

**The experiences of staff in a specialist mental health service in relation to development of skills for the provision of person centred care for people with dementia.**

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### **Abstract**

It is estimated that 820,000 people in the UK have dementia (Alzheimer's Society 2012). Dementia costs the UK 17 billion a year and in the next 30 years this will treble to over £50 billion a year (DH 2009a). There is a need to raise competence of staff delivering care to people living with dementia across health, social and voluntary sector provision. Effective education and training will build capacity and improve staff knowledge. However, at present not enough is known about the experiences of staff involved in gaining the skills, knowledge and attitudes required to support provision of high quality care for people with dementia.

This study was conducted within a large National Health Service Trust in the UK serving an urban, ethnically mixed population, in collaboration with a local university. The Trust responded to government policy by seeking to identify staff training needs.

The aim was to explore the experiences of staff working within a specialist mental health service in relation to development of skills for the provision of person-centred care for people with dementia. To achieve this, staff roles, experiences of dementia training and the ways in which staff feel they learn were explored through focus group interviews. Relatives' views of staff competencies necessary for effective care provision were also explored to supplement the data from staff. Seventy staff and sixteen family carers participated and data was subjected to inductive thematic analysis.

Five themes emerged: competency based skills, beliefs, enablers and barriers and ways of learning. Findings suggested participants felt that skills for person-centred

care were innate and could not be taught, while effective ways of learning were identified as learning by doing, learning from each other and learning from experience.

**Key Words** Dementia, Training, Education, Mental Health Personnel

### **Context**

In the last 15-20 years psychosocial understandings of dementia have emerged to supplement biomedical understandings. These approaches, such as that of Kitwood (1997), are situated within a bio-psychosocial framework and emphasise individual identity, personal history and social relationships in addition to neurological and health factors. Therefore in offering interventions for people living with dementia there is a need for a holistic person-centred focus.

Three systematic reviews have recently considered evidence for the effects of educational interventions on delivery of dementia care. Perry et al. (2010) concluded that to improve outcomes, educational interventions need to be combined with wider organisational support including social network strategies, adequate financial reward for both training participation and quality of care, and be supported by protocols for structured care and management.

Livingston, Johnston, Katona, Paton, and Lyketsos, (2005) found that there is consistent well supported evidence for the use of staff education in the management of neuropsychiatric symptoms. However improvements in knowledge and skills were not always sustained over time. McCabe, Davison and George (2007) concluded that the variety of education programmes, including the content and training modalities, with research teams implementing various programmes of differing intensity and length, based on different theoretical frameworks, and with a mixed content make it hard to draw conclusions about how to best ensure competence.

There are a small number of RCTs that examine the effectiveness of staff training (Chenoweth et al., 2009; Kuske et al., 2009; Visser et al., 2008). Chenoweth et al. (2009) compared person-centred care (CADRES), dementia care mapping and usual care in dementia across 289 patients. There was a reduction in agitation in sites providing mapping and person-centred care, compared with usual care. Fewer falls were recorded in sites that used mapping but there were more falls with person-centred care. Kuske et al (2009) attempted to measure staff's sensitisation to the experience of the residents with dementia and their communication competencies. Their findings suggested significant positive effects of their training programme on caregivers' overall competence in managing patients with dementia and a reduction in the use of neuroleptic medication. However, again this effect was not sustained at the six month follow up.

Echoing the conclusions of Perry et al.'s (2010) review, studies suggest that staff organisational and environmental factors are important determinants of whether newly learned skills are implemented in the workplace. On-going support, changes in working conditions and more time for residents beyond basic physical care, as well as other organisational or environmental changes, have been found to facilitate the implementation of newly learned skills (Cohen-Mansfield, 2001; Burt & Aylward 2000; Kuske et al. 2007).

Visser et al. (2008) found staff training did not impact on residents' behaviour, quality of life or on staff levels of burnout; despite a positive change in staffs' attitudes to working with people with dementia. According to Visser et al. (2008) staff training

offered in isolation from the socio-cultural context may not be an effective way of managing behavioural symptoms in dementia.

