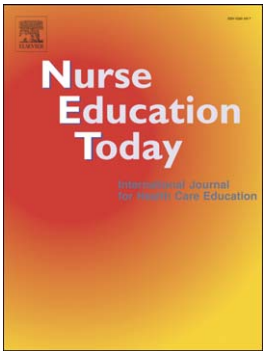


# A qualitative study investigating training requirements of nurses working with people with dementia in nursing homes

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# A QUALITATIVE STUDY INVESTIGATING TRAINING REQUIREMENTS OF NURSES WORKING WITH PEOPLE WITH DEMENTIA IN NURSING HOMES

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## Introduction

"Dementia" is a term used to describe a progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities (DOH, 2009). It has been estimated that globally thirty six million people are living with dementia (Thomas 2013). Alzheimers Disease International (2013) reported that in high income countries 34% of people with dementia lived in care homes while in low or middle income countries the figure was much lower at 6%. In the UK changes in patterns of health care provision in the 1990s have resulted in fewer hospital beds, reduced length of stay and increased reliance on community health and social services for older people (Department of Health, 2000). As a result over 18,000 care homes provide places for approximately 440,000 people (Wild et al. 2010).

Pot et al (2013) suggested that a national strategy is essential for structuring care for people with dementia, reporting that 11 countries had strategies in place. The UK National Dementia Strategy (NDS, DOH 2009) stated improved care for people with dementia can be delivered through an informed and effective dementia workforce. Tolson et al. (2013) confirmed the international nature of this emphasis and suggested

there is a need for greater career opportunities and better working conditions for nurses working in nursing homes worldwide.

Cultures of care need to be addressed through training, improved workforce support and supervision (NHS Confederation, 2012, Francis Report, 2013). Quality of care for people with dementia could be improved by enhancing nurses' leadership skills and clarifying professional values (Edberg et al 2015). The authors aimed to improve cultures of care by designing a training and support intervention.

**Background**

The care home workforce (over half a million people in the UK) has a pivotal role in the quality of care provided to vulnerable people (Royal College of Nurses (RCN) 2012). Care home staff carry out work seen as unattractive, at pay rates that are seen as under-valuing, in a sector marked by constant change and resulting in high levels of emotional exhaustion and negative attitudes to people with dementia (Tadd et al., 2012). Staff often receive inadequate training, little respect and few opportunities for career growth (Alzheimer's Society 2013). Nurses in this sector may experience lack of specific education for clinical leadership and poor professional support (Dwyer, 2011), and hence risk job strain. Edvardsson et al., (2009) argued that the combination of these factors leads to annual turnover rates of up to 96%. Care in this setting is often inadequate; it lacks a person-centred focus and neglects the dignity of residents (NHS Confederation, 2012). Tadd et al. (2012) found that there were often difficulties in recruiting and retaining staff, who often worked long hours. The combination of the factors outlined above is associated with burnout, which in turn is linked to poor quality of care (Edberg et al 2015). Therefore, if burnout could be addressed through an educational intervention, quality of care and nurses' experiences should improve.

The focus of the research reported in this paper was to collect data to inform the design of this intervention.

**Methods**

This study was designed to explore the training needs of nurses working with people with dementia in nursing homes with a view to designing a training package. In addition, we sought to understand nurses' roles within the care homes, experience of previous training and gaps in knowledge. Focus group interviews were identified as the most suitable methodology as they enable insight into collective views and a range of viewpoints (Lawrence 2013) and facilitate reflective discussion (Gray and Brown 2016). Focus groups interviews have been successfully used to develop educational programmes (Barnack-Tavlaris 2013). Data was analysed using Braun and Clarke's (2006) six –step approach.

**Recruitment and Participants**

Nursing homes were identified through the Care UK website and a flyer describing the nature of the study was circulated to them via email inviting participation from qualified nurses. The sampling was purposive to ensure that we included a range of nursing homes, including small and large homes which were both independently owned and part of larger organisations. 11 qualified nurses (1 male, 10 female) from four nursing homes took part; with focus groups conducted at the participants' workplaces. Between two and four participants were present in each group.

**Data Collection**

The focus groups were conducted by two members of the research team (AS and CJ). Each of the four focus groups lasted approximately 1 hour and consisted of open-ended questions, in a semi-structured format. A semi-structured interview guide, based on a literature review, was developed to inform the training intervention. We

aimed to explore the competencies and skills necessary for working in nursing homes with people with dementia, nurses' roles within the care homes and their experiences of past training.

