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Becoming a Person Again
A classic grounded theory of psychosocial
intervention use with residents with
dementia in long-stay care.

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Abstract

This study set out to develop a theoretical understanding of staff's psychosocial intervention use with residents with dementia in long-stay care. This study applied classic grounded theory procedures. Data was collected from interviews with participants based in or associated with 9 long-term care settings: 14 residents with dementia, 19 staff nurses, 1 clinical facilitator, 7 nurse managers, 21 nursing assistants and 5 relatives. Researcher memos and applicable extant literature were also included as data. There were four phases of data collection with participant recruitment directed by theoretical sampling based upon the ongoing data analysis. All of the data was analysed through open coding, selective coding and theoretical coding to develop the core category and its properties. Constant comparative analysis produced the core category 'becoming a person again'. This core category accounts for a conceptual process comprising a cycle with four phases: balancing the influences, which accounts for the interaction of institutional and personal factors; individualising status, which accounts for individuals' capacity and inclination towards psychosocial intervention utilisation; striving to make the most of time, which accounts for staff's main concern and actual psychosocial intervention care delivery; interpreting care, which accounts for how staff reflect on and react to the psychosocial interventions delivered. Analysis showed that while participants aspired towards psychosocial intervention use, in practice a range of competing priorities should be balanced to allow psychosocial intervention use. By providing a conceptual explanation of psychosocial intervention use, this grounded theory contributes understanding of staff motivation towards educational change within the institutional context. This thesis also provides recommendations to service developers and educational researchers. It explains how institutional factors impact upon and unbalance personal inclination towards psychosocial intervention utilisation. Therefore these institutional factors should be addressed as part of any staff educational programmes if these are to result in a positive change in psychosocial intervention use.

Keywords: dementia, classic grounded theory, psychosocial interventions, long-stay care

Publications

Find listed below the publications that this thesis has contributed towards to date.

Peer Reviewed Articles

O'Shea, E., Devane, D., Cooney, A., Casey, D., Jordan, F., Hunter, A., Murphy, E., Newell, J., Connolly, S., Murphy, K. (2014). The impact of reminiscence on the quality of life of residents with dementia in long-stay care. *International Journal of Geriatric Psychiatry*, doi:10.1002/gps.4099

Murphy, K., Jordan, F., Hunter, A., Cooney, A., Casey, D. (2014). Articulating the strategies for maximising the inclusion of people with dementia in qualitative research studies. *Dementia: The International Journal of Social Research and Practice*, 0 (0), 1–26.

Dempsey, L., Murphy, K., Cooney, A., Casey, D., O'Shea, E., Devane, D., Jordan, F., Hunter, A. (2014). Reminiscence in Dementia: A concept analysis Dementia. *The International Journal of Social Research and Practice*, 13 (2), 176–192.

Cooney, A., O'Shea, E., Casey, D., Murphy, K., Dempsey, L., Smyth, S., Hunter, A., Murphy, E., Devane, D., Jordan, F. (2013). Developing a structured education reminiscence-based programme for staff in long-stay care facilities in Ireland. *Journal of Clinical Nursing*, 22, 13-14.

Houghton, C., Hunter, A., Meskell, P. (2012). Linking Aims, Paradigm and Method in Nursing Research: Three Practical Examples. *Nurse Researcher*, 20 (2), 34-39.

O'Shea, E., Devane, D., Murphy, K., Cooney, A., Casey, D., Jordan, F., Hunter, A., Murphy, E. (2011). Effectiveness of a structured education reminiscence-based programme for staff on the quality of life of residents with dementia in long-stay units: A study protocol for a cluster randomised trial. *Trials*, 12:41.

Hunter, A., Murphy, K., Grealish, A., Casey, D., Keady, J. (2011). Navigating the Grounded Theory Terrain (Part 1): A neophyte researcher's journey around the headlands of grounded theory. *Nurse Researcher*, 18, 4, 6-10.

Hunter, A., Murphy, K., Grealish, A., Casey, D., Keady, J. (2011). Navigating the Grounded Theory Terrain (Part 2): Justification for and application of Classic Grounded Theory. *Nurse Researcher*, 19, 1, 6-11.

Book Chapters

Hunter, A. Positive Relationships in Residential Dementia Care. In Murphy, K., & Kazer, M. (Eds.), *Improving the Quality of Life of Older Adults Across Environments of Care*. New York: Springer.

The Author

I qualified as a mental health nurse in 1996 and practiced in various inpatient and community services in Edinburgh, training in cognitive behavioural therapy and interpersonal psychotherapy while completing my MSc in Education in 2000. I went on to lecture in mental health nursing at Edinburgh University while working as a researcher, developing integrated care pathways for young people with mental health problems. In 2003, I took up a post at The University of Manchester where I coordinated the BSc in mental health nursing whilst undertaking further research into service provision for young people with mental health problems.

In January 2008, I relocated to the Republic of Ireland taking up a lecturing post at The National University of Ireland Galway, School of Nursing and Midwifery. Having gained experience of varied research approaches as well as experience in staff training and clinical expertise in the use of psychosocial interventions I began to consider what would be an appropriate area for my own PhD research. Following discussion with researchers in the School of Nursing and The National University of Ireland Galway the opportunity to contribute to the Dementia education programme incorporating REminiscence for Staff (DARES) research study, funded by the Health Research Board became clear. In May 2008, I registered for this PhD. This undertaking has provided an opportunity to utilise and build my research and psychosocial intervention knowledge. It has also been an invaluable opportunity to conduct research with residents with dementia and the staff who work with them.

Writing Conventions Used

In this thesis the numbers one to nine will be written, with the numbers 10 and above represented numerically. Exceptions to this are when sample sizes ('n') are provided, when numbers appear at the start of a sentence and when numbers form part of a title, for example: Table 1; Chapter 5 and so on.

Direct quotes from the literature will be presented with double quotation marks and italicised. Single quotation marks are used within the thesis to denote conceptual categories such as 'balancing the influences', single phrases and colloquialisms. Direct quotes from participant data or from author memos will be italicised.

Within the thesis the author will be referred to as 'the author', 'researcher', 'I' or 'me' dependent upon the context.

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Chapter 1: Background and Introduction

1.0 Introduction

Currently there are 14,266 people with dementia living in long-stay care in Ireland (Cahill et al., 2012). There is concern that the psychosocial needs of residents with dementia are often left unmet and that the care delivered is often not person-centered (Cahill & Diaz-Ponce, 2011; Murphy et al., 2006). This thesis focuses on developing an understanding of psychosocial intervention use in the care of residents with dementia in long-stay care settings in Ireland.

In this introductory chapter the global prevalence of dementia, the growing impact of dementia on societies around the world, and the impact of dementia on individuals will be presented. The understanding of dementia, changing historical context, changing international and Irish policy context and strategies for dementia care will be explored. This chapter will also examine the extent to which dementia policies are implemented in Ireland and the utilisation of psychosocial interventions in practice. In addition the rationale, aim and objectives for this research will be presented. Finally, the chapter will conclude with an outline of the overall thesis.

1.1 Prevalence of Dementia

Global estimates suggest that there are currently 35.6 million people with dementia worldwide, with this number due to increase to over 63 million by 2030 and over 114 million by 2050 (Ferri et al., 2005; Prince et al., 2013a; Prince et al., 2013b). This equates to an additional 7.7 million new cases of dementia across the globe each year (WHO, 2012). Zanetti et al. (2009) estimate that prevalence rates of dementia by age group range from 0.9% at age 65, 4.2% at age 75 and 14.7% at age 85. Zanetti et al. (2009) also estimate that for people with dementia the main predictor of life expectancy is age at time of diagnosis. For instance, a person aged 60-70 at time of diagnosis of dementia can expect to live for 7-10 years, with

this figure dropping to 3 years or less for a person diagnosed in their 90s. Prince and Jackson (2009) note that while there is no overall gender difference in dementia incidence, longer life expectancy amongst women results in there being significantly more women with dementia over the age of 75. Given that both increased age and diagnosis of dementia are predictors of admission to long-stay care (Fossey, 2008), it is clear that the population of people requiring long-stay care is set to rise significantly in the coming years.

European estimates of the prevalence of dementia calculate that in 2005 there were 4.9 million people living with dementia in Western Europe, suggesting that this figure would rise to 9.9 million by 2040 (Ferri et al., 2005). These findings are supported by Prince and Jackson (2009) who estimate that in 2010, there were 7 million Western Europeans who have dementia and that this will increase to 10 million in 2030 and 13.4 million by 2050.

