## Introduction

There is significant concern about nurse burnout in nursing homes. This paper reports on the impact of training in person-centred dementia care in combination with supervision, designed to reduce burnout and impact on other related outcomes.

Approximately a third of the 850,000 people living with dementia in the UK live in nursing homes (Alzheimer’s Society 2014). The proportion of people with dementia who are cared for by professionals increases as countries develop and at present, formal care of people with dementia makes up 40% of dementia related costs in developed countries (Alzheimer’s Disease International 2015). Despite the financial investments in care and care environments, underfunding of care is an ongoing issue due to pressure on budgets and increasing complexity of need (Royal College of Nursing (RCN) 2012). There is a shortage of nurses worldwide (RCN 2012) and nursing home nursing is often perceived as low status and unrewarding (RCN 2012). Staff shortages and lack of investment mean that life is often difficult for nursing home residents and stressful for the nurses who care for them (RCN 2012) with unresolved work stress having the potential to lead to burnout.

Heinemann and Heinemann (2017) commented on the emergence of burnout research and claimed that despite the growing health science literature on this topic and efforts to clarify the concept over the past forty years, there is still much confusion around the term. There is no consensus around the definition of burnout however it is commonly perceived as a form of stress and as a process rather than a significant event. Job-related burnout was described by Maslach et al. (1996) as a syndrome that occurs among people who work in the human services. According to this theory which remains the most prominent in the literature, the key components of burnout are increased feelings of emotional exhaustion (as emotional resources are worn-out staff are no longer able to give of themselves at a psychological level); the development of depersonalisation (disengagement from the residents who staff care for); and reduced personal accomplishment (where staff feel unhappy about themselves and dissatisfied with their accomplishments on the job) (Maslach et al. 1996).

Nurses who work with older people in nursing homes share experiences in common with nurses who work within the acute and primary health-care sectors (Jeon et al. 2010). O’Connor et al. (2017) included 59 studies in a meta-analysis on the determinants of burnout which included individual factors, high workloads and role conflict. Low rates of burnout were associated with a sense of autonomy at work, and a sense of community at work. Burnout is clearly directly linked to the quality of care that a workforce delivers and has negative consequences which include poor health outcomes and poor job performance (DH 2009; Rose et al. 2010).

Cooper et al. (2016) found that burnout presents a threat to workers’ own health and to residents’ quality of care. In addition, staff turnover, referred to as ‘churn’, has negative consequences for people with dementia who need person-centred care, care provided by staff who know their history and preferences and with whom they have an ongoing relationship (Sjogren et al 2013). Rafi et al. (2004) also found that burnout impacts on the quality of patient care and has negative effects on most areas of personal, interpersonal and organizational performance. Burnout has been linked with dispassionate care as staff develop negative attitudes to those being cared for (Duffy et al. 2002) as well as diminished patient contact (Maslach and Jackson 1981; Dellefield 2015) and negative attitudes towards people with dementia (Broady et al. 2003). Therefore, it is essential that burnout among nursing home nurses is addressed.

## Background

This paper reports on the qualitative findings of a mixed-methods study investigating the impact of training in person-centred dementia care which included skills-based training and ongoing supervision intended to help embed and sustain learning in practice.

Links have been identified between burn-out in nurses and poorer quality of care (Johnson et al. 2018). Both the Marmot Review (2010) and National Institute for Health and Clinical Excellence (2006) have recommend a strategic and coordinated approach to reducing burnout. In an evidence on interventions to reduce burnout Public Health England (2016) reported that much of the literature on interventions to reduce burnout have focused on large scale health care organisations such as the NHS and identified that there was a gap in the evidence for effective interventions for small and medium organisations e.g. nursing homes. The UK National Dementia Strategy (Department of Health (DH) 2009) requires the workforce working with people with dementia to have ‘the necessary skills to provide the best quality of care’. It has been suggested that education of both pre-and post-registration nurses should include a stronger focus on dementia (Blakemore, 2014, Honan 2016) and this is particularly relevant for those working in nursing homes. However, unlike their counterparts in primary and secondary care, nurses working in nursing homes often have limited opportunities for on-going training, may gain little or no respect and recognition for good work, and have very few opportunities for career growth (RCN 2012).