Interview Guide

1. *Would you be able to explain your role? What do you spend your time doing?*
2. *What sort of skills do you need to do your job?*
3. *Can you tell us about your previous training*
4. *Training is not always effective in changing practice; do you have any ideas or theories to explain this?*
5. *What would you like to see in future training?*

The focus groups were audio-recorded, transcribed verbatim and anonymised.

**Analysis**

The data was subjected to thematic analysis, a well-recognised method for identifying, analysing, and reporting themes within qualitative data (Braun and Clarke, 2006). Transcripts were read independently by the research team members in order to minimise researcher bias. The lead researcher kept a reflexive diary to record and explore the interpretation process (Noble and Smith 2015).

**Ethical considerations**

Ethical approval for the study was received from NRES Committee East of England on the 6th June 2014. Reference 14/EE/0168 IRAS ID 15922. All participants were fully informed and consented to their involvement in the study. Participants were aware that they could withdraw from the study at any time.

**Findings**

Four main themes were derived from the analysis of the transcripts: Responsibilities and frustrations, It's not like the NHS, Barriers to learning, and Future training. The first theme evolved as participants described their roles and responsibilities. This led to discussion about working in nursing homes, nurses' perceptions of how this differs from working in hospital environments and the perceived relative value of work in each environment. In responding to prompts about learning needs, the nurses reflected on their previous experiences, noting the difficulties of applying traditional and online learning to practice and their need for active, experiential, relevant training interventions in which they felt supported by both peers and experienced educators and mentors.

Responsibilities and frustrations

When asked about their role the participants from all 4 focus groups agreed that directing and supporting staff was their main responsibility. However, the overall impression from the data was of the overwhelming nature of the different responsibilities, complexity of the roles within a context of little support, considerable isolation and perceived low status of their work.

Many participants reflected on their regret at having to leave behind the caring, person-centred aspects of nursing as they had little time to sustain relationships with residents due to the need to prioritise tasks (e.g. medication rounds, catheterisation, and dressings) 'paperwork' and management issues:

> "*The nurses are pretty much in the supervisory role and it is hard. I think it is hard coming off away from the hands on role*"

The focus on tasks and management left many nurses feeling deskilled and regretful, it was also evident that the nurses felt that the unqualified carers had more opportunities for contact and therefore were able to develop the skills which they themselves feared that they were losing, as demonstrated in the extract below:

> "*I mean sadly, with the role of nurses and amounts of paper work and legal stuff that we have to do, nursing, you don't do as much nursing sadly. The carers are who are the front role*"

Lack of opportunity to take part in hands on care seems to lead to weaker relationships with residents. This lack of connection is a reflection of the dominance of medical discourse, in which behaviours were seen as symptoms of dementia rather than understood as expressions of emotions or the communication of needs of the person with dementia:

> *"I mean, she started, she came here she was chucking things across the room. She was bum shuffling across the floor. It is really quite difficult (…) how to react to that?"*

In the extract below the nurse implies the residents are '*un-fresh'*. This language reflected a non-person-centred approach, including objectification and lack of hope:

*"That what is the problem with a nursing home, with dementia. It is not like working in a psychiatric hospital where people are fresh, and when they get better they are going back home"*

This theme demonstrated the extent of nurses' responsibilities and their frustrations resulting from feelings of disempowerment. Lack of a person-centred perspective and understanding or residents' experiences may have undermined connection and job-satisfaction.

It's not like the NHS

Participants were asked general questions about their feelings about working in a nursing home setting. Nurses reported feeling isolated and different from their counterparts working in the National Health Service. They felt that other health care professionals perceived them to be unskilled, but they appeared ambivalent about their own abilities, describing conflicting feelings about the huge responsibilities and their ability to work independently:

*"You know, what hospital are you working at? I am working in a nursing home...they think you have a half a brain here"*

*"We don't have things on hand like dressings. We haven't got a big drug pot, you know, big drug trolley that we can just fish things out of so I mean, yes it is different"*

The findings indicated that many nurses working in nursing homes had stressors outside their working lives as well as in them. They were often single parents and needed to work close to home and schools, factors which meant they would be less likely to leave their job. These stressors meant that the nurses themselves often reported poor physical and mental health. The nurses reported being unsupported at work and undervalued by their organisations. They felt this lack of support was illustrated by poor training opportunities, career development, low pay and lack of support. The staff appeared to recognise their own worth, but were angered by organisational factors that undermined this:

> *"I think traditionally, in comparison to the NHS settings, you know care homes particularly private care homes don't pay the rates you could expect from the NHS. I would think that is the barrier to improvement. And I think equally retention is the problem, because when people come on a fairly low rate of pay and realise what it entails…they find that there is a lot expected of you"*

> *"It is not like the NHS, you are very often just one nurse on the shift, on the unit. You haven't got a colleague that you are working alongside very often so if you are not up there then there is no one to do your job"*

The theme illustrates the extent of nurses' ambivalence about roles which were experienced as stressful, isolated and unrecognised.