In Ireland, the precise number of people with dementia is not known. That said estimates suggest that as people age the likelihood of developing dementia doubles every five years after the age of 65 (Cahill et al., 2012). Cahill et al. (2012) compared European figures to the 2006 Irish census figures, concluding that there are 41,470 persons with dementia in Ireland; of these 3,584 are under the age of 65 and 700 are people with Down's syndrome. The increasing longevity of the general population means that the prevalence of dementia is set to dramatically increase (Cahill et al., 2012). The Central Statistics Office (CSO) (2008) estimates that by the year 2041 the number of Irish people aged 65 and over will double. These estimates indicate that there will be 140,580 people with dementia living in Ireland by 2041 (Cahill et al., 2012). As a result of women's greater life expectancy, Ireland follows the international pattern having more women than men over the age of 75 with dementia (Cahill et al., 2012; Ferri et al., 2005). Having considered the growing prevalence of

dementia internationally, the next section will consider the impact of dementia on individuals and the communities they live in.

1.2 Impact of Dementia

The term dementia refers to a range of conditions that typically result in impairment of higher brain function (Adams, 2008a). These progressive conditions can present a number of difficulties for the individual with dementia, their family members and carers. Dementia can impact the individual's memory, ability to communicate, social functioning, overall mental health and personality (Stephan & Brayne, 2008). Batsch (2012) identify that the challenge faced by people with dementia and their carers is compounded by low levels of public understanding about dementia resulting in stigma and prejudice, a situation that is unfortunately manifest worldwide.

In their Global Burden of Disease Report, WHO (2006) identify that dementia accounts for 4.1% of all disease burden amongst people over the age of 60, 11.3% of years lived with the disability and 0.9% of life years lost. Prince and Jackson (2009) identify that in addition to the consequences for individuals with dementia there is an impact on families and communities. Carers' experience of burden can manifest in a number of ways, for example 40-75% suffer from mental health problems, including 15-32% with major depression (Prince & Jackson, 2009).

Prince and Jackson (2009) differentiate between '*indirect*' care costs, care that is provided by families; and '*direct*' care costs, care provided by the state or by private providers. Currently only 44% of care costs in low income countries relate to, '*direct*' care compared to 69% in high income countries such as the USA and Western European countries. Prince and Jackson (2009) suggest that demographic trends and social change will alter this ratio as '*indirect*' costs reduce, being replaced by '*direct*' costs, with a resultant impact upon national budgets. Prince and Jackson (2009) further differentiate between the economic costs of dementia care in high

and low income countries. Low income countries such as China and India account for only 28% of the total global spend on dementia which is estimated at 315 billion dollars annually. Currently in high income countries the use of long-stay care is increasing (Prince & Jackson, 2009). In Northern Europe (including Ireland) the current estimated cost of care is €36,000 per person per annum, in the UK it is €29,000 per person per annum (Knapp & Prince, 2007; Wimo et al., 2011). In Ireland the current 'direct' cost of long-stay care is estimated at €40,500 per person, per annum. This contributes to a yearly Irish spend on dementia of €1.69 billion per annum, 43% of which is being spent on the care of the 10% of people with dementia in long-stay care (Cahill et al., 2012; O'Shea & O'Reilly, 2000).

1.3 Dementia Subtypes and Symptoms

While over 200 subtypes of dementia have been identified the most prevalent subtypes are Alzheimer's disease, vascular dementia, dementia with Lewy bodies, Picks disease and Korsakoff's Syndrome (alcohol-related dementia). It should be noted that the actual prevalence of dementia subtypes is somewhat unclear as estimates are subject to variation in diagnostic techniques, methodological differences and variation in samples (Stephan & Brayne, 2008). In addition, there is increasing evidence for mixed dementia, a type of dementia arising from the presence of both Alzheimer's disease and Vascular Dementia (Stephens et al., 2002).

Alzheimer's disease accounts for over 50% of dementias (Lobo et al., 2000). The impact of Alzheimer's disease is typified by gradual impairment of memory, language and function caused by growing deposits of amyloid plaques and neurofibrillary tangles which initially occur in the neocortex and become more widespread as the disease progresses (Stephan & Brayne, 2008). Vascular dementia accounts for 10-20% of dementias. Stephan & Brayne (2008) describe vascular dementia as having an effect the individual's concentration and communication skills

along with causing paralysis and weakness of the limbs due to ischaemic, anoxic or hypoxic brain damage. Dementia with Lewy bodies has been identified as causing up to 10% of dementias which will often comprise episodes of confusion and in some cases psychotic symptoms caused by the presence of Lewy bodies, which are abnormal structures within nerve centres in the brain (Stephens et al., 2002). Fronto-temporal dementia accounts for less than 10% of dementias and is associated with gradual personality or behavioural changes in response to frontal lobe degeneration (Stephens et al., 2002). Picks disease and alcohol-related dementia account for smaller numbers; Pick's disease results in impaired emotional and social capacity in response to damage to the frontal and temporal lobes, whilst alcohol related dementia impairs memory, social skills, balance and social functioning due to vitamin B¹ deficiency in response to excessive alcohol intake (Stephan & Brayne, 2008). Other notable instances of dementia include people with Parkinson's disease of whom 30% to 70% will develop dementia (Aarsland et al., 2003) and people with Down syndrome who have a significant risk of developing dementia as they age (Cahill et al., 2012). While this section has established the current understanding of dementia subtypes and symptoms it should be noted that the understanding of dementia and dementia care exists within a changing historical and social context. This context will be explored in the following section.

1.4 Dementia Historical Context

This section will discuss the changing historical understanding of what is meant by dementia and the subsequent change in approaches to care of people with dementia. The term dementia arises from the Latin term '*demens*', without mind. This term became broadly used to describe medical conditions in the 18th century, specifically associated with unresolved hypertension though its precise usage and treatment has varied over time (Roman, 2003). In the 20th century the term '*senile dementia*' became popular describing a neuropathic disorder which was associated with old age. Alzheimer's disease, the most commonly known

form of dementia, was identified at this time. Identification of Alzheimer's disease stems from the work of Alois Alzheimer, who noted neurofibrils and plaques in the brain of a 51-year old woman who presented with memory difficulties, language deficits and changes in behaviour. This was identified as an example of early onset senile dementia (Sachdev, 2000). In recent years the term senile dementia has given way to the term dementia when describing the range of dementia subtypes, including Alzheimer's disease. While this development of terms does in part track a development of general understanding of dementia, it does remain questionable whether use of the term dementia aids understanding of the condition or alters the quality of care people with dementia receive (Sachdev, 2000).

Innes (2002, 2009) argues that the terms dementia and Alzheimer's disease have negative, socially embedded and stigmatising meanings for most people. The very use of the term dementia has stigmatising societal connotations that can remove the person so labelled from the process of making decisions about their care. Innes (2002, 2009) views this stigmatising use of, and understanding of the term dementia to be a component of a pervasive interplay of economic, social and political factors. These factors serve to support a medically focused view of dementia care and undermine efforts to improve the quality of care for and well-being of people with dementia.

From a nursing care perspective, Adams (2003) and Keady et al. (2009) note that until recently the understanding of dementia and attitude to people with dementia amongst the healthcare workforce has been poor. Keady et al. (2009) use the term '*Cinderella*' to describe service provision for people with dementia and discuss the ongoing lack of appropriate training and resources for staff caring for people with dementia. Adams (2003) described the prevailing regime of nursing care for people with dementia as marginalising and ineffective; therefore, reducing the care of residents with dementia to a regime of feeding and dressing.

1.4.1 Models of Dementia Care

Given the focus of this research on psychosocial interventions it is important to explore the models that underpin dementia care provision. There have been a number of attempts to describe and define the model by which dementia care, particularly long-stay nursing care, is provided, these include the bio-medical, psychosocial and bio-psychosocial models (Sabat, 2008).

The bio-medical approach is viewed as the dominant model that underpins approaches to dementia care globally (Sabat, 2008). Although the bio-medical understanding of dementia offers the potential for medical interventions that may reduce the incidence of dementia and may in time provide a cure for dementia, adopting this focus alone is considered problematic (Innes, 2009; Keady et al., 2009; Kitwood, 1993b). The bio-medical model is based on the belief that dementia has a biological cause and as such dementia treatment and management of symptoms must be biologically based. Use of this model alone to understand dementia and direct approaches to care has contributed to some of the current failings noted in residential dementia care (Sabat, 2008). Nolan (2002) suggests that the lack of a cure for dementia combined with the assumption that people with dementia lack the capacity to benefit from psychosocial interventions has resulted in bio-medically focused care that does not do enough to address the psychosocial needs of people with dementia.

The psychosocial model views dementia to be a product of neurological impairment plus the individual's psychology and psychosocial context. Keady et al. (2009) argue that this approach acknowledges that dementia and importantly the person with dementia are more than just a collection of signs and symptoms. Kitwood (1997) is perhaps the best known advocate of this approach taking an overtly political stance concerning the positioning of people with dementia by those they socially interact with. The psychosocial model holds that maintenance of personhood and focus on the lived experience of the person with dementia are central to

understanding how people with dementia are socially positioned (Keady et al., 2009). The psychosocial approach holds that many of the problems experienced by people with dementia arise from the nature of interaction with those caring for them rather than the illness itself (Kitwood, 1997).

