EVALUATION OF DEMENTIA TRAINING FOR STAFF IN ACUTE HOSPITAL SETTINGS

Analisa Smythe and colleagues investigated the effectiveness of a brief psychosocial intervention delivered in the workplace compared with a standard teaching approach.

Abstract

The development, pilot and evaluation of a brief psychosocial training intervention (BPTI) for staff working with people with dementia in an acute hospital setting are described.

The project had two phases. Phase one involved adapting an existing competency framework and developing the BPTI using focus groups. For the pilot and evaluation, in phase two, a mixed methods approach was adopted using self-administered standardised questionnaires and qualitative interviews.

Qualitative analysis suggested that delivering skills-based training can develop communication, problem-solving and self-directed learning skills; benefit staff in terms of increased knowledge, skills and confidence; and be problematic in the clinical area in terms of time, organisation and the physical environment. These factors must be taken into consideration when delivering training. These changes were not reflected in the quantitative results and measures were not always sensitive to changes in this setting.

Definitive conclusions cannot be drawn about the efficacy of the intervention, due to the contradictory outcomes between the quantitative and qualitative data. Further developments and research are required to explore how staff and organisations can be supported to deliver the best possible care.

Keywords

Acute hospital, cognitive impairment, dementia, service evaluation, skills, training, ward based
Having enough time to spend on one-to-one care. The report highlighted that acute hospital staff should have the right knowledge and skills to better meet the needs of patients with dementia.

A number of randomised controlled trials (Fossey et al 2006, Visser et al 2008, Ballard and Aarsland 2009, Chenoweth et al 2009, Kuske et al 2009) have sought to evaluate the effect of training for mental health or acute hospital staff on the quality of dementia care, as have two systematic reviews (Livingston et al 2005, McCabe et al 2007).

The results demonstrate substantial variability in the content, length and type of training interventions that have been evaluated. Interventions have been based on different theoretical frameworks (Mustafa et al 2013) with a mixed content (McCabe et al 2007). Person-centred care and behaviour management are common areas of focus.

When assessing the effect of training, McCabe et al (2007) found that most studies considered impact on staff knowledge or attitudes, while some explored staff behaviour or outcomes for people with dementia.

Ganesh et al (2012) and the Royal College of Psychiatrists (2011) examined the adequacy of dementia care training for acute hospital staff and found deficiencies in areas such as coping with signs of distress.

Conventional didactic classroom approaches to training have not improved knowledge sufficiently to support practice change (Ballard and Aarsland 2009, Smythe et al 2013). Staff have little opportunity to leave the clinical environment for training, or to meet as a team to reflect and learn together (Smythe et al 2013). Therefore training delivered in the clinical setting may be more feasible and have greater potential to enhance practice. It is difficult to isolate the main ingredients for success, but ensuring training is embedded in a whole-systems approach could prove necessary to deliver sustained application of new knowledge (Kuske et al 2009, Perry et al 2011).

**Aim**

The aim of the project was to develop, pilot and evaluate a brief psychosocial training intervention (BPTI) for staff working with people with dementia in an acute hospital setting.

**Method**

The first phase involved adapting an existing competency framework (Smythe et al 2013) to meet the needs of staff in acute hospital settings. Focus groups were conducted with acute hospital staff and the findings used to design the BPTI.

The second phase was to pilot and evaluate the BPTI using self-administered standardised questionnaires and qualitative interviews.

**Phase 1** Potential focus group participants were consulted about the BPTI’s parameters and content to promote a sense of ownership (McCarron et al 2008) and identify their needs. Six focus groups were conducted with 32 participants, drawn from a range of disciplines, including nursing, and service settings.

These discussions were recorded, transcribed verbatim and analysed using thematic analysis. Participants self-selected by attending at advertised times. Verbal consent was deemed acceptable in the context of a service evaluation.

Five themes were drawn from the thematic analysis:

- Everybody should be trained.
- Understanding the disease and the person.
- Dealing with challenges.
- Hands-on training.
- Making it practical.

**Everybody should be trained** Unqualified staff reported not having enough knowledge to provide effective care for people with dementia:

- 'I mean as much as I love my job... I could never say I know what I am doing' (P1, FG1).
- Staff recognised that ‘everybody should be trained’ (P2, FG3) in dementia care and how to best care for people with the condition, ‘because everyone interacts with them’ (P1, FG2).

**Understanding the disease and the person** Training also needed to include an understanding of the perspectives of people with dementia:

- 'Thinking how that would feel... just being frightened all the time and not understanding' (P5, FG3).
- Staff reported a need to know how the dementia process affected the person:
  - '... the difference between dementia, delirium, and depression, you know, could be identified, the progression of the disease process itself... I mean a lot of people don’t know that dementia is a terminal illness' (P3, FG6).