Many employers choose to provide online or brief training interventions (for example lasting one or two hours) only to their employees despite the evidence (Jenkins, Smythe and Galant-Miecznikowska 2014, Surr et al 2016) that these approaches may improve knowledge but have minimal impact on practice. Therefore, more in-depth training is needed (Surr et al 2016) that addresses the roots of problems such as burn-out that lead to staff turnover and poor care. A recent literature review conducted by Spector et al. (2016) suggested that person-centred approaches were effective in managing behaviours which challenge. However, there are difficulties in evaluating which approaches to training have sustained impact on practice (Hazelhof et al. 2014, Surr et al. 2016).

### The potential of training in person-centred care to reduce burnout

Person-Centred Dementia Care Training has the potential to impact on burnout, empower nurses and improve the experiences of nursing home residents while also enabling nurses to (re-)gain professional satisfaction and commitment to their roles (Surr et al. 2016). Training in person-centred dementia care, that helps nurses to understand behavioural distress, may also have benefits for the nurses in terms of reducing stress and reducing behaviours which challenge and levels of resident agitation (Chenoweth et al. 2009; Teri et al. 2005; Testad et al. 2005; Edberg and Hallberg 2001; Passalacqua and Wood 2012; Barbosa et al. 2017). Training in person-centred care may also be a means for reducing the risk of abuse and neglect which can be associated with high levels of burnout. This is particularly the case for depersonalisation (Vahey et al. 2004) as it encourages the member of staff to value the person with dementia, assisting in the development of a person-centred relationship (Edvardsson et al. 2011). For example, the significance and role of everyday activities may become more meaningful as they are seen as opportunities for connecting with and valuing the person with dementia, rather than tasks (Edvardsson et al. 2013).

Furthermore training in person-centred dementia care may also lead to a reduction in staff turn-over and improved staff satisfaction (Broughton et al. 2011). Duffy et al. (2009) suggested training programmes aimed to increase self-efficacy and reduce caregivers’ frustrations could assist with reducing burnout in care staff. In addition, Duffy et al. (2009) also found that knowing how to provide person-centred dementia care, as well as being able to achieve positive outcomes at work may lead to an increased sense of personal accomplishment.

## THE STUDY

### Aims of the study

The study was designed evaluate the impact of training and supervision on burnout and related outcomes.Focus groups were used to inform adaptation of the training. Mixed methods including quantitative measures (primarily the Maslach Burnout Inventory), and subjective experience were used to evaluate the impact of training and supervision. This paper focuses on the qualitative evaluation.

Focus groups were conducted to adapt existing training revealed that alongside traditional knowledge-based training delivered in the lecture room, nurses also wanted practical, hands-on training that models person-centred practice (Brooker and Latham 2016) and is delivered by credible trainers (Smythe et al. 2014). The training that was the subject of the evaluation described in this paper was designed to facilitate a deep approach to learning (Biggs and Tang 2011). There is tentative evidence to support the hypothesis that training combined with supervision or on-going support is more likely to maintain outcomes and have a positive impact (Surr et al. 2016; Westermann et al 2014). Therefore, the formal classroom training sessions of our intervention were followed by reflective coaching sessions in the workplace and by clinical supervision.

The intervention combined classroom-based and skills-basedtraining, which involved the trainer working alongside the nurses. We explored howthe knowledge and skills that were taught were implemented in practice. One third ofthe nurses subsequently received restorative supervision which was intended to sustain outcomes from the training. Restorative supervision is an evidence-based model offers a reflective space where conflicting ideas can be discussed and restores the clinicians capability to think. It is suggested that the restorative function recognises the emotional effects on individual work and in particular the work of people in distress (Scarfie 2001).

### Design

#### The training and supervision intervention

The training intervention involved a five day programme of classroom-based training focusing on person-centred approaches to the care of people with dementia, leadership and self-care. This was followed by a ‘working alongside’ practice-based intervention over two five-hour shifts per nurse. This involved modelling person-centred approaches to dementia care and advice about applying theory from the training intervention to practice. Please see Figure 1 for an overview of the training

### Method

The qualitative evaluation of the training described here involved interviewing a subset of those who had received the training and supervision intervention. Overall, the training and supervision intervention was delivered to 74 registered nurses, from 47 nursing homes within a cluster randomised controlled trial which used quantitative questionnaire-based measures. The quantitative aspects will be reported separately.

