?

- Which competencies and attributes of the role make it most effective and how does this relate to traditional Admiral Nursing competencies and the *My* Home Life philosophy?

- What is the most appropriate case load of the MHLAN role within OSJCT care homes?

An Appreciative Evaluation approach was adopted in order to explore the nature and impact of the My Home Life Admiral Nurse (MHLAN) role, with data collected from three main sources, (Cooperrider, 2003):

- a survey exploring the role of Admiral Nurses working in OSJCT care homes (completed by 101 care home staff and 24 operations staff);

- in-depth telephone interviews with a range of OSJCT staff (13) and attendees of the dementia cafes (3).

- case study work with four care homes, including interviews with staff in a range of roles, (10).

- Two discussion groups: One with MHLAN and one with Admiral Nurses working with other care home organisations.

Data were analysed for thematic content and descriptive statistics, allowing the development of a description of the MHLAN Admiral Nursing role and its impact in OSJCT care home settings. The evaluation received approval from an ethics committee at the University of Worcester and was supported by a steering group that met quarterly.

The Findings

By far the most frequent task undertaken by the MHLAN was, unsurprisingly, giving advice and support to staff, residents and families in a variety of ways. Significantly, it was not simply the practical elements of support such as meetings with staff and relatives, co-ordinating dementia lead meetings etc. that were valued, but also the emotional aspects of that support given through encouragement, providing objectivity, acting as a sounding board or simply listening to difficulties and concerns. In addition, the MHLAN advice also extended to support with processes and procedures such as internal anti-psychotic medication reviews or care planning, or external events such as safeguarding meetings. MHLANs also acted as a link with external professionals to advocate on behalf of the resident and to expedite issues with which the homes were experiencing difficulties.

In this section we present some highlights from the findings that describe the MHLAN role and demonstrate its impact in care home settings.

The MHLAN Role: what they do and how they do it

The MHLANs worked with staff in three main ways: face-to-face, e-mail and telephone contact. Face to face contact was slightly more common than the other approaches. The value of the MHLAN being able to respond in these different ways was appreciated by the care home staff as it enabled the MHLAN to be accessible and flexible in their approach.

Advice was the most common type of support provided by the MHLAN, followed by practical help and signposting to other services. They are contacted about a wide range of different topics, with the most common being distress behaviours, (both verbal and physical); resident behaviour and resident health needs.

Contact in relation to any topic was not likely to be needed more than six times a year, and job role appeared to make no real difference to the types of support care home staff were contacting the MHLAN about.

Contact regarding types of relative/visitor support formed a substantial part of the MHLAN role and included providing advice and support on involving relatives in their resident's care, providing emotional support to relatives and working with relatives who might be viewed as 'challenging'.

Care quality issues were a smaller part of the MHLAN role and include topics such as the use of antipsychotic medication, meeting internal audit/quality requirements, quality of life assessments and safeguarding concerns.

Respondents also reported substantial contact with MHLANs about training issues, with the most common being understanding distress reactions, general dementia awareness and life story work.

Finally, the MHLANs had an important function in relation to external professionals. This included direct contact in order to advocate on behalf of residents and address issues with which the homes were experiencing difficulties, as well as facilitating contact between care staff and external professionals.

The Impact of the MHLAN Role

The evaluation provides evidence for the impacts of MHLANs both in terms of the people with whom they work and processes within the care home and organisation as a consequences of their work. It speaks highly of their influence that, when asked to rate the importance of the role respondents scored them very highly across the board, with their input around each subject area being seen as 'important' or 'very important' by approximately 90% of care home staff. No respondents reported this support to be unimportant. Input around resident care and relative/visitor support was rated most highly, reflecting both the frequency of contact and the strength of expertise of the MHLANs in these areas.

This impact can be demonstrated in terms of its benefits for residents, staff, the care homes and the organisation more widely.

Impact on Residents

Evidence demonstrates that MHLANs had a direct impact on the experiences of residents within the care home, improving quality of life overall and solving particular challenges:

> *"The Admiral Nurse sorted out the pain relief for one of our residents as well… So that was something that the Admiral Nurse thought of… The gentleman now is on patches and his behaviour is much calmer. It's just that, you know, she knows all these different avenues"* (Care Home Manager)

This is an indicative example of a range of resident impacts interviewees spoke about including improved physical health, reduced pain, increased independence, increased meaningful engagement and general well-being.

Other examples come from care home staff indicating that working with the MHLANS helped them to be better able to work with residents' distress behaviours (68% of respondents) and reduce the number of residents living with dementia receiving anti-psychotic medication (46%).

In addition, nearly half of survey respondents (48%) agreed that the MHLAN input had a role in preventing moves to other settings. This is significant because it can improve the quality of the resident experience by, for example, reducing transitions that are often traumatic. This suggests a strong business case for such a role, as it appears to help ensure that changing resident needs can be met for longer and that care homes supported by the MHLAN can provide care for people whose needs may not be met by other providers.

Impact on Relatives

The support of the MHLANs had a positive impact on relatives and families of residents living in the care home and on those external to the care home who attended dementia cafes. Although highly individualised in its impact, overall the impact was to improve the support experience and the confidence in navigating the journey of dementia:

> *"Well, we have our Admiral Nurse and she's absolutely amazing, and she actually helps me run a relative support group, to support the relatives of people with dementia, so they come and see her once a month. If they have any questions she helps people gain diagnosis and helps direct them into how to get the diagnosis and different memory support groups and things like that"* (Activities Co-ordinator)

Additional areas of impact for relatives included providing emotional support to relatives (64% of respondents), involving relatives in decisions about their relative's care (57%) and involving relatives in the general life of the care home (54%).

Impact on Staff

The impact on care home staff can be divided into two categories; the impact on knowledge and skills and the impact in terms of saving time and reducing workload by providing timely interventions or support with challenging issues:

> *"knowing that there is somebody there that I could actually call on…..and it wouldn't be, like, 'Oh, it'll be in three months' time,' or anything, it would be when they were needed"* (Care Home Manager)

Key areas of impact included improved knowledge and skills (67% of respondents), being able to provide better care for residents living with dementia (64%), feeling more supported in doing their job (58%), being more confident about doing their job (54 %) and identifying changes that need to be made in their care home (51%). Only 5% of care home staff felt that there had not been a change as a result of their contact with the MHLANs.

Although operations staff reported much lower levels of contact with MHLANs than care home staff, not surprising considering nature of their role, they rated the importance of their contact with MHLANs very highly in every area, with at least 85% of respondents saying that contact was important or very important. This was confirmed by a range of comments, such as:

> *"I feel we are very fortunate to have the role as part of the Trust as it has enhanced the quality of life for our residents"*

Impact on Care Homes and the wider organisation

Through their knowledge, expertise and support of staff, residents and relatives, the MHLANs had an impact on the processes of the care home, up-skilling staff and changing culture in various ways. For example, particularly when mediating in challenging situations, MHLANs facilitated better relationships and communication not simply in those particular situations prompting intervention, but more widely:

> *"Just enabling people, like, you know, to talk to each other when they need to. I think it's like the communication thing, isn't it, like, you know, because people are not always able to communicate and I think with her input, like, you know, it's enabled people to actually communicate more effectively"* (Head of Care)

The evaluation also found evidence that the MHLANs raised the profile of OSJCT as an organisation through specific events such as dementia cafes, by sharing good practice with wider audiences, and through their interactions with external professionals.

What is valued about the role?

A range of characteristics of the MHLAN role as implemented in OSJCT homes appear to be key to its effectiveness in delivering the impacts summarised above.

Firstly, having a MHLAN dedicated to a particular region significantly increases the level of contact they have with care homes. Possibly related to this is the finding that the

speed of MHLAN responses to their requests was valued by care staff, with no respondents reporting that they had to wait too long for support.

The flexibility and responsiveness of the My Home Admiral Nurses was highly valued, because it provided a timely support in keeping with the unpredictable nature of issues arising in a care home. This meant being able to use different methods of contact, with a range of stakeholders, at different times. Staff particularly valued the fact that even though the MHLAN could not be present on the premises at all times, they were still available by telephone or e-mail to provide support, and this enhanced their responsiveness to issues.

The breadth of the MHLAN role was also an important factor for participants in the evaluation, with input that spanned a comprehensive list of topics including meeting with staff and relatives, co-ordinating dementia lead meetings, emotional support, acting as a sounding board, listening to difficulties and concern, support with processes and procedures such as medication reviews or care planning, advice on safeguarding, contributing towards staff recruitment and supporting community awareness-raising.

The congruence between the experiences of operations staff, care home staff and café attendees would suggest that an advantage of the role is its ability to work across different levels of an organisation to the same effect and for the same ends. A large proportion of evaluation participants also mentioned the independence and objectivity of the role, which provided them with the opportunity to turn to a third party in challenging situations. This is significant for a role such as the MHLAN, because its connection with Admiral Nursing may set it apart from other specialist in-house roles in this regard.

How the role relates to Admiral Nursing and *My* Home Life

As noted in the background and context of section of this report, the My Home Life Admiral Nurse role was developed by the Orders of St John Care Trust in collaboration with Dementia UK and *My* Home Life. The aim was to develop a role that combined the expertise of dementia specialist nursing with best practice in improving the quality of life for those living, working and dying in care homes.

The evaluation findings indicate that the role has a high level of consistency with the Admiral Nurse core competency framework, with some aspects more strongly evidenced that others. Sharing information and promoting best practice were the two most common and impactful competencies demonstrated in the MHLAN role. In addition, there was a strong overlap with the ethical and person-centred care competency. The role involved significant expertise in delivering training and practice

guidance within care home settings, which would not necessarily be evident in community-focussed Admiral Nursing work. Moreover, this required a holistic view of care home culture overall, rather than a narrower focus on aspects of dementia care, suggesting a wider skill set in this regard.

The role also resonated strongly with the *My* Home Life philosophy and ways of working, including fostering the senses framework themes of belonging, purpose, achievement, security, significance and continuity, as well as working in appreciative, relationship-centred, reflexive and evidenced-based ways. However, it is important to note that there are also high levels of congruence in the evidence related to the *My* Home Life themes, the Admiral Nurse competencies and the most significant aspects of the MHLANs' practice. This raises questions about the extent to which *My* Home Life enhanced the Admiral Nurse role as implemented in OSJCT. From the outset of this evaluation it was clear that within the day-to-day functioning of the MHLAN they were referred to as 'Admiral Nurse'. The absence of recognition of the MHLAN title meant that for this evaluation the role had to be referred to as 'Admiral Nurse' in order to achieve clarity. This, together with the limited integration of the *My* Home Life practice at the inception of the first post, as discussed in the report would suggest that the *My* Home Life philosophy has not been an explicitly separate or distinct element of the MHLAN role.

The congruence between the MHLAN role, Admiral Nursing and *My* Home Life approaches was explored as part of the focus groups with the MHLANs (familiar with the *My* Home Life framework) and Admiral Nurses working in other care home organisations, (unfamiliar with the framework). Both of these groups felt that, whilst the themes and ways of working resonated strongly with their practice, this was because it was aligned with the core competencies of Admiral Nursing. Specifically, both groups felt that they worked in these ways *because of who they were as people* as opposed to any framework or competency to which they subscribed. This is not to say that knowledge and understanding of *My* Home life and its evidence base is not an important new way of working for Admiral Nurses within care home organisations, but rather to suggest that it is not a determining factor of the ways in which they work.

Admiral Nurses in both focus groups did identify that a broad understanding of what works in care homes, the challenges they face and what supports positive practice change (of which *My* Home Life is a significant part) is an important element of the knowledge Care Home Admiral Nurses need; one that is not a given for Admiral Nurses, particularly if they have only community-based experience. The inclusion of a specific competency relating to what works in care homes would therefore be advantageous.

This point is particularly relevant with reviews to the Dementia UK Competency Framework due to be undertaken in 2015.

Conclusion

In summary, the MHLAN provides a highly varied and impactful function within OSJCT, with influence extending from individual resident outcomes to organisation-wide change. MHLAN input was universally valued by those who had contact with them; suggested improvements focused on increasing the number of posts and levels of contact rather than changing their roles in any substantial way. The role had a high level of consistency with the Admiral Nurse core competency framework, although some functions occurred more frequently than others. In addition, practice consistent with the *My* Home life philosophy and ways of working infused the work of the Admiral Nurses at every stage. This also appeared true with the focus group conducted with Admiral Nurses working in other care home organisations, suggesting that a strong model could be emerging within the sector, to which this evaluation contributes.

The intended outcomes of the MHLAN role within OSJCT were fourfold and this evaluation suggests that each has been fully met by the practice of the MHLAN thus far. Both qualitative and quantitative evidence presented here suggests that, as a result of the MHLAN's practice there is:

- An improved quality of care and wellbeing provided to people with a dementia;
- Empowerment of staff through increasing knowledge, skills and confidence in relation to dementia;
- Enhanced relationships with families and relatives of people with dementia;
- Residents enabled to stay in the care home in which they are settled if their dementia care needs become more acute;
- Assistance provided to relatives and carers of people living with dementia (both living in care homes and in the community) which enables them to feel more confident and empowered in their support and more confident in care home provision as an option.

Recommendations

The following recommendations stem from the findings of this evaluation. A number of them are already being acted on within OSJCT which suggests that the organisation recognises the value of the role and is constantly seeking to improve its impact on residents, staff and visitors.

1. Routine and reactive work

When addressing areas of enhancement of the role, many participants identified that having regular and routine contact with 'their' Admiral Nurse would be beneficial, particularly as a way to pre-empt some of the reactive work they are often called upon to do. Survey responses suggested that when a home had contacted the Admiral Nurse about one issue, they were more likely to do so again about other issues. It is recommended that the role should be structured to allow this routine involvement. Structuring the role so as to have approximately one day every two months in each care home would enable the Admiral Nurse to develop relationships with key people, get to know (and be part of) the home and undertake many of the organisational care quality tasks without compromising their reactive availability. In addition this would raise the profile of the role throughout the organisation's care homes.

2. Contact with external professionals

Engaging with external professionals was a valued and impactful part of the MHLAN's work. However, it proved difficult to obtain accurate data about such contacts for this evaluation. The relationships between care homes and external systems are of crucial importance to the culture within that care home, (Killett et al. 2013) and are often a problematic area. Therefore it is recommended that systems be put in place to systematically capture the levels and impacts of MHLAN contact with external professionals. This will enable a picture to emerge as to how and why MHLANs engage with such roles. This should be done without overly burdening the MHLAN role itself.

3. Relationship with Admiral Nursing

The specialist nature of this work, its location within the Dementia UK Admiral Nurse structure, and the personal attributes of an Admiral Nurse were all significant to the impact of the role, particularly as it ensured that the role was positioned as an 'external role in-house'. This led to a perception and experience of objectivity that was crucial to the role's influence and value and arguably could not be guaranteed within a more 'in-house' model. Therefore it is recommended that this is acknowledged and maintained within any future developments in OSJCT and Dementia UK.

It is also recommended that OSJCT and Dementia UK explore the factors that may contribute to this perceived objectivity and the ability of MHLANs themselves to maintain it.

4. Care home practice and culture change expertise

It is clear from this evaluation that the MHLANs bring not only their dementia expertise, but also experience and knowledge of how to support practice and culture change within care home environments. This is something that would not routinely be required of a 'traditional' Admiral Nurse. In fact for the MHLANs and those working in other care home organisations, much of this has been learned 'on the job' or through previous work experience. It is therefore recommended that with regard to future posts, consideration is given (whether by Dementia UK or employing organisations) to providing the following as part of continuing professional development:

a) Development of an up-to-date knowledge base regarding UK care home culture, supporting organisational change and training and practice development (of which *My* Home Life is a significant part). Competencies may be developed to reflect this within the forthcoming Competency Framework revisions;

b) Development of a peer-support network/community of practice for Admiral Nurses working within care home organisations.

We also recommend that Dementia UK undertake to consider more fully the 'care home' core competency (including *My* Home Life's place within that) in recognition that care home environments are unique settings, requiring specialist expertise that Admiral Nurses will not necessarily have through their nursing or dementia experience.

5. Relationship with *My* Home Life philosophy

Whilst awareness of the *My* Home Life evidence base is a crucial part of the care home competency recommended above, an explicit and exclusive adherence to the *My* Home Life approach was not a significant factor in the function and impact of the MHLAN role. Instead, the role of Admiral Nursing and the attributes of individual Admiral Nurses seem to reinforce the evidence-base of *My* Home Life.

However, this is in the context of a minimal level of integration between the MHLANs and the *My* Home Life framework from the inception of the role. Therefore it is important to consider the future relationship between MHLAN in OSJCT and *My* Home Life. We therefore recommend that OSJCT review their intended outcomes for the role and the extent to which it is intended to be a dementia specialist role or a care home culture transforming role. If it is to be the latter, consideration should be given to more fully integrating with the *My* Home Life evidence base and philosophy.

6. Awareness raising

This evaluation found that awareness of the MHLAN role (or Admiral Nurse role) was inconsistent, and reliant on a home having received contact from the MHLAN themselves. It is therefore recommended that OSJCT consider how to raise awareness of

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such roles amongst its own operational staff, as well as to visitors and staff in care homes. However, this needs to be done in consultation with the MHLANs in recognition that increased awareness will lead to increased workload. Too high a workload will likely impact upon the responsiveness of the MHLAN which was a highly valued feature of the role. Considering more routine ways for MHLANs to have contact with care homes might be a way to raise the profile, whilst carefully monitoring the impact this on workloads.

7. Caseload

It is of huge credit to the OSJCT Admiral Nurses currently in post that their flexibility and responsiveness was cited as impactful even in the region in which they were not based. It would appear from this evaluation that the appropriate case load for the OSJCT is based on number of care homes rather than residents within care homes, as it is the relationship with care home management and staff that determines the ease of access and success of input in each home. A case load of between 15-20 care homes allows for one day of routine contact with each care home on a bi-monthly basis, whilst also allowing a flexible response to reactive case work. Therefore, this would mean an Admiral Nurse per geographical region would be appropriate for the current work type of the OSJCT Admiral Nurses. It is notable that this structure is now in place within OSJCT.

8. What's in a name?

Given this evaluation's finding that awareness of the Admiral Nurse role was inconsistent, the inclusion of '*My* Home Life' as a role descriptor may not be helpful in raising this awareness, particularly given that the framework did not appear to be integrated substantially in the function of the role. OSJCT will need to consider if the impact of the more complex 'MHLAN' is helpful in increasing role recognition. This will depend on the outcome of recommendation 5.

Introduction

The Orders of St John Care Trust (OSJCT) (http://www.osjct.co.uk/) was one of the first care home provider organisations to employ an Admiral Nurse to provide in-house dementia specialist consultancy, training, advice and support. The role was created as part of OSJCT's clinical governance strategy to ensure excellence in care and nursing practice across its services. Working in collaboration with Dementia UK (DUK) (http://www.dementiauk.org) and My Home Life (MHL) (www.myhomelife.org.uk), the role aimed to combine the expertise of dementia specialist nursing with the evidence-base of best practice in improving the quality of life for those living, working and dying in care homes.

While the Admiral Nurse role, created by national charity Dementia UK in 1990, is relatively well established, the operation of the role within care homes is a much newer phenomenon. OSJCT employed its first Admiral Nurse in 2010, and this was only the second such post in the UK. Since then, OSJCT has employed additional posts (totalling four at the time of writing) and a number of other care home provider organisations have also done the same. However, because of the organic development of such posts over recent years and their evolution from an originally community-based model, there is currently no single role description for such a post and thus each organisation's Admiral Nurses could operate in different ways according to the needs and intentions of the organisation itself.   This is a therefore a rapidly increasing area of work for Admiral Nursing and a potentially significant development in the delivery of residential care for people living with dementia. However, to date there has been no systematic evaluation of such a role.

In early 2013, OSJCT applied to the Burdett Trust for Nursing (http://www.btfn.org.uk) for funding to support an evaluation of this role. The Burdett Trust makes grants in support of nurse-led projects, aimed at empowering nurses and improving the patient care environment, (Burdett Trust for Nursing, 2014). The application was successful under the 'Delivering Dignity through Empowered Leadership' funding stream. A grant of £50,000 was provided, with remaining costs including an organisational project lead, to be met by OSJCT. In September 2013, OSJCT commissioned the Association for Dementia Studies (ADS) at the University of Worcester to design and carry out the evaluation in line with OSJCT's original proposal to the Burdett Trust.

This evaluation ran from January 2014 to January 2015 and sought to evaluate the structure, impact and possible improvements of the Admiral Nurse role within OSJCT. It

addressed the functioning of the role since its conception within OSJCT in 2010, which encompasses the initial post and the additional two posts created prior to October 2013. The findings and recommendations from the evaluation are contained in this report.