The bio-psycho-social model takes the view that the person with dementia must be seen holistically, rather than reduced to purely biological, psychological or social components. Sabat (2008) argues that to maintain well-being for people with dementia those providing care must remain flexible. By addressing the person with dementia's physical needs, their psychological reaction to the cognitive impact of dementia, the social environment they live in and their reaction to their social environment; a holistic, a bio-psycho-social response can be achieved (Sabat et al., 2004).

In a further effort to better conceptualise the understanding of dementia, Keady et al. (2012) developed a bio-psycho-social-physical model of dementia. This model accepts that the psychological and social elements of personhood must be addressed while reflecting the physical reality of living with dementia. Keady et al. (2012) suggest that in reality physical well-being, physical health and examination, physical care, physical treatment and physical environment must be attended to if person-centred care is to be achieved.

1.4.2 Basis for Quality of Care

These alternative models for understanding dementia and dementia care indicate how the underlying understanding of dementia can impact on quality of care. The work of Bond (1992), Kitwood (1997) and Nolan et al. (2004) represent attempts to re-conceptualise what is meant by the term dementia. These aimed to communicate alternative models of care to staff working with people with dementia, in an effort to alter their approach to care and improve quality of care. This ongoing work has expanded the understanding of dementia beyond the purely bio-medical understanding.

Kitwood (1997) argues that poor quality of life is not an inevitable result of the onset of dementia. As noted, the influential work of Kitwood (1997) takes a social view of how dementia becomes a problem and of how well-being is lost. This view indicates that quality of care for people with dementia is in part a result of the lowly political prioritisation of dementia; the subsequent lack of preparedness, and the low status of dementia care workers (Kitwood, 1997). In considering the contribution of health care workers Innes (2002) identifies the social positioning of dementia care. Pointing out that as with health care in general, dementia care is gendered, that is traditionally understood to be role to be undertaken by women. Innes (2009) adds that where healthcare is not cure focused, it is deemed non-skilled and to be a role more suited to women the status of the endeavour is diminished. As a result of these social factors dementia care is poorly rewarded and investment in workforce training limited. This discussion of the understanding of dementia and basis for dementia care leads on to a discussion of where care for people with dementia takes place.

1.6 Dementia Care Settings

It has already been noted that globally the bulk of dementia care is provided informally, by families at home (Prince and Jackson, 2009). In spite of the vast majority of people with dementia living in the community there is an internationally recognised lack of community provision, training and support for people with dementia and their carers (Innes, 2002; Prince & Jackson, 2009; Prince et al., 2013a). The lack of community care provision along with social changes and increasing prevalence is resulting in higher numbers of people with dementia in high and low income countries, seeking long-stay care from privately or publicly funded agencies (ADI, 2009). Prince et al. (2013a) estimate that in high income countries 30-50% of people with dementia are cared for in long-stay care, with 75% of people with dementia requiring long-stay care at some point. By contrast, in lower income countries only 6% of people are currently in long-stay care, though demand for long-stay care is rising (Gibson et al., 2010; Prince et al., 2013a). It is clear that the demand for long-stay care is increasing globally (Prince et al., 2013a). This change towards people seeking long-stay care adds to the pressure to reconsider the way in which care for people with dementia is provided.

1.6.1 Long-Stay Care

Review of the literature shows that long-stay care settings are referred to in a range of different ways across the globe (Cahill et al., 2012; Prince et al., 2013a). The terms used include long-term care, residential care, nursing home, care home, aged care facility, skilled nursing facility, long-stay care or assisted living facility. The different models of long-stay care available internationally show efforts to offer residents with dementia varying levels of support and autonomy as an alternative to living independently at home. These include dementia specific units, housing with care, nursing homes, sheltered housing and hostels (Fossey, 2008).

In spite of the variation in long-stay care provision there is a developing international consensus on the need to re-shape service providers' understanding of what dementia is, and how best to support people with dementia to live well in long-stay care (Gibson et al., 2010; Prince et al., 2013a; Snowden, 2010). This consensus indicates that long-stay care requires urgent funding, increased staff resources and improved staff training, if the required changes in the nature of dementia care delivery are to be achieved (Gibson et al., 2010). There is also consensus on the need for society wide changes in attitude to dementia and the identification of dementia as an urgent healthcare priority (Gibson et al., 2010; Snowden, 2010; WHO, 2012).

There is a developing international consensus that care should be provided in small scale, dementia specific settings in an effort to have people live well in long-stay care (Cahill et al., 2012; Verbeek et al., 2008). These dementia specific units should have appropriately designed indoor and outdoor spaces and be staffed by a well-motivated and trained workforce (Moïse et al., 2004; RCN, 2012). Calls for dementia specific units are a direct response to the traditional approach to long-stay care; large scale settings that 'warehouse' residents with dementia attending to physical care while neglecting their social and psychological needs (Adams, 2003, 2008; Gibson et al., 2010). Davies (2003) presents a vivid picture of

routine long-stay care in '*a controlled community*' arguing that all people have a '*bio-psycho-social*' nature and long-stay care settings that do not address this reality are no longer seen as sustainable or acceptable. In a review considering optimal sizes for specialist-dementia care settings, Verbeek et al. (2008) identify international average sizes ranging from 5 to 15 beds per dementia-specific unit. Verbeek et al. (2008) conclude that higher numbers are likely to impact negatively on care quality noting that higher numbers often occur in response to factors such as reduced staffing levels and insufficient funding.

While the evidence is that smaller specialist-dementia care settings are best, the reality is that most people with dementia who require long-stay care will be cared for within existing non-specialist settings. Unfortunately estimating the percentage of people with dementia in long-stay care is difficult due to international variation in rates of diagnosis and methodology. Fossey (2008) notes the percentage of people with dementia in long-stay care is increasing in the UK, ranging from 50-70%. In a French study of over 75 year olds, Helmer et al. (2006) found that 71.6% of long-stay care residents had dementia. In Ireland it is estimated that of the 41,470 people with dementia, 14,266 (34%) are thought to be in long-stay care settings. If the ratio of people with dementia in long-stay care does not rise in the coming years, which seems unlikely given the increasing longevity of the population, there will be around 47,797 residents with dementia in Irish long-stay settings by 2041 (Cahill et al., 2012). The following section will now consider Irish long-stay dementia care provision in detail, outlining the prevailing model of long-stay care provision, funding arrangements, the changing private-public context and application of psychosocial interventions.

1.7 Long-Stay Dementia Care Settings in Ireland

Long-stay care in Ireland consists of public, private and voluntary provision with around 75% of long-stay care provision in the private sector (Cahill et al., 2012). The majority of Irish long-stay care settings

accept residents who do not have dementia as well as those who do. The ratio of private to public long-stay care places is rapidly changing in Ireland as more public settings close. Over the last 10 years the ratios have changed from 60/40 private/public to 75/25. Cahill et al. (2012) estimates that in 2010 there were 598 long-stay care settings in Ireland, with 75% of these provided by the private sector. Cahill et al. (2012) also note that while Ireland has some dementia-specific bed capacity, in 2010 only 21 of the 151 public and voluntary settings had dementia-specific beds and 21% of private long-stay care settings indicated that they had dementia-specific units. It should be noted that the average size of Irish dementia-specific units is 19 beds in private settings and 18 in public settings, both of which exceed the size identified as optimum for dementia specific units (Verbeek et al., 2008).

In Ireland the most common long-stay care model is the non-dementia specific '*nursing home*' (Cahill et al., 2012). The Agency for Health Care Quality (2011) provides a definition of Irish long-stay care settings '*nursing homes*' was used to define the study sites used in this research: '*Nursing homes are institutional facilities licensed by the state that offer 24-hour room and board, supervision and nursing care.*' (Page 4)

Given the Irish context where generic nursing homes are the most prevalent providers of long-stay care and the current economic situation, change towards specialist dementia long-stay care settings is likely to be slow. What is clear from Irish research is that the current long-stay care context is lacking in both capacity and in quality and will not be able to address the current growing need without significant additional resources and staff education (Cahill & Diaz Ponce, 2011; Connolly et al., 2014). Research in Ireland indicates that residents with dementia enjoy improved quality of life when cared for in small-scale dementia specific units (Murphy et al., 2006). Cahill et al, (2012) note that these types of unit are still in the minority and the policy intention is to increase the number of these types of units developing dementia specific 'homelike' settings.