The above studies demonstrate substantial variability in the length, intensity, content and type of training interventions that have been evaluated, with research teams implementing various programmes based on different theoretical frameworks, and including many with a mixed content (McCabe et al. 2007). Common areas of focus are person-centred care (though details of how this was operationalised were not always given) and behaviour management but the differing modes of delivery mean that it is hard to draw conclusions about whether they impact on quality of care. Almost half of the studies reviewed found no positive changes as a result of the training that had been delivered.

In a related area, McCarron et al. (2008) carried out a large qualitative study in order to understand the experiences of staff in supporting persons with intellectual disability and advanced dementia. The accounts were interpreted to gain an understanding of their education and training needs. A core theme which emerged from the focus groups was staff perceptions of the fundamentals of good care at end-of-life for persons with dementia. These perceptions included the belief that person-centred care, comfort and spiritual support are paramount.

The lack of comparability and varied training programmes make it hard to draw evidence-based conclusions about topics or areas of competence that need to be covered when training for staff working with people with dementia (Tsaroucha et al 2013). In addition, it is hard to isolate the key ingredients in successful training

(NCCMH 2007), but some of the findings imply that ensuring training is supported by and embedded in the organisational structures is important. Ongoing support and organisational change may prove necessary to demonstrate sustained implementation of new knowledge (Kuske et al. 2007).

It is evident that there is a lack of research that evaluates well-designed in-service training programmes for health care professionals who are caring for people with dementia. In addition, the majority of studies have been carried out within residential and nursing homes and there is little research which focuses on the training needs of staff within specialist mental health services. There is therefore a need for further studies which establish the training needs of staff, particularly within specialist mental health services. Such research could inform the development of effective training.

In this study, we aimed to explore staff experiences of working with people with dementia within a specialist mental health service with a view to developing a better understanding of the skills, attitudes and knowledge they feel they require to provide high quality care. We also hoped to develop an understanding of how staff feel they best learn and develop their ability to provide good quality care. Furthermore we aimed to supplement staff perspectives by gaining relatives' views of staff competencies necessary for effective care provision. Our method was somewhat similar to that of McCarron et al. (2008) reviewed above.

## Method

### **Design**

The investigative approach was based on a qualitative/naturalistic method, since we wished to explore the subjective experiences of staff. In particular, a phenomenological approach seemed suitable. Phenomenology investigates subjective phenomena in the belief that critical truths about reality are grounded in people's lived experiences (Darroch & Silvers, 1982). The goal of a phenomenological study is to fully and accurately describe the lived experience and the perceptions to which it gives rise, not to generate theories or models or to develop an explanation (Morse and Field, 1996). In tune with the foundations of one major phenomenological approach, interpretative phenomenological analysis (IPA; Smith, Flowers & Larkin 2009), we aimed to attempt, as far as possible, to gain an insider perspective of the phenomenon being studied, whilst acknowledging that the researcher is the primary investigative instrument (Fade, 2004).

Data was collected through focus groups. Willig (2001) describes focus groups as group interviews that use interaction among participants as a source of data; the researcher takes on the role of a mediator gently guiding the discussion. It was considered that this medium would provide a containing and stimulating setting in which staff would feel empowered to express their views. The participants shared experience of working in the same environment (e.g. of caring for people with dementia on a particular ward). In order to ensure a further degree of homogeneity, and thereby both safety and focus, wherever possible focus groups were conducted separately with qualified and unqualified staff and different disciplines.

## **Participants**

A total of 14 focus groups were conducted with staff, with 70 participants in total. Two further focus groups were conducted with caregivers with a total of 16 participants. Purposive sampling was used as staff were selected on the basis of being from a particular setting and discipline. The participants were from a range of professional disciplines, including nurses, occupational therapists and physiotherapists, and included qualified and unqualified staff from two continuing care wards, two community mental health teams and two assessment wards. Family carers were recruited from a carers' group whose relatives had been admitted to a continuing healthcare setting.

## **Procedure**

### *Ethical issues and recruitment*

Although ethical approval was not sought, as the project was considered a service evaluation, we obtained approval from the Trust research and development department and ethical principles were followed. Staff were invited to take part and those expressing an interest were given information sheets and were made aware that they could withdraw from the study at any time. Written informed consent was gained. Staff were reassured that steps had been taken to ensure their anonymity, that the data would remain confidential and identity would be protected.