Background and context

Overview of OSJCT

The Orders of St John Care Trust (OSJCT) is a charity that provides care in over 70 care homes as well as a domiciliary care service in seven independent living (extra care housing) schemes across Lincolnshire, Oxfordshire, Gloucestershire and Wiltshire. OSJCT employs approximately 4,000 staff and look after over 3,500 residents.

OSJCT is sponsored by two historic Orders of Chivalry. One is the Sovereign Military and Hospitaller Order of Jerusalem, Rhodes & Malta ("the Order of Malta"). The other is the Most Venerable Order of the Hospital of St John of Jerusalem ("the Venerable Order"). Between them, these two Orders bring a combined total of over 1,000 years of experience in care, relief and service.

The majority of care is commissioned and funded by local authority placements with the remainder being funded by residents themselves. The majority of homes are registered to provide residential care only, and so are without in-house nursing support.

Each of the four counties has its own operational management team reporting into an operational director, based at the Trust offices in Witney, Oxfordshire.

Overview of Admiral Nursing

The Admiral Nurse specialist dementia role was established by the national dementia charity Dementia UK in 1994. The traditional role of the Admiral Nurse provides support to family carers living in the community and caring for a person with dementia living in their own homes. The role offers skilled assessment of the needs of family carers and people with dementia, as well as providing information and practical advice on the different aspects of care.

All Admiral Nurses operate within the Admiral Nursing Competency Framework, which outlines the key responsibilities and areas of concern for Admiral Nurses and supports their continuing professional development. The eight core competencies are as follows:

- Undertaking therapeutic work (interventions)
- Sharing information about dementia and carer issues
- Advanced assessment skills

- Prioritising work

- Preventative work and health promotion

- Ethical and person-centred care

- Balancing the needs of the carer with the needs of the person with dementia

- Promoting best practice

(RCN, 2004)

The care home model of Admiral Nursing is less well-established, although it is becoming more common. To date, there are 15 Admiral Nurses working in the care home sector, with this changing on regular basis. Within OSJCT, the Admiral Nurse role differs in the provision of support to both formal carers and informal carers and entails a much more extensive practice development function. In particular, the Admiral Nurse role within OSJCT actively incorporated the *My* Life Home framework into the work of the Admiral Nurse with its focus on improving relationships and culture in care homes.

Overview of *My* Home Life

My Home Life's vision of best practice is structured around eight themes which identify what evidence-based best practice in care homes for older people looks like in the 21st century. The work of *My* Home Life acknowledges and draws upon 'Relationship-Centred Care' and the 'Senses Framework' (Nolan et al, 2006), which proposes that in the best care environments residents, families and staff all need to experience a sense of security (to feel safe), belonging (to feel part of things), continuity (to make connections), purpose (to have goals), achievement (to move towards goals) and significance (to matter as a person). To help identify what matters to residents, relatives and staff to enhance their well-being, *My* Home Life has been drawing, more recently, on Caring Conversations (Dewar & Nolan, 2013) to help make this happen – encouraging people to be courageous, connect emotionally, be curious, collaborate, consider other perspectives, compromise, and celebrate.

My Home Life identifies evidence-based ways of working that contribute to achieving the senses framework in practice. These ways of working are grouped into three different areas and are applicable not only to older people, but also, families and staff:

i) Those best practices which seek to personalise and individualise care in homes – tailoring care to the needs of each individual:

- Maintaining Identity (See who I am!)

- Creating Community (Connect with me!)

- Sharing Decision-making (Involve me!)

ii) Those which are concerned with what needs to be done to help residents, relatives and staff navigate their way through the journey of care:

- Managing Transitions (Support me to adapt!)

- Improving Health and Healthcare (Enhance my well-being!)

- Supporting Good End of Life (Guide me to the end!)

iii) Those concerned with the issues of leadership and management required to transform care into best practice:

- Keeping Workforce Fit for Purpose (Facilitate my learning!)

- Promoting a Positive Culture (Help to flourish!)

The *My* Home Life Admiral Nurse role within OSJCT

The Orders of St John Care Trust recruited their first Admiral Nurse post in November 2010 to lead on best practice across all its care homes. The post was based in Oxfordshire and was only the second appointment of an Admiral Nurse within the care home sector. This individual remains in post to date.

An additional two posts had been recruited to OSJCT at the time of this study with the Lincolnshire post recruited in May 2012 and the Gloucestershire post in January 2013. The fourth region (Wiltshire) was covered by these three Admiral Nurses together. A fourth post was recruited for this region in October 2014 following the end of this evaluation.

The post was titled '*My* Home Life Admiral Nurse' (MHLAN) to reflect the collaboration between Dementia UK, *My* Home Life and OSJCT. Acknowledging evidence from previous research that in-reach work in care homes needed to embrace the importance of culture in a home (Keating et al. 2013), the post was intended to actively incorporate the *My* Home Life framework, which highlighted the most effective ways to improve the quality of life of those working, living and dying in care homes.

In practice, the first MHLAN post holder took part in the *My* Home Life facilitation course as part of her induction to the role. Following this the MHLAN was unable to attend further *My* Home life meetings and events. Subsequent MHLAN post holders

received only minimal *My* Home Life input, largely through the original MHLAN post holder. Therefore, while this evaluation is of the MHLAN role as implemented within OSJCT homes, it should be acknowledged that the extent to which the *My* Home Life framework was formally embedded in the role was limited. Findings must therefore be considered in this context.

The examples of practice development and value accorded to the MHLAN role by OSJCT care teams should nonetheless be considered within the framework of the eight MHL themes, the senses framework (Nolan et al. 2006), and the Admiral Nursing Competency Framework, as these have informed its inception and development, albeit to greater or lesser degrees. They are not considered within the framework of Caring Conversations (Dewar & Nolan, 2013), as this has only been a more recent development in *My* Home Life.

The anticipated outcomes of the first OSJCT MHLAN post were:

- An improved quality of care and wellbeing provided to people with a dementia
- Empowerment of staff through increasing knowledge, skills and confidence in relation to dementia
- Enhanced relationships with families and relatives of people with dementia
- Residents enabled to stay in the care home in which they are settled if their dementia care needs become more acute.

It should be noted that, despite the collaboration with *My* Home Life these anticipated outcomes all relate to dementia care specifically, in line with the foundation of Admiral Nursing, rather than care home care more widely, which is the foundation of *My* Home Life

Rationale for this evaluation

Whilst there has been some evaluation of the Admiral Nurse role generally (Bunn, 2013), there has to date been no systematic evaluation of the Admiral Nurse role within the care home sector.

In their scoping of the role of the acute dementia nurse specialist, Griffiths et al. (2013) suggest there should be one whole time equivalent dementia nurse specialist for every 300 hospital admissions for people with dementia per year into the acute sector, to have a realistic chance of success. Currently there is more evidence as to the effectiveness of the role of the dementia nurse specialist in the acute sector than in the

care home sector. This highlights a stark absence of evidence in relation to the care home sector, particularly given that the majority of long-term institutional care for people living with dementia is provided by care homes.

In the context of decreasing income as a result of local authority cutbacks (Laing and Buisson, 2012), many care home organisations struggle to justify funding clinical nurse specialist posts and as such an evaluation of the effectiveness and scope of such a post, is timely.

In particular, including within such an evaluation a comparison between the Care Home Admiral Nurse role and the competencies of the more traditional Admiral Nurse and identifying the influence of the *My* Home Life values on the conduct of the role, could provide important information for future development of such a role.

Parameters of this evaluation

As highlighted above, the role of the MHLAN within OSJCT has been an evolving development at the forefront of changes to the Admiral Nurse role and its presence within the care home sector. It is therefore inevitable that this evaluation reflects the evolving nature of the post/s. This is manifest in the following way:

This project is an evaluation of MHLAN role as operating in OSJCT between November 2010 and October 2014. This period reflects a time in which the geographical spread of the role was uneven, with Oxfordshire being the base for the initial post, and additional roles based in Lincolnshire and Gloucestershire starting in May 2012 and January 2013 respectively. Whilst the roles were always available as a Trust-wide resource, we would still expect geographical unevenness and length of time in post to be reflected in the data.

Methodology

Overall Aim

The overall purpose of this evaluation was to establish the nature and impact of the Admiral Nurse role within OSJCT and to make recommendations for the most appropriate model and future development of the role within OSJCT and the care home sector as a whole.

It sought to provide a rich description of the current post, its operation and impact by exploring the perspectives of a range of stakeholders: MHLAN's, Care Home staff; OSJCT operations staff; external partners to the care homes (GPs, district nurses, community psychiatric support teams etc.); and attendees of OSJCT-based dementia cafes which include people living with dementia and people supporting someone living with dementia both within OSJCT care homes and in the community.

The evaluation used an Appreciative Inquiry approach and was carried out through two key phases: a survey phase and a follow-up phase comprising telephone interviews and case study work. In addition, preliminary findings were shared with discussion groups towards the end of the evaluation to compare and contrast findings with the experiences of key stakeholders. Each of these phases is discussed below following an outline of research questions and the Appreciative Inquiry approach.

Research Questions

The evaluation sought to address the following broad questions:

- What impact has the MHLAN role had on the care homes within OSJCT, their staff and the work they do?

- What impact has the MHLAN had on the individuals who attend dementia cafes, some of whom are living with dementia or caring for someone living with dementia in the community?

- Which competencies and attributes of the role make it most effective and how does this relate to traditional Admiral Nursing competencies and the *My* Home Life philosophy?

- What is the most appropriate case load of the MHLAN role within OSJCT care homes?

An Appreciative Evaluation

This evaluation adopted an Appreciative Inquiry (AI) approach, due to its congruence with the *My* Home Life value-base and a desire to explore and improve the role of the MHLAN. AI begins with an intention to investigate what is successful or valuable in what people do and how that can be expanded, as opposed to focussing on problematic areas, (Cooperrider et al., 2003). In particular, AI demands a collaborative approach from researchers, seeking the engagement of research partners throughout the research process, and conducting research *with* participants rather than *of* a certain role, setting or group, (Dewar, B. & Nolan, M., 2012).

An AI model usually contains four stages: *discovering* achievements, *dreaming* of ideal states, *designing* how states can be reached and *delivering* changes, (Reed, 2010). An AI approach was adopted during the following key phases of the project to contribute to the 'discovery' and 'dreaming' stages in particular.

i)   The focus of the survey, interviews and case study phase were based on discussions with the MHLAN and members of a dementia café run within OSJCT. This ensured that the areas to be explored within the evaluation were grounded in the experience of MHLAN, their work and those who had contact with them.

ii) When designing interview schedules, questions adopted positive phrasing rather than focussing on problems.

iii) Each individual who took part in evaluation interviews was offered a copy of their interview transcript and invited to provide clarifications and further comments.

iv) The preliminary findings of the evaluation were shared with the MHLAN and Admiral Nurses working in care home organisations other than OSJCT in order to explore congruence with their experience and seek opinions on recommendations. Efforts were made to do the same with dementia café attendees, but this was not possible prior to the completion of the evaluation.

As this was an evaluation rather than an action research project, additional work will be required from the organisations implementing and supporting the MHLAN in order to achieve desired change in line with a true AI approach. It is hoped that the discussion and recommendations contained in this final report support the relevant organisations to achieve the ultimate AI intentions of *designing how states can be reached* and *delivering changes*.

Data Collection, Recruitment Processes and Participants

Data collection took place across two distinct phases as described below. Descriptive detail of the recruitment strategy and participant numbers to each phase is provided, together with a discussion of any difficulties faced and changes from the original research protocol.

Phase 1 - Survey

Survey design

The survey was designed to capture quantitative and brief qualitative data on the activity, scope and impact of the MHLAN, with the intention of ensuring that later, qualitative stages of the research could explore key trends and issues in depth.

The survey was constructed following a short period of background research into the structure and intention of the role as originally conceived by OSJCT. In addition, a discussion group was held with the MHLANs (**n=3**) and members of a dementia café run within OSJCT (**n=7**) to ensure that pertinent issues and experiences from their perspective were explored through the survey.

This background research and consultation influenced both the content and distribution of the survey. Due to the range and diversity of contact with the MHLAN, each stakeholder group received a different survey containing questions tailored to their specific type of contact. Relevant job roles and routes for distribution were also identified by the MHLANs, OSJCT Project managerand the steering group. Table 1 summarises the four distinct survey groups, and the means of identification and distribution.

Table 1: Survey group respondents and distribution strategy

Survey Group	Indicative respondents	Identification and distribution
Care Home Staff	Registered managers; heads of care; dementia leads; activities coordinators from every care home within OSJCT	OSJCT project manager provided e-mail contacts.
Operations Staff	Non care home staff employed within OSJCT e.g. Area operations managers, training managers, care directors.	OSJCT project manager provided e-mail contact.
Dementia Café Attendees	Any visitor/carer or person living with dementia who contact with the Admiral Nurse through dementia café or other means.	Admiral Nurse distributed hard copies of survey to participants
External Professionals	Any external professional who had contact with the care homes/Admiral Nurses.	OSJCT project manager to identify contacts through OSJCT staff

The survey was designed by the project team at ADS to be distributed electronically, with a hard-copy version available on request. It was developed using 'Survey Monkey©', a popular and user-friendly tool for creating and completing surveys. Content was reviewed and adapted by members of the evaluation steering group prior to distribution.

Survey participants – OSJCT Staff

Potential survey participants were identified following the initial discussion groups and with steering group input according to the indicative roles outlines in table 1 above. All staff currently in those roles were invited by email to participate in the evaluation. This initial communication explained the purpose of the evaluation and emphasised that participation was voluntary. At two points during the survey period, OSJCT project manager sent follow up e-mails as a reminder. In addition, a small selection of former employees (9) were contacted via post and invited to take part in the survey, as it was thought that staff turnover rates within OSJCT (20%) might mean that key informants were no longer in post. As a result of this approach two past employees completed the survey.

In total, the survey was distributed to **280** care home staff with a response rate of **35%**, and **29** operations staff with a response rate of **83%.** The tables below present the total number and geographical/role breakdown of respondents in these two groups.

Table 2: Region and Role of Survey Respondents – Care Home Staff

Job role	Gloucestershire	Lincolnshire	Oxfordshire	Wiltshire	Overall
Registered Care Home Manager	10	11	12	8	41
Head of Care	2	6	8	6	22
Team Leader	0	1	4	1	6
Activities Co-ordinator	4	3	5	4	16
Other	2	6	2	3	13
Totals	18	27	31	22	**98**

Of these 98 respondents, 32 also classed themselves as dementia leads (a designation combined with another job role). Gloucestershire and Wiltshire had six dementia leads respond to the survey, Lincolnshire nine and Oxfordshire 11. Three respondents did not specify a job role and/or region.

Table 3: Operations Staff Respondents

Job role	Gloucestershire	Lincolnshire	Oxfordshire	Wiltshire	Total in role
Area Operations Manager / Director	2	3	4	2	11
Training	5	5	5	5	5
Housing	1	2	1	2	2
Care	1	2	1	2	2
Quality	2	3	2	2	3
Totals	11	15	13	13	**24**

Operations staff can work across more than one geographical region and so could select more than one option. One respondent did not select a job role and/or region.

Reasons for non-response to the survey are unknown. Despite the relatively low response rate for care home staff, it is notable that the percentage of care homes from each region represented by at least one respondent is high for both Lincolnshire and Oxfordshire, where the MHLAN post has been operative for the longest. It would be expected that Wiltshire would have lower response rate due to the absence of a dedicated admiral nurse. The cause of Gloucestershire's lower rate is unknown.

Table 4: Operations Staff Respondents same as page 37?

Area	Number of homes	Homes responding
Gloucestershire	19	13 (68%)
Lincolnshire	16	15 (94%)
Oxfordshire	17	16 (94%)
Wiltshire	21	14 (67%)
Totals	73	58 (79%)

Survey Participants – Dementia Café attendees

Contact between the MHLAN and attendees of the dementia cafes (and other visitors/relatives) is not recorded centrally within OSJCT. Therefore, the MHLANs themselves were provided with hard copies of the survey for this group and asked to distribute it to anyone with whom they had contact. Approximately 16 surveys were

distributed in Gloucestershire and Lincolnshire. No surveys were distributed in Oxfordshire or Wiltshire as they had no active dementia cafes at the time of the survey.

It was expected that respondent numbers would be small because only a few dementia cafes were running within OSJCT at the time of the survey, these cafes typically had low numbers of regular attendees and contact outside of such cafes would not necessarily result in contact details being recorded. Six respondents from dementia cafes completed the survey, three from Gloucestershire and three from Lincolnshire.

Survey participants – External Professionals

The initial intention was to survey external professionals with whom the MHLANs had had contact because liaising with such professionals was identified as being a key part of MHLAN work, particularly in relation to specific resident interventions. Following discussion groups and steering group input, a list of possible external professional roles was identified including: General Practitioners; District Nurses; Community Mental Health Teams; Adult Social Care; Regulators; and Care Home Liaison teams. Two successive strategies were used to distribute the survey to these role types:

- Hard copies and electronic links to the survey were provided to the MHLAN to distribute to any known contacts
- OSJCT project manager was asked to identify contact details for such respondents from OSJCT staff and forward to the research team directly

In total four surveys were distributed and two replies were received, both from external professionals who had had limited (one-off) contact with an OSJCT care home. This low level of response may in part be explained by changes in personnel within these teams and by a persistent difficulty in ensuring engagement with such professionals in the course of Admiral Nurse work overall. In addition, during the period of the survey, the MHLAN reflected that much of their work was internally-focussed, thereby creating few opportunities to distribute the surveys. In light of this low response rate, it was decided by the steering group that the issue of contact with external professionals should be explicitly explored through interviews and case studies with OSJCT staff.

It is notable that, as the findings show, contact between the MHLAN and external professionals was cited as an important part of the work by OSJCT staff. This suggests that there is a need to find alternative ways of capturing this data, as it is currently under-recognised. A recommendation is made regarding this issue in the conclusions of this report.

Phase 2 - Telephone Interviews and Case Studies

The interview and case study phase was designed to explore the experience of the MHLAN role from several perspectives: different positions within OSJCT, dementia café attendees and external professionals. In particular the aim was to investigate in more detail emerging issues from analysis of the survey results, such as geographical differences or the impact of contact.

Semi-structured interview schedules were designed for each stakeholder group and/or job role to explore the following issues:

- Involvement of the MHLAN

- Impact of the MHLAN

- Specific examples of contact relating to resident care, relative support, staff development and external relationships

- Aspects of the role that were valued and those that might be enhanced/improved

Interview schedules were reviewed and revised by members of the steering group to ensure pertinent issues relating to Admiral Nursing, *My* Home Life and the context of Care Homes were explored. Similar schedules were used for both the telephone interviews and case studies

As a result of the absence of external professional contacts and survey responses it was not possible to conduct telephone interviews with the group.

Telephone interview participants

Respondents to the survey were asked to indicate if they would be interested in taking part in a research interview. In addition, MHLANs were asked to provide the names of any care homes where they had experienced particularly high levels of contact. This was to ensure selection at this stage could capture different levels of contact and thereby reflect variations in the nature and impact of the role.

From the 60 initial volunteers to take part in an interview, participants were purposefully selected to reflect the following:

- Representation from each geographical region

- Representation of a variety of different roles, (ensuring a range of operations staff roles, a range of care home staff roles and dementia café attendees)

- Representation of a variety of levels of contact with MHLAN

Selected volunteers were e-mailed to confirm their continued willingness to take part and to arrange a suitable date/time. Where chosen volunteers withdrew, a similar replacement was chosen from remaining volunteers whenever possible. Those volunteers who were not chosen were e-mailed to thank them for their offer. Table 5 describes the participants to the telephone interviews.

In total, **16** interviews were conducted, a higher number than initially planned. This was to compensate for the absence of external professional participants and to ensure sufficient representation of operations staff, as some survey respondents had reflected that the survey did not capture the breadth of their contact with the MHLAN.

Table 5: Participants in telephone interviews

Classification		Gloucester-shire	Lincolnshire	Oxfordshire	Wiltshire	Overall
Care home staff (#)	Manager	0	1	1	0	2
	Team Leader	0	0	0	1	1
	Activities Co-ordinator	1	1	1	0	3
	Trainer	0	0	1	0	1
	Other	1	0	0	0	1
Totals		**2**	**2**	**3**	**1**	**8**
Operations staff*		2	3	3	3	5
Dementia café attendees		0	1	2	0	3

(#) Three participants from the group were also designated dementia leads.
(*) Some work across more than one region

Case Study Participants

From 27 initial volunteers, case study participants were chosen to reflect geographical differences, and, (for ease of access), where the registered manager had volunteered as a case study as opposed to another member of staff. Whilst there were initially volunteers from all four regions, withdrawal meant that no case study could be found for Gloucestershire, despite follow up from OSJCT project manager. A final case study was therefore selected from the other regions. Reasons for withdrawal are unknown as withdrawal was indicated by the lack of response to follow up contact.