The next section will describe the arrangements that are currently in place to fund long-stay dementia care in Ireland. In 2009 the Irish Government implemented the Nursing Home Support Scheme (NHSS) (DoH, 2009a). Under the NHSS scheme, long-stay care residents contribute 80 per cent of income, including pension and 5 percent of assets per annum to pay for care, with the state paying the balance. This scheme was implemented as a means of providing public funding to all people who require long-stay care, including those with dementia. Since its introduction, the ratio of provision for people with dementia has altered with 75% of places being provided by private facilities (Cahill et al., 2012). Within the Irish context, concerns have been raised regarding the availability of long-stay care places and the impact of the NHSS on the transition from community to long-stay care. A report by the Office of the Ombudsman (2010) considered a number of complaints and concerns. It noted the system is currently not demand led and that financial concerns rather than the needs of the person with dementia become the deciding factor when planning care. This financial arrangement has resulted in concerns over reduced uptake of long-stay care and the resultant reduction in overall dementia care funding. The concern is that people with dementia who are already poorly supported in the community are delaying transition to long-stay care due to financial concerns (Office of the Ombudsman, 2010). This situation has the potential to precipitate acute crisis admissions and poorly planned transition to long-stay care, adding to the uncertainty and distress for people with dementia along with their carers (Cahill et al., 2012).

Murphy et al. (2007) compare staffing levels and quality of life in public and private settings. This research reveals staffing differences in terms of ratio of trained staff to residents as well as ratio of trained staff to health care assistants. Murphy et al. (2007) identify that private long-stay care settings have a morning shift staff to resident ratio of 1:19.5 (1:21.8 for facilities with more than 40 residents) and a nurse to health care assistant ratio of 1:2.0 (1:2.7 for facilities with more than 40 residents). Public long-

stay care settings have a morning shift staff to resident ratio of 1:6.9 (1:8.9 for facilities with more than 40 residents) and a nurse to health care assistant ratio of 1:0.7 (1:0.7 for facilities with more than 40 residents). Murphy et al. (2007) do not look at the link between staffing levels, ratios and quality of care directly, but note significant difference in resident choice over fundamental issues such as time of rising and going to bed. They identify that private facilities, with less staff offer more choices to residents about the time of rising or going to bed, also that there are variations in the amount of choice given to residents even where staffing levels are similar (Murphy et al., 2007). This suggests that while staffing levels can contribute to quality of care, the ethos of care in any given setting is likely to influence how care is provided and the experience of residents with dementia.

In Ireland, there are ongoing regulatory efforts to address the need to change the ethos of care away from one that favours routine. In spite of guidance from the Health Information and Quality Authority (HIQA) (HIQA, 2009), stating that care should be person-centred and that psychosocial interventions should be used in support of person-centred care, the psychological and social needs of residents with dementia in Irish long-stay care settings often remain unmet (Cahill et al., 2012; Cahill & Diaz-Ponce, 2011; Murphy et al., 2007; O' Shea, 2007). The next section will consider how dementia care policy is changing from an international, European and Irish perspective.

1.8 Changing International Dementia Policy

The increase in the number of people with dementia along with changes in the understanding of dementia and how to help people to live well with dementia, are fuelling an international effort to develop policy. WHO (2012) has helped direct this policy movement, stating that dementia presents a global health priority. Cahill et al. (2012) note an international effort to direct change, listing a range of countries who are producing evidence based dementia strategies including Scotland, Wales, Northern

Ireland, Norway, Malta, Australia, Canada, England, the Netherlands, the USA and France.

Alzheimer's Europe (2007) used the term '*demographic time bomb*' to emphasise the need for rapid prioritisation of dementia services and the need to sufficiently resource dementia services across Europe. The development of a European Initiative on Dementia (European Commission, 2009) has gone some way to highlight the great importance of acknowledging and addressing dementia at a European level and at the level of member states, via national dementia strategies and action plans. In spite of this organisations such as Alzheimer's Europe, still indicate a lack of policy and action across Europe (Alzheimer Europe, 2012).

1.9 Changing Irish Dementia Policy

This section will consider the current Irish policy context along with the likely direction of change for Irish long-stay dementia care.

The 2011, Irish census placed the total Irish population at 4,658,825 (Central Statistics Office, 2012). The population of people over the age of 65 in Ireland is 11%. This number will double from 0.5 million to 1 million by 2031 (Cahill et al., 2012). These changes in population necessitate a change in Irish policy and the way dementia care is provided.

Cahill (2010) notes that Ireland is seeking to address the growing challenge of dementia care from a somewhat disadvantaged starting point, when compared to the UK and Scandinavian nations. Ireland has a history of failing to sufficiently fund community and residential dementia services, with a resultant heavy burden being placed upon the families of people with dementia (O'Shea, 2007). Cahill (2010) suggests that Ireland has been slow to respond to the increasing numbers of people with dementia and that there is an urgent need to produce policy and political will for the development of new service provision. In preparation for Irish National Dementia Strategy, Cahill et al. (2012) undertook a review of international

best practice in dementia care; the resultant report, 'Creating Excellence in Dementia Care. A Research Review for Ireland's National Dementia Strategy', offers a range of recommendations. These recommendations include the need to improve dementia prevention measures, raising public awareness of dementia, improving rates of diagnosis, greater emphasis on staff training in community and long-stay care settings, developing staff capacity for psychosocial intervention provision, and moving long-stay care provision away from the generic nursing home model towards small-scale dementia-specific units.

It is clear from the work of Cahill et al. (2012) that the policy direction for dementia care in Ireland is likely to remain focused on prevention, early diagnosis and supporting people with dementia to live well at home, whilst attempting to improve long-stay care quality. Cahill et al. (2012) argue that the promised Irish National Dementia Strategy needs to address the current unsustainable context of insufficient funding, intolerable burden on family carers and the need to develop integrated dementia care services.

O'Shea and O'Reilly (1999) and O'Shea (2007) have identified that since the 1980s Irish dementia care policy has focused on keeping people at home as long as possible. Unfortunately the failure to adequately resource community services has resulted in diminished well-being for people with dementia living at home and has added to the financial and psychological burden for families and carers. O'Shea and Reilly (1999) advocate a case management approach, which involves multi-disciplinary community teams addressing individual needs to support living well at home; noting the societal, economic and quality of life benefits that could arise from this approach.

The levels of staff training and service infrastructure that are required to support people with dementia to live at home are not currently in place in Ireland (O'Shea, 2007). In considering the educational preparation of the

dementia care workforce in Ireland, De Siún and Manning (2010) found continued low levels of dementia education and expertise. In more recent analysis, Connolly et al. (2014) describe current Irish community dementia care provision as fragmented, poorly co-ordinated, inflexible and nationally variable. Connolly et al. (2014) also identify the significant economic and social impact of the failure of Irish community dementia care provision, arguing that people with dementia who would be better served remaining at home with support are currently forced to seek long-stay care.

The need to address quality of care immediately has prompted Irish policy discussion that mirrors international calls to introduce the use of psychosocial interventions within existing long-stay care settings. These call for existing long-stay care settings to be more person-centred with more emphasis on individual needs (Cahill et al., 2012; DoH, 2009; O'Shea, 2007; O'Shea & O'Reilly, 1999). In addition, there are a number of studies that recommend staff training to meet the needs of residents with dementia regardless of the long-stay care model in place (Cahill & Diaz-Ponce, 2011; Hancock et al., 2006; Vernooij-Dassen et al., 2010; Ward & River, 2011). While such approaches can be applied within the current configuration of long-stay care, there is recognition of the need to not only educate staff, but to ensure the provision of sufficient resources and ongoing staff support to encourage psychosocial intervention use (Brooker, 2007; Keady et al., 2004; O'Shea, 2007).

1.10 Strategies for Dementia Care

Having considered the changing context of Irish dementia care and policy this next section will explore strategies for caring for residents with dementia in long-stay dementia care. The manner in which this care is currently provided and strategies to improve quality of care will also be discussed.

For any individual the uncertainty and upheaval associated with moving out of their own home into long-stay care is considerable (Fossey, 2008). There are a range of reasons why people with dementia are admitted to long-stay care. Fossey and James (2008) note that deterioration in the physical or mental health of the person with dementia along with change in social circumstances and carer burden can contribute to the decision to move into long-stay care.

It should then, be no surprise that the literature indicates such moves are particularly challenging for people with dementia. Brodaty et al. (2003) note the high incidence of behaviours that challenge, associated with dementia, exhibited by residents with dementia following the transition to living in a long-stay care setting. Behaviours that challenge such as aggression, shouting, wandering, agitation, insomnia and sexual disinhibition are often associated with the transition to long-stay care settings, presenting great difficulties for residents with dementia, staff and relatives (NICE-SCIE, 2006). Cohen-Mansfield (2008) argues that these behaviours that challenge often occur because of the existence of unmet need in the resident with dementia. Whether these behaviours that challenge arise on transition to long-stay care or in response to ongoing unmet need; this view holds that the needs of residents with dementia remain unmet when staff are not supported or educationally prepared to meet the physical, social and psychological needs of the person with dementia in a person-centred manner (Cohen-Mansfield, 2008).