### *Focus groups*

The groups were conducted in a quiet room in participants' clinical areas and were facilitated by two members of the research team. Each focus group lasted

approximately 45 minutes. Key areas of discussion included current roles and skills, gaps in skills and knowledge, experiences of previous training and suggestions for improving training outcomes. The focus groups were audio-recorded, anonymised and transcribed verbatim.

### **Analysis**

The aim of the analysis was to identify key themes arising across the 14 focus groups to gain understanding of staff experiences and perspectives around necessary competencies, learning and skill development. We achieved this by carrying out an inductive and interpretive analysis of the scripts, combining the methods of thematic analysis (Braun & Clark, 2006) and those of IPA (Smith et al 2009). The initial steps of analysis were reading and re-reading the text to gain familiarity with the material; assigning codes which captured the meaning of sections of the text; integrating these to draw out themes; and identifying clusters of themes and giving them descriptive labels which were often drawn from the participants' own words (e.g. "ways of learning" or "feeling misunderstood"). These steps are common to both inductive thematic analysis (Braun & Clark, 2006) and IPA (Willig 2001). In the process of analysis, we paid attention to underlying meanings implied in participants' language as well as superficial content. In order to identify major themes that were common across the large number of focus groups, as well as to develop some idea of the differences between professions, we drew from IPA's idiographic emphasis. Thus we constructed a summary table of themes, together with illustrations of each theme, for each focus group. Comparing these across the 14 groups, emergent themes that appeared more commonly in the accounts of particular grades of staff or professions

were exposed. This comparison allowed us also to generate a list of master themes to reflect common experiences across the whole sample (Smith et al., 2009; Palmer et al. 2010). Data from the two focus groups with carers was separately analysed using the same approach.

### **Findings**

The aim of the research process was to explore the participants' lived experiences, making sense of these to gain an understanding of skills development for the provision of person centred care for people with dementia. Five themes emerged from the analysis of staff focus groups: competency based skills, beliefs, enablers and barriers and ways of learning. Each of these will be discussed in turn.

#### **Competency-based skills**

At times the participants struggled to define the core skills they use when working with people with dementia. Although they felt confident in providing care, they seemed to find it difficult to define the process, perhaps because it had become automatic and engrained. This is demonstrated in the following extract:

*“Sometimes when you work with a specific group, you take your skills for granted don't you? It's kind of natural, it's like second nature and then when someone says what do you do, it seems so natural, it's hard to exactly explain what you do” (Occupational Therapist, FG 9).*

When discussing specialist skills the focus group participants described being able to draw on reasoning, problem solving and observational skills (for example,

understanding behaviour as a form of communication of unmet need). Depth of knowledge and the ability to apply this in a meaningful way to a range of situations were also seen as important. Teaching, consultancy and sharing knowledge with other colleagues, carers and families also emerged as an important part of the specialist role:

*“I think we are very good at sharing information with the carers and explaining basic things with them in a way that they understand. Where, perhaps other people might think that they already know about it, or they have heard it before when actually nobody has took the time to sit down and explain”* (Physiotherapist, FG 14).

Differences between professional groups emerged from the analysis. In contrast to other disciplines, nurses tended to talk about their competence in generic core skills, such as communication, basic counselling skills and flexible approaches to person-centred care rather than profession specific skills. In some focus groups the nursing staff referred to their competence in terms of practical tasks. Examples of these tasks included: *“Depot injections, administering medication, organising the unit and supervising doctor’s reviews, etc.”* It is important to acknowledge that some of these tasks may be profession specific. Nurses working in more specialist or advanced roles such as community psychiatric nurses (CPNs) identified assessment, liaison and risk assessment as key skills.

The Health Care Assistants (HCAs) perceived themselves as specialists in managing perceived challenging behaviour and carrying out interventions around personal care. This was recognised by the trained staff:

*“The fact that they spend so much time on the floor and you know, they are involved in a lot of personal care with them and they are observing them throughout the day. I think they are very, very good at picking up changes in people. You know, it’s not necessarily people saying that they feel unwell, but just a general change in demeanour or you know, they are very good.”* (Nurse, FG 4).