Registered managers were contacted to arrange a suitable day for the researcher to visit and it was explained that the research team would like to interview the manager, the head of care, the dementia lead and a selection of staff (of the manager's choosing) who may have had contact with the MHLAN. In practice, interviews with this range of people were often not possible on the day of the visit due to changing shift patterns, work demands or sickness. Where this was the case, telephone interviews were offered following the visit in an attempt to capture missing participants, particularly as it was noted that frontline staff members were under-represented. However, this strategy only yielded one additional participant. Table 6 describes the case study participants:

Table 6: Case Study participants

Job role	Gloucestershire	Lincolnshire (*)	Oxfordshire	Wiltshire	Overall
Manager/ Head of Care/ Care Manager	0	3	1	3	7
Activities Co-ordinator	0	1	0	0	1
Other (front line staff, volunteers)	0	1	1	0	2
Totals	0	5	2	3	10

(*) Two case studies took place in Lincolnshire

Data Analysis

Data were analysed using a basic thematic approach, with the aim of identifying themes and patterns of meaning across a data set in relation to the research questions (Braun & Clarke, 2012). Analysis took place in three distinct phases throughout the course of the project as described below.

Survey analysis

Responses from each survey group were exported from *Survey Monkey* into an Excel spreadsheet. Results were analysed to produce basic descriptive data for each survey group. A summary of these data was examined by two researchers to identify emerging themes and issues to explore in the qualitative phase of the evaluation and to support development of interview schedules. There was strong correlation between the themes identified by both researchers at this stage.

Qualitative data analysis

Interview and case study data were transcribed, anonymised and imported to NVivo 10, a specialist software package designed to aid systematic thematic analysis. A broad, skeleton coding framework was developed by the same researchers who had conducted the interviews and reviewed the survey data. This was based on their developing understanding of possible themes through undertaking the data collection in relation to the research questions regarding:

- The impact and contact/case load of the MHLAN role

- The most effective competencies and attributes of the MHLAN role

- The relationship between these effective competencies and attributes and the Admiral Nursing and *My* Home Life frameworks

This broad coding framework identified three distinct areas for analysis using first an inductive thematic approach and then a theoretical thematic approach, (Braun & Clarke, 2012). Firstly, an inductive thematic analysis was undertaken to explore the descriptive elements of the MHLAN role within OSJCT (tasks, determinants, impact and value of the role). Secondly, a theoretical thematic analysis was undertaken to compare the MHLAN role with the core competencies of Admiral Nursing. Thirdly, a theoretical thematic analysis was undertaken to compare the MHLAN role with the *My* Home Life framework according to the senses framework and ways of working. All data were coded and sorted according to these areas and then each sub-section of data was analysed further to determine: Sub-themes of the broader themes (e.g. the different types of impact of the Admiral Nurse); patterns within the themes and sub-themes (e.g. which Admiral Nursing competencies were most common); and connections between the themes and sub-themes (e.g. Where *My* Home Life ways of working were strongly associated with an impact of the role).

Discussion groups

Once preliminary findings from the qualitative analysis were established they were shared with two distinct discussion groups: MHLANs working in OSJCT homes and Admiral Nurses working in other care home organisations. The purpose of these discussion groups was not to collect data but to strengthen data analysis by exploring resonance and relevance and identifying any gaps by:

- Contrasting the preliminary findings with the experience of discussion group members

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- Identifying any possible explanations for similarities and differences between findings and experiences
- Exploring possible recommendations and ways forward following the evaluation

A short summary of key points from each discussion group was produced by the researchers and is incorporated in the conclusions and discussion section of this report.

Discussion group participants

For the discussion group with MHLANs the researcher requested permission to attend a scheduled meeting to share and discuss findings. **Four** MHLANs were present (including a new recruit) and a member of Dementia UK. For the discussion group with Admiral Nurses working in other care home organisations, volunteers were identified through contact with Dementia UK, and a suitable time and venue for the group arranged. In total, **five** Admiral Nurses (from three care home organisations) attended their discussion group. Despite considerable efforts, it was not possible to arrange a discussion group with dementia café attendees prior to the end of the evaluation.

Timescale

Table 7 presents an overview of the timescale and key phases of the project. Some phases overlapped to ensure that the project was completed on time.

Table 7: Project timetable

Phase of project	Month
Project set up	December 2013 – February 2014
Survey phase	February 2014 – June 2014
Interview and case study phase	July 2014 – September 2014
Analysis phase	October 2014 – November 2014
Discussion groups	November 2014 – December 2014
Reporting phase	December 2014 – January 2015

Project Governance

The research for the evaluation was overseen by Dr Simon Evans (Principal Research Fellow, ADS). Isabelle Latham (Senior Lecturer, ADS) acted as project manager,

coordinating day-to-day management, data collection and analysis. Teresa Atkinson (Senior Research Fellow, ADS) and Jennifer Bray (Research Assistant, ADS) supported data collection and analysis. Victoria Elliot (Principal Care Consultant (Research & Innovation) OSJCT) acted as project manager within Orders of St John Care Trust and was responsible for ensuring effective liaison between the research team and participants for the purposes of data collection.

An evaluation steering group was established that comprised Dr Simon Evans and other members of the ADS project team, Victoria Elliot (OSJCT); Professor Julienne Meyer, (City University); Dr Julia Botsford, (Dementia UK); Sharon Blackburn, (National Care Forum); and Trish Jay (2gether NHS Foundation Trust). This group met on a quarterly basis throughout the evaluation and provided advice and support for achieving the project's key aims and objectives as well as ensuring delivery to timescale. Expertise regarding Admiral Nursing, *My* Home Life, and the UK care home context was present to enhance the methodology, data collection, analysis and dissemination of findings.

It was initially intended to recruit an 'expert by experience' to the steering group. Expressions of interest were invited from attendees of OSJCT-run dementia cafes. These expressions of interest were followed up in writing and by telephone by the OSJCT project manager. Despite the offer of assistance with transport and expenses it was not possible to secure attendance by an 'expert by experience' to the steering group.

Ethical approval for this project was sought from the University of Worcester ethics committee and was confirmed in February 2013.

Findings

Findings are divided into two separate but interconnected sections; survey findings and qualitative findings. This allowed the distinct analysis of each data set and recognition of the different respondent groups (care home staff, operations staff and dementia café attendees), particularly in terms of how each group might interact with MHLANs in different ways. The interconnections between findings from the two data sets are incorporated into the text and any contradictions or concurrence highlighted.

Survey findings

The survey findings below are presented according to stakeholder group: care home staff, operations staff and dementia café attendees. At the request of the steering group many survey findings are presented in text without the use of graphs.

Care Home Staff

General Response information

101 care home staff responded to the survey, 99 of whom were current OSJCT employees and two former employees. Nearly 80% of the 73 OSJCT care homes were represented by the survey responses, with at least two thirds of homes being represented in each of the four areas (see Table 8). Wiltshire had the lowest response rate, which might be expected due to the absence of a dedicated OSJCT Admiral Nurse, but it was actually only slightly lower than Gloucestershire.

Table 8: Responding homes per area

Area	Total number of homes	Homes with at least one member of staff responding to the survey	
Gloucestershire	19	13	68%
Lincolnshire	16	15	94%
Oxfordshire	17	16	94%
Wiltshire	21	14	67%
Overall	**73**	**58**	**79%**

The most common job role of respondents was Registered Care Home Manager (41 respondents), followed by Head of Care, (22 respondents), and Activities Coordinator,

(16 respondents). Other respondents' roles included Team Leader, Carer, Senior Carer, Acting Home Manager, Acting Head of Care and Care Leader. Many of the respondents were also Dementia Leads, although this dual role was less common amongst the Registered Care Home Managers and Heads of Care. The majority of care home staff respondents (77%) had been working with OSJCT for at least two years.

94 of 101 respondents (93%) reported some form of contact with a MHLAN and the following findings are based on the responses of these 94 respondents. Staff were asked to reflect on their contact with the MHLAN overall, rather than contact that occurred during a specific period of time.

Type of contact with the MHLAN

Respondents were asked to indicate the ways in which they received support from the MHLANs. Across all four geographical areas a roughly even split between face-to-face, e-mail and telephone contact was reported, with face-to-face support marginally more common. The value of the MHLAN being able to respond in different ways was appreciated by the care home staff as it enabled the MHLAN to be flexible in their approach and more easily accessible. This fits strongly with the findings of the qualitative data.

Advice was the most common type of support provided by the MHLAN followed by practical help, with signposting care home staff to other services being less common.

Response times were generally very quick, and no respondents felt that they had to wait too long or missed out on receiving support from the MHLAN. The speed of response was valued by the respondents, as reinforced by additional comments from the care home staff who said that:

> *"Any time we request the Admiral Nurses [sic] input [they] always gets back to us very quickly. Always replies to e-mails as soon as is able to, we always get meetings set up as and when [they have] got free dates and times to suit all"*

Additionally, they:

> *"always returns my call either the same day or the following day… supports with what we need very quickly and will always organise time to come and support us as soon as [they] can"*

MHLAN contact regarding resident support

Care home staff were asked to identify the types of resident support about which they had contacted the MHLAN. Table 9 demonstrates that they are contacted about a wide range of different topics, with the most common being distress behaviours, (both verbal and physical); resident behaviour in general; and health needs. Pets as Therapy was the topic that prompted least contact. No additional topics than those listed below were identified by respondents. It should be noted that some topics have a degree of overlap; for example a contact regarding resident behaviour may result in advice relating to meaningful occupation.

Table 9: Care home staff contact with MHLAN regarding resident care and support

Resident care contact	Overall % of respondents
Distress behaviours: physical	78%
Distress behaviours: verbal	73%
Health needs	63%
Monitoring resident/s behaviour	63%
Resistance to personal care	59%
Involvement of other professionals	57%
General care planning	53%
Providing meaningful activity	49%
Communication skills with residents	47%
Complying with the Mental Capacity Act	46%
Investigating life history	46%
Dementia diagnosis	46%
Nutrition/hydration needs	45%
Care home routines	43%
Cognitive stimulation therapy	41%
End of life care needs	39%
Physical environment of the care home	36%
Sexually inappropriate behaviour	33%
Attachment (doll) therapy	31%
Supporting move into/from the care home	28%
Pets as therapy	18%

Contact for any topic was not likely to be needed more than six times a year, with only a few respondents reporting more frequent contact from homes that had received high levels of intensive input from a MHLAN. Overall, there was also no notable difference between different job roles and the topics for which contact was sought. However, Heads of Care were slightly more likely to ask about involving other professionals and resistance to personal care than many other topics, while Registered Managers were more likely to ask about moving into/from a care home.

Additional information provided by respondents suggested that care home staff found the presence of the MHLAN to be reassuring.

> *"Knowing someone is there at the end of a phone call or email to help and advise us is so important to the well-being of the residents"*

> *"It is reassuring to know that there is someone in the Trust that we can turn to for all types of support regarding dementia care"*

MHLAN Contact regarding relative/visitor support

Contact regarding types of relative/visitor support formed a substantial part of the MHLAN role. All areas of contact were experienced by more than 50% of care home respondents. These area are listed below in the frequency order from highest to lowest.

- Involving relatives/visitors in their resident's care (69%)
- Providing emotional support to relatives/visitors (64%)
- Involving relatives/visitors in decisions about their resident's care (57%)
- Involving relatives/visitors in the general life of the care home (54%)
- Working with relatives/visitors who are viewed as 'challenging' (50%)

Job role appeared to make no real different to the types of support care home staff were contacting the MHLAN about, although Registered Care Home Managers were slightly more likely to ask about providing information to relatives/visitors. Requiring contact on any topic in this area more than six times a year was very rare.

The provision of relative support groups/dementia cafes varied between areas, with care homes in Gloucestershire and Wiltshire being less likely to run groups than those homes in Lincolnshire or Oxfordshire. The same regional variations was seen regarding dementia awareness sessions and overall these sessions were slightly less common than the relative support groups.

Where relative support groups are held, they are most likely to be run by Care Home Managers, followed by MHLANs. However, MHLANs lead the dementia awareness sessions more often than other members of staff. Running regular groups and sessions across multiple care homes therefore forms part of MHLAN role, which could be logistically challenging. This suggests a potential area for capacity building within OSJCT. A possible way forward may be for MHLANs to skill-up internal members of staff to facilitate such groups.

In addition, some support is provided to individual relatives on a one-to-one basis, or through dementia cafes. Some care home staff reported that although they do not currently run groups, their homes held similar groups and sessions in the past or are planning to hold them in the future. Comments provided on this topic were overwhelmingly positive, with the following representative comment;

> *"Admiral Nurse attended relative support groups. Relatives found this invaluable and appreciated the expertise being available and sharing their feelings of loss, guilt and talking about their journey"*

MHLAN contact regarding care quality

As seen in Table 10, contact regarding care quality was generally less common than for resident care support or relative/visitor support. The least likely topic of contact in this area was support in response to a disciplinary issue. This indicates that although care quality issues are part of the MHLAN role, they form a less significant part than other areas.

Table 10: Care home staff contact with MHLAN regarding care quality issues

Care quality contact	Overall % of respondents
Review/reduce anti-psychotic medication use in my home	40%
Support in meeting internal audit/quality requirements	40%
Quality of life assessments for residents	38%
Support in response to a safeguarding concern	37%
Support in meeting external regulatory requirements	33%
OSJCT/Dementia UK accreditation	30%
Support in response to a complaint	27%
Support in response to a disciplinary issue	13%

Additionally, Activities Co-ordinators and 'Other' care home staff were generally less likely to contact MHLAN about care quality issues overall, and this is probably reflective of the nature of their roles.

Although there was a lower level of contact around care quality, comments still indicated that the MHLAN were an *"essential resource"* providing *"invaluable support"*. Additionally, their presence was again seen as being reassuring for staff as it was *"good to know someone [is] there to help."*

MHLAN contact regarding staff team training and support

Respondents from care homes reported substantial contact with MHLANs regarding a wide variety of training topics, with the most common being understanding distress reactions, general dementia awareness and life story work (see Table 11). These fit well with the resident support areas seen previously. The high level of contact indicates that training and staff development forms a significant part of the MHLAN role.

Table 11: Care home staff contact with MHLAN regarding training and support, and other staff-related topics

Training and support input	Overall % of respondents
Understanding distress reactions	69%
General dementia awareness	67%
Life story work	64%
Health issues	52%
Communication skills	50%
Mental Capacity Act issues	43%
Meaningful activities	38%
Care planning	38%
Nutrition/hydration	36%
Working with relatives/visitors	36%
Daily record keeping	28%
Changing care home environment	27%
End of life	27%
Quality of life measuring	27%
Improving team work	24%
Attachment therapy	21%

Changing routines	20%
Contact regarding other staff-related topics	
Concerns about practice	24%
Facilitating reflective meetings	14%
Disciplinary matters	7%
Support with staff recruitment	4%

Respondents in all job roles had requested input relating to all topics. Overall, job role did not appear to have a pronounced effect on the type of contact with the MHLAN in this area. Although, unsurprisingly, due to the nature of their roles, Activities Co-ordinators had no contact with MHLAN around staff recruitment or disciplinary matters, leaving these mainly to Registered Care Home Managers.

With regards to how training for staff was provided, most commonly it took place as a session for multiple staff, although a variety of other methods were used in each area, such as one-to-one contact, observations of practice and advice-giving. In addition, it was noted that some training was also given at Dementia Leads meetings. Again, comments suggested the benefits of using MHLAN input to this area, with one respondent highlighting that:

"The expertise of the Admiral Nurse promotes staff confidence in these areas"

This indicates the flexibility and varied skill-set required by the MHLAN to deliver training in different ways and adapt their approaches to meet the needs of frontline staff. This is supported by the qualitative findings, in which the expertise and approachability of the MHLAN was highly valued.

Importance of My Home Life Admiral Nurse contact

It speaks highly of the work and influence of the MHLAN that, when asked to rate the importance of the role in each topic area, care home respondents scored them very highly across the board, with their input around each subject area being seen as 'important' or 'very important' by approximately 90% of care home staff (see Table 12). No respondents reported this support to be unimportant. Input around resident care and relative/visitor support was valued most highly, reflecting the frequency of contact regarding these areas and strong areas of expertise of the MHLAN role.

Table 12: Importance of MHLAN contact for care home staff

Contact area	% of respondents rating contact as 'important' or 'very important'
Relative/visitor support	91%
Resident care	89%
Care quality	89%
Staff team training and support	88%

Many care home staff chose to make additional comments relating to the importance of the service provided by the MHLAN role, including:

> "the support we have received has been invaluable and has helped to improve care practices in the home for our residents with dementia"

Impact of contact with the MHLAN role – residents

Contact with the MHLAN has had a positive impact on each of the areas shown in Table 13, with approximately 50% of care home staff at least agreeing with each statement. Unsurprisingly, the findings suggest that care homes in areas without a dedicated MHNLAN were least likely to have seen an impact from MHLAN contact.

Table 13: Impact of MHLAN contact for care home staff

Impact	% of respondents			
	'Strongly agree' or 'Agree'	'Neither agree nor disagree'	'Strongly disagree' or 'Disagree'	No response
We have become better able to work with residents' distress behaviours	68%	12%	4%	16%
We have become less likely to request prescription of anti-psychotics for residents living with dementia	50%	20%	9%	21%
We have reduced the numbers of residents living with dementia receiving anti-psychotic medication	46%	23%	9%	22%
We have reviewed anti-psychotic prescriptions for residents living with dementia	55%	17%	9%	19%

Impact of contact with MHLAN on residents: preventing unnecessary moves

A similar pattern is seen when considering the impact of the MHLAN on reducing the need for residents to move to another care home. Overall, nearly 50% of respondents agreed that the MHLAN have had a positive impact on this, making it an important outcome. Where information was provided (seven respondents) it was indicated that 1-5 residents remained in a particular home because of the MHLAN intervention. This is significant because it improves the quality of the resident experience by reducing transitions that can often be traumatic and improving the skill set of staff teams to manage the changes and challenges that can occur for residents. Additionally, this impact represents a strong business case for such a role, as it appears to help ensure that changing resident needs can be met for longer and that care homes supported by the MHLAN can provide care for people whose needs may not be met by other providers, as this survey comment illustrates;

> "(we take) residents from other providers who cannot manage challenging behaviours. The environment is a happy place where residents can express their needs and staff are more than happy to help"

Impact of contact with My Home Life Admiral Nurse – Staff

The positive impact of *My Home Life* Admiral Nurses is also reflected in the changes felt by respondents on their own and others' care practice. Of the options provided in Table 14, seven have been observed by at least half of the respondents. It was also promising to see that only 5% of care home staff felt that there had not been a change as a result of their contact with *My Home Life* Admiral Nurses.

Overall, there has been an improvement around skills and care quality, but also around confidence levels and being supported to cope with the demands of the job. As indicated by one respondent:

> "altho [sic] we haven't needed much individual contact with the AN team, I know our dementia lead feels very supported and well lead [sic] by them. She brings back all info from meetings and cascades good practice, monitoring the staff team for improvement"

Table 14: Care home staff perspectives on the impact of MHLAN

Impact from a staff perspective	Overall %
My knowledge and skills have improved	67.0%
I am able to provide better care for residents living with dementia	63.8%
My understanding of what is important when caring for people living with dementia has improved	62.8%
I feel more supported in doing my job	58.5%
I have improved confidence in doing my job	54.3%
I have the opportunity to receive advice and guidance about doing my job	54.3%
I can identify changes that need to be made in my care home	51.1%
I have the opportunity to share some of the difficulties of doing my job	46.8%
Our residents have an improved quality of life	45.7%
The confidence of other staff has improved	43.6%
The skills and knowledge of other staff has improved	42.6%
The overall standard of care in my care home has improved	41.5%
I have improved confidence when working with relatives/visitors	40.4%
Our residents are more involved in their daily lives	39.4%
The way we work as a team has improved	37.2%
The overall quality of my care home has improved	37.2%
The relationships I have with relatives/visitors have improved	37.2%
Relatives/visitors are more involved in the care home and/or their resident's care	35.1%
The well-being of other staff has improved	29.8%
My understanding of internal and external quality requirements has improved	27.7%
My confidence in meeting internal and external quality requirements has improved	26.6%
Our residents show fewer distress behaviour/s	25.5%
No change	5.3%

Impact of contact with MHLAN – My Home Life themes

Respondents were asked to rate how much their contact with the MHLAN had affected the performance of their care homes in relation to the *My* Home Life themes. The themes are an evidence-based understanding of what helps to support good quality of life for residents, staff and visitors of care homes.