Gibson et al. (2010) attempt to articulate what constitutes '*good care*' for residents with dementia identifying the challenge of balancing the resident with dementia's needs against the needs and abilities of staff. Innes (2002) makes a similar case asserting that personhood (Kitwood & Bredin, 1992a) and the ability to keep the individual involved with, and at the centre of care must lie at the core of providing good quality care. The tendency for staff to provide care that arises from a predominantly bio-medical understanding of care results in the personhood of residents with

dementia not being attended to and undermines the quality of care (Cahill & Diaz-Ponce, 2011; Kitwood, 1997; Murphy et al., 2007). The following section will now consider pharmacological and psychosocial intervention strategies for the care of the resident with dementia.

1.10.1 Pharmacological Interventions

Pharmacological interventions for the psychological needs of residents with dementia are common (Banjeree, 2009; NICE-SCIE, 2006). Given that there is currently no cure for dementia, the pharmacological strategies to meet the needs of residents with dementia can be divided into two broad areas: strategies that seek to reduce the rate of cognitive decline; and strategies that seek to address behaviours that challenge.

There are a number of pharmacological approaches designed to reduce the rate of cognitive decline experienced by people with dementia.

Acetylcholinesterase (AChE) inhibitors are now routinely used following a diagnosis of Alzheimer's disease. Howland (2010) reports growing evidence for the efficacy of the AChE inhibitors donepezil, galantamine and rivastigmine in the reduction of the rate of cognitive impairment.. AChE inhibitors do stimulate gastrointestinal motility so their use is limited by the common side effects of diarrhoea, nausea and anorexia (Stuart, 2013).

In addition to pharmacological interventions designed to slow the rate of cognitive decline there are a range of drugs used in response to behaviours that challenge. While behaviours that challenge are known to cause great distress for both the person with dementia and those caring for them (NICE, 2011), the use of pharmacological approaches, specifically anti-psychotic medication is also known to be potentially harmful when prescribing is indiscriminate (Alzheimer's Disease International, 2012; NICE-SCIE, 2006).

A review of anti-psychotic prescribing in the UK estimated that 140,000 of the 180,000 anti-psychotic prescriptions for people with dementia were inappropriate (Banjeree, 2009). Banjeree (2009) suggests that regardless

of clear guidance against using pharmacological treatments in response to behaviours that challenge, including anti-depressants, benzodiazepines and anti-psychotics, they are the default response of care staff when faced with behaviours that challenge. In an American study Chen et al. (2010) report that 29% of residents with dementia were on at least one antipsychotic. Vigen et al. (2011) identify that the use of antipsychotic medication resulted in impaired cognitive function for people with dementia. A report from the All Party Parliamentary Group on Dementia (2008) on pharmacological responses to behaviours that challenge advise that service providers must address unmet need before resorting to pharmacological treatments. It also identifies the need to improve staff training, improve understanding of dementia and enhance staff ability to provide person-centred care.

Stuart (2013) reiterates the need for great caution when using pharmacological treatments with people with dementia due to the risk of unintended consequences to people with existing cognitive impairment. Cohen-Mansfield (2008) offers the view that pharmacological approaches are routinely utilised by staff because these approaches are '*reimbursed*' meaning that there is a clear system in place for their utilisation, delivery is relatively simple and appears to be cost effective in terms of time as well as actual cost. The use of psychosocial interventions are not similarly '*reimbursed*' as most long-stay care settings lack the systems for their implementation and staff lack the appropriate knowledge, skills and support. The next section will consider the use of psychosocial interventions with residents with dementia and the evidence that these approaches are not being utilised in Irish long-stay care settings.

1.10.2 Psychosocial Interventions

The term psychosocial intervention refers to a range of interventions. These include formally trained and delivered approaches such as behavioural therapy, patient educational approaches, psychotherapy and structured group interventions (Stuart, 2013). The term psychosocial

intervention also applies to skilled individualised communication and socialisation approaches designed to therapeutically engage, orientate, involve and stimulate the resident with dementia (Adams, 2008b). Bates et al. (2004) provide a broad but applicable definition and understanding of what constitutes a psychosocial intervention:

“a psychosocial intervention is defined as a therapeutic endeavour involving human interactive behaviour” (p.e2)

Vernooij-Dassen et al. (2010) add to this definition arguing that psychosocial interventions should be used as part of ‘every day’ care between staff and residents with dementia. These conceptualisations offer the understanding that psychosocial interventions are central to all aspects of person-centred dementia care, and should include individualised communication that is part of overall care. In the research described in this thesis, psychosocial interventions are defined as: *everyday therapeutic endeavours involving purposeful human interactive behaviour between staff and residents with dementia.*

It should be noted that while this research aims to understand psychosocial intervention provision for residents with dementia in long-stay care settings, overall quality of care for residents with dementia cannot be achieved without attending to peoples’ physical and social well-being at the same time (Adams, 2008b; Gerritson et al., 2004; Rewson & Moniz-Cook, 2008). Fossey (2008) indicates that staff must be aware of a range of complex physical, social and psychological needs that can arise in long-stay care in addition to the range of factors that result in admission. As noted, reasons for admission can include physical care needs, carer stress, other mental health problems, lack of suitable accommodation in the community, bereavement, lack of family support and loneliness. The challenge faced by staff in long-stay care settings is to attend to all of these needs in a manner that meets the resident’s physical, social and psychological needs (Gerritson et al., 2004). The Office of Fair Trading (2005) identify complex overlapping sets of needs amongst the long-stay

care population. The result being most residents in such settings deemed to have high dependency levels regarding their physical health and/or cognitive abilities which require 24 hour nursing care (DoH, 2011).

O’Conner et al (2009) describe three broad theoretical models that can be used to understand the behavioural changes that occur in people with dementia. Learning theory holds that behaviours have an antecedent, behaviour and consequence. Therefore psychosocial approaches that follow this understanding aim to reinforce appropriate behaviours and discourage behaviours that challenge. The unmet need model (Cohen-Mansfield, 2003) takes the view that behaviours that challenge arise from people with dementia having needs that are not being recognised and addressed. The stress model holds that a person with dementia has diminished ability to cope with stresses resulting in behaviours that challenge (O’Conner et al., 2009).

In practice most psychosocial interventions use elements of all of these models. They can be delivered by a range of different people including professionals who are trained in psychosocial interventions and only come into contact with residents with dementia to deliver those interventions, as well as professional care staff or informal/family carers that have received specific training in psychosocial interventions.

1.10.3 Psychosocial Interventions Research

Innes (2009) and O’Conner et al. (2009) note that most research studies into psychosocial interventions are small observational studies, with little blinding, short intervention periods producing short-lived or limited outcomes. Other methodological problems include lack of clarity regarding severity of dementia, poorly described interventions and unclear inclusion criteria (Opie et al., 1999; O’Conner et al., 2009).

A broad range of outcomes have been used to evaluate the effectiveness of psychosocial interventions. These include measures of cognitive function

change, change in mood, levels of agitation, incidence of behaviours' that challenge, anxiety, communication levels, social interaction, well-being, quality of life and carer well-being. Innes (2009) identifies that the lack of funding for dementia care research, the complex social nature of dementia and inappropriateness of current research approaches pose considerable challenges when trying to evaluate the effectiveness of psychosocial interventions.

Currently in the UK the only psychosocial intervention recommended by NICE-SCIE (2006) is cognitive stimulation therapy. This is recommended for the cognitive symptoms of dementia and maintenance of function. This recommendation is based on evidence that cognitive stimulation therapy is as effective as pharmacological approaches for maintaining cognition (Chapman et al., 2004; Onder et al., 2005; Spector et al., 2003).

A number of systematic reviews summarise the evidence on psychosocial interventions. Bates et al. (2004) found evidence supporting the use of reality orientation with people with mild dementia, but did caution that the quality of the research was limited. Boote et al. (2006) list a number of psychosocial interventions that have been used with people with dementia. These include multi-sensory stimulation, group exercise, reality orientation, combined walking and talking, and reminiscence therapy. While some evidence for the effectiveness of exercise, walking and talking and reality orientation is identified, Boote et al. (2006) note a lack of evidence supporting the efficacy of these approaches and the need for further research. In a Cochrane review of reminiscence therapy, Woods et al. (2005) identify improvements in cognitive function and in mood 4–6 weeks after treatment. This research also noted reduced stress amongst those delivering reminiscence groups (Woods et al., 2005).