**Dealing with challenges** Staff also thought they needed skills in managing perceived challenging behaviour:

- 'How to deal with aggression, and I think it is important, as sometimes it is really hard. You have patients sometimes where it takes four or five nurses to hoist the patient back to bed, kicking and scratching us' (P4, FG1).
Communication training was also identified as a need:
- 'Alternatives to repeating yourself... I was finding it frustrating that I was saying the same thing over and over and I wasn't getting anywhere. As far as I was concerned, I was hitting a brick wall’ (P3, FG4).

**Hands-on training** Qualified staff thought the best way to teach staff about dementia care was through observation:
- 'How do you teach for dementia? The range is so huge... You can't teach for that, but if you observe someone doing it... you show people' (P1, FG6).

**Making it practical** Participants thought training should be relevant and realistic for the ward setting:
- 'It’s like you have a training session, and it’s not practical on the ward. We can’t do it that way ’cause it’s just not practical – we haven't got the time, we haven't got the equipment, or whatever... It’s all good and well when you’re sitting in a classroom but when you are actually putting it into practice, you don’t have a lot of time, you know, or the staff’ (P7, FG6).

Staff were aware of the effect of their lack of knowledge and skills on people with dementia and their own work. They expressed enthusiasm for learning and training. As a result of insufficient training opportunities they appeared to see learning from each other as an option, if a suitable role model was available. They emphasised that training must be practical, realistic and relevant.

Previous work exploring training needs in a specialist mental health setting (Smythe et al 2013) found similar themes around skills, attitudes, barriers and enablers. Staff in both settings perceived practical or 'hands-on' training to be more valuable than didactic teaching, particularly when working with positive role models. Gaps in knowledge about the aetiology of the disease process, managing behaviour, lack of time and inadequate staffing were all identified as barriers to person-centred care.

**Phase two** The project aimed to examine the feasibility and staff’s experiences of implementing the BPTI on the wards compared with a standard teaching approach or no training. The standard teaching approach consisted of a six-week, classroom-based rolling programme. Content included delirium, managing behaviour perceived as challenging, nutrition and hydration, the importance of activities, falls management and end of life care. Delivery was didactic and focused on physical health needs.

Participants appeared to see learning from each other as an option, if a suitable role model was available

We hypothesised that, in contrast to the standard teaching, the BPTI would facilitate development of professional confidence and self-efficacy, self-esteem and acknowledgement of emotional labour. The BPTI aimed to provide opportunities for staff to address attitudes, and therefore develop emotional competence, empathy and a non-judgemental approach. Training aimed to address the barriers identified and to enable staff to make connections with people with dementia by exploring ways to provide meaningful occupation and enhance wellbeing.

The BPTI was designed to be delivered for one hour a week over five weeks. The trainers were a mental health nurse/researcher with teaching experience and two general nurses. A manual was written and used to ensure implementation fidelity. Each session began with a conversation outlining training objectives and delivering important messages, followed by working alongside the staff member and subsequent feedback and reflection. This was expected to be cost effective as staff were not required to leave the clinical area to attend the training.

Thirty participants, from three different wards, received the BPTI. This group was diverse in terms of age, gender, length of experience and qualifications.

Most staff did not attend the standard training; attendance was sporadic and 86 staff in total attended one or more sessions in 2012. We hypothesised that poor attendance rates related to difficulties releasing staff, prioritisation of statutory training and staff preferences for a hands-on approach.

Descriptive data about staff demographics were collected and a range of self-administered standardised questionnaires were completed by both groups at baseline and pre- and post-training:
- The Inventory of Geriatric Nurse Self-Efficacy, which measures confidence (Mackenzie and Peragine 2003).
- The Approaches to Dementia Questionnaire (ADQ), which measures attitudes (Lintern et al 2000). Two sub-dimensions were measured: 'hope' and 'recognition of personhood', along with a combined total score ('total approaches to dementia').
- The Maslach Burnout Inventory (MBI), which measures personal accomplishment (PA),
These measures have been used together in similar UK studies and all showed high interrater reliability and validity (Rose et al 2010, Moyle et al 2011). The questionnaires were returned to an independent researcher rather than one of the trainers.

Scores were compared between the two groups at baseline and post-training. Initially, descriptive statistics were computed to explore the distribution of the obtained data, for example, measures of central tendency, assessments of normality, internal reliability, and frequency distributions.

A series of statistical tests for differences, predominantly the t-test, was carried out using the Statistical Package for Social Sciences to explore any possible relationships across the key variables measured pre- and post-training. Further analysis was carried out using all the data sets together to identify any significant changes.

**Ethical considerations** The project was considered by the organisation’s research and development department to be a service evaluation and was subject to trust research governance procedures. All the staff volunteered to take part in the project having received an information sheet. Data were anonymised and stored securely.