At least 50% of care home staff felt that there had been an improvement against each of the themes listed below, with none being of the opinion that there had been any negative impact.

- We are able to promote a positive culture in our care home

- We are able to support the training and development needs of all our staff

- We are able to support good end of life care for our residents

- We are able to support our residents, visitors and staff to deal with losses that occur towards the end of life

- We are able to access the full range of healthcare support for our residents

- We are able to support people when they make the move into our care home

- We are able to involve everyone in the care home in decisions about the daily life of the home

- We are able to promote positive relationships between staff, residents and visitors to our care home

- We are able to create a sense of community in our care home

- We are able to help our residents maintain their individual identity

However, it should however be noted that a fair proportion of respondents said there had been no change or did not respond, which may indicate that it can be difficult for respondents to isolate the impact of such contact on long term cultural changes. In addition, as highlighted in the background and context section of this report, the extent to which the MHLAN was explicitly implementing the *My* Home Life framework through their work is open to question. This issue is emphasised within the qualitative findings as well in relation to the *My* Home Life framework and the senses framework and is further addressed in the conclusion and recommendations of the report.

Overall comments – Care home staff

At various points throughout the survey, respondents were able to provide additional comments related to specific topics or their contact and experiences of the MHLAN role. These comments highlighted several pertinent issues.

In many cases, care home staff try to resolve issues within their own home themselves before contacting a MHLAN , but are glad to know that they are there if needed. This suggests that the MHLAN is not replacing the function of various care home staff roles, but is instead providing an 'added extra service' to improve quality in difficult situations.

Further to this, many MHLANs indicated that they would like them to have more contact with the wider staff team rather than dealing mainly with dementia leads or in response to particular resident issues.

Overall, comments were overwhelmingly positive as highlighted by this respondent:

> *"The home has improved so much in various subjects. With the help of the AN, we have created a very good sense of community, supporting our residents and their families to deal with difficulties they experience in all aspects of their illnesses"*

In summary, the survey results showed that the MHLAN were a highly valued and impactful resource for care home staff. In particular, their expertise and availability were significant in their success. It is also notable that, taken together, the results appear to show that once a care home or staff member has had contact with a MHLAN they are more likely to be involved again about additional issues. This would suggest that ease of availability and awareness of the role are important aspects in ensuring their involvement across the Trust.

Operations Staff

General response information

24 operations staff responded to the survey and represented a range of job roles covering the areas as shown in Figure 1. Of the 24 respondents, 23 had been in contact with an MHLAN and one did not specify.
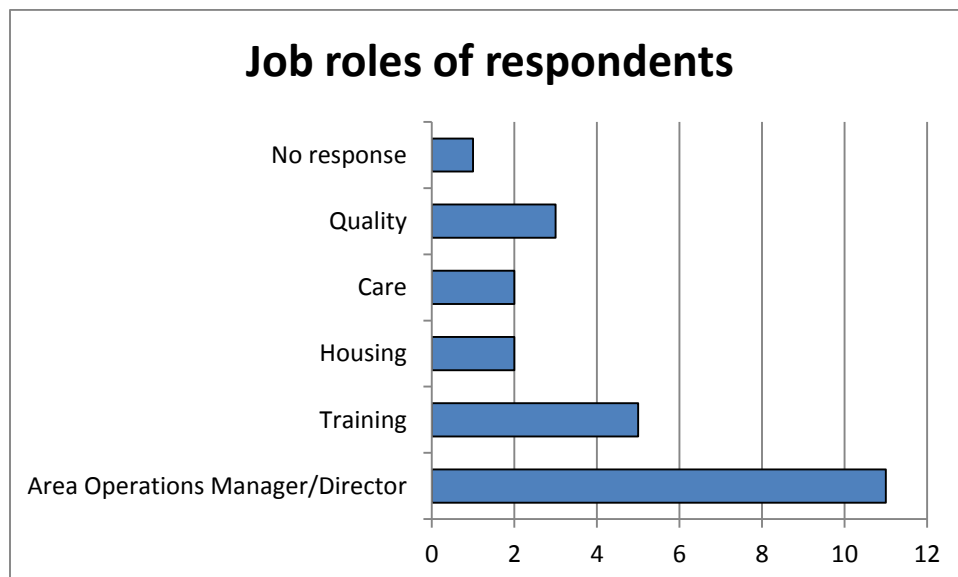

Figure 1: Job roles of operations staff

As with the care home staff, most of the operations staff (75%) had been working with OSJCT for at least two years. Although many respondents worked across more than one area, there was fairly even coverage across all four counties. Due to the combination of cross-area working, wide variety of job roles and fewer respondents, it is not possible to provide analysis based on area or job role. Findings are therefore reported on the operations staff group as a whole.

MHLAN contact regarding resident care and support

As with the care home staff, the operations staff had contacted the MHLAN regarding a variety of topics relating to resident care and support, as listed in Table 15 . The same three topics were least common as for care home staff.

Table 15: Operations staff contact with MHLAN regarding resident care and support

Resident care contact	Overall % of respondents
Care planning	92%
Monitoring residents' behaviour	92%
Communication with residents	83%
Mental Capacity Act Compliance	83%
Physical environment of the care home	79%
Activities for residents	79%
Life history/biography work	75%
Care home routines	71%
Health issues	71%
Involving other professionals	67%
Positive risk taking	63%
End of life care needs	63%
Nutrition/hydration needs	54%
Cognitive stimulation therapy	50%
Pets as therapy	42%
Attachment (doll) therapy	42%
Moving into/from the care home	38%

Requiring contact more than six times a year was uncommon, again similar to the experiences of care home staff, and, overall there was generally a much lower level of contact from operations staff. One respondent described the reasons for this:

> *"I usually advised the Home Managers to contact the Admiral Nurse for support and am rarely involved in any Admiral Nurse interventions or visits to the homes"*

However, where OSJCT Admiral Nurses were contacted, their expertise and support was valued.

MHLAN contact regarding relatives/visitor support

Contact between operations staff and MHLAN regarding relative/visitor support was quite similar across all topics, with the least common contact being around involving relatives/visitors in wider organisational decisions. Frequency of contact was again low across each topic, with it being unlikely that contact would be required more often than six times a year.

Table 16: Operations staff contact with MHLAN regarding relatives/visitor support

Relatives/visitor support	Overall % of respondents
Providing information to relatives/visitors	71%
Involving relatives/visitors in decisions about their resident's care	67%
Providing emotional support to relatives/visitors	67%
Involving relatives/visitors in the general life of the care home	63%
Working with relatives/visitors who are viewed as 'challenging'	63%
Involving relatives/visitors in the resident's care	58%
Involving relatives/visitors in wider organisational decisions	50%

MHLAN contact regarding care quality

Contact regarding care quality was also very similar across all topics, with support in response to a disciplinary issue being the least common topic, as it was for the care home staff (see Table 17). Between 20-30% of operations staff required contact regarding care quality more than six times in a year.

Table 17: Operations staff contact with MHLAN regarding care quality issues

Care quality contact	Overall % of respondents
Support in meeting external regulatory requirements	75%
Support in response to a safeguarding concern	75%
Support in meeting internal audit/quality requirement	71%
Support in response to a complaint	67%
Review/reduce anti-psychotic medication use in our care home/s	67%
Quality of life assessments for residents	58%
OSJCT/Dementia UK accreditation	58%
Supporting transitions from old to new services	58%
Objective assessment of quality within our care home/s	54%
Objective assessment of the team dynamics within our care home/s	54%
Objective assessment of the culture within our care home/s	54%
Advice and guidance when developing new services	54%
Advice and guidance in assessing the impact of new services/ development	46%
Support in response to a disciplinary issue	29%

MHLAN contact regarding staff training and development

Contact regarding training and development topics and the ways in which that support was provided are again similar between care home staff and operations staff. This is to be expected as contact from operations staff is likely to be with requests for care home input in this regard. Table 18 illustrates the variety of topics. Again, this indicates the breadth of knowledge required by the MHLAN in order to respond to requests for support.

As can be seen in Table 18, contact regarding concerns about practice and facilitating reflective meetings were the key areas of 'other staff-related contact' for operations staff. While these are the same as for the care home staff, the level of contact was proportionally a lot higher for the operations staff at nearly 70% compared to less than 30% for care home staff. This reflects the job focus of a number of operations staff respondents, as their roles are specifically concerned with issues of quality and practice improvement.

Table 18: Operations staff contact with MHLAN regarding staff training and development and other staff-related topics

Care quality contact	Overall % of respondents
Understanding distress reactions	92%
General dementia awareness	83%
Mental Capacity Act Issues	83%
Communication skills	79%
Life story work	79%
Working with relatives/visitors	75%
Health issues	63%
Improving team work	54%
Meaningful activities	50%
End of life care	50%
Care home environment	50%
Attachment (doll) therapy	46%
Quality of life measurement	42%
Nutrition/hydration	42%
Daily record keeping	42%
Care home routines	42%
Leadership skills	21%
Other staff-related contact	
Facilitating reflective meetings	67%
Concerns about practice	67%
Support with staff recruitment	13%
Disciplinary matters	4%

MHLAN contact regarding policy and procedure support

In terms of policies and procedures, contact was fairly infrequent in general, with least contact being made regarding equality/diversity and guardianship policies (see Table 19). It was uncommon for respondents to require information more frequently than six times in a year. Infrequency of contact however does not mean a lack of importance, as

expert input in developing usable policies and procedures will not necessarily occur repeatedly, only when new developments require it.

Table 19: Operations staff contact with MHLAN regarding policies and procedures

Policy and procedure support	Overall % of respondents
Mental Capacity Act	79%
Dementia in general	75%
Safeguarding	75%
Monitoring/responding to distress behaviour	71%
Mental Health	63%
Restraint policy	58%
Care home environment	54%
Guardianship	46%
Equality and diversity	46%

Overall, the operations staff responses to type of contact with the MHLAN illustrate that they are congruent with the type of contact experienced and valued by care home staff. Whilst the focus of operational job roles may be different, the MHLAN is still a valuable resource used frequently and effectively in their work. In addition, their input at operational level translates into improved staff experience at care delivery level.

Importance of the MHLAN

The operations staff, as with the care home staff, rated the importance of their contact with MHLANs very highly in every area, with at least 85% of respondents saying that contact was important or very important (Table 20).

Table 20: Importance of MHLAN contact for operations staff

Contact area	% of respondents rating contact as 'important' or 'very important'
Resident care	96%
Relative/visitor support	88%
Care quality	92%
Staff team training and support	92%
Policy and procedure	92%

Additional comments provided by respondents reinforced the positive views of the MHLAN, highlighting their value, efficiency, expertise and impact:

> *"I feel we are very fortunate to have the role as part of the Trust as it has enhanced the quality of life for our residents"*

Impact of the MHLAN

As with the care home staff, operations staff felt that the MHLAN had a positive impact on their care homes, with over 50% agreeing that progress has been made in each area (Table 21). No respondents disagreed with the statements.

Table 21: Impact of MHLAN contact for operations staff

Impact	% of respondents				
	'Strongly agree' or 'Agree'	'Neither agree nor disagree'	'Strongly disagree' or 'Disagree'	Not applicable	No response
The care home has become better able to work with residents' distress behaviours	83%	0%	0%	13%	4%
The care home has become less likely to request prescription of anti-psychotics for residents living with dementia	54%	13%	0%	29%	4%
The care home has reduced the numbers of residents living with dementia receiving anti-psychotic medication	54%	17%	0%	25%	4%
The care home has reviewed anti-psychotic prescriptions for residents living with dementia	58%	8%	0%	29%	4%

Over 50% of the operations staff also agreed that resident moves had been prevented or delayed as a result of MHLAN involvement (see Figure 2), which was slightly more positive than the responses from the care home staff. This may indicate that operations staff were able to consider the impact of the role in this regard for care homes that did not respond to the survey, or whose respondent was unaware of such issues for their home. Operations staff gave no indication of the number of residents that this affected, but again this makes a strong business case and quality care case for such a role.
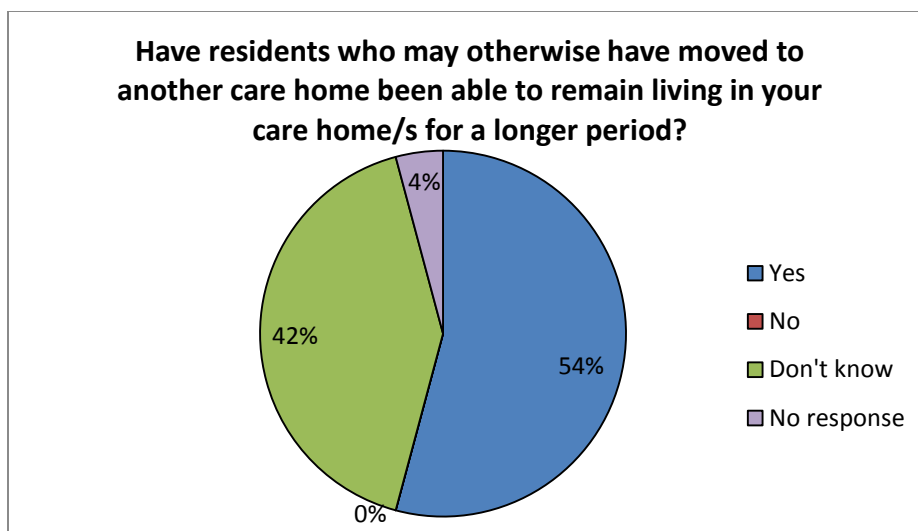
Have residents who may otherwise have moved to another care home been able to remain living in your care home/s for a longer period?

- Yes: 54%
- No: 0%
- Don't know: 42%
- No response: 4%

Figure 2: Impact of MHLAN contact on resident moves

There was recognition of the wider range of positive impacts of the MHLAN contact, with at least 50% of respondents reporting a change in 13 of the areas given in Table 22. Reassuringly, no-one felt that there had been no change following input.

Table 22: Operations staff perspectives on the impact of MHLAN

Impact	Overall %
I have the opportunity to gain an independent perspective on situations within our care homes	66.7%
My understanding of what is important when caring for people living with dementia has improved	62.5%
My knowledge and skills have improved	62.5%
I have the opportunity to confidentially discuss concerns about our care homes	62.5%
The confidence of our staff has improved	62.5%
The overall culture in our care home/s has improved	58.3%
The skills and knowledge of our staff has improved	58.3%
I can identify changes that need to be made in our care home/s	58.3%
I have the opportunity to receive advice and guidance about doing my job	58.3%
Relatives/visitors are more involved in our care home/s	54.2%
Our residents have an improved quality of life	54.2%
I feel more personally supported in doing my job	54.2%
The overall standard of care in our care home/s has improved	50.0%
The way we work as a team has improved	45.8%

Our residents are more involved in their daily lives	41.7%
I have the opportunity to share some of the difficulties of doing my job	41.7%
Our residents show fewer distress behaviour/s	37.5%
I have the opportunity to confidentially discuss the problems I encounter in doing my job	37.5%
Our policies and procedures are better fit for purpose	37.5%
Our new services are developed and designed with people living with dementia in mind	33.3%
I have improved confidence in our care home/s ability to respond to internal and external quality requirements	29.2%
Our policies and procedures are better followed in practice	29.2%
The well-being of our staff has improved	29.2%
I have improved confidence in doing my job	20.8%
Nothing has changed	0.0%

Regarding *My* Home Life themes, the responses shown in Table 23 were very positive with at least 50% of operations staff feeling that there had been an improvement against each theme, and some themes being rated much higher.

Table 23: Operations staff contact with MHLAN contact on My Home Life themes

The care home/s is able to…	Overall % of respondents
Help residents maintain their individual identity	88%
Promote positive relationships between staff, residents and visitors to the care home	83%
Promote a positive culture	79%
Create a sense of community	75%
Support the training and development needs of their staff	75%
Support good end of life care for its residents	71%
Involve everyone in the care home in decisions about the daily life of the home	67%
Support people well when they make the move into the care home	67%
Support residents, visitors and staff to deal with losses that occur towards the end of life	67%
Access the full range of healthcare support for their residents	54%

However, it was commented that such issues are ongoing, rather than being down to one particular role or specific input; a recognition of the complexity of improving and sustaining positive care home cultures. As one respondent summed up:

> *"it is still very much work in progress but all homes are moving in the right direction thanks to the expert advice and support from the Admiral Nurse's advice and interventions"*

In summary, as with care home staff, the MHLANs are a valued and impactful resource for operations staff, providing expertise across an even wider range of areas. The congruence between the experiences of operations staff and care home staff would suggest that an advantage of the role is its ability to work across different levels of an organisation to the same effect and for the same ends.

Dementia Café Attendees

General response information

Six people completed the survey who attended a regular support group at an OSJCT care home. Of the six respondents, three were from Lincolnshire and three were from Gloucestershire. Four respondents had a relative or friend currently or previously living in an OSJCT care home.

Contact with OSJCT Admiral Nurses

In terms of having contact with an OSJCT Admiral Nurse, all six respondents had attended a dementia café on a monthly basis. In addition, one relative had attended a weekly dementia awareness/information session and two had some degree of one-to-one contact with OSJCT Admiral Nurse.

Carers/relatives reported contact with OSJCT Admiral Nurses regarding advice and support on a wide variety of topics, including:

- Information/advice about support or services that are available to my relative/friend
- Information/advice about communicating with my relative/friend
- Information/advice about end of life care
- Information/advice about the importance of my relative/friend's life history
- Information/advice about keeping my relative/friend occupied and interested in activities
- Information/advice about my relative/friend's physical health

- Suggesting ways in which I can support or care for my relative/friend
- Information/advice about monitoring or responding to me relative/friend's behaviour
- Explaining what my relative/friend may be experiencing
- Information/advice about diagnosis of dementia
- General information about dementia and its effects

The six respondents reported that not only had they received support regarding each area but also that it has helped improve their knowledge and/or confidence in dealing with the issue.

With regard to support for themselves, carers/relatives identified a range of different areas of advice as shown in Figure 3.
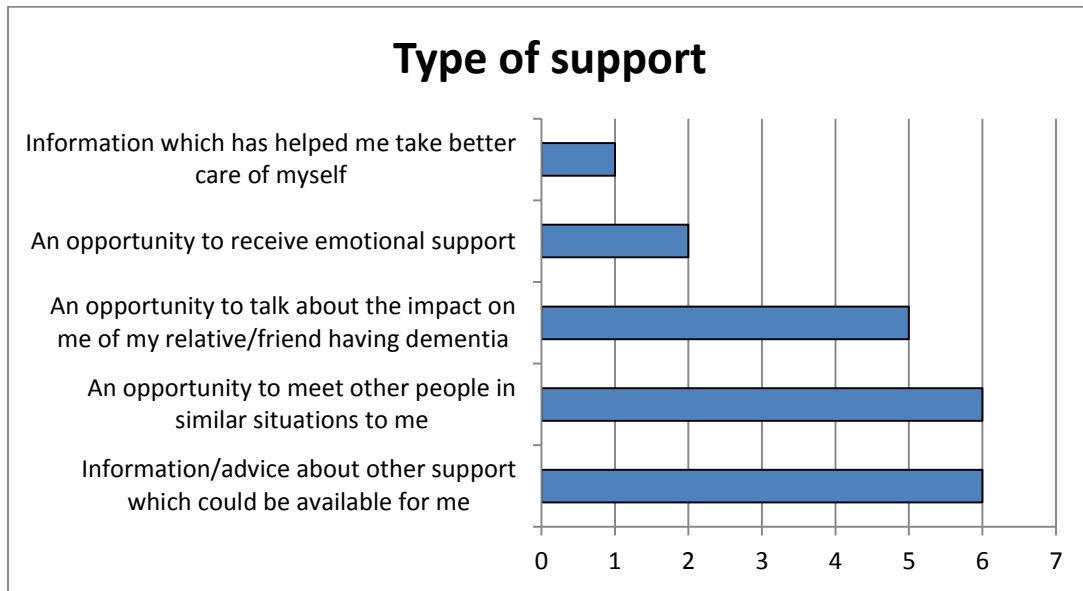

Type of support

Information which has helped me take better care of myself	1
An opportunity to receive emotional support	2
An opportunity to talk about the impact on me of my relative/friend having dementia	5
An opportunity to meet other people in similar situations to me	6
Information/advice about other support which could be available for me	6

Figure 3: Type of support provided by the MHLAN to carers/relatives

All six respondents said that they received face-to-face support from the MHLAN and all considered that the support they provided was either important or very important. This indicates that the carers/relatives valued the input highly.