Verkaik et al. (2005) look at studies by outcome measure (depression, aggression and apathy). They found that cognitive therapy can be an effective intervention for depression and that there is evidence that multi-

sensory stimulation therapy (snoezelen) can reduce levels of apathy. Overall though, Verkaik et al. (2005) conclude that psychosocial interventions cannot be recommended due to the lack of high quality studies and limited impact the interventions. Three Cochrane reviews by Bradt and Dileo (2014), Clare et al. (2003), and Neal and Barton Wright's (2003) review the impact of music therapy, cognitive training/cognitive rehabilitation interventions and validation therapy respectively. All three reviews noting that there is insufficient evidence from RCTs to reach any conclusion about the effectiveness of these psychosocial interventions.

In another review, O'Connor et al. (2009) conclude that aromatherapy, bed baths, gentle sounds, individualised music and muscle relaxation training were all effective psychosocial interventions for reducing the incidence of behaviours that challenge. It should be noted that O'Connor et al. (2009) comes to these conclusions after adjusting their quality criteria to better suit the complex nature of psychosocial interventions for residents with dementia. Vernooij-Dassen et al. (2010) come to a similar view suggesting current quality criteria do not reflect the complexity of long-stay care research and that randomised control trials may not be the best means of testing the efficacy of psychosocial interventions in long-stay care settings.

In their review Vernooij-Dassen et al. (2010) highlight the efficacy of educational interventions aimed at improving the quality of interaction between staff and residents, specifically when the psychosocial intervention approaches were incorporated into every day care (Kuske et al., 2007; Levy-Storms, 2008; Vasse et al., 2010). Vernooij-Dassen et al. (2010) argue that there is still insufficient evidence regarding the efficacy and implementation of psychosocial interventions and offer a number of recommendations. Psychosocial interventions should be individualised, staff require a '*toolkit*' of evidence based psychosocial interventions, residents with dementia should be offered activities they like in conjunction with cognitive stimulation, psychosocial interventions should be part of everyday care, staff education should take place in the

residential setting and include psychosocial intervention training and knowledge, skills and attitude training, the resident with dementia's family, context and life history should be known and staff-family contact encouraged.

Boote et al. (2006) also discuss the practical and financial challenges faced when attempting to research psychosocial interventions for residents with dementia within complex social environments. Bartlett and O'Connor (2007) identify similar challenges, including low levels of dementia awareness amongst staff, minimal staff resource, bio-medical focus and lack of psychosocial intervention capacity. They argue for a pragmatic approach to dementia research that considers the agency of the person with dementia in the context of their complex relationship with staff and society. Woods et al. (2007) also take the view that staff should focus upon communication with and forming effective relationships with relatives. Woods et al. (2007) argue that high quality care for the resident with dementia arises from this relationship building approach. Supporting this view, Innes (2009) argues that psychosocial intervention approaches that build relationships and enhance communication between residents with dementia, their relatives and staff can reduce the '*emotional labour*' associated with care work. Research considering demands of '*emotional labour*' on staff indicates that when staff are not empowered through education and managerial support to provide psychosocial interventions that build relationships, they will avoid providing emotional support and care, resorting instead to institutional routine consisting of inflexible physical care (Lopez, 2006).

In response to an identified lack of person-centred care and in an effort to '*reimburse*' (Cohen-Mansfield, 2008) and formalise psychosocial intervention use, Nolan et al. (2004) developed the senses framework as a means of helping staff to address the unmet psychological needs of residents with dementia. This framework offers a means of understanding how building positive relationships can protect the personhood of resident

with dementia and affect care. Application of the senses framework is aimed at ensuring that the interaction with staff results in residents with dementia experiencing security, belonging, continuity, purpose, achievement and significance (Nolan et al., 2004).

The emphasis placed on building positive relationships found in the literature offers some understanding of how psychosocial interventions can best be applied in practice (Gibson et al., 2010; Keady et al., 2009; Murphy et al., 2007; Nolan et al., 2004). Explicitly linking psychosocial intervention application with positive relationship building offers a broad, accessible view of what a psychosocial intervention is, with emphasis on communication and positive social interaction between residents with dementia and staff (Boote et al., 2006; Douglas et al., 2004; Fossey et al., 2006; Woods et al., 2005).

However, it is evident that care for residents with dementia remains largely physically orientated and does not attend to the personhood individuals (Cahill & Diaz-Ponce, 2011; Fossey et al., 2006; Fossey & James, 2008). In the Irish context there is evidence that staff lack the knowledge and skills required to provide psychosocial interventions to residents with dementia (Cahill et al., 2011; Heath, 2010; Murphy et al., 2006). Person-centred approaches to care are associated with identifying and meeting the unmet need of residents with dementia and reducing behaviours that challenge. Moreover, understanding and applying the concept of personhood when working with residents with dementia helps staff to address the deficits present in a predominantly bio-medical approach to care (Kitwood, 1997). Psychosocial intervention approaches to care that are person-centred have a holistic emphasis. This builds upon the capacities of the resident with dementia within the context of their relationship with staff (Kitwood & Bredin, 1992a). These approaches set out to understand and know the person and in doing so meet their psychosocial needs (Bates et al., 2004; Boote et al., 2006; Brooker et al., 2007). The broad definitions of psychosocial interventions provided by

Bates et al. (2004) and Vernooij-Dassen et al. (2010) assume that any such approach to care will include efforts to know and include the resident with dementia and favour their preferences and perspective. This approach is based on a growing understanding of dementia research that accepts that person-centred care requires the application of psychosocial interventions at all points in care delivery, based upon staff awareness of personhood and willingness to use this awareness to underpin care (Brooker et al., 2007; Cohen-Mansfield, 2003; Innes, 2009; Keady et al., 2004; Kitwood, 1997).

Irish research raises specific concerns over current provision, suggesting that caring for residents with a wide range of cognitive impairments adds to the workload and stress of staff; while reducing the quality of life of residents with dementia (Cahill & Diaz-Ponce et al., 2010; Cahill & Diaz-Ponce, 2011; Murphy et al., 2006). The literature indicates the need to address the failings identified in current Irish dementia care provision. O'Shea (2007) makes the general observation that services both inpatient and community based are not rising to the challenge. While there are moves to establish smaller dementia specific units within Ireland and to educate the care workforce in the use of psychosocial interventions; reconfiguring Irish long-stay care towards smaller dementia specific units is still a distant goal.

Calls for change in the way care is delivered indicate the need for person-centred care to include psychosocial interventions as the skilled basis for all interaction between staff and residents with dementia (Keady et al., 2009; Kitwood, 1997). This approach is a means of consolidating holistic person-centred care, not just responding to behaviours that challenge.

At present there is limited understanding of how psychosocial interventions can be successfully adopted in residential care settings and the emphasis of care changed (Moniz-Cook et al., 2003; Turner, 2005). For all of the policy emphasis upon change not enough is known about the

mechanisms by which change is brought about in healthcare organisations. Davies and Nutley (2000) argue that change in the means of care delivery can be achieved through positive interaction between the organisation, its goals and individuals. Promoting *'learning organisations'* as a means of bringing about change:

"Within any busy organisation there is a tension between "doing" and "learning about doing." Providing incentives as well as resources to develop learning about doing may help ease this tension." (p.1001)

Given the uniquely difficult working conditions faced by staff working with people with dementia (Edberg et al., 2008), the *'tension between doing and learning about doing'* faced by workers in long-stay care settings can be viewed as being particularly acute. The pressure to maintain the physically dominated requirements of the institution can in part be held responsible for the failure of such settings to adopt psychosocial intervention usage and develop person-centred care. Downs (2000) adds to the understanding of why implementation of person-centred care and psychosocial interventions has been so slow in the field of dementia care suggesting that there needs to be improved understanding of dementia across society in support of change. This suggests that identification of the importance of personhood is not in itself enough to challenge the dominant bio-medical model of care. Ward and River (2011) takes up this idea suggesting that there must be better understanding of how stakeholders; residents with dementia, staff, researchers, educators and policy-makers interact. Such an understanding will help support efforts to bring about positive change in the way residents with dementia are cared for.

1.11 Utilisation of Psychosocial Interventions

Internationally there is a gap between the service provision which policy makers advocate and that which occurs in practice, specifically in terms of providing psychosocial interventions as part of person-centred care. The Care Quality Commission (2010) sums up the current situation:

“Dementia is often unrecognised in care homes and needs are left unmet or not addressed in a person-centred way that takes account of social and emotional needs.” (p.22)

There are numerous examples of research that indicates that rather than meeting the needs of residents with dementia, staff base their care provision and ways of working on their perception of the needs of the institution, assuming a default position that physical care takes priority over other needs (Bird et al., 2007; Edberg et al., 2008, Ward et al., 2008).