Barriers to learning

We explored barriers to learning and participants' experience of previous training in order to identify gaps in knowledge and inform design of the planned training. Poor quality and basic levels of training were frequently reported as barriers to learning. Previous training was perceived as inadequate, reflected in participants' inability to recall what they had learnt, even recently:

> "*sometimes you just go through the e-learning training and blab bla bla dusted and you tend to forget*"

> "*You have asked us before what was booklet one about and we already forgot what was it about*"

Many experiences of the training described were based on the 'cheaper options' such as workbooks, DVDs and free computer-based learning, which were perceived as '*very poor'*, '*pointless*' and '*repetitive*':

> "*I mean, it didn't go down particularly well and I tried to implement it with, you know, it tended to be DVDs and sessions which the DVDs are very long…and it is about taking, depleting your staff off the floor*"

These methods did not acknowledge the skills level and experience of the nurses or reflect the principles of adult learning in which learners build on previous knowledge. In addition adult learners respond best to active, experiential, social learning opportunities in which they construct understanding together. If nurses took on learning independently, the support from their organisation was not guaranteed,

meaning they attended training after a night shift or in their free time. This added extra pressures:

> "'*What it is in a nursing home, it's not like that you have a sunny day and you are off….So sometimes I had to go, finish here, go to uni, come back and I have to come to work. So I was really tired, I couldn't just cope with everything … so I had to stop at that time*"

The quotes in this theme show how poor opportunities for professional development are denied to many nurses working in nursing homes, despite their aspirations to develop knowledge and understanding.

Future training

Nurses were clear about the content which they required in future training. Most focused on the knowledge and practical skills relevant to their roles. Gaps identified included lack of knowledge about dementia and progression of the illness:

> "*I think I would like more knowledge of details…the process of the diseases associated with dementia, not only Alzheimer's. There are various diseases and just to be more in depth into dementia and progression of the illness"*

More than half of participants mentioned communication with people with dementia and their relatives as something which they found "*challenging*", therefore it was evident training was required in this area. The skills required to communicate with relatives were identified as another gap. Relatives seemed to expect the nurses to

provide them with emotional support, and while family carers were no longer responsible for day-to-day care, they appeared to see 'checking up on' the nurses as part of a new role, acquired in the transition to full time care:

> "*Patients with dementia cannot say the words anymore…..How to communicate with them? We need more skills on how to really communicate so we know, you know, what they need"*

Similarly, further skills were required to support relatives:

> *"because some nurses find it so difficult to speak to relatives. Because it is a very sensitive issue and relatives ask. I think that's another skill that would help and support nurses, to deal with that difficult conversation, issues…because some nurses find it very difficult"*

Participants were asked to make suggestions for future training. Applicable 'real-world' relevance to practice was seen as central. Participants highlighted the need for interactive training and valued opportunities to listen to each other's views and learn from each other's experiences:

> "*And we are talking about being practical; we are providing care for people with dementia and you have to be practical"*

> "*When you are in a group, you see other nurses who are from different backgrounds and when you are discussing in a group, you know from what others are saying."*

During the focus groups more than half of the participants mentioned the importance of training being available for all staff regardless of the role they are appointed to within a nursing home:

> *"I think when the carers do the same thing, then we are speaking the same language really. Which helps*"

There appeared to be a lack of understanding around responding to indications of distress. Outdated language used in the focus groups demonstrated attitudinal issues congruent with "old culture" thinking, perhaps reflecting lack of training and the impact of workplace cultures:

> "*So I think more on how to handle challenging behaviours like that, with aggression, you know, put nurses and the carers to have training. Some of us here are RGNs and we haven't had access to the patients so don't really know how to handle that"*

Generally the nurses showed insight into the areas of knowledge and understanding they required to improve the quality of care, although the language they used reflected lack of exposure to current thinking.