When asked to reflect on the dementia cafes they had attended, the carers/relatives were very positive regarding their impact as shown in Figure 4.
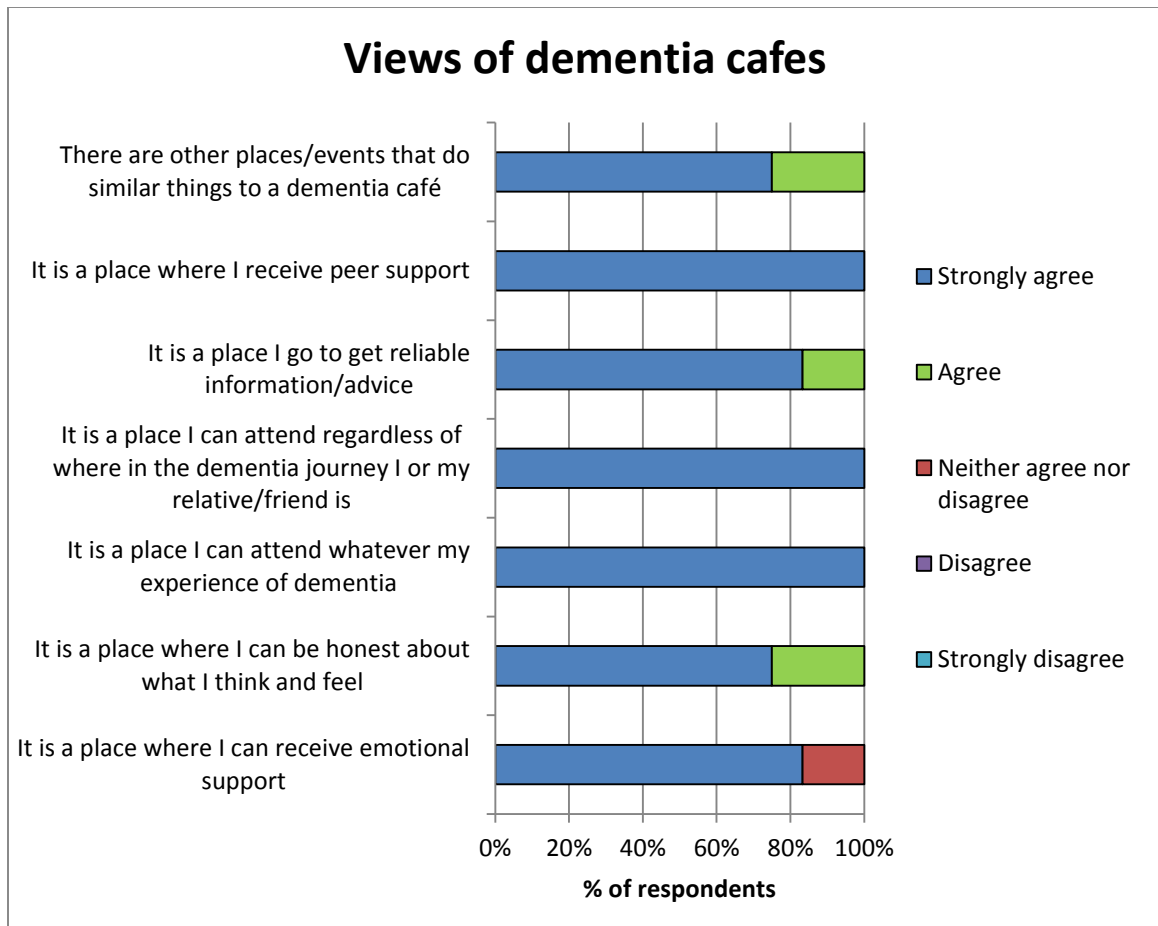
Views of dementia cafes

Legend:
- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Categories (top to bottom):
- There are other places/events that do similar things to a dementia café
- It is a place where I receive peer support
- It is a place I go to get reliable information/advice
- It is a place I can attend regardless of where in the dementia journey I or my relative/friend is
- It is a place I can attend whatever my experience of dementia
- It is a place where I can be honest about what I think and feel
- It is a place where I can receive emotional support

X-axis: 0%, 20%, 40%, 60%, 80%, 100%
% of respondents

Figure 4: Carer/relative views of dementia cafes

Impact of the MHLAN

Although only three respondents had a relative or friend living in an OSJCT care home, making it difficult to draw any firm conclusions, it was reassuring that all three agreed or strongly agreed that contact have had a positive impact across each of the areas shown below:

- Helped reduce the worry about my relative/friend living in a care home
- Helped to make the transition to living in a care home easier
- Helped my friend/relative to feel like they belong in the care home
- Helped me to feel like I belong when I visit the care home
- Helped me to improve my relationship with the staff at the care home
- Helped me to be involved in my relative's/friend's life in the care home

- Helped me to improve the support I can give to my relative/friend whilst in the care home

- Helped improve the care my relative/friend receives in the care home.

Similarly, the three respondents who did not have a relative or friend living in an OSJCT care home all agreed or strongly agreed on the positive impact of the contact with the MHLAN on the following:

- Enabled me to continue caring for my relative/friend

- Improved my knowledge of what support is available

- Improved my confidence in the support I give my relative/friend

- Provided advice/guidance on how I can best support my relative/friend

A significant finding, although based on a small number of respondents, is that contact with the MHLAN had improved the respondents' view of care homes, and in some cases influenced their choice of care home. All respondents stated that, as a result of the impact of MHLAN they were: more likely to consider a care home if needs be in the future; more likely to consider an OSJCT care home if needs be in the future; more confident in care homes generally. This means not only is care home use viewed more positively, but that OSJCT care homes can benefit from that change.

Qualitative findings

This section presents the findings from the interviews and case studies undertaken within the evaluation. Interview transcripts were analysed according to three different broad thematic frameworks: the MHLAN role; the Admiral Nursing core competencies; and the *My* Home Life framework. Each of these broad areas is presented below, together with detail of the sub-themes and cross connections that emerged through analysis of both quantitative and qualitative data. Where differences between job role or location of interviewee were evident they are explained. Overall, it should be noted that a few key themes emerged as important across all three thematic frameworks, such as the responsiveness and approachability of the MHLAN and their knowledge and expertise. These are therefore significant and should be considered as the cornerstone of the MHLAN role.

No distinctions were manifest between information provided within case study interviews or telephone interviews. Therefore all interview data is treated as a single data set. In addition, discussion groups were designed to contextualise the findings of the evaluation, ensure consistency with experience and highlight any areas for future consideration and so where pertinent issues were raised these are addressed within the conclusions.

The MHLAN Role

In order to address the central research questions it was important to establish the current parameters of the MHLAN role. Therefore the qualitative data was interrogated to establish the following: determinants of Admiral Nurse involvement; ways of working; role tasks; impact; factors contributing to effectiveness; and most valued aspects of the role. Each of these is presented and discussed below together with details of any sub-themes which emerged. The themes and subthemes are not presented in order of importance, instead all emerged sufficiently frequently within and across the qualitative data to be considered significant. Where a theme or sub theme was demonstrated particularly strongly this is identified and discussed.

Determinants of MHLAN Involvement

This theme focuses on the reasons that an MHLAN might become involved with a care home. The sub-themes that emerged from analysis provided evidence that involvement is initiated for a number of different reasons: routine events; requests for specific input; and ways of working differently. Input from the Admiral Nurse is requested for a range of stakeholders.

❖ Advice and support for families

Staff within the care home often identified a need for the relatives of the person with dementia to receive additional support above and beyond what they had provided. In some circumstances this was also requested for members of the wider community:

> *"the assessment wasn't a true picture of what this lady actually was like, and within a couple of days problems started. So the Admiral Nurse was contacted in that situation, and was really good. They came to the home, they met with the family, they were really supportive towards them."* (Home Manager, Lincolnshire)

This highlights that for the MHLAN, the traditional tasks of supporting informal/family carers that is a significant feature of the community Admiral Nursing role remains important and valued within the care home setting from the perspective of care home staff. This was also demonstrated within the survey findings.

❖ Advice and support for the care home

Advice and support for the care home more widely was requested for a number of different reasons: in situations requiring in-depth knowledge of dementia care; trouble-shooting in difficult situations such as disagreements with families or challenge in meeting a person's needs; and finally in situations where staff required help to reflect on and understand certain situations:

> *"If we have a specific issue that we, you know, that we can't resolve then the admiral nurse would come in"* (Care Staff, Oxfordshire)

Again, it is notable here that the involvement of the MHLAN with the needs of family carers is highlighted as an aspect of the support for care home staff themselves. It appears that the ability to turn to a third party in challenging situations with families has a benefit not only to the family but also to the care home itself.

❖ Routine and reactive availability

MHLANs were involved at two distinct levels; in response to specific requests and as a routine resource, such as regular meetings within the organisation. There was evidence to suggest that more routine support would be advantageous, as a number of respondents both from with care homes and operational teams identified that this would enable more general practice issues to be raised and discussed, rather than in response to emergent care issues which resulted in a call out to the MHLAN.

> *"Instead of, 'Oh, I'm going because there's something wrong,' but, 'I'm there because I like it because I see that everything is working and I can just make slight changes or alternate things,' but she will be not solely coming in as a trouble-shooter, do you know what I mean?"* (Dementia Lead, Care Home, Gloucestershire)

However, the flexibility and responsiveness of MHLANs was highly valued, because it provided a timely support in keeping with the unpredictable nature of issues arising in a care home. This highlights that the ability of the MHLAN to balance reactive and routine tasks is an important part of the role and that organisational arrangements going forward should consider the impact of changes in this area.

❖ Working differently

MHLANs were often involved by staff within the care environment for a range of innovative reasons, beyond the need for advice and support about dementia care. This

included occasions such as support for recruiting staff, and supporting community awareness-raising:

> *"So between the Admiral Nurse and myself we spoke to the secondary school, and for the past three years the Admiral Nurse and I have gone and talked to the health and social care class and A-Level students about dementia care and what dementia is"* (Activities Co-ordinator, Oxfordshire)

This highlights that a third party such as the MHLAN can be a useful addition during periods of organisational change. However, it was unclear how much of this systemic change was initiated by the MHLAN themselves.

Ways of Working

This theme focuses on the ways in which the MHLANs worked with care homes, staff, residents, families and communities. Underpinning each of these ways of working was the knowledge and expertise freely given by them regardless of how they were involved. This underpinning theme links strongly with the ways of working embedded within *My* Home Life, in particular, relationship-centred and appreciative approaches. Whether this is an explicit incorporation of *My* Home Life by the MHLAN or a by-product of something else is discussed later. However it does illustrate that there is a strong compatibility between what is notable and valued about the MHLAN and the approach of *My* Home Life.

❖ Onsite

MHLANs were able to provide onsite, face-to-face support for residents, staff, families and the wider community. This support took a variety of routes including reflection, formal and informal conversations with relatives and staff support and, most importantly, the flexibly to meet everyone's needs:

> *"They know they can see her the second Thursday of every month, but she's also come in late in the evenings to talk to wider members of families that maybe can't make it on those Thursdays"* (Activities Co-ordinator, Oxfordshire)

It would appear from the qualitative data that where routine onsite availability was seen it increase the amount of informal and non-emergent issues to which the MHLAN could have input and this suggests an important implication if more routine work is to be considered for the MHLAN role in the future.

❖ Remotely

Staff valued the fact that even though the MHLAN could not be present on the premises at all times, they were still available by telephone or e-mail to provide support, and this enhanced the responsiveness to issues:

> *"Just to have them at the end of the phone. They don't need to be here, they're on the end of the phone, they can give you support or answer any questions"* (Care Home Manager, Wiltshire)

It was striking how many respondents cited that the MHLAN was 'there to call on' when needed and this appeared to provide a great source of reassurance and confidence for care home staff and registered managers in particular. Therefore considering ways to retain this availability should inform any future developments.

❖ Formal and informal support

MHLANs were often called into care settings to provide formal group or one-to-one training sessions/workshops or to provide a dementia/memory café but also informally, simply by being visible within the home:

> *"I think by the end of these sessions that were done with the Admiral Nurse and the other person, they actually had a bit more insight. She's also done one-to-one sessions with staff, you know, who have had problems for different things, like, you know, worried about, say, how residents react and all the rest of it"* (Head of Care, Oxfordshire)

Again, this has implications for maintaining the balance between routine and reactive availability of the MHLANs. Whilst formal support in response to specific issues was valued, the informal support provided simply by 'being there' should not be underestimated, and therefore capacity to respond in a timely manner should be maintained.

❖ Liaising with external professionals

There were occasions when the MHLAN provided expert liaison with external professionals such as GP's, community psychiatric nurses, etc.:

> *"You know, she does liaise with a lot of other outside people, especially when, as I say, they had to have a best interest meeting"* (Care Staff, Oxfordshire)

A number of care home managers and heads of care in particular highlighted that the ability to call on the MHLAN to help contact and liaise with external professionals was very useful, and the 'success' rate of this contact was reported to be higher than if

undertaken by care home staff themselves. This is highlighted again within the tasks undertaken as part of the MHLAN role.

The tasks undertaken by MHLAN

This theme focuses on tasks that MHLANs carry out within their role. There was substantial evidence throughout the analysis of tasks which fell into the categories of advice/support, liaising with external professionals, bespoke training/knowledge sharing and resident interventions. Several of these naturally link directly to the core competencies within the Admiral Nurse Framework. An interesting sub-theme arose around the objectivity of the MHLAN role within their tasks which provided an alternative perspective, particularly valued by staff in relation to work with families.

❖ Advice and support

By far the most frequent task undertaken by the MHLAN was, unsurprisingly, giving advice and support to staff, residents and families in a variety of ways. Significantly, it was not simply the practical elements of support such as meetings with staff and relatives, co-ordinating dementia lead meetings etc. that were valued, but also the emotional aspects of that support given through encouragement, acting as a sounding board or simply listening to difficulties and concerns. In addition, the MHLAN advice also extended to support with processes and procedures such as internal anti-psychotic medication reviews or care planning, or external events such as safeguarding meetings:

> *"a great help with the antipsychotic medication reviews, with some care planning, with some, kind of, complicated and complex safeguarding issues"* (Home Manager, Oxfordshire)

> *"I have shared myself with [Admiral Nurse's name] my frustration sometimes, you know, my feelings in my job role, how am I feeling, you know, as a manager, and she's absolutely ... you know, she's got those skills, hasn't she, that really understand and can empathise"* (Home Manager, Oxfordshire)

Advice and support also included specific interventions for residents as opposed to more general issues and requests. As this interviewee demonstrated;

> *"Monday I had to email our Admiral Nurse. A lady was scratching, throwing things, and the staff, no matter what we tried ... and she knew what she was doing. She knew why she was doing it, so I emailed the Admiral Nurse ... they came in, you know, spoke with the lady and gave us some advice"* (Head of Care, Lincolnshire)

❖ Liaising with external professionals

MHLANs acted as a link with other external professionals to advocate on behalf of the resident, care home and expedite issues with which the homes were experiencing difficulties:

> *"they're able to support on a much more professional level, and liaising with CPNs and psycho-geriatricians, that sort of thing. And they do that, they work with local GPs and we can't fault them and we wouldn't be where we were today really without them, to be fair"* (Operations staff, Lincolnshire)

In particular, it appeared that the MHLANs were of influence in this regard when external professionals were difficult to contact. Many interviewees felt that this was an area in which the MHLAN could achieve success when they themselves were struggling and for which the MHLAN's objectivity was useful.

The contradiction between the extent to which interviewees identified this as an important task of the role and the experience of OSJCT in identifying contacts as part of this evaluation should be noted. The interview data would suggest that work with external professionals is occurring and is having a positive impact. Therefore, the reasons why such contacts could not be identified by OSJCT may be worth exploring, and future evaluation of this area of work considered.

❖ Bespoke training and knowledge sharing

MHLANs provided bespoke training to care homes which was tailored to the individual needs of the staff, residents and families of that home. They also shared their knowledge in a variety of ways, cascading this through dementia leads and staff and bringing new skill sets to the home:

> *"The Admiral Nurse has also upskilled the staff team within the home now to be able to carry out those quality of life surveys"* (Operations staff, Lincolnshire)

The provision of targeted training and knowledge sharing was highlighted as important by interviewees, particularly those operational staff, who perhaps had a broader sense of what took place across a whole organisation or region. Within the interviews this training appeared to focus around dementia care, although the survey respondents did indicate that additional content was covered. It is notable that only training provided to the Dementia leads through their dedicated meetings appeared to be proactive as opposed to being in response to a particular issue. This would suggest that the *My*

Home Life approach of leading change towards workforce development and positive cultures occurred more within the dementia lead relationship than elsewhere.

❖ Objectivity

It would appear strange at first that 'objectivity' is a task of the MHLAN role. However, it emerged so strongly within the data as the underlying purpose for contacting or involving the MHLAN that it could not be ignored as a major function of the role. For many interviewees, MHLANs were able to bring a level of objectivity to situations that enabled staff to see others' perspectives and also enabled decisions taken by staff to be validated with families in difficult situations:

> *"It's really nice to have someone that's attached to us, but not involved, so you get a far more objective viewpoint for it, and the family then don't feel like they're being fobbed off"* (Home Manager, Wiltshire)

This aspect is highly significant, not least because it illustrates again the frequency with which the traditional 'relative support' role of the Admiral Nurse is needed within the care home environment. Moreover, it demonstrates that the nature of the MHLAN role as operated within OSJCT appears to enable the post-holder to sit apart from the organisation itself and, crucially, to be perceived in such a way by those who may call on the role. Whilst it is not possible to identify what, other than the practice of the MHLAN's themselves, contributed to this it should be considered a vital component to maintain and maximise in any future decision-making regarding the role.

The impact of the MHLAN Role

The importance of this theme is reflected in the large number of references relating to impact which were prevalent throughout the data. Impacts of the work of the MHLANs are noted both in terms of the people with whom they work and processes within the care home and organisation as a consequences of their work. Within this theme of impact the overarching importance of objectivity which the role brings to the culture of the care home was emphasised, highlighting the significance of the role's external position to the actual care home and line management structure.

❖ Impacts on people

The MHLANs had an impact on relatives, residents and staff working both within the care homes and at operational level.

- Impact on residents

Evidence demonstrates that MHLANs had a direct impact on the experiences of residents within the care home, improving quality of life overall and solving particular challenges:

> *"The Admiral Nurse sorted out the pain relief for one of our residents as well… So that was something that the Admiral Nurse thought of… The gentleman now is on patches and his behaviour is much calmer. It's just that, you know, she knows all these different avenues"* (Home Manager, Oxfordshire)

This is an indicative example of a range of resident impacts interviewees spoke about including improved physical health, reduced pain, increased independence, increased meaningful engagement and general well-being.

- Impact on relatives

The support of the MHLANs had a positive impact on relatives and families of residents living in the care home and on those external to the care home who attended dementia cafes. Although highly individualised in its impact, overall the impact was to improve the support experience and the confidence in navigating the journey of dementia:

> *"Well, we have our Admiral Nurse and she's absolutely amazing, and she actually helps me run a relative support group, to support the relatives of people with dementia, so they come and see her once a month. If they have any questions she helps people gain diagnosis and helps direct them into how to get the diagnosis and different memory support groups and things like that"* (Activities Co-ordinator, Oxfordshire)

For those attending dementia cafes, the impact of the MHLAN was highly individualised, but appeared to be contrasted favourably with regard to other health and social care professionals. This support appeared to bolster the person's ability to support a person living with dementia and, when necessary, reduced the stress and worry inherent to transition into a care home. As this dementia café attendee reported regarding a move into an OSJCT care home:

> *"This is where the Admiral Nurses are at their most effective, not only for resident care but also the carers who have struggled to maintain a suitable quality of life over 4-5 years with little help. Settling into a care home must be difficult after looking after a home and family but with the help of the care home staff and Admiral Nurse, in our case, this went smoothly,"* (Dementia Café Attendee)

- Impact on staff

The impact on staff can be divided into two categories; the impact on knowledge and skills and the impact in terms of saving time and reducing workload by providing timely interventions or support with challenging issues:

"I feel they're invaluable to all of us, and their knowledge is enormous" (Care Home Manager, Wiltshire)

"knowing that there is somebody there that I could actually call on…..and it wouldn't be, like, 'Oh, it'll be in three months' time,' or anything, it would be when they were needed" (Care Home Manager, Wiltshire)

It is impossible to quantify such impact, but a number of interviewees highlighted that MHLAN interventions, particularly in supporting family members, or reviewing care approaches for residents, had saved them significant amounts of time, not only through taking on certain tasks but also through resolving issues that could have been persistent without their intervention.