In attempting to understand the context of care delivery and the influences upon the way care is provided the work of Lipsky (1980), whose study of workers in the public service Street Level Bureaucracy, gives insight into the theoretical complexity of the workplace. This work considers the challenge of implementing policy in practice and the factors that influence workers to produce their own idealised conception of their role. Lipsky (1980) suggests that ‘*Street level*’ staff, which can be substituted here as staff caring for residents with dementia, will interpret policy direction in a manner that responds to their own prevailing conditions, be those personal or institutional:

“Huge caseloads and inadequate resources combine with the uncertainties of method and the unpredictability of clients to defeat their aspirations as service providers” (Lipsky, 1980, p.xii).

The service provision model described and explained by Lipsky (1980) is reminiscent of the context within which psychosocial interventions are delivered to residents with dementia. In long-stay care, it seems clear that the nature of care is defined within the setting regardless of policy aspiration. In Ireland the majority of nursing staff in long-stay care settings are general trained and do not have dementia specific education (Heath, 2010; Murphy et al., 2007). The care provided in these long-stay care settings is physically focused, arising from a bio-medical approach to

care. Institutional routines emphasise the physical care needs of residents with dementia to the detriment of their social and psychological needs.

The current international and Irish context of psychosocial intervention utilisation for residents with dementia in long-stay care raises a number of issues. Globally there is an effort to address the evident failings in dementia care quality as countries produce national dementia strategies to direct future healthcare policies for dementia and impact on care provision (Cahill et al., 2012). WHO (2012) suggest that if care providers are to improve the quality of life for people with dementia there is a pressing need to raise the individual, organisational and societal understanding of dementia. These efforts to influence international dementia policy reflect the concerns arising from research which suggests that, limited staff knowledge of dementia and lack of training in approaches to dementia care continue to limit the quality of life of residents with dementia, in long-stay care (Moniz-Cook et al., 2008; Murphy et al., 2007; Vasse et al., 2010).

There is clear evidence that the growing number of people living with dementia will result in increased numbers of people requiring long-stay care (Cahill et al., 2012). There is also evidence that the current bio-medical focus of care is not meeting the needs of residents with dementia (Health & AIGNA, 2010; Murphy et al., 2007; Ward et al., 2008). With specific reference to residential care, O'Shea (2007) focuses on skills development when discussing the nature of change required and the complex nature of care delivery for residents with dementia:

“Quality of life for people with dementia is a complex issue, but it is influenced by many things other than conventional nursing and medical care. Some progress has already been made in this area and the view that ‘there is nothing that can be done’ is rightly now seen as unsupportable. There is, however, scope for improving the communication skills of people caring for dementia patients at all levels” (p.22).

1.8 Summary

This chapter described a range of areas relevant to psychosocial intervention utilisation for residents with dementia in long-stay care. The prevalence of dementia, impact on societies around the world, impact of dementia subtypes on individuals, changing historical context, the changing international policy context, impact on Irish dementia care and policy have been discussed along with strategies for dementia care including psychosocial interventions. This final section has presented the evidence that psychosocial interventions are not being utilised for residents with dementia in long-stay care. Doing so has illustrated the need for research that develops an understanding of psychosocial interventions for residents with dementia in long-stay care.

1.9 Rationale for Research

There is a consensus that the skilled use of psychosocial interventions can improve the quality of life for residents with dementia, what is not known is the mechanism by which individual and organisational factors influence access to psychosocial interventions training and skilled implementation in practice. What is also clear is that the non-dementia specific nursing home will continue to be the main model of long-stay care for residents with dementia in Ireland for some time. As such understanding the means by which psychosocial interventions can be adopted by staff and applied to the everyday care of residents with dementia is crucially important.

It is evident from the literature that we do not fully understand what factors influence psychosocial intervention delivery in long-stay care settings. As such an exploration of psychosocial intervention utilisation with residents with dementia in long-stay care settings is both timely and necessary. This research will contribute to the evidence base aimed at enhancing the quality of psychosocial interventions provided for residents with dementia.

1.10 Research Aim

This study aims to develop an understanding of psychosocial intervention use with residents with dementia in long-stay care settings.

1.11 Research Objectives

- To explore participants experience and perceptions of the use of psychosocial interventions with residents with dementia.
- To produce an understanding of psychosocial intervention utilisation with residents with dementia that provides transferable theoretical understanding.
- To develop a conceptual understanding of participants motivations for psychosocial intervention delivery.
- To identify those organisational factors that support and sustain participation in psychosocial intervention delivery.

1.12 Organisation of Thesis

This thesis has nine chapters:

1.12.1 Chapter 2 Preliminary Literature Review

This chapter provides context for the thesis, describing the relationship of this research to the Dementia education programme incorporating REminiscence for Staff (DARES) project. This chapter then provides further context to the research with a discussion of the approach to the extant literature taken in a classic grounded theory study. Finally a preliminary literature review is presented providing an exploration of the literature in two areas; the first, considers the development of the theoretical understanding of dementia care; the second, explores the understanding of psychosocial interventions in dementia care.

1.12.2 Chapter 3 Research approaches

This chapter identifies the most appropriate research approach for developing theoretical understanding of staff's psychosocial intervention utilisation with residents with dementia in long-stay care settings. In

doing so, this chapter gives an overview of paradigms, research approaches and the rationale for choice of classic grounded theory.

1.12.3 Chapter 4 Research Methods

This describes the research methods and classic grounded theory procedures used in this research for data collection and analysis. It also describes how the quality of classic grounded theory is gauged. Finally the sites and participants accessed will be described and ethical approval discussed.

1.12.4 Chapters 5-7 Data Collection, Analysis and Theoretical Development

These three chapters present three phases of theoretical sampling, constant comparison, theoretical modelling and subsequent theoretical sampling. Constant comparison of 67 interviews with residents with dementia, staff and relatives, across the three phases of data collection is presented. The theory of becoming a person again is presented along with its component categories and properties.

1.12.5 Chapter 8 Comparison with the Extant Literature

This chapter presents the literature sampling strategy and comparison of the conceptual stages of the theory of becoming a person again with the extant theoretical, policy, research, education and practice literature. It shows that the theory of becoming a person again displays similarity and applicability to the sampled literature along with identifying areas for refinement of the existing conceptual model.

1.12.6 Chapter 9 Conclusion

This concluding chapter commences with a discussion of research quality. This is followed by concluding comments on the main findings of this research comprising research limitations, practice implications, recommendations for practice and contribution to knowledge.

1.12.7 References and Appendices

Chapter 2: Research Context and Preliminary Literature Review

2.1 Introduction

This chapter provides context for the thesis, initially the relationship of this research to the Dementia education programme incorporating Reminiscence for Staff (DARES) project (Trial registration ISRCTN99651465) is described and how this classic grounded theory study differs from and contributed to the DARES project is explained. This chapter then provides further context to the research with a discussion of the approach to the extant literature taken in this classic grounded theory study. Finally a preliminary literature review is presented providing an exploration of the literature in two areas; the first, considers the development of the theoretical understanding of dementia care; the second, explores the understanding of psychosocial interventions in dementia care.

2.2 The DARES Project

The classic grounded theory study presented in this thesis contributed to the qualitative arm of the DARES project, supporting the development of the structured education programme and exploring the use of reminiscence with residents with dementia. The DARES project sought to evaluate the effectiveness of a reminiscence programme, DARES for people with dementia residing in long-stay care settings in Ireland (O'Shea et al., 2014).

Three hundred and seventy nine residents with dementia from 18 participating long-stay units were initially screened for participation. From these 304 residents with dementia were randomised, with 153 participants in the intervention group and 151 in the control group. Nine long-stay units were allocated randomly to the intervention group and nine to the control group. DARES involved the development of a structured education programme and delivery of this structured DARES programme to staff participants in 9 long-stay units, each of which had a minimum of

17 residents with dementia. The staff participants subsequently integrated reminiscence into the care delivered to resident participants, both formally and informally over an 18 week period.

The educational component of DARES involved staff participants (nurses and healthcare assistants) receiving a structured education reminiscence-based programme and undertaking reminiscence with an allocated group of residents with dementia. The three day educational programme was delivered by nurse educators. The first two days informed staff about the study, provided dementia education, information on memory, guidance on approaches to communication with people with dementia and reminiscence training. The third training day was held six weeks later. It allowed staff to discuss their experience of implementing the structured education programme and raise any issues they had. Overall the aim was to enable staff participants to include reminiscence strategies when developing care plans for residents with dementia (Cooney et al., 2013).

Once the DARES training was completed each participating nurse and a health care assistant dyad, were allocated three or four residents with dementia. The dyads were then required to complete a life history for each resident to facilitate reminiscence (Cooney et al., 2013). The dyad then undertook reminiscence with each resident with dementia including at least one planned formal session and three spontaneous sessions each week. These sessions were planned and recorded in the resident with dementia's nursing notes.

For a long-stay care site to be eligible to participate in the classic grounded theory study they had to have consented to participate in the DARES study. Sampling for the classic grounded theory study was therefore undertaken within these sites and theoretical sampling dictated which of these sites were selected and which were not.