## Discussion

The well-being of the nurses working in nursing homes has been addressed in the literature (RCN 2012) and similar issues arose in this study. Dwyer (2011) found that nurses in nursing homes felt valued by residents but under-recognised both at work and at home. Poor support for staff at work included widespread lack of sick pay, minimal breaks, lack of training, bullying management and high levels of unpaid overtime (RCN 2012). The lack of training opportunities identified by our participants is yet another indicator that these nurses' roles are undervalued, despite their responsibilities and ability to work in isolation. The isolation of staff working in nursing homes has been known for some time (Chambers and Tyrer, 2002; Davies, 2001; RCN, 2001).

In our sample, the majority of participants focused on their responsibility for direction of staff when asked to describe the main aspects of their role. According to Wild et al. (2010) the practice interface is narrowing between nurses and care staff, with basic nursing skills being delegated and care staff undertaking what may have previously been considered nursing activities. Therefore it is unsurprising that our findings indicate that, although the input of knowledge and skills from registered nurses (RNs) is recognised as essential in supporting carers' learning and practice, nurses are frequently undertaking management and supervisory roles rather than direct care.

There is a shortage of nurses in all sectors the nursing workforce is ageing (Imison and Boher, 2013, Centre of Workforce Intelligence, 2013). Therefore it is easier now for nurses to find jobs elsewhere, adding to the problem of 'churn' and increased

stress on remaining colleagues. According to Wild et al. (2010) organisations will employ greater numbers of care staff, a less expensive option, rather than RNs. Within a business model, investment in nurses' education may be seen as counterproductive due to the high turnover of staff. In addition face-to-face training has extra costs related to backfill. These factors exacerbate an already challenging situation for underprepared and overworked staff.

Technical procedures such as dressings and dispensing medication are, however, still regarded as constituting nursing care (Tadd et al., 2012). This is illustrated in the study findings as the participants indicated that these tasks are fundamental parts of their responsibilities. Participants therefore placed a great emphasis on their clinical skills; the technological aspects of care giving have increased significantly due to the greater complexity of residents' needs (RCN 2012). However, the person-centred aspects of care tend to be neglected in favour of these visible technical responsibilities and the necessity of managing staff. In small organisations nurses do not have the opportunity to compare different strategies for problem-solving nor to share the emotional labour of nursing home work.

The nurses recognised the need for active, experiential learning opportunities to address gaps in their skills-base, for example to guide them in communicating effectively with residents and family members, and responding sensitively to behaviours which indicate underlying unmet needs. Relative isolation meant our participants were not exposed to alternative practices and new thinking, which may have led to some lack of awareness about the gaps in their own knowledge-base.

The RCN (2012) found that nurses' experience of being treated fairly and valued equally in terms of career opportunities, pay and grading, and working hours is not consistent. This may also be tied in to social attitudes towards older people, negative media coverage and the low value society places on caring for older people (Jenkins and Macken, 2014). Limited access to training may also be related to assumptions about caring being 'natural' rather than skills based (Brooker and Latham 2015). Limited resources mean that managers tend to focus on legislative requirements and practical issues at the expense of non-mandatory training and promoting person-centred approaches that would enhance the quality of care. Paucity of training opportunities may reinforce the perception of low-value accorded to nursing home nurses.

**Limitations**

Our findings were based on a small sample from four nursing homes from the same geographical area. The focus groups were also small, this may have impacted on the dynamics of the group and quality of the group discussion. More research with larger samples, from other countries with different cultural and organisational contexts is needed to validate our findings.

**Conclusions**

Nurses working in nursing homes highlighted high levels of responsibility, low levels of support and remuneration and frustrations related to the complexities and demands of their role. They recognized some training needs but were not always aware of their limitations due to the isolated nature of their work. However, they highlighted the barriers to accessing training that may actually change practice. In order for training

to be effective it should incorporate interactive, practical sessions with relevant content related to the needs of people with dementia and their relatives. Training could be viewed as an opportunity to demonstrate the value of staff and should include all members of the staff team. Training should also include consideration of how barriers to high quality care can be overcome and so promote person-centred approaches for residents, staff and relatives.

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Highlights

- Focus groups were conducted with nurses working in nursing homes with people with dementia
- Effective approaches for future training were explored
- The findings demonstrated that for training to be effective it should incorporate interactive practical sessions, with relevant content related to the needs of people with dementia and aspects focused on effective leadership