❖ Impacts on process

Through their knowledge, expertise and support of staff, residents and relatives, the MHLANs were able to have an impact on the processes of the care home, up-skilling staff and changing culture in the following ways:

- Impact on quality of care

Providing support to the staff and involvement in challenging situations had an impact on quality of care provided because it often pre-empted problems or prevented situations from escalating:

"I think it could potentially be quite detrimental because we could end up with some serious complaints, very, very serious. You know, probably the safeguarding could have gone much worse because they were all closed, because the Safeguarding team had confidence in us that we've done everything as it should be doing" (Head of Care, Oxfordshire)

In addition, many interviewees highlighted that this had had an additional effect in terms of their reputation with external agencies.

- Impact on relationships

The MHLANs, particularly when mediating within challenging situations, served to facilitate better relationships and communication not simply in those particular situations prompting intervention, but more widely:

> *"Just enabling people, like, you know, to talk to each other when they need to. I think it's like the communication thing, isn't it, like, you know, because people are not always able to communicate and I think with her input, like, you know, it's enabled people to actually communicate more effectively"* (Head of Care, Oxfordshire)

- Impact on profile

The ability of the MHLANs to demonstrate quality care and good practice, sharing this with wider audiences, raised the profile of the organisation, through specific events (such as dementia cafes) but also in much of their interactions with external professionals. It is of particular note that many contributors to the evaluation felt that the profile of the MHLANs within OSJCT could be raised further, with the suggestion that it reflected very well on the organisation:

> *"We've got some really good examples of the life stories, because they've changed now and they're called All About Me, and the difficulty that we had was trying to get the information, so the Trust celebrated Dignity Awareness Day, and we feel that we do offer quite a lot of dignity within the home, so what we actually did that day was, we used that -- we had the opportunity to get families involved and it was to do life stories. We've got some really good examples, to the point that I think the Admiral Nurse did a conference about life stories at one of the dementia conferences, and he used some of the work that we'd actually done"* (Home Manager, Lincolnshire)

What makes the MHLAN role effective?

This theme focuses on the characteristics and attributes which make the MHLAN Role effective. Again, objectivity was a theme running through participant views of the effectiveness of the role. Respondents valued the level of professional objectivity which is easily available for the home as an organisational resource but sufficiently separate that it is seen as neutral.

- ❖ Personal characteristics

Participants in the evaluation referred to a wide range of personal characteristics possessed by MHLANs including empathy, listening skills, good communication,

understanding, approachable, non-judgmental, having a 'personal touch', being person-centred, passionate, reflective and being 'hands on':

> *"they're very hands-on, but they can also -- they're very good at empathising and understanding from both sides, from a staff member's point of view but obviously from the resident's. It's about life experience skills"* (Operations Staff, Gloucestershire)

These personal characteristics appear to resonate strongly with the ways of working advocated by *My* Home Life, in particular appreciative and relationship-centred approaches. However, interviewees did not allocate these features specifically to *My* Home Life and very much reflected on the personal skills and warmth of post-holders.

❖ Specialist knowledge and expertise

A widely-mentioned element of effectiveness of the MHLANs was their depth of knowledge and expertise in dementia care. In particular, their willingness to share that expertise and encourage others to expand their knowledge was important to their effectiveness:

> *"She's got more awareness of the dementia and what's out there for dementia people, more so than what we do or a social worker or a GP does"* (Home Manager, Lincolnshire)

This aspect is, obviously, reflected again when examining the MHLAN in relation to Admiral Nursing competencies. Throughout the qualitative and quantitative data it is clear that respondents viewed and interacted with the MHLAN on the basis that they were dementia specialists. Impact beyond that appeared to occur inadvertently through the dementia-specialist work. This would suggest that the congruence with the Admiral Nursing competencies is more strongly demonstrated than that with *My* Home Life, which is concerned with all care home practice, not dementia specifically.

❖ Accessibility

Perhaps the most significant aspect of the MHLANs' effectiveness was the fact that they were easily accessible whenever support was needed:

> *"I just think having her support and knowing that we can contact her at any time ... she will always get back to us, so you know that that support is there"* (Head of Care, Oxfordshire)

Whilst some of this may be attributed to the way in which the role is currently structured, allowing reactive work to take precedence, there was also a strong sense that accessibility was due to the work ethic of the MHLANs themselves. This is both a personal characteristic and evidence of an understanding of the ever-changing often urgent needs of care homes being embedded within their work.

What is the most valued aspect of the MHLAN role?

It is not surprisingly that the two most valued aspects of the MHLAN role have been highlighted previously. The most valued aspects were the support provided, both practical and emotional, together with the knowledge and ideas that come from a different perspective.

❖ Support

Staff valued the support that was given by the MHLANs in general but particularly its accessibility. They also expressed that the support was empowering and enabling, having an improving effect within staff teams after the MHLAN's involvement. Underlying this was an appreciation that the MHLAN had the same intention and purpose as the care home in providing the best care for residents. This was particularly contrasted with experiences of external professionals:

> *"The support and just knowing that they're there, really, and that they will help us to get it right"* (Home Manager, Lincolnshire)

> *"they have the same goal that we have, which is so different to, say, like CPNs and things, you know"* (Operations Staff, Oxfordshire)

❖ Knowledge and expertise

Staff valued the knowledge and expertise offered by MHLANs, which was also available to support residents through the memory cafes. In particular, the provision of new ideas and perspectives through the expertise was seen as important:

> *"The Admiral Nurse's been around it a long, long time and has so much knowledge"* (Care Staff, Oxfordshire)

> *"(ANs) got ideas at the meetings we go to. You can bounce ideas off (them) and (they'll) say whether… it's good or not, or, 'Try this'"* (Head of Care, Lincolnshire)

Difficulties and challenges

This theme focuses on things which could be improved about the MHLAN Service. The data collected demonstrate how valued the service was by those who participated in the evaluation. By far the most prevalent sub-theme was around the number of MHLANs and their availability. In addition, more routine availability, through regular visits to homes, was identified as being an advantage of having more MHLANs and something that would help the service to provide support proactively as well as reactively. Finally, the need to raise awareness of what services and support the MHLANs can provide both within the organisation and the wider community was identified as something which could improve their influence:

> *"It would be nice if they could contact us more regularly to actually see if we have any problems instead of just waiting for a problem to start and then us contact them,"* (Care Staff, Wiltshire)

> *"Everybody knows what a Macmillan Nurse is, everyone knows that it's a specialist cancer nurse, but not so many people know what an Admiral Nurse is or even that they are around, which is a shame,"* (Activities Co-ordinator, Oxfordshire)

Admiral Nursing Core Competencies

The MHLANs operate within the framework of Admiral Nursing, albeit with a different focus to the original role. Therefore it is necessary to explore the relationship between the work of the role and the core competencies of the Admiral Nurse as defined by Dementia UK, in order to establish the similarities and differences. The competency framework was developed in 2003 (Traynor and Dewing) to enable Admiral Nurses to develop a portfolio of evidence demonstrating the work they undertake as part of their role. The competency statements were developed in consultation with Admiral Nurses and designed to be outcome focused. The eight core competencies were:

- Therapeutic work
- Sharing information about dementia and carer issues
- Promoting best practice
- Prioritising work
- Preventative work and health promotion
- Ethical and person-centred care
- Balancing the needs of the carer and the person with dementia

- Advanced assessment skills

Research questions for this evaluation were designed to identify how the work of the MHLAN within a care home was consistent with the competencies of those Admiral Nurses working, more traditionally, within the community.

The data demonstrated that the MHLAN role undertakes work that is consistent with the Admiral Nurse competency framework. Significantly, the placement of the role with an organisation providing residential care appears to add an additional aspect to each competency; extending the 'usual' profile of Admiral Nurse work to include staff working within care homes and the organisational influences that surround them. It is notable that there is a great deal of overlap between the evidence of competencies in practice and what emerged as key tasks and impacts of the MHLAN role above. This would suggest that the practice of the MHLAN is strongly consistent with the core competency framework of Admiral Nursing.

Findings will be presented under each of the core competency headings and is discussed together with details of any sub-themes which emerged. The competencies and sub-themes are not presented in order of importance, instead whether they were represented strongly or weakly in the data is identified and discussed.

Therapeutic Work

Therapeutic work focuses on actions, advice or support suggesting or implementing interventions for individual residents. This can include psychotherapeutic interventions, cognitive behavioural therapy, bereavement counselling, etc. Data demonstrates that under this heading the following themes emerged identifying that MHLANs have had an impact in the following ways:

❖ Family support

In providing interventions for the resident, family also feel supported. Analysis has provided evidence that this support occurred in a number of ways. MHLANs were able to act as mediator in situations where discrepancies or disagreements arose between the wishes/needs of family members and those of the residents. They were also able to offer support to families to help them to understand what was happening to their loved one. Often this took the form of bespoke one to one meetings with individual families to help them to understand changes in behaviour or progression of the symptoms of dementia. Through this very focused work families felt listened to:

"We've had a problem with a resident just recently. She's only been with us about four or five weeks and her family want one thing for her, she doesn't want to do these things, and the admiral nurse will be a mediator between the two. You know, help them understand it's her life and she needs to live it how she feels she wants to, not how they want her to live" (Operations Staff, Lincolnshire)

"I think that they felt listened to. I think they felt supported … they didn't understand how Mum's behaviours were affecting the home" (Home Manager, Lincolnshire)

❖ New strategies and new perspectives

The MHLAN was able to provide insight into situations which had become frustrating for care staff when dealing with individual residents. Sometimes this was about spending more time with individual residents to explore new strategies and sometimes it was about providing new avenues to explore looking through a different lens. Crucially, they were able to provide this support in a way which validated staff approaches using non-threatening and non-judgemental advice and support:

"She actually came and observed while we went to the gentleman, and to be fair we were doing everything right anyway" (Care Staff, Gloucestershire)

Sharing information about dementia and carer issues

This core competency relates to actions, advice or support given to help share information about dementia, supporting someone with dementia, or support available for carers. An aim of this element of the role was to meet local need and develop strategies for information sharing with colleagues in statutory and voluntary sectors. There was strong evidence within the data to suggest that this is one of the most important competencies within the Framework. The work of the MHLANs in this area was provided in a number of ways, all of which contributed to its success:

❖ Support

The Admiral Nurse was available to offer information to both staff and families. The nature of this support was seen as valuable as a consequence of the Admiral Nurses' objectivity and their ability to give information and advice from a different perspective.

"The Admiral Nurse is an outside person, who comes in and can see things from maybe a different perspective" (Head of Care, Lincolnshire)

❖ Accessibility

Knowing that the MHLAN was accessible and available to provide information around dementia and carer issues was reassuring for staff, especially as their response was provided swiftly in urgent situations. A key feature of accessibility to the MHLAN was that this resource was made available to *everyone*, including relatives, frontline staff and external contacts, not just residents and management at the care home. Crucially, this support was available to wider members of the community.

> *"they know that we have an Admiral Nurse, they know that he's available, and so if they're at all concerned or worried they know they can come and say to me, 'This is concerning us'"* (Home Manager, Lincolnshire)

❖ Expertise

Expert information was provided by MHLANs, often in the form of troubleshooting in specific situations or as a source of new ideas or perspectives.

> *"It fascinated me how much knowledge they do have. You know, in the support groups, it didn't matter what question they were asked, they knew the answer"* (Home Manager, Wiltshire)

Promoting best practice

This is a core competency focusing on actions, advice or support given that recommends, signposts, models or demonstrates best practice in dementia care, either through face to face work or through training and consultancy. Along with 'Sharing Information' there was ample evidence throughout the analysis demonstrating the importance of this competency within the work of the MHLAN. Their work contributed to this in the following ways:

❖ Training

There was evidence of formal training as a route to best practice, which was enhanced by the knowledge and expertise of the Admiral Nurse. Importantly, staff felt MHLANs were able to articulate best practice by reference to real-life case scenarios which contextualised issues for staff and gave them different perspectives:

> *"I think it is their level of knowledge and experience that they have, they've got lots of scenarios and case histories to be able to put that into practice with the staff, you know, and it is actually, you know, giving them examples of how things can improve"* (Operations Staff, Oxfordshire)

❖ Informal advice and support

Staff felt the Admiral Nurse was there as someone to turn to, ask advice, validate their actions and support their decisions. Best practice was often promoted through these ad hoc, informal exchanges in addition to formalised training. Confidence in their advice was based in MHLANs' 'ownership' of expertise in dementia care and their extensive knowledge of dementia:

> *"Yes, just as advice, just to make sure that I was going through the right procedures, whether or not there was anything that I'd missed, did anything jump out at him?"* (Home Manager, Lincolnshire)

❖ Challenging myths and beliefs and providing a different perspective

There was evidence that the MHLAN supported practice development by challenging common myths and beliefs about dementia both in training and through informal advice and support. This was often enhanced by the MHLANs' capacity to take a different perspective through a more holistic approach. This fresh perspective was highly valued by staff:

> *"When you reflect back on practices they're horrific, really. So to have somebody like [the] Admiral Nurse to come in and talk about modern dementia care, it's very good for your older staff. 'We've always done it this way, there's never been a problem before.' It's good to have somebody like the Admiral Nurse to come in and say, 'Well actually it was a problem, we just didn't realise it at the time, and this is better and this is how we do it,' so I think that that makes a difference, definitely"* (Home Manager, Lincolnshire)

Prioritising work

This competency focuses on actions, support or guidance to help others prioritise actions for care of residents or support of staff. This includes balancing workloads both in terms of the face to face work and training provided by MHLANs and in facilitating others to develop strategies to achieve goals within their own setting. This competency within a care home setting differs slightly to that in the community and in a similar vein to 'Balancing the needs of the person with dementia and the carer' there was less evidence in support of this through the analysis. However, data demonstrated there were clear benefits in having the opportunity to reflect, to understand and to plan:

❖ Refocusing

In order to prioritise the needs of residents sometimes there has to be an opportunity to reflect and refocus on the work done by staff with residents. The MHLANs often provided the impetus and skills for this within care homes or in response to particular issues:

> *"The Admiral Nurse will sit and observe for a while how staff interact with the residents, and feed that back as a group to the whole of the home, and then the whole of the home will talk about how they could have done that slightly better"* (Operations Staff, all areas)

This gave staff an opportunity to take a more holistic perspective in reflecting on how they prioritise interactions with residents.

❖ Clarifying understanding

Sometimes the input of the MHLAN in prioritising the needs of the resident was around clarifying and correcting staff understanding around particular difficulties experienced by individuals or caused by organisational processes:

> *"It got other carers realising the importance of it…….if somebody's shouting in their room all the time they're going to be shouting because they're going to be bored, and somebody talking to them for at least ten minutes would just, you know, just take away that from them, for other carers to realise the importance of it"* (Care Staff, Gloucestershire)

❖ Planning

Much of the influence of MHLAN within this competency was in supporting staff to plan effectively for individuals' care and planning for instituting successful change within their homes:

> *"Each of our homes has a Dementia Lead, so the Admiral Nurse and I meet with them regularly, about quarterly, and they come together and they share best practice and experiences, any issues, developments in the home"* (Operations Staff, Lincolnshire)

Preventative work and health promotion

This competency focuses on actions, advice or support given to promote other health and well-being needs or to prevent issues or challenges arising.

The themes identified were a reflection of the MHLANs' role in proactive, holistic support to change the culture within the care home. Thus they were looking at health issues which impacted on a person's dementia, they were providing training around specific issues and importantly they were involving everyone; families, the person with dementia, care staff, domestic staff, and external professionals etc. There was a strong overlap between these themes.

❖ Health issues which impact on dementia**.**

Involvement of the MHLAN in this area usually focused on health issues that exacerbated the symptoms of dementia, and supporting staff to identify such influences and thus prevent escalation:

> *"They won't just come in and, say, look at just the emotional well-being of that person, they'll look at how it affects their diet and how it affects their sleep and everything"* (Operations Staff, Gloucestershire)

❖ Involving everyone

Part of the role of the MHLAN was seen as bringing everyone together for the benefit of the resident and ensuring that everyone had enough awareness of dementia to work and support individuals in effective ways:

> *"The support with speaking to managers, handymen, you know, kitchen staff, because if they're battling against it, it has been great for them, it's been fantastic"* (Head of Care, Lincolnshire)

❖ Training

The Admiral Nurse undertook preventative work through training for staff, both through formal means and informal observation, advice and guidance:

> *"A couple of the carers thought he needed something to calm him down, which would have been an antipsychotic, wouldn't it? But you see, we'd done the training and I was arguing the case and she came in said, 'No, he doesn't actually need that, he just needs this'"* (Care Staff, Gloucestershire)

Ethical and person-centred care

This competency focuses on actions, advice or support given to provide person-centred care or to resolve challenges in an ethical way. The themes which emerged identified areas where the Admiral Nurse had been able to help staff and family to focus on the psychological and social needs of the resident. Sometimes this was about taking a

different perspective; having a fresh pair of eyes. The staff and families were able to identify a change in quality of life for residents through taking a more person-centred approach. In turn, this impacted upon the culture of the home in a wider sense, both through more ethical practice and through looking beyond the individual at the wider care home environment.

❖ Focusing on needs

By taking a person-centred approach the Admiral Nurse was able to compile a richer picture of the individual and suggest strategies which focused care more holistically taking into account other factors including the wider care home environment:

> *"We had one person that was just not eating at all, and I know she came in and spent quite a bit of time just working with that resident and working with the Head of Care and the staff, put things in place"* (Care Staff, Oxfordshire)

❖ Quality of life

Taking a person-centred approach improves the quality of life of individual residents and of the care home generally and gives strategies and tools to empower staff to continue the work:

> *"I mean, one lady, when I first started here, she wasn't talking, she wasn't supporting herself with nutritional needs, and we've reduced [antipsychotic medications] ... well, it's gone. She's not on it anymore, and now she's talking, she's singing, she's supporting herself. A totally different lady, you just wouldn't recognise her"* (Home Manager, Lincolnshire)

❖ Changing culture

Working in a relationship/person-centred way, through ethical practices, and challenging what has been 'taken-for-granted', changes the culture of the care home:

> *"They might well say, 'Well actually, the staff need a training session on understanding distressed reaction,' which traditionally was always called 'challenging behaviour'"* (Operations Staff, all areas)

Balancing needs of the carer and the person with dementia

Balancing the needs of the carer and the person with dementia can be complex in a traditional community based service where the Admiral Nurse should be recognising and addressing the needs of both, but with an emphasis on working directly with carer in the event of conflicting needs. Themes under this competency were less well

represented, possibly reflecting the less complex nature of this competency within the care home setting compared to the traditional community setting. Evidence did however, demonstrate that the MHLAN works within this competency to ensure the needs of the carer (paid carers, volunteers and family) and the person with dementia are met through mediation with the family and through support:

❖ Mediation with the family

When there was conflict between the needs of carers and the needs of residents, staff in care homes found it helpful to have someone to mediate between the family and the person in care, or coming into care:

> *"We had a situation also regarding a lady who ... she lived with dementia and she was refusing meals very often, but then when we invited an Admiral Nurse for discussion together with family and the resident, we found out that part of it was that the family was trying to take over control a bit more, but in discussions with the Admiral Nurse and everything, we found out really what the resident wants, what she wished to eat"* (Care Home, Gloucestershire)

❖ Support

Providing greater support and guidance to staff and managers enabled staff to balance their own needs with that of the person with dementia and others living in the home:

> *"[The Admiral Nurse] suggested giving residents things to distract them, something that calms them for example, relieves the carers to be able to not spend so much one-to-one with that person, offering them something which means they can come away and do something, you know, something with someone else that also needs that time"* (Home Manager, Oxfordshire)

Advanced assessment skills

Advanced assessment skills are used by the MHLANs' to assess people's needs or to appraise complex situations giving advice for best care outcomes. Through expertise and training they were able to make a difference within individual assessment and support others to make a difference more widely:

❖ Expertise

The MHLAN was able to assess complex situations and provide expertise to address specific issues as a consequence of the range of their knowledge and experience. This expertise was trusted and admired:

> *"If we've got anybody that's got challenging behaviour, you know, and we're not really equipped for challenging behaviour then we'll ask the Admiral Nurse to come in and guide us"* (Head of Care, Oxfordshire)

❖ Providing targeted training

As a result of their expertise, MHLANs were able to provide targeted training and advice, to both staff and families:

> *"So it's very bespoke, the training that (AN's) been delivering about individual residents,"* (Home Manager, Lincolnshire)

> *"They also do specials for their homes around distressed reaction and how to support people who are distressed by their condition"* (Operations Staff, all areas)

My Home Life Ways of Working and the senses framework

The MHLAN is unique in its relationship with the *My* Home Life movement. Therefore, it is necessary to consider the role within this context and establish the extent to which its supports, or is enhanced, by the *My* Home Life philosophy.