We took a naturalistic and constructivist stance to focus on nurses’ accounts, experiences and meanings, concentrating on how the nurses’ interpreted their own social world (Robson 2011). Through interviews we aimed to acquire multiple perspectives (Robson 2011), in tune with the constructivist position (Creswell and Plano Clark 2007). We aimed to understand whether, why and how the intervention had made a difference (Woods and Russell 2014) and to explore the most important parts as viewed by its recipients, as this has implications for the refinement of the intervention.

### Sampling approach

We recruited interviewees from thirteen of the 47 homes either post-training or post-training and restorative supervision. We included a proportion (eight) who had received training and supervision (T+S) and five who received training only (TO). Numbers were chosen to allow the collection of a range of experiences with recruitment continuing to a point where nothing new was emerging (Creswell and Plano Clark 2007). It was not possible to recruit equal numbers from each group due to time constraints.

### Participants

Twelve participants were female and one male; all were qualified to diploma level and had extensive experience of working with people with dementia.

### Setting

Participants were drawn from 47 nursing homes in the Midlands of the United Kingdom. The classroom-based training intervention was conducted in training facilities in a local university or hospital training room. The skills-based element was conducted in the nursing home where the participant worked, as did the restorative supervision.

### Data collection methods

Interviews took place shortly after the completion of the intervention. The interviews were used to gain insights into the impact of the training and supervision intervention in terms of the impact on nurse burnout and the nurses’ attitudes to dementia, sense of self-efficacy, and leadership skills, participants’ experiences of training and supervision. The interviews took place in the nursing homes, lasted approximately one hour and were audio recorded.

### Ethical considerations

The study team took steps to protect participants by ensuring their awareness that participation was voluntary and informed consent was received. All data was anonymised and no information could be linked to individual participants or homes. All records, including those of supervision, were confidential. All data has been stored in accordance with Good Clinical Practice guidelines (National Institute for Health Research 2016)**.** It was agreed with participants that any concerns about safeguarding issues would be raised with the Care Quality Commission.

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.

### Data Analysis

The interviews were recorded and transcribed verbatim and analysed using Template Analysis (TA). This is a process for organising and analysing textual data according to themes (King 1998). Central to the technique is the development of a coding template and the use of a priori codes. To develop these codes the half-way position described by Waring and Wainwright (2008) was adopted, where codes were developed based on the theoretical position of the research as well as after exploration of the data from initial interviews. Our initial template reflected the aims of the research and included Reactions to Training and Experiences of Supervision.

After the first four interviews were analysed the template was modified in to include some tentative inductive sub-themes (e.g. sub themes for nurses’ perspectives on and reactions to the training included feeling overloaded, self-blame and enhancing self-efficacy), hierarchically linked to the two main topics (Reactions to training and Experiences of Supervision) which emerged from these first interviews. The template was revised over the course of the analysis, additional codes were included as needed, when new ideas emerged. Any predefined codes which turned out not to contain any significant data were deleted. (For example, codes of “a person-centred approach” and “a taking a protective stance” were not retained.) Related codes with only small amounts of data were merged into a single code. (For example, “presenteeism” was merged with “feeling overloaded”). Data was sorted and scrutinised to explore possible relationships and trends in themes (King 1998). The final template served as an organising framework for the interpretation of the findings.

### Reflexivity and Trustworthiness Criteria

The COREC qualitative checklist was used (Tong et al. 2007), to ensure that rigour was achieved, and that credibility, transferability, dependability and confirmability were promoted.Approaches to ensure credibility included looking across the data to explore deviant cases which contradicted our expectations in relation to major themes (Mays 2000). To assist with the process of reflexivity and enhance confirmability, coding was undertaken independently by the researchers and compared to allow for reflection, discussion and reconciliation of different interpretations. Therefore, there was a clear audit trail evidencing how decisions were made throughout the study.

Reflexivity was crucial during the analysis of the qualitative data (Parahoo 2006), therefore the authors attempted to consider the effects of our experiences and backgrounds throughout this process. Context was also considered, ensuring that the findings of the research were meaningful, to demonstrate this, a thick description was provided when presenting the qualitative data (Korstjens and Moser, 2018).