Allied health professionals were much more confident in articulating the specialist elements of their role. Occupational Therapists, for example, were clearly able to define discipline specific skills such as knowing how to work with activity and occupation, the retention of functional abilities, enhancement of capabilities and social integration. In contrast, nurses reported feeling unclear regarding the remit of their role. They described it *“as a bit of this and a bit of that”* or even *“General dogsbody....taking charge of the ward”*. This seemed to be associated with a lack of professional confidence, the word *“dogsbody”*, for example, giving an impression of being in a lowly position. This is also reflected in the quote below:

*“I think that our sort of accountabilities has gone up and up and yet our ability to make anything happen has gone down and down. Our status, in any group, I think we are probably... you know, well I think we don’t have any status in any conversation compared to O.T ,and psychology. I often feel that,*

*I don't know if you feel very side-lined and as though your input isn't particularly... Do you ever get that feeling?" (Community Nurse, FG 5).*

In addition to talking about skills or areas of knowledge, participants identified a wide range of qualities or attributes which they felt were essential in the delivery of person-centred care (PCC). These included attributing value to people with dementia, respect for subjective experiences, a non-judgemental approach, patience, an emphasis on seeing the person as a whole, enabling and empowering the individual with dementia and taking a person-centred approach.. The participants commonly used terms such as “communication”...“respectfulness, calmness and dignity”.

### Beliefs

The belief that skills for person-centred care are “*built in*” or “*implanted*” was a theme in ten out of the sixteen focus groups. This belief, shared by all levels of staff, potentially challenges the idea that PCC can be taught. Although the participants here tended to identify themselves as having “*natural*” abilities, the belief could be undermining to others perceived as needing to learn how to be person-centred. Many of the participants found it difficult to articulate, place or conceptualise their skills thus the idea of an “*indefinable something* and “*magical touch*” emerged.

*“I think it's fair to say that the majority of staff have got it built in already otherwise they wouldn't be here. The caring bit is built in or you could say already implanted” (Health Care Assistant, FG 3).*

*“I question how much you can teach somebody.... They can all sit here around this table saying exactly how they should behave, and they go out there and behave exactly the same way they were. And there are people who never do a patient centred care course that are fabulous with the patients. So I do wonder how much you can actually teach somebody”* (Unit Manager, FG 3).

*“We tend to meet the needs and the patients are so different in our environment than when they were at the other place. So we probably have some kind of magical touch.....”*(Health Care Assistant, FG 3).

Nurse managers and health care assistants shared the belief that caring abilities are ‘natural’, but this belief was not shared by allied health professionals who focused more on their skills and the competencies required to carry out their roles.

#### Barriers and Enablers

Participants spoke of a number of barriers to the provision of person centred care (PCC). Some participants felt that they had adequate knowledge and understanding of PCC approaches but were unable to provide PCC due to lack of time or inadequate staffing. In their view, it was not a lack of knowledge which meant they could not deliver PCC but other factors over which they had limited control. Participants seemed to feel that providing PCC would take up too much time. This is demonstrated in the following extract taken from a focus group conducted within a continuing care unit: *“It’s difficult to implement it, you know you want to spend time with each client but you know time doesn’t ... allow you...”* (Nursing Assistant FG 3).

Some described the very pressured environment in which they felt they worked:

*“Because they need to be fed and everything. It’s very difficult when you’ve got 18 dementia patients up, down, round and about, and you are trying to gather them altogether and you know, probably just 3 of us. One’s shouting, one’s trying to sit down, one’s wandering... maybe...and you have to go and get him and you feel just whoa!!”* (Nursing Assistant, FG 3).

The participants felt that if they set aside time for PCC this would mean they would not have enough time to complete essential tasks. PCC was therefore seen as a separate task or activity rather than as part of a holistic approach which could co-exist with other activities. This is demonstrated in the following extract, in which the participant is explaining her view that true PCC would involve letting some residents stay in bed until they chose to get up; however, the set dinner time means that this is not possible, as if she left the residents in bed they would miss their meal:

*“We just haven’t got the time to do that [PCC]. I’m afraid you know we do go in and if they are asleep we might go back and leave them till last but they need to get up all in one swoop. There would be nobody up for dinner.”*  
(Nursing Assistant, FG2).