The broad framework of *My* Home life is described in the context section of this report. However, in examining the data it was important to ensure that the underpinning philosophy and ways of working of *My* Home Life - achieving the senses framework (Nolan, 2006) - was also identified. To this end, data were analysed according to the six senses, (explicitly incorporating the evidence-based practices identified by *My* Home Life) and four ways of working; appreciatively, relationship-centred, evidence-based and reflectively. Each of these is explained in the relevant themes below.

Overall, it is important to note that qualitative data did not show any areas where the actions or approach of the MHLAN detracted from achievement of a *My* Home Life philosophy, although some areas were enhanced more strongly than others. The qualitative findings reinforce the qualtitative findings in this regard. Enhancement of the *My* Home Life philosophy was often evidenced more significantly in relation to dementia care (whether as individual resident input, staff skill improvements or overall care home influences) than non-dementia care, although improvements in an aspect of dementia care often led to improvements that benefitted the whole home. This is to be expected given the dementia-specialism of the Admiral Nurse. However, it does suggest that Admiral Nursing competencies may be more influential in the role of the MHLAN than *My* Home Life, which is unsurprising given the light-touch integration of *My* Home Life into the construct of the role at the outset, as explained in the context section of this report.

Each theme and sub theme are discussed below and are not presented in order of importance as all emerged sufficiently frequently within and across the qualitative data to be considered significant. Where a theme or sub theme was demonstrated particularly strongly or weakly in comparison to others this is identified and discussed.

Fostering a sense of security

My Home Life identifies that a sense of security for all involved in care home life is fostered by efforts to: improve the training and development of staff, improve overall care quality and secure contact with external professionals, particularly in healthcare. The qualitative findings highlight that the MHLANs contribute to this in a number of ways.

❖ Providing an 'external perspective' in-house

The MHLAN role provides an objective viewpoint and source of expertise which care homes can call upon in potentially challenging situations with family members (where there was high level of conflict or problematic dynamics), or with external professionals (such as safeguarding meetings). This results in an increased confidence in the professionalism and care quality of the care home and a support for the care home in what can be very challenging and time-consuming situations. A number of cases highlight that the involvement of the MHLAN in this way resulted in prevention of escalation or the transformation of negative situations into positive comments. As this manager illustrated

> *"(AN) is considered an expert, you know, in this field really and I think that's why some of the relatives, although we know that we do our best, it's like that extra isn't it and above all support and advice," (Manager, Oxfordshire).*

❖ Providing support for staff

The MHLAN role provides support for both frontline staff and management that results in improved care practice – particularly in relation to dementia care – and an increased confidence in that care practice. This support is provided through the provision of training and development opportunities, both formal training and responsive opportunities such as reflective meetings or discussions. In addition, the provision of ad-hoc advice, guidance and reassurance to both managers and staff is highlighted as crucial because it improves staff confidence in their own actions

> *"I think people come to me and want answers, [AN] has been a huge support. When this [resident] was having difficulty with personal care…None of the other*

carers could get in and it took me an hour and 15 minutes…When [AN] came in and I spoke to him and I was telling him this he said, 'You did the right thing,' so it's nice to hear" (Head of Care, Lincolnshire)

❖ Response to quality issues

The MHLAN role responds to issues of concern, both reactively and proactively. They are a resource called upon in the event of a concern over care practice (of individuals or whole homes). In addition, they are used by managers and staff as sources of advice over potentially problematic issues of care (particularly in relation to dementia care) and as such may prevent such situations escalating into more serious concerns.

> *"I can see from where we started to where they [staff] are now. I can see that the staff are choosing [to move away] from the idea of everything's about the task. We're training, 'you can do it', 'you can do it', but actually when they start to see to in action you start to see that [resident's] benefit"* (Operations Staff, all regions)

❖ Facilitating work with external professionals

The work of the MHLAN appears to be particularly beneficial in supporting care homes' interactions with external professionals such as GPs, district nurses, CPNs and care home liaison teams. This is particularly so when care home report difficulties in their relationships with such professionals. MHLANs facilitate this relationship by acting as an intermediary between the home and the external source, and many homes reported this was because they were seen as the 'professional' face of the care home in relation to dementia care. Most significantly, the MHLANs were often seen to fill the gap created by the absence, delay or lack of expertise of some external professionals, enabling enhanced care quality as a result.

> *"they have the same goal that we have, which is different to say, like, CPNs…They really are wanting to deliver the very best care and they look at the person as a whole as we do…so it's having a person that thinks like you and not from the NHS who purely think about prescriptions"* (Operations Staff, Oxfordshire)

> *"We contacted [resident's] social worker and left a message. It took over a week for them to get back to us. We left message after message and the family were getting irate" (*Head of Care, Wiltshire)

Fostering a sense of belonging

A sense of belonging for all involved in care home life is fostered by efforts to: encourage participation of all within the home; encourage participation of the external community in the home; encourage links with external organisations; maintain connections both within and without the care home. The MHLAN role contributes to this in a number of ways as outlined below:

❖ Input to dementia cafes and support groups

The provision of dementia cafes and support groups for care home visitors and people living in the community who support people with dementia was highly valued where they occurred and appeared to enhance connections between those who attended the cafes and care homes, even when they were not residents or visitors to the care home themselves:

> *"I do feel part of the home because I come to the memory café…I get involved with everything [for the home]"* (Café Attendee, Gloucestershire)

❖ Changes to home life that enhance connections

In a number of situations, suggestions and support given by the MHLAN to improve aspects of home life resulted in improved connections within the home. These changes tended to focus on areas such as: increasing the 'everyday' occupation available for residents; altering the approach of daily events such as mealtimes; and changing the physical environment. The prompt for such changes was often the care needs of the person/s living with dementia but the effect advantaged all in the home.

> *"At the moment we're trying to expand on the dining experience and how it works…for the residents [and staff] and get it more of a social event rather than just another meal time, and that's for everybody, really"* (Care Staff/Dementia Lead, Oxfordshire)

❖ Supporting communication between staff, residents and family

The MHLAN role also appeared to enhance connections within the home (and other OSJCT services) by facilitating positive relationships between members of the community. This was achieved as a by-product of the staff support and objectivity provided by the MHLAN. By acting as an intermediary and external perspective in difficult situations and by providing support and guidance to staff, difficult situations were resolved and communication skills of staff enhanced.

"Just enabling people to, you know, talk to each other when they need to. I think it's like the communication thing, isn't it? Because people are not always able to communicate and I think with her input…it's enabled people to actually communicate more effectively" (Head of Care, Oxfordshire)

"We have a gentlemen in [Extra Care Housing]…all of the staff refused to work with him…Our Admiral Nurse went in and worked with that team of people and now they're queuing up to work with him…So that is [an] extreme success that I'm not sure we would have achieved quite so quickly" (Operations Staff, all regions)

❖ Connections outside the care home

In a few cases the MHLANs were seen to have facilitated relationships between the care home and external organisations such as schools or supermarkets. This was either through externally facing dementia cafes or through the encouragement or support of Dementia Leads with ideas related to community work.

"[Care home] was quite close to my [old school] and students got to the care home for work experience and I remember my friends talking about a 'crazy old man in the corner that would shout at them' and I thought that's an awful thing to come away thinking. So between [AN] and myself we spoke to the secondary school and…talked to the [students] about dementia care" (Activities Co-ordinator, Oxfordshire)

Fostering a sense of continuity

A sense of continuity for all involved in care home life is fostered by efforts to: improve transitions to, from and within the care home; support good end of life care; and support all to deal with losses that occur within a care home environment. The MHLAN role contributes to this in a number of ways. Overall, this aspect appeared less commonly in people's accounts and experiences of the Admiral Nurses. However, the work done with external professionals addressed in earlier themes would have a strong crossover.

❖ Advice & support for families, carers and people living with dementia

By far the most significant way in which the MHLAN role contributes to a sense of continuity is through their work directly with family members and (non-formal) carers for people living with dementia. Their input was seen to provide the necessary support to help families adjust to changes caused by dementia and to provide a source of

mediation when problems or conflicts occurred. In addition, family carers themselves saw the advice and guidance as a way to cope with the changes dementia brought. This had an impact inside the care home, but also for those still supporting someone living at home.

> *"I think they felt supported and I also I think they felt that it wasn't just the Home Manager thinking Mum was a problem that needed to be got rid of…So it could have turned out to be quite negative but it did turn around and ended up as a positive"* (Home Manager, Lincolnshire)

❖ Supporting successful change internally

The work of the MHLANs also showed an impact on continuity within the home through their support of change. Their role appeared to encourage change that was evidence-based, well planned and evaluated for success, which enabled transitions to occur smoothly and successfully whether large-scale (such as moves to new buildings) or small-scale (such as changes to routines).

> *"We had a group of residents that were transferring between services…And [AN] was very active and supportive during that move…we did a quality of life survey so we could actually see whether the new environment was working"* (Home Manager, Lincolnshire)

❖ Individual transitions

MHLAN support and advice regarding individuals' care, particularly in relation to distress behaviours, appears to ensure that transitions are minimised and, if necessary occur at the right time for the individual. This may be in relation to enabling a family carer to continue to care for longer at home, or ensuring that a move to a new setting is undertaken only when all options have been explored within a current environment:

> *"we didn't know what to expect…we knew [the dementia] was getting worse but we didn't know what to expect the next week…With the help of the [AN] we learned something every week"* (Café Attendee, Gloucestershire)

> *"Support for families… and for us to support us to look after the residents in the best way without giving medication or their needing to transfer to another home"* (Operations staff, Oxfordshire)

Fostering a sense of purpose

A sense of purpose for all involved in care home life is fostered by efforts to help all identify and progress towards personal goals. The MHLAN role contributes to this in a number of ways as outlined below.

❖ Holistic goals

In providing advice and guidance on interventions for individuals with dementia the impact of the MHLAN appeared to promote holistic, quality of life goals as opposed to solely behaviour management goals. This approach appears to influence the work of staff not only towards quality for the individual but also to measures that impact all, such as improved occupational engagement or mealtime experiences:

> *"One lady, when I first started working here she wasn't talking, wasn't supporting herself with nutritional needs…now she's talking, she's singing, she's supporting herself"* (Home Manager, Wiltshire)

> *"she talks to the doll, she feeds it, she dresses it, so she's much more settled. So it's meant that she's been able to stay in the care setting she is used to rather than maybe having to go to a different care setting"* (Activities Coordinator, Oxfordshire)

❖ Those supporting people living with dementia in the community

For those participating in dementia cafes, identification and progression towards goals centred on individual strategies in responding to and supporting someone throughout their journey of dementia. Whilst not directly related to the work of OSJCT care homes, these individuals often cited a better understanding of the condition, and more comfort with the idea of residential care as an option in the future. This has a potential impact on positive transitions with residential care for those individual in the future.

> *"I don't lose my temper as I used to. I'm much quieter, I don't argue with [my partner] because I realised from what's been said [by AN] that that's the worst thing you can do…I've tried not to coerce into doing anything but to go at it in a different way. So it really has been helpful"* (Café attendee, Lincolnshire)

❖ Individual staff contact

A number of individuals cited the influence and support of the MHLAN in helping them to set personal goals, such as exploring an area of interest or achieving a qualification as

well as setting goals for their own workplace or work team. This aspect contributed to an organisational appetite for change as explained below.

> *"I spoke to [AN] and said 'I would really like to develop [end of life care]'… I put in an intervention programme [for a resident]…it was such a special moment and this lady was smiling, she was aware…I've written up the programme and shared that with the [AN]"* (Activities Co-ordinator, Lincolnshire)

❖ Organisational change

Organisational goal setting, both in terms of improvements within individual care homes or broader initiatives such as workforce training or policy, appear to be strongly influenced and encouraged by direct contact with the MHLANs and their indirect influence though dementia leads. This influence appears to direct this change towards evidence-based, well planned and critically evaluated efforts; an important element in ensuring 'successful' change across organisations.

> *"We went to this conference myself and [AN] and there was research done on specialist lighting… we did this series of observations for the residents that were done prior to the [installation of the specialist lighting] and then we got it evaluated afterwards as well"* (Home Manager, Oxfordshire)

Fostering a sense of achievement

A sense of achievement for all involved in care home life is fostered by efforts to: celebrate the work of staff and the lives of residents; and efforts to encourage events which maximise participations across the home. The MHLAN role contributes to this in a number of ways although it was evident in accounts that there is a strong focus on staff achievements in particular. In addition, there was a strong overlap between fostering a sense of purpose and a sense of achievement.

❖ Cascade effect through dementia leads

This element appeared to particularly focus on the work of the dementia leads, with MHLAN's providing influential support and encouragement to this group of staff, celebrating and sharing their work. This, in turn, enabled dementia leads to do the same within their home.

> *"They support the Dementia Leads…they come together and they share best practice and experiences and issues, developments in the home"* (Operations Staff, Lincolnshire)

❖ Personal support and encouragement

The emotional and practical encouragement given by MHLAN's to members of staff in a variety of different roles was consistently cited within the evaluation. This ranged from specific encouragement to pursue personal qualifications or projects to a simple 'you're doing the right thing', in conversation.

> *"When I started as dementia lead I really did get quite a lot of support…I applied for QCF level 3…an idea given by the Admiral Nurse. She really helped me going through that process…Pushing me to do some more training…that I could be promoted because [AN] sees that potential in me. That was really nice"* Dementia Lead, Gloucestershire)

Fostering a sense of significance

A sense of significance for all involved in home life is fostered by efforts to: encourage involvement of residents in decision making about their care; encourage involvement of all in decision-making about the care home and organisation; and highlight the contributions of staff residents and visitors. The MHLAN role contributes to this as outlined. It is important to note that there was a strong correlation between fostering a sense of significance and the personal and appreciative approach of the Admiral Nurses.

❖ Mediation

The involvement of the MHLAN in supporting family members and providing advice and guidance where there was conflict about care appeared to serve a mediating role; enabling all to see differing perspectives, understand their importance and work together to make decisions about a person's care.

> *"[Admiral Nurse] came in and we all just sat down together with the family and we discussed our problems and she just gave us some ideas and directions of which ways to look after this gentleman"* (Care Staff, Oxfordshire)

❖ Reassurance

One of the most valued aspects of the MHLAN work was providing reassurance for staff at all levels about the actions taken in relation to resident care. Whilst often as a result of requests for advice or guidance, reassurance was specifically about acknowledging the skills already in place and ensuring staff confidence in those.

> *"it's about reassurance to the care staff that they have done the right thing…with the Admiral Nurse it's that reassurance, because sometimes staff are concerned*

you know, 'did I do the right thing,'…the Admiral Nurse with their experience is really important" (Operations Staff, all regions)

❖ Cross-staff team contact

The MHLANs had contact across the staff team, from working alongside staff in the frontline to advising policy developers and colleagues in the quality team. This cross-sectional contact appeared to be important in highlighting the input of all within the organisation to good quality care and in connecting decision-making at all levels to the experience of residents.

> *"She will come in and she will go and flit around the different [parts of the home] and you know, just offer advice. It involves not just the residents but the staff as well. There are lots of ways and it's made a big difference"* (Care Staff, Oxfordshire)

❖ Staff involvement in organisational decision-making

This approach and contact across the staff team appeared to facilitate the involvement of frontline staff in organisational decision making, such as methods used for life story work, or changes to environments. In addition, it appears to facilitate the transfer of learning across different care homes within the organisation, as the MHLAN can take experiences from one care home to another, and identify places in which to pilot new initiatives.

> *"They're wanting to improve the dining experience, but they're having resistance from the dining staff…inviting some of the cooks from the homes to the Dementia Lead meetings to look at what can be done"* (Home Manager, Lincolnshire)

An appreciative way of working

Creating a positive ethos as envisaged by *My* Home Life requires practitioners to demonstrate an appreciative way of working. This may be evidenced through: valuing of different perspectives and skills; encouragement and gratitude for the input of others: Use of others' skills; recognition of difficulties of care home work/living/visiting; encouraging others to adopt an appreciative approach. Evidence suggests this is a major aspect of the MHLAN role and it is manifest in the following ways:

❖ Responsive

The most consistently valued aspect of the MHLAN role was their responsiveness. They were seen as someone reliable and emotionally supportive who both staff and family

members could call on. Crucially, this sense of reliability was fostered by MHLANs responding to requests quickly and helpfully, and this was contrasted strongly with people's experiences of other health and social care professionals. These actions culminated in those who had contact with the MHLANs believing that they understood the realities of life and work in a care home or supporting someone living with dementia.

> *"It was knowing that there was somebody there that I could…actually call on and ask a question and get an answer, or ask them for their support and help and they would be out, now, and it wouldn't be 'oh, it'll be three months' time or anything. It would be when they were needed. I don't know how they managed it, but they did"* (Day Centre Co-ordinator, Wiltshire)

❖ Practical support

The MHLAN work was particularly valued and influential because they were seen by staff to be hands-on in the work they did, rather than simply instructing others. This appeared to enhance their credibility will all precisely because they showed themselves to be willing to understand and undertake the roles of others. Moreover, this hands-on approach provided opportunities to enhance the skills of others through role-modelling.

> *"It wasn't just a case that she was standing about observing, she was hands-on…she was helping them with breakfast, dishing out breakfast, you know doing activities with them. You know, she was spot on"* (Care Staff, Oxfordshire)

❖ Emotional support

The emotional aspects of the support provided by MHLANs was arguably more highly valued than the practical aspects of their role, and appeared to be a unique aspect of this role compared with other roles within the organisation (such as line management etc.). Their empathy, reassurance, non-judgemental and confidential approach was consistently cited as being influential on both a personal and professional level. The resulting 'sounding board' that MHLANs provided, particularly for those in managerial positions, was significant in helping staff to feel valued and confident in their roles.

> *"A cheerful disposition… [AN] doesn't judge, not judgemental in the slightest…For [staff] to offload, because they can't always say it, can they? Especially if they're having difficulty with their manager or they've got no one they can go and offload to"* (Head of Care, Lincolnshire)

❖ An independent voice

The mediating role played by the MHLANs in difficult situations appeared to help all involved appreciate and accommodate the perspectives of others in their work.

> *"[they're] outside, [AN]) doesn't work in here every day like we do, and she's a specialist…they work for the company but they're neutral"* (Head of Care, Oxfordshire)

A relationship-centred way of working

Creating a positive ethos as envisaged by *My* Home life requires practitioners to demonstrate a relationship-centred way of working which is delivered with attention to the six senses described by the framework. This may be evidenced through: consideration of the impact of their work on the relationship between staff, families and residents in the care home; and fostering good relationships within and without the care home. The MHLAN role contributes to this in the following ways and experiences evidenced a strong overlap between appreciative ways of working and a relationship-centred approach.

❖ Varied and flexible approaches

MHLANs were reported to demonstrate highly flexible ways of working, in terms of hours, venue and type of support provided. This demonstrated a willingness to fit around the needs of others in delivering their support and as such created positive working relationships and reinforced a sense that the MHLANs understood the realities of living and working in a care home or caring for a person living with dementia. This was contrasted with many people's experiences of other health and social care professionals.

> *"[AN] came into the home every month, just for the staff to talk one-to-one because it was a big change for them. The process took nearly two years. [AN] was a point of contact for them, you know, to help them"* (Home Manager, Lincolnshire)

❖ Focus on positives, improvements and joint problem-solving

One reason for the high value placed on the work of the MHLAN was their focus on positive improvements and praising positive aspects. This helped to build open and trusting relationships in which people could be honest about difficulties and more easily take advice and guidance. This was also enhanced by joint problem solving in which the focus was on 'getting together' and looking for solutions as opposed to giving

instruction. Accounts suggested this enhanced the sense of equality, value and self-confidence. Again, this strongly supported both the building of relationships and appreciative approaches within those relationships.