Other methods of assuring credibility included the use of purposive sampling for the qualitative interviews. Murphy et al. (1998) stated that wherever possible purposive sampling should be used to endure quality. Transferability refers to the degree to which qualitative findings can be transferred to other settings (Bitsch, 2005). This was addressed in our study through providing a thick description of the data, referring to context, setting, and by providing details of the methodology. This helps other researchers to replicate the study (Anney, 2014) and readers of research to know whether the findings might apply to their own setting. Dependability relates to consistency and repeatability, this was assured through the use of an audit trail where all documents e.g. interview notes, scores and transcripts were kept for checking and auditing.

## Findings

Findings from the qualitative interviews are presented under the two main aims, Reactions to the training and Impact of supervision. Pseudonyms have been given to the participants. Beneath participant quotes, ‘T&S’ refers to participants who received training plus Supervision, ‘TO’ refers to those who received training only.

### Reactions to the training:

### This theme set the backdrop for understanding how the training impacted on the nurses, as the findings shed light on how the nurses feel at work, their roles and responsibilities, and the significant pressure that they are under. Sub-themes included experiences of burnout, implementing a person-centred approach to dementia care, feeling more confident, and opportunities to participate.

#### Experiences of burnout

The sub-theme of “experiences of burnout” emerged from a series of introductory questions that were used to explore whether and how the nursing home nurses experienced burnout, and how this was expressed.

Analysis of the data revealed the nurses felt overloaded, isolated and in poor health.

These factors combined to result in burnout. Physical and emotional exhaustion arose from feelings of being overloaded and unsupported. Individuals’ poor coping strategies and unhealthy habits appeared to combine to exacerbate the impact of unsupportive environments. There was a wealth of data relating to staff feeling unsupported at work andundervalued by their organisations. This is demonstrated in the quotation below:

*“Because it’s like ... you give someone a drop of blood, but they want two drops, so you give them three drops and it keeps going and going, you know and now I’m always lifeless. Because I can’t give any more blood, do you know what I mean? I can’t give any more to this organisation. If burnout means that I’ve done my job, then yes I’ve done my job. I can’t take this Home any further”. (Sahib T+S)*

As the lone qualified member of staff the nurses expressed a sense of isolation,

having no colleagues to turn to for clinical guidance, reassurance or peer support.

*“Yes, and then you have to make sure they are alright and take over and take them off but nobody comes into the office and takes you off. Nobody says to you, you’ve had enough now, so down to the staff room. Hold on, I can’t remember the last time I had supervision and that’s down to staffing and not having enough nurses and managers and having to do shifts because there are no nurses”. (Jane T+S)*

The 24-hour, seven day a week nature of needs in the Nursing Homes combined

with staff shortages meant that the nurses were aware that no one else was there to

solve any problems that arose in their absence. This led them to feel ‘on duty’ even

when at home.

*“It’s like if you’re off today you’re thinking oh no I’ve got to go to work tomorrow. You just can’t relax at home because you’re even having calls at home, so you couldn’t even have an off day”. (Matilda T+O)*

Despite the feeling of being under pressure, the nurses appeared to feel a compulsion to ‘be there’. They often recognised this was unhealthy but were unable to explain their own behaviour.

*“It makes me think I’m not good at it, and I get angry with myself, well why can’t you do it, other people manage… they do. …I need to carry on until I’ve done it and if it half kills me I’ll carry on…” (Vanya TO)*

Despite their personal commitment to continue at work, the nurses described the impact on the quality of care of colleagues being off work, as the pressures resulted in increased sickness, absenteeism and staff turnover as demonstrated in the quotation below:

*“They also had a big staff turnover, people came and went all the time and so there was no continuity. The residents didn’t get used to faces, they used a lot of agency nurses so there was no continuity so I suppose that didn’t help”. (Gemma T+S)*

It also appeared Senior Managers did not restrict the long working days and continued to foster this unhealthy behaviour*:*

*“It was easier for them [management] to ignore it because I was then still getting the job done, as long as I was churning out the results I needed, coming to work so they [management] wouldn’t need to worry about replacing me, or having another man down or having disruption and chaos coming to the workplace, they allowed me to continuously work these hours.” (Matilda TO)*

The high demands, including pressure to work long, sometimes unpaid, hours, appeared to be associated with physical and emotional symptoms of stress.