The HCAs and nurses in particular felt at times that they lacked control, had a low status within the organisation and that their role was undervalued by more senior staff.

*“You care about the clients on a one-to-one, but about the work environment and that...you’re like...oh, I don’t care, I’m just coming to work. You’ve got no passion for it and that’s what happens. You start losing your passion when people don’t listen to you and that really gets you down”* (Nursing Assistant, FG 4).

Participants perceived the environment as stressful and challenging. This was attributed to a number of factors, such as not feeling valued, time restraints, working with signs of distress and the emotional labour of “*counselling*”, “*advising, negotiating between individuals and other patients/family/the outside*” and generally “*comforting people through illness, fear and upset.*”

A number of factors that might enable PCC were also described including mutual support from colleagues, job satisfaction, and connections with individuals with dementia. The participants frequently spoke about the strong emotional ties which they developed and “*we care*” was a major theme throughout the focus groups. Mutual support from colleagues was viewed as an important source of job satisfaction. The participants also perceived mutual support as an important means of managing stress. Participants who reported high levels of job satisfaction appeared to find “*joy*” in their work, looking for rewards in caring. This was accompanied by feelings of self-esteem and vicarious happiness: “*To see them happy, it kind of gives you know. It, you’ve done something you have given something back, sort of thing. That thing you need.*” (Nurse, FG 3).

### Ways of Learning

Participants valued learning from experience and learning by doing. Staff described how they had learnt their skills “*on the job*” usually through working with more experienced staff. Participants looked for positive role models, staff who they could look up to, who they identified as “*trainers*”. On occasions negative role models were identified who “*get the job done quicker*”. Positive role models or “*trainers*” appeared to be people who were very experienced (“*they had done it for years*”) –and who expected a lot from themselves and others (“*expect high standards*”). They were also perceived to “*have got it*” in terms of being person centred. This is demonstrated in the following extract:

*“It’s a god send to be fair. They know what they’re doing, and you can watch ‘em. There’s no point just watching them once or twice, you’ve gotta really watch them. You gotta think oh I’ll do that next time, or I’ll do that next time you know..”* (Nursing Assistant, FG 2).

Some nursing assistants seemed to have little regard for qualifications or training. Formal training was viewed as unnecessary and resistance to it was strong. The nursing assistants felt that they had been trained already by the “*trainers*”. Some also felt they knew more than external trainers as they worked with individuals with dementia everyday. They claimed that the way practices were taught in the classroom did not “*fit*” with their daily work and felt that the external trainers were out of touch with the “*real world*” describing them as “*outsiders*”. This can be seen in the following extract:

*“Like I said it’s not effective on the actual unit, it’s ok from the classroom on the board where they’ve got all their information from the Internet. But they need to come and do it for real, because you don’t.....You do role play on a course, it’s totally different in the ward.....Because when you role-play getting them up, they don’t start biting, or punching, or kicking” (Health Care Assistant, FG 4).*

#### *Findings from focus group with family carers*

Three themes emerged from the focus groups conducted with family carers including “a caring nature”, approach and kindness and patience.

The carers’ views echoed many of the themes identified in the focus groups held with staff. They valued those staff who they perceived to “*have got it*” in terms of being person-centred. Carers described nursing as a “*vocation*” and felt staff needed to have a “*good heart*” and a “*caring*” nature; “*It’s a vocational job. You have either got a vocation to do this. I think a lot of people just do it to earn money and some people do it because they love it*” (Carer, FG 16).

They also identified approach as key; one carer described the staff as having “*winning ways*”. When asked to elaborate she explained how staff “*can read the patients..., understand that they are all individuals*”. Another carer described staff as having a “*knack*” in using their experience and skills to de-escalate situations. Carers perceived that a person centred approach involved the ability to listen and understand, create a warm atmosphere, and demonstrate respect and empathy. “*Kindness*” and “*patience*” were also identified as important qualities. Family carers’ beliefs reflected

those of nurses, in feeling that a caring nature comes from the heart rather than from training.

## **DISCUSSION**

The focus group conversations seemed to reveal that staff believed that the skills for person-centred care were built in and could not be taught. This was also a belief held by family caregivers, who felt that nursing is a vocation. In addition, some groups of staff found it difficult to identify their skills and thus the idea of “magical touch” emerged.