> *"[at the Dementia Lead meetings] it was just like how could we improve? What do we think? Is it not right, too noisy? It's just about getting it a relaxed and 'how would you like it? And we've all come up with these ideas and come back and changed things"* (Activities co-ordinator, Oxfordshire)

An evidence-based way of working

Creating a positive ethos as envisaged by *My* Home Life requires practitioners to demonstrate an evidence-based way of working. This may be evidenced through: showing knowledge and application of the latest methods and interventions in their own practice and advice-giving; encouraging others to seek out latest guidance and evidence; and seeking opportunities to discover and new methods and interventions.

It is notable that the evidence bases which were most commonly mentioned within the interviews related primarily to dementia care, rather than the *My* Home Life evidence base. Where *My* Home Life evidence based was referenced it was exclusively by dementia leads in reference to discussion topics at the dementia lead meetings. This suggests again that the MHLAN role cannot currently be said to be explicitly and consciously embedded within the *My* Home Life framework.

❖ Expertise admired and respected

The expertise of the MHLAN was consistently cited as the rationale for their involvement and the basis for the respect afforded them by all who had contact with them. MHLANs were always reported to have up to date knowledge, based in the latest research evidence, around a variety of issues in particular: issues of dementia care, support available in the community for people living with dementia and carers, and the MCA and DoLS.

> *"I think (AN) are more trained for that certain topic, aren't they? The dementia…they've got more background knowledge of the disease, because we're not actually a nursing home or a dementia home, we're just a residential home… (we) haven't got the knowledge of a person with dementia and what could happen with the person's brain and their characteristics and all that…We can get the nurse in to give us a bit more advice and a bit more help for the carers,"* (Head of Care, Lincolnshire)

❖ Good dementia practice

Of unsurprising significance was the depth of knowledge provided around dementia care practice. In particular the MHLAN influence regarding issues of life history, interventions for distressed behaviours, risk, pain and medications were all cited frequently within the data and in keeping with latest knowledge in these areas.

> *"so to have somebody come in and talk about modern dementia care, it's very good for your older staff. 'we've always done it this way, there's never been a problem before,' It's good to have somebody like [AN] to come in and say 'well, actually, it was a problem, we just didn't realise it…this is better and this is how we do it'…That makes the difference, definitely"* (Home Manager, Lincolnshire)

❖ Evaluation

MHLAN work often involved the teaching or use of evaluation measures such as the QUIS (Quality of Interactions Schedule), particularly in conjunction with specific changes. This ensured that innovative approaches were implemented in the context of an evidence base from within the individual care home and organisation as well as externally established good practice.

> *"the fact that [AN] always then monitors things and comes back, so she's never just in and out and she then evaluates her own work as well as obviously what the staff have been doing…That's why [they're] so effective because [AN] does really evaluate and if it isn't working [AN] will try absolutely anything and everything to try and make it better"* (Operations Staff, Oxfordshire)

A reflective way of working

Creating a positive ethos as envisaged by *My* Home Life requires practitioners to demonstrate a reflective way of working. This may be evidenced through: seeking opportunities for feedback; consideration of strengths and areas of improvement; and encouraging others to be reflective in practice by providing feedback and support.

Reflective ways of working were not evidenced as strongly as others ways of working within the data, but there was nothing to suggest that non-reflective ways of working were present. It is also possible to argue that relationship-centred, appreciative and evidence-based ways of working are implicitly reflective, which could explain why this aspect is less obvious within the data. Accounts suggested that the MHLAN role explicitly contributes to reflective ways of working in the following ways:

❖ Reflective meetings

A specific task of the MHLAN role was to support reflective meetings with staff after particularly difficult or challenging events. These were always cited as significant in learning from such events. However, it was unclear whether this was then something replicated on others occasions, without the input of the MHLAN.

> *"[AN] has done one to one sessions with staff, you know who have had problems with different things…she's done reflective meetings, and not specifically regarding dementia. Regarding death and regarding incidents that have happened"* (Head of Care, Oxfordshire)

❖ Evaluation

As highlighted above, the MHLANs' work often involved the teaching or use of evaluation measures such as the QUIS. This appeared to emphasise the importance of reflecting upon measures to identify areas of success and improvement. Moreover, where changes to resident care or care home provision were instigated and supported by the MHLAN evaluation was always a key element. This suggests a role-modelling of the importance of embedding opportunities for feedback within any new approach.

❖ Supportive solution-finding

The MHLAN approach of supporting and involving others in decision-making and solution finding appeared to encourage a reflective approach both on the role of the MHLAN and within others' practice. This opened up opportunities for feedback on success or experiences of changes and measures within the context of an ongoing dialogue and relationship.

> *"Often it's about helping people to reflect on what's gone on and to come up with solutions themselves…saying 'well, why do you think that's happening, what's going on there, what could you have done better? So it's about getting them to a solution that they've achieved themselves rather than the nurse coming and saying"* (Operations Staff, all regions)

Discussion and Conclusions

In summary, the MHLAN provides a highly varied and impactful function within OSJCT, with influence extending from individual resident outcomes to organisation-wide change. It was universally valued by those who had contact with the role and suggested improvements focused on increasing the number and contact with the Admiral Nurses rather than changing their roles in any substantial way. The role had a high level of consistency with the Admiral Nurse core competency framework, although some functions occurred more frequently than others. In addition, practice consistent with the *My* Home life philosophy and ways of working infused the work of the Admiral Nurses at every stage. This also appeared true with the focus group conducted with Admiral Nurses working in other Care Home organisations, suggesting that a strong model could be emerging within the sector, to which this evaluation contributes.

The intended outcomes of the MHLAN role within OSJCT were fourfold and this evaluation suggests that each has been fully met by the practice of the MHLAN thus far. Both qualitative and quantitative evidence presented here suggests that, as a result of the MHLAN's practice there is:

- An improved quality of care and wellbeing provided to people with a dementia
- Empowerment of staff through increasing knowledge, skills and confidence in relation to dementia
- Enhanced relationships with families and relatives of people with dementia
- Residents enabled to stay in the care home in which they are settled if their dementia care needs become more acute.

These achievements were guaranteed through certain features of the role and personnel which are addressed below.

The MHLAN Role

Overall, three features of the role consistently emerged as significant in their function and impact:

i) The practical and emotional support provided

ii) The flexibility and responsiveness of the role, and overwhelmingly,

iii) The objectivity provided by the role

Our evaluation suggests that any future arrangements for the role must ensure to maintain and maximise these features.

The impacts of the MHLAN role were myriad and often highly individualised to the benefit of residents or staff members. Impacts were particularly shown in improving overall care quality, improving staff skills and confidence and in supporting appropriate transitions for residents. With regard to transitions, there were examples throughout the evaluation of times when carers or care homes were able to do the following things as a result of their contact with the MNLAN:

- Maintain their caring role in the community for longer;
- Have more confidence if care home placement needed to be made, particularly within an OSJCT care home;
- Support the needs of residents within the care home; and
- Identify in a timely manner when an individual may need to move to an alternative setting to ensure the most appropriate care.

When considering enhancements to the role, suggestions made were not only to ensure a nurse for each county but also to establish more routine contact between each home and their MHLAN. This was discussed with the MHLANs themselves and it appeared that such ways of working were already being considered. It was felt that, once established, this would help pre-empt many of the reactive reasons for involvement. Survey results showed that contact on any issue tends to be less than six times a year, which would suggest that a bi-monthly approach would be consistent with the level of support required. This would also address the issue of variable levels of internal awareness of the role.

However, such routine work should not prevent the MHLAN from maintaining an ability to respond in a timely and flexible manner. MHLANs working in other care home organisations also reflected a predominance of reactive involvement, but reflected on the benefits more routine arrangements could provide. There will need to be a constant recognition of the need for the MHLAN to consider the balance between reactive and routine involvement, recognising that raised awareness inevitably increases the workload.

In discussion with the MHLANs it was clear that their involvement (and thus impact) was constrained by the extent to which operational management was aware and sought to engage them. This was mirrored by the Admiral Nurses working in other care home organisations who experienced a variable level of challenge in their roles, depending on the extent to which the care home organisation itself embraced the ethos of person-centred care and understood the role of the admiral nurse. This suggests that one specific area for enhancement within OSJCT may be to ensure organisational procedures and management structures fully integrate the involvement of the MHLAN and raise awareness of the role.

Both MHLANs and those Admiral Nurses working in other care home organisations reflected that the objectivity provided by the role was highly significant, which confirmed this evaluation's findings. Objectivity was not only important in terms of providing mediation in challenging situations, but also in the emotional support provided. The knowledge that the Admiral Nurse was not situated within the line management structure and could be used as a confidential 'sounding board' appeared to improve people's confidence and willingness to ask for advice and support. It would also highlight that it is not a role that could be replicated by a solely in-house post and that future positioning of such a role should be mindful of this objectivity as part of line management considerations. This would also indicate that the Admiral Nurse role is significant in supporting positive cultures through empowering staff. This is consistent with the findings that such a feature is a crucial element of positive care home cultures, (Killet et al., 2014).

It was also clear that work with external professionals was of particular value to homes where relationships were challenging. This too was reflected by the Admiral Nurses working in other care home organisations. The extent to which both care homes and Admiral Nurses could struggle with engaging external professionals highlights an area known to impact care home culture and care outcomes (Killet et al., 2014), and again suggests that the MHLAN is contributing to positive care home cultures by supporting care homes in this regard. However, the inability of OSJCT to identify such contacts suggests that, whilst it is a feature of the work, it is not being routinely recorded and reflected upon.

The MHLAN and Admiral Nursing

The MHLAN role shows a high level of consistency with the core competencies of Admiral Nursing. Some aspects were considerably more strongly evidenced than others,

suggesting that care home work lends itself towards certain functions. In addition, each core competency evidenced work that was not part of the traditional competency, extending its function to staff needs and organisational dynamics.

Sharing information and promoting best practice were the two most common and impactful competencies evidenced in MHLAN work. In addition, there was a strong overlap with the ethical and person-centred care competency, which was also shown to be a highly impactful area of work. This experience was also shared by Admiral Nurses working in other care home organisations. Crucially, this involved significant expertise in delivering training and practice guidance within care home settings that would not necessarily be evident in community-focussed work. Moreover, this required a holistic view of care home culture change overall, rather than a narrow focus on aspects of dementia care, suggesting a wider skill set in this regard than a community-focussed Admiral Nurse.

Prioritising work appeared to be the least-evidenced competency within MHLAN work, with a large proportion of impact occurring through their links with OSJCT dementia leads. This is a similar experience to that of Admiral Nurses working in other care home organisations, who also had key link personnel operating on the frontline in each care home. This suggests that the cascade model can be effective in transferring some of the influence of Admiral Nurses within such a broad role.

Moreover, it appeared that with a care home function, Admiral Nurse work was often focussed on internal practice change rather than outward-facing case work and this was an apparent tension within the work of all Admiral Nurses who contributed to the evaluation. Significantly, it was identified that in order to be effective, the Admiral Nurse had to ensure that they had the capacity to take on external case work arising from outward facing events such as dementia cafes, and to a certain extent this depended on the internal performance of the care home/s itself.

Attendees at the dementia cafes who contributed to the evaluation were effusive in their praise of the MHLANs, their support and expertise. It was also apparent that this external work did increase such external individuals' contact with and confidence in care homes generally and OSJCT care homes in particular, leading to a higher likelihood of placements when and if necessary. Therefore, this aspect of work should not be ignored, not least because positioning care homes as a positive option and proactive choice for care is a vital step in securing the status of care homes and care work and thus ensuring positive cultures and experiences (Meyer & Owen, 2008). Therefore the need to continue to balance these two aspects is likely to be an important part of the care home Admiral Nurse work, to ensure that one does not exclude the other.

Crucially, this will require flexibility within any job description and role management to allow judgements to be made about when outward-facing work may be appropriate.

Case load in terms of care homes and residents varied significantly cross all the Admiral Nurses working in care home organisations, and depended as much on the structure of the employing organisation as on the intention of the role itself. The key aspect was the extent to which the Admiral Nurse could devote the time necessary to each care home in their portfolio and the relationships they were able to create with necessary personnel within the organisation. This would suggest that the expectations of the role, the existing quality of care within care homes and the extent to which organisational aims (such as care delivery models, new developments, training, staff support etc.) complement the work of the Admiral Nurse are all considerations that should be brought to bear when developing appropriate caseloads. Within OSJCT, the overwhelming area identified for enhancement was the need for a MHLAN within each geographical region as it was felt this would enable a better balance of routine and reactive tasks and enable the development of crucial relationships between MHLANs and key personnel in each area.

The MHLAN and the *My* Home Life Philosophy

As the analysis and extracts from the qualitative data show, the work of the MHLAN resonates strongly with the senses framework themes, ways of working and evidence base of the *My* Home Life framework. Each area was evidenced in some way within people's experiences of the role, with certain areas overlapping strongly with aspects of the role that were most impactful: fostering a sense of security, continuity and significance and working in appreciative and evidenced-based ways.

However, it is significant that there are also high levels of congruence in the evidence related to the *My* Home Life themes, the Admiral Nurse competencies and the most significant aspects of the MHLANs' practice. This raises questions about the extent to which *My* Home Life enhances, or is simply a by-product of, Admiral Nursing practice in general and Admiral Nurse attributes in particular.

Moreover, from the outset of this evaluation it was obvious that within the day-to-day functioning of the MHLAN they were referred to as 'Admiral Nurse'. The absence of recognition of the MHLAN title was so embedded that in conducting the survey and interviews for this evaluation the role had to be referred to as 'Admiral Nurse' in order to achieve recognition. This, together with the minimal integration of the *My* Home Life

practice at the inception of the first post, would suggest that *My* Home Life has not formed an explicit basis of the work of the MHLAN.

It was decided to explore the congruence between the MHLAN role, Admiral Nursing and *My* Home Life approaches in the focus groups with the MHLANs (familiar with the *My* Home Life framework) and Admiral Nurses working in other care home organisations, (unfamiliar with the framework). Both of these groups consistently felt that, whilst the themes, senses and ways of working resonated strongly with their practice, this was because it was aligned with the core competencies of Admiral Nursing. Specifically, both groups felt that they worked in these ways *because of who they were as people* as opposed to any framework or competency to which they subscribed. This highlights the importance of personal attributes of individual nurses in determining their effectiveness within a role such as this. This should continue to be an important consideration in the selection of Admiral Nurses by Dementia UK, and of care home Admiral Nurses by care home organisations.

This is not to say that knowledge and understanding of *My* Home life and its evidence base is not an important new way of working for Admiral Nurses working in care home organisations, but rather to suggest that it is not a determining factor of the ways in which they work.

Significantly, Admiral Nurses within both focus groups did identify that a broad understanding of what works in care homes, the challenges they face and what supports positive practice change (of which *My* Home Life is a significant part) is an important element of the knowledge Care Home Admiral Nurses need; one that is not a given for Admiral Nurses, particularly if they have only community-based experience. All current Admiral Nurses (whether MHLAN or others) reflected that this knowledge either came from past practice within care home settings or through 'learning-on-the-job' when they began as a Care Home Admiral Nurse. This appears to suggest that a specific competency, relating to what works in care homes would be advantageous to such a role regardless of organisation. Moreover, Admiral Nurses working in other care home organisations reflected that the culture of the organisation (or parts of an organisation) drastically affected the ease with which they could work. This suggests that the role of the Care Home Admiral Nurse may require additional competencies or knowledge in this area.   This point is particularly relevant with reviews to the Dementia UK Competency Framework due to be undertaken in 2015.

Recommendations

The following recommendations stem from the findings of this evaluation. A number of them are already being acted on within OSJCT which suggests that the organisation recognises the value of the role and is constantly seeking to improve its impact on residents, staff and visitors.

1) Routine and reactive work

When addressing areas of enhancement of the role, many participants identified that having regular and routine contact with 'their' Admiral Nurse would be beneficial, particularly as a way to pre-empt some of the reactive work they are often called upon to do. Survey responses suggested that when a home had contacted the Admiral Nurse about one issue, they were more likely to do so again about other issues. It is recommended that the role should be structured to allow this routine involvement. Structuring the role so as to have approximately one day every two months in each care home would enable the Admiral Nurse to develop relationships with key people, get to know (and be part of) the home and undertake many of the organisational care quality tasks without compromising their reactive availability. In addition this would raise the profile of the role throughout the organisation's care homes.

2) Contact with external professionals

Engaging with external professionals was a valued and impactful part of the MHLAN's work. However, it proved difficult to obtain accurate data about such contacts for this evaluation. The relationships between care homes and external systems are of crucial importance to the culture within that care home, (Killett et al. 2013) and are often a problematic area. Therefore it is recommended that systems be put in place to systematically capture the levels and impacts of MHLAN contact with external professionals. This will enable a picture to emerge as to how and why MHLANs engage with such roles.

3) Relationship with Admiral Nursing

The specialist nature of this work, its location within the Dementia UK Admiral Nurse structure, and the personal attributes of an Admiral Nurse were all significant to the impact of the role, particularly as it ensured that the role was positioned as an 'external role in-house'. This led to a perception and experience of objectivity that was crucial to the role's influence and value and arguably could not be guaranteed within a more 'in-house' model. Therefore it is recommended that this is acknowledged and maintained within any future developments in OSJCT and Dementia UK.

Further to this it is recommended that OSJCT and Dementia UK explore the factors that may contribute to this perceived objectivity and the ability of MHLANs themselves to maintain it.

4) Care home practice and culture change expertise

It is clear from this evaluation that the MHLANs bring not only their dementia expertise, but also experience and knowledge of how to support practice and culture change within care home environments. This is something that would not routinely be required of a 'traditional' Admiral Nurse. In fact for the MHLANs and those working in other care home organisations, much of this has been learned 'on the job' or through previous work experience. It is therefore recommended that with regard to future posts, consideration is given (whether by Dementia UK or employing organisations) to providing the following as part of continuing professional development:

a) Development of an up-to-date knowledge base regarding UK care home culture, supporting organisational change and training and practice development (of which *My* Home Life is a significant part). Competencies may be developed to reflect this within the forthcoming Dementia UK Competency Framework revisions

b) Development of a peer-support network/community of practice for Admiral Nurses working within care home organisations.

We also recommend that Dementia UK undertake to consider more fully the 'care home' core competency (including *My* Home Life's place within that) in recognition that care home environments are unique settings, requiring specialist expertise that Admiral Nurses will not necessarily have through their nursing experience.

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5) Relationship with *My* Home Life philosophy

Whilst awareness of the *My* Home Life evidence base is a crucial part of the care home competency recommended above, an explicit and exclusive adherence to the *My* Home Life approach was not a significant factor in the function and impact of the MNLAN role. Instead, the role of Admiral Nursing and the attributes of individual Admiral Nurses seem to reinforce the evidence-base of *My* Home Life.

However, this is in the context of a minimal level of integration between the MHLANs and the *My* Home Life framework from the inception of the role. Therefore it is important to consider the future relationship between MHLAN in OSJCT and *My* Home Life. We therefore recommend that OSJCT review their intended outcomes for the role and the extent to which it is intended to be a dementia specialist role or a care home culture transforming role. If it is to be the latter, consideration should be given to more fully integrating with the *My* Home Life philosophy.

6) Awareness raising

This evaluation found that awareness of the MHLAN role (or Admiral Nurse role) was inconsistent, and reliant on a home having received contact from the MHLAN themselves. It is therefore recommended that OSJCT consider how to raise awareness of such roles amongst its own operational staff, as well as to visitors and staff in care homes. However, this needs to be done in consultation with the MHLANs in recognition that increased awareness will lead to increased workload. Too high a workload will likely impact upon the responsiveness of the MHLAN which was a highly valued feature of the role. Considering more routine ways for MHLANs to have contact with care homes might be a way to raise the profile, whilst carefully monitoring the impact this on workloads.

7) Caseload

It is of huge credit to the OSJCT Admiral Nurses currently in post that their flexibility and responsiveness was cited as impactful even in the region in which they were not based. It would appear from this evaluation that the appropriate case load for the OSJCT is based on number of care homes rather than residents within care homes, as it is the relationship with care home management and staff that determines the ease of access

and success of input in each home. A case load of between 15-20 care homes allows for one day of routine contact with each care home on a bi-monthly basis, whilst also allowing a flexible response to reactive case work. Therefore, this would mean an Admiral Nurse per geographical region would be appropriate for the current work type of the OSJCT Admiral Nurses. It is notable that this structure is now in place within OSJCT.

8. What's in a name?

Given this evaluation's finding that awareness of the Admiral Nurse role was inconsistent, the inclusion of '*My* Home Life' as a role descriptor may not be helpful in raising this awareness, Particularly given that the framework did not appear to be integrated significantly into practice. OSJCT will need to consider the impact of the more complex 'MHLAN' is helpful in increasing role recognition. This will depend on the outcome of recommendation 5.

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