Participants reported adopting unhealthy coping strategies, such as smoking and drinking, and prioritising client well-being over that of their families. Several interviewees highlighted that physical symptoms of stress were having a negative impact on their life and health.

*“It happened twice at work where they had to call for an ambulance for me and that was due to stress at work. It was related to the acidity and the gas but it was like a crushing; a severe pain like a heart attack, I was really sweaty and when you’re in a medical field, you know what’s happening”. (Catherine T+S)*

The health problems affected the nurses’ emotional well-being at home, which led on to an impact on relationships with others. The nurses were aware of the negative consequences of their behaviours, and expressed concern for their own long-term well-being:

*“I wouldn’t even smile and when I got home the children would run away… yes it affected my personal life because I would get home after twelve hours, I couldn’t walk or talk, let alone eat, it affected my life as a whole” (Sue T+S).*

*“I work very long hours … but I need to stop doing that now because it’s taken a toll on my health and my mental state so I will do whatever I think is necessary to do but no more now, and that’s it, because if not I’m going to kill myself”. (Yvonne TO)*

This theme suggests that the nurses may be struggling to meet the competing demands of the home, balancing the heavy workload along with the needs of the residents and the emotional burden of caring. The nurses felt that this had an impact on their physical and emotional health.

### Implementing Person-Centred Approaches: “Thinking About the Person”

The classroom training included learning material about the experience of dementia and enhanced communication skills. Subsequently it seemed from the accounts that some of the nursing home nurses were more likely to adopt a person-centred approach to dementia care following the training intervention.

While participants did not explicitly use this term, to know the person’s history and understand their identity appeared to be something which they now considered:

*“a woman here … that has Alzheimer’s and it was her birthday a few days ago and she kept saying to everybody … 21 ½ nearly. Well we never really….So that if she is in that sort of age, in her early twenties, to get her daughter to try and think of things she can talk about to see if she can have a conversation with her mum about something her mum will remember”. (Sheila T+S)*

Another participant explained how she was now much more aware of the importance of recognising residents’ past lives to treat them with respect in the present:

“I think knowing about these people’s pasts you know. You’re talking to them like they’re stupid and they’re not and you get into that habit where you’re like ‘come on’ because you’re disappointed and frustrated” (Catherine T+S).

### Enhanced self-efficacy

A second strong theme under the main theme of reactions to the training, reflected an increase in the sense of self-efficacy reported by some of the nurses following the training intervention. Some of the nursing home nurses appreciated their own worth and said that they were more positive about their skills and abilities than they were before the training. Enhanced confidence enabled the nurses to share new knowledge and influence care. This had a subsequent impact on workload management as some realised they could delegate responsibility rather than carry it all:

*“Before the training I used to find pride when people phoned me at home…. And I felt glad that people are phoning me. But when … actually mentioned that when your team can’t deal without you, it really made me think, I really need to share the education and when you do, things you just go smoothly so now I can go for a meeting for two hours and they don’t look for me because they know what they’re doing and why they’re doing it”. (Sue T+S)*

The skills-based training appeared to be a beneficial aspect in terms of enhancing

the participants’ confidence as the trainer was able to provide positive feedback on

practice in the home, providing opportunities for embedding and reinforcing good

practice within the home.

*“ Everybody needs … a pat on the back and when you don’t get it you know so when the change comes around and you do, you do feel really valued you know especially because within yourself you feel undervalued you act that way and when you’re praised and valued you act that way as well.” (Jaz TO)*

Positive reinforcement was valued and seemed to boost morale. The training appeared to reduce feelings of isolation. Participants reported that the classroom training had provided valuable opportunities for sharing practice and experiences of working in a nursing home. They seemed to feel reassured that “*everyone was in the same boat*” and “*they were the same as everyone else*”. They valued sharing ideas with a view to problem solving for managing difficult situations at work.