### *Unconscious competence*

The findings illustrated that participants, particularly nursing staff, frequently found it difficult to identify their specialist skills, although a wide range of skills and in-depth knowledge regarding working with people with dementia was evident during data collection. This combination of evident knowledge and lack of awareness of it seems to illustrate “unconscious competence”. The conscious competence model posited by Maslow (1940) includes stages of learning, progressing from 1. Unconscious Incompetence (you don't know that you don't know something), to 2. Conscious Incompetence (you are now aware that you are incompetent at something), to 3. Conscious Competence (you develop a skill in that area but have to think about it), to the final stage 4. Unconscious Competence (you are good at it and it now comes naturally). Compared to the other professional groups interviewed, nursing staff found it harder to articulate the nature of their professional role. Similarly, Hurley (2009) found nurses lacked a distinctive professional identity, sharing overlapping skills with

other professionals, but identifying pride in their unique ability to carry out a wide range of skilled functions. Thorsteinsson (2002) deconstructed the idea of the ‘magical touch’ of nurses, identifying instead that this embodies attributes such as kindness, and a good attitude and manner, as well as clinical competence.

### Professional confidence

Lack of professional confidence was an issue for some individuals particularly those from nursing backgrounds. Professional confidence is associated with having the confidence, belief and ability to do your job effectively (Adams, 2008) and is related to being able to make decisions independently and being open to new ideas or evidence (Cowen and Moorhead 2006). This appears to be related to the concept of self-efficacy which describes a person's belief in their own competence (Bandura, 1977). This may be an important variable because it affects students’ motivation and learning (Dinther, Dochy and Eggers, 2011). There is a lack of research evidence exploring issues of professional confidence and models for its development, although Watson, Hockley and Dewar (2004) demonstrated that nursing staff, who acquired additional knowledge of interventions developed new confidence in their role. Nolan (2000) conducted focus groups with 50 nurses, from which they concluded that nurses feel “disempowered”. Elderly care nurses may delegate personal care to lesser status workers particularly in settings such as continuing care, thus making contact care work a marginal part of their role. This in turn may underlie the HCAs’ attitude that they know how to work with people with dementia better than those who are assigned to teach them. Chesser-Smyth and Long (2013) identified a correlation between

professional confidence and competence, indicating that nurses who were self-confident also carried out care more effectively and achieved better patient outcomes..

#### *Barriers and enablers*

Staff identified barriers and enablers to good practice. Perceived barriers included staff shortages and time pressures and the culture of the organisation, this being consonant with the conclusions of Perry et al. (2010) and Visser et al. (2008). Lack of role clarity and professional confidence, as well as stress, burnout and emotional labour were also identified as barriers. In addition, some of the comments made by staff revealed that they thought of PCC as being an additional, time-consuming demand on their time. Enablers included making connections with people with dementia, mutual support and job satisfaction. The findings suggest staff value learning from experience, learning by doing and learning from each other.

**Commented [JO1]:** I think this needs linking to the studies in the intro which show the importance of organisational factors. I'll suggest how.

#### *Ways of learning:*

The participants spoke of finding it difficult to translate and apply class room learning to their practice. This is a central issue for teaching and curriculum design. The value they placed on learning by experience support the use of approaches based on active and experiential learning and also the use of problem-based approaches to learning delivered in the clinical area.

The findings suggested staff valued pragmatic learning or “learning by doing” as a means of gaining knowledge from observation and experience. Experiential learning is learning through “reflection on doing” and focuses on the learning process for the individual and complex information processing (Palmer and Kimchi, 1985). Kolb (1984) developed a theory of experiential learning known as the Kolb cycle, learning

cycle or experiential learning cycle. This characterises how experience followed by reflection, can lead on to understanding, which results in changes in action that improve competence.