**Results**

**Quantitative** A total of 81 staff from the three wards completed questionnaires and received either training as usual or the BPTI. Of these, 15 (19%) participants did not complete the follow-up questionnaires, due to various reasons, such as staff moves, night shifts and sickness. Complete data were obtained for the remaining 66 (81%).

No significant differences were found between the group of participants who did not receive the BPTI (training as usual/standard approach) and the group who received the BPTI. On the third ward positive trends were identified, but again these were not statistically significant.

For ‘self-efficacy’, the mean values measured in the groups ranged from 46-56. The possible range of scores is 9 to 63, which suggests that although the instrument does pick up a spread of scores, these mean values particularly at baseline were close to the ceiling of possible scores and therefore it is questionable that a change could have been detected.

For the ADQ (‘hope’, ‘recognition of personhood’ and ‘total approaches to dementia’), only values for ‘hope’ lay close to the ceiling of possible values (19). However, being close to the floor of possible values does not prevent sensitivity to possible change, that is, increase, with this instrument.

For the MBI PA the mean measures across the groups were between 20 and 23, with the possible range of scores 0 to 48. For the MBI DP the mean measures across the groups were between 1 and 6, with the possible range of scores 0 to 30. For the MBI EE, the mean measures across the groups were between 9 and 18, with the possible range of scores 0 to 54. Only in the case of the MBI DP was there a question of the sensitivity of detecting change as in all cases the mean scores were close to the floor of possible values.

Finally, for the ADKS, the mean values of the groups were between 20 and 38, with the possible range of scores 0 to 30, which gives confidence that the instrument has the potential to map changes in either direction.

**Qualitative findings** Interviews were conducted with staff from both groups (n=15) to explore their experiences of training. Interviews were audio-recorded and transcribed verbatim. These transcripts were analysed using thematic analysis.

Wards were busy, staffing was an issue and it was a struggle to cope with training demands alongside clinical duties. Some staff would have preferred to receive the training while off duty.

Staff reported feeling self-conscious because they perceived they were being watched or assessed. Others preferred the practical approach of the BPTI compared with theory-based learning:

- ‘Rather than sitting people in classrooms, listening which can be frustrating and it was just long enough... it was more easier to talk to everyone, I liked it because you were doing something practical, I learnt a lot more than if it’s a big group in a classroom, mainly because I don’t stand up and talk myself’ (P5, FG2).

Staff thought that the training increased their awareness of the needs of people with dementia and that they were more knowledgeable and more skilful as a result. They described better understanding the emotions and behaviour of people with dementia, which increased their tolerance, understanding and confidence:
Staff described better understanding the emotions and behaviour of people with dementia, which increased their tolerance

The project design had limitations as there were insufficient resources to ensure staff attended standard training or to provide a dummy intervention for the classroom-based group. Therefore, it was not possible to measure the impact of the extra time and attention that the staff who were allocated to the BPTI arm may have received. Participants may not have had enough time to complete the questionnaires in the practice environment and questionnaire fatigue may have arisen.

It was not possible to explore the variation between the trainers because they did not work independently with participants. Therefore a participant may have received training from one or more trainers.

It is accepted that this is a limitation. Due to limited resources and from a practical point of view, it was not possible to ensure the rater was blind to treatment allocation. We considered this, but concluded that as soon as the researcher started talking to the staff, it would be obvious to them whether they had received the BPTI.

Initially, it was anticipated that staff would be trained in small groups of five to enable peer support, however, time pressures and restrictions with staff rotas made this impossible. Therefore, staff had to be seen individually and this increased the time needed to deliver the training substantially while limiting chances for role modelling and group teaching, thus diluting its impact. In addition the physical environment prohibited opportunities for patient group activity and engagement.

The approach had been identified as cost effective; being ward-based there was no requirement for expensive backfill provision. However, in practice, one of the trainers was required to backfill for staff. It was difficult to ensure implementation fidelity as trainers were similarly constrained by competing organisational demands.

In summary, skills-based training delivered in the clinical area can be restricted by time, organisational and environmental factors that should be taken into consideration when delivering this approach.

Conclusion

Definitive conclusions cannot be drawn about the efficacy of the intervention, due to the contradictory outcomes between the quantitative and qualitative
data. The intervention was based on sound learning and psychological theories, a systematic literature review and was congruent with the outcomes of the focus groups. However, due to the barriers discussed, it was not possible to implement the BPTI as envisaged and this may have contributed to the discrepancy between the findings.

While an acute care setting is not ideal for people with dementia, inevitably many will require this type of admission, therefore effective training for staff is essential. This project explored the use of a practical ward-based approach that may be considered as a stage in progress towards training that will support acute staff in delivering the care they would like to offer people with dementia. The perspectives of people with dementia and their families should be sought. This was not possible in this project due to the nature of the ethics permission. Further developments and research are required to explore how staff and organisations can be supported to deliver the best possible care for people with dementia in acute hospitals.

References