*“It was really nice to feel like ‘Oh God it’s good to know that were not the only ones’ because you do tend to get a bit, ‘are we being picked on’? So you know it’s nice to know that we’re not, you know any different from anybody else. We have the same sort of problems with the kitchen staff and with the caring staff and the relatives and all the normal types of things.” (Jaz TO)*

### Opportunities to Participate: “There was Something Different about it”

The participants reported that the training was very different from the training which they usually received, which was usually in the form of workbooks, DVDs and free computer-based learning, which they described as ‘very poor’, ‘pointless’ and ‘repetitive’.

Participants reported how they had been able to bring what they had learnt from the

training into their work. This included their use of new leadership approaches and

strategies for managing stress at work which were both part of the curriculum. (See Figure 1: Outline of Intervention)

Participants favoured active learning methods such as role play, group exercises and discussion used in the classroom and found these particularly enjoyable.

*“We did loads, the leadership bit was when we did the role play, that was good, and a lot we did on dementia and following through, and picking up on the communications and behaviours, although we still need behaviour training, not for the residents, for the staff!” (Matilda T+O)*

### Impact of Supervision

There were numerous examples in the interviews where the supervision appeared to

support staff in preventing burnout, in implementing their new learning, and in encouraging experimentation and reflection. The supervision process seemed to support participants to work flexibly and creatively, and adopt a solution-focused approach to manage challenging situations at work:

*“Afterwards bringing into the Home the bits we have learnt but then it’s tweaking it for here. For me, for my staff and also tweaking it for nights, because that’s different from days. So the supervision brought it more centred for me, for my staff and residents” (Amanda T+S)*

The supervision modelled a way for the nurses to direct responsibilities back to their teams, rather than taking on everything as the senior member of staff. Socratic questioning was used, an approach which this participant was able to adopt in her own role supervising others:

*“I found it really helpful especially when you have to supervise the carers or the senior care nurse. So we will ask them a question like: ‘Which way do you feel better?’ So we are not telling them ‘You do it this way’ and they will get the feeling that they have told you what the solution is” (Gemma T+S)*

The nurses spoke of the way that engaging in the process of supervision enabled them to become effective supervisors themselves, eager to create opportunities for providing effective supervision in their workplace.

## Discussion

Although recent studies have investigated burnout amongst nurses, most have been conducted in acute care settings or have focused on quantitative outcomes (e.g. Cooper et al. 2016). Baker et al. (2015) reported that there had only been one study examining stress and burnout in staff caring for residents with dementia in nursing and residential homes (Zimmerman et al 2005). In this study, nurses’ accounts appeared to indicate that both classroom-based training and workplace-based training impacted positively. They reported reduced feelings of burnout, adopting a more person-centred approach to dementia care, and enhanced leadership skills. The workplace-based training was described as being particularly helpful in assisting the nurses with applying the training to real world care practice.

A recent review looking at the provision of dementia training for the wider workforce (Surr and Gates, 2017) recognised common features which were similar to the ones here, suggesting that training should be relevant to staff’s role in the work place, be facilitated by a credible trainer, and involve group learning. The nurses who experienced supervision were able to articulate a sense of job satisfaction which may have resulted from a more genuine ‘deep acting’ response to the stresses of managing high levels of emotional labour (Maxwell and Riley 2017).

Our findings confirmed those of previous studies indicating that working as a nurse in nursing homes is stressful (Engstrom, Skytt and Nilsson 2011, Westermann et al2014). The accumulation of devaluing but accepted experiences in nursing homework, such as low pay and few opportunities for progression, have been found to have a negative impact on health over time (Sojo Wood and Genat 2016). This, in combination with perceived lack of control, high levels of responsibility and anticipated criticism is recognised as damaging for workers and known to lead to burnout and ill health (Engstrom, Skytt and Nilsson 2011). In this study, the nurses’ accounts indicated strong feelings of responsibility, isolation and overload that were impacting on mental and physical health and well-being. Many of the nurses in our study had been diagnosed with serious long-term conditions and this is consonant with research suggesting that long-term stress has an impact on the immune system and results in vulnerability to long-term health problems (Kendall-Tackett 2015).

Caring for people with dementia, whose distressed behaviour can be challenging ,has been found to be associated with poor physical health for nurses, together with high levels of burnout (Cookson et al 2014). However, the nurses in this study did not complain of stress arising from looking after the residents of the homes, but spoke of holding sole responsibility, professional isolation and staffing levels as the main sources of stress. This echoes work with continuing care nurses and other health professionals which has found that burn-out is more related to team and organisational relationships than to caring for patients (Rose et al. 2010). It seemed that the isolation and overload resulted in perceived barriers to using constructive ways of coping such as taking time for relaxation or using social support, including spending time with family, or having professional support. Instead the nurses’ gave accounts of using harmful temporary stress management strategies.