Androgical theory suggests participants who are offered an opportunity for experiential learning have life experience to draw on, take a problem solving approach, perceive themselves as self-directed and are orientated to fulfilling social roles (Knowles 1984). This pragmatic approach appears to facilitate deep learning as opposed to superficial learning. Deep learning is characterised by the learners' active engagement with the subject matter which leads to the internalisation of new knowledge (Gibbs, 1992) as the information is actively processed (Lehrl and Fischer, 1990). Deep learning is promoted by being able to transfer knowledge from the specific to the general, relate new information to old, generate high quality inferences and exhibit integrated problem solving plans. This is different from a superficial approach which is characterised by memorisation of information and procedures. Examples of this appeared when staff used terms associated with Kitwood's (1997) observations of poor practice such as "objectification" or "malignant social psychology" without understanding the underlying concept of the social construction of the experience of dementia.. The language used in the focus groups indicated that some staff objectified the patients, so even though they were clearly familiar with the language of PCC it would appear that they did not understand their fundamental meaning, in order to apply this to their everyday practice. Indeed Fook and Gardner (2007) note that being exposed to, or knowing, a theory does not necessarily mean that it is integrated into functioning and action.

Staff identified mutual support and learning from each other as enablers in terms of delivering PCC and as an important means of managing stress and emotional labour. The staff identified their own “trainers” within the clinical area. Those perceived as trainers were experienced, expected high standards, and were perceived by others to “have got it” in terms of being person centred. Vygotsky’s (1978) theories stress the fundamental role of social interaction in the development of cognition, and view interaction with peers as an effective way of developing skills and strategies. Vygotsky’s work suggests that learning occurs during situated activity or in authentic settings and that learning, thinking and knowing arise through collaboration with others (Samaras and Gismondi, 1998). The prominence of teamwork in the findings of the focus groups implies that there would be advantages from providing training in the clinical area as this ensures goals and learning are shared by all members. The principles of social learning theory include that people can learn by observing the behaviour of others (Ormrod,1999). Thorsteinsson (2002) found that modelling caring behaviour can possibly perpetuate caring behaviour in others.

#### Strengths and limitations

Respondent validation (Appleton, 1995) enhanced the credibility of the study as the lead researcher returned to participants to summarise and confirm the themes. The staff reactions were very positive and the group frequently used terms such as “You’ve got it” and “That’s right”, thus confirming plausibility and transparency (Reid Flowers and Larkin 2005). In addition two colleagues (JO,PB) reviewed the transcripts from the focus groups and suggested their opinion of emerging themes.

There was no opportunity to carry out a validity check with carers due to time constraints related to the needs of the funding body.

Participants appeared to be open and honest about their experiences and to feel comfortable discussing difficult and sensitive topics such as serious incidents of violence and aggression. Therefore disclosure seemed to be enhanced rather than inhibited through the presence of other participants. As the researchers had worked within the organisation in a number of roles, they already had predetermined ideas about what staff might consider useful in terms of training. Therefore the process of “epoche” (Giorgi, 1985) was adopted in which the researchers consciously put aside preconceptions and reflected on their ability to do this. The research could not be undertaken elsewhere as the focus was established by the funding body who agreed to pay the Trust to undertake the project. Although a wide range of professionals were included, it was not possible to recruit medical staff to take part in the focus groups.

### **Conclusions**

The findings suggest that staff believe they learn through experience, doing and modelling themselves on peers who they perceive as having high standards, extensive experience and natural ability. This focus on the importance of experience and natural ability means that staff tend not to value classroom learning. They also feel that trainers do not value their experience or appreciate the skills that they have developed through their practice. Indeed, they expressed the view that they often felt they knew more than trainers who were not seen as credible. As previously stated staff also found it difficult to relate theory to practice.

To offer training which is congruent with the findings of the study, we recommend that training will be more likely to be successful if it includes strong elements of experiential learning; if it gives opportunities for learning through modelling alongside credible trainers using a problem based approach, and ‘learning through doing’-. The accounts above suggest that training would be more likely to result in changes in practice if it is situating learning within the working environment and is undertaken with teams, facilitating collaborative learning.

Within a problem-based learning approach (PBL) the teachers/trainers take on the role of “facilitators”. PBL recognises the expertise of staff, creating an adult learning environment. The problem-based approach has an extensive evidence base and is widely used in medical education and has been since the 1960s (Kohet et al. 2008). This approach is congruent with the belief system of the participants and the principles of adult learning, harnessing learners’ strengths and addressing opportunities for changes in practice.

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