Against this backdrop of stress and burn-out, we sought to discover whether and

how the training intervention had impacted. In the nurses’ accounts of their experiences of training, it seemed that among the most well-received aspects of training in person-centred dementia care were the trainers’ collaborative approach and credibility, as well as the value placed on practical tips and group activities. It appeared that the solution-focused approach (Franklin 2015) which was used in the classroom, workplace and supervision elements of the intervention to address problem-solving, self-care and leadership led to an enhanced sense of control at work. Having a sense of job control has been found to be associated with person-centred practice, more positive engagement with work responsibilities (Kubicek et al 2014) and job control (Fearon and Nicol 2011) and seems to be protective by mitigating the consequences of job demands (Schmidt and Diestal 2013). It is suggested that good care can be achieved through strengthening the position of nursing home nurses, alternative models of paying for care (Horton, 2017) and better staffing (Dellefield et al. 2015).

In addition the opportunities in the classroom that allowed the nurses to share stories seemed to be a crucial element in reducing their sense of isolation. It increased the feeling of being in a similar situation to others, and this was experienced as mutually supportive and reassuring, perhaps because when similar experiences emerged, responsibility could no longer be attributed to an individual (the nurse themselves) but instead could be perceived as systemic (Sojo Wood and Genat 2016), thus enabling the nurses to reject self-blame. Telling stories is congruent with the culture of nurses’ professional life, and is an acknowledged informal method for sharing values and developing empathy (Wood 2014).

The nurses who experienced supervision were able to articulate a sense of job satisfaction which may have resulted from a more genuine ‘deep acting’ response to the stresses of managing high levels of emotional labour (Maxwell and Riley 2017).

The nurses noted an increase in confidence and emotional well-being and greater willingness to share their knowledge. The implications of our findings are that there are ethical and business reasons to teach nurses working in nursing homes about high quality dementia care and leadership skills, and to support them and reinforce their personal development with a working-alongside model and clinical supervision. This training approach reinforces the value of nurses, including, importantly, to the nurses themselves.

Reducing staff turnover is essential to the smooth running of the Home and to the well-being of people with dementia, who are better nursed by people who know them well, understand their life history and are committed to a person-centred approach. Delivering care from a person-centred perspective is dependent on staff too meeting their needs for personhood. The physical health of nurses also needs attention and working conditions should be designed to facilitate nurses taking care of their own physical and emotional health.

## Limitations

The sample was purposive with nurses being selected based on their availability and willingness to participate. Selection bias may be difficult to overcome and is difficult to avoid completely (Kukull and Ganguli 2012). Studies which evaluate staff’s reactions may be at risk of bias due to social desirability bias where the participant may be likely to say what is socially acceptable (Lavrakas, 2008). It is possible that more motivated participants, or those who perceived themselves to be experiencing burnout, agreed to be interviewed. Our study participants were all qualified at diploma, rather than degree level, so we were not able to explore the relationship between the level of a nurse’s education and their susceptibility to burnout.

## Conclusions

Working long hours, feeling overloaded, unsupported, isolated, and not feeling valued all combined to create an extremely unfavourable work environment and led to nurses’ experiences of burnout. The training and supervision appeared to reverse or break through some of the conditions that led to burnout. The nurses reported the intervention had enhanced their confidence and reduced isolation. It also appeared that the training and supervision created the beginnings of change in individual practices with the nurses seemingly more likely to adopt a person-centred approach to delivering dementia care.

Both the skills-based aspect of the training and the supervision appeared to assist the nurses in applying what they had learnt in the classroom. Therefore it seemed that the training and supervision had the effect of starting to reverse the vicious circle associated with development of burnout, by providing the nurses with strategies to cut through their sense of isolation and powerlessness, and to deal more effectively with the pressures of work. The findings suggest a need for further research to examine the effectiveness of supervision alone and alternative strategies to improve the well-being of nurses working in nursing homes.

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