The researcher had a dual role within DARES, as a research assistant collecting data for the DARES trial, and contributing to the qualitative component of DARES. The qualitative component of DARES, including the researcher's classic grounded theory study, had two main contributions to the trial.

The first was to support development of the DARES programme by collecting and analysing qualitative data, to develop an understanding of psychosocial intervention use for residents with dementia in long-stay settings. This first contribution is detailed in Phase 1 of the classic grounded theory study presented in this thesis, described in Chapter 5. This details the collection and analysis of interviews with 3 residents with dementia and 8 staff, along with observational data collected in 4 long-stay residential settings. This data was subject to constant comparative analysis (see Chapters 3-5) and the findings informed both the classic grounded theory study and the development of the structured education programme used in the DARES trial.

Phase 2 of the classic grounded theory study (see Chapter 6) further developed the understanding of psychosocial intervention use in long-stay settings, collecting interviews and observational data from 18 staff in 3 sites who had not received the DARES intervention.

The second direct contribution to DARES coincides with Phase 3 of the classic grounded theory study (see Chapter 7). Phase 3 represents continued development of the classic grounded theory as data collection and analysis sought understanding of the perceptions, experiences and impact of psychosocial intervention education (DARES) on the lives of 11 residents with dementia, 23 staff and 5 relatives following participation in DARES. This work built on the growing understanding of psychosocial intervention use gained in Phases 1 and 2. Across the three phases the researcher undertook interviews and observations in 10 long stay settings, these are described in Appendix 1.

As part of preparation for both the classic grounded theory study and the DARES project, the author was required to familiarise himself with the literature around psychosocial intervention use in long-stay dementia care and the theoretical concepts arising from the literature. This chapter now presents a discussion of the use of literature in a grounded theory study, followed by two distinct preliminary explorations of the literature. The first considering the development of the theoretical understanding of dementia care, and the second considering the use of psychosocial interventions in dementia care.

2.3 Use of Literature in a Classic Grounded Theory Thesis

The use of literature in grounded theory research presents the researcher with a unique challenge. This next section provides explanation and justification of the approach used in this study. In a grounded theory study the researcher must endeavour to balance the need to justify their research area in terms of the literature against the concerns articulated by Glaser & Strauss (1968). These concerns suggest that over familiarity with the substantive literature will divert the researcher's conceptualisation, forcing the analysis. The following section gives an account of the various arguments around the use of the literature. The strengths and weaknesses of the different approaches are discussed and a justification for the approach chosen is presented.

According to Glaser (1978, 1998) a classic grounded theory thesis should differ from a traditional thesis approach in the manner that the literature is approached and utilised. Whereas in traditional approaches there a substantive literature review is undertaken prior to the research commencing, in classic grounded theory the literature pertaining to the substantive area should not be not fully incorporated until the emergent theory has been developed from the data. Glaser and Strauss (1968) argue that reviewing and incorporating the literature after the theoretical framework has been constructed serves two key purposes in grounded theory. The first is to situate the newly developed emergent theory within

the extant literature. The second is to provide an clear conception of how the new emergent theory applies beyond the data and substantive area it emerged from.

The direction from Glaser (1978, 1989) not to access the literature until the theory has developed from the data, will now be considered and concerns over the practicalities of this approach discussed. The main reason given for not fully accessing the literature until as late as possible is to avoid the development of preconceived theoretical structures that will constrain or force the resultant theory (Glaser, 1978; McGhee et al., 2007). Stern (2007) agrees with this view, suggesting that if the researcher is overly fond of or familiar with existing theories their inductive processes may be influenced. Stern (2007) also cautions that a literature review undertaken without awareness of the direction the research will take them may result in the researcher gathering a great deal of irrelevant information. McGhee et al. (2007) suggest that researchers with prior knowledge of the substantive area should endeavour to minimise reading around the substantive area in an attempt to avoid forming preconceived ideas and applying them to substantive area of the research.

Given the practical challenges presented by this approach to the literature concerns have been raised about delaying the full literature review until after the theoretical framework is constructed from the data. Dey (2007) argues that researchers who do not access the literature in advance may not be aware of the existing theories that apply to the field of interest. The resultant theory may be considered novel when it is not and will lack full conceptual depth and understanding. Similarly, Cutcliffe (2000) while defending the convention of not accessing literature in detail until as late as possible suggests it would be naïve to enter the substantive area with no knowledge. In addition Cutcliffe (2000) notes that funding bodies, ethics committees and research committees usually require a literature review (Cutcliffe, 2000).

The use of literature also relates to researcher reflexivity, and their prior professional knowledge on the research process. It is reasonable to assume that many researchers will have some level of prior knowledge of, or insight into, the topic area and the substantive literature (McCallin, 2003; McGee et al., 2007). In this research, as a mental health nurse, cognitive behavioural therapist, and mental health lecturer, the author could not avoid some prior knowledge and pre-conceptions regarding psychosocial interventions and dementia care.

Awareness that this prior knowledge was somewhat at odds with the apparent 'do not read' message of Glaser (1978) prompted the researcher to re-read the literature relating to prior access to the literature in grounded theory. Consideration of the literature indicates that the direction of Dey (2007) and Glaser (1978) are not entirely at odds. Glaser (1978) in fact suggests that the researcher having prior-knowledge derived professionally or through familiarity with the literature should not inhibit the inductive processes required for classic grounded theory. Any pre-conceptions must earn a place in the analysis and emergent theory in the same way as all other data (Glaser, 1978). In more recent clarification Glaser (1998) addresses the apparent contradiction in the read/don't read message present in classic grounded theory methodology, by directing the nature of the reading. Glaser (1998) suggests that by reading broadly, the researcher is building up their theoretical knowledge, but not limiting their openness to the substantive area of interest. Also by reading various theoretical works, including grounded theory studies, the researcher is developing a familiarity with theoretical codes (discussed in Chapter 3) which allows them to conceptualise their own study. Glaser (1978) argues that theoretical sensitivity is further enhanced by reading a range of theoretical writing in other research areas. This broad reading is designed to help the researcher develop their coding and conceptual abilities as well as enhancing their familiarity with theoretical codes and their theoretical writing capacity (Glaser, 1978). When the newly discovered theory emerges from the data it can then be compared with and located in the

existing literature. Doing so identifies areas of similarity and difference establishing the novel contribution of the newly developed theory (Glaser, 1978).

Glaser (1978) argues that the literature is a constant, *'it is not going anywhere'* (personal communication with Glaser, 2012). Therefore, positioning the new theory amongst the literature can wait and will be more meaningful if undertaken after theory development. Moreover, Glaser (1978) makes the point that when undertaking the process of searching the literature after construction of a theoretical framework, the researcher will inevitably identify similarities as well as differences. Glaser (1978) argues that new theoretical findings (differences) are welcome, and that similarities should also be viewed positively. Identification that emergent ideas replicate theory in the literature shows the abstract applicability of the new theory. As Glaser (1978) puts it, such identification should be welcomed,

"The other author discovered it too, as might any theoretically sensitive analyst in dealing with the same or similar data" (p.137).

A useful synthesis of the *'read-don't read'* direction in the literature is offered by Urquhart and Fernandez (2013). The approach provided by them is cognisant of the arguments around use of the literature in grounded theory. As such it provides a structured approach where the literature serves different purposes and is utilised in different ways, at different points in the research. The approach provided by Urquhart and Fernandez (2013) comprises a noncommittal phase, in which literature is initially accessed allowing the researcher to develop theoretical sensitivity and understanding of the research area, and an integrative phase during which a thematic and theoretical comparison of literature with the emergent theory takes place.

The non-committal phase in this study is made up of the background and introduction presented in Chapter 1 and preliminary literature review in

this chapter. The non-committal phase affords the researcher valuable, broad, access to the theoretical developments and policy context of psychosocial intervention use in long-stay care with residents with dementia. Doing so allows the researcher to more confidently engage with the substantive area, participants and supervisors. This non-committal stage continues as the study progresses. Literature is identified and stored for use during the integrative stage, Chapter 8, where the emergent theory is subject to constant comparison with the literature. The integrative stage is where this identified and stored literature is subject to constant comparison with the emergent theory.

The structuring into non-committal and integrative phases proposed by Urquhart and Fernandez (2013) allows the researcher to develop theoretical sensitivity and understanding of the research area while being free to accept concepts as they emerge from the data. Urquhart and Fernandez (2013) acknowledge the challenge of balancing the need to compare with and be informed by the literature verses the danger of the literature diminishing the impact of the concepts generated by the researcher. For these reasons this thesis will be presented with noncommittal phases of literature consideration (Chapters 1-2) and the emergent theory first (Chapters 5-7). Followed by the integrative phase (Chapter 8) where the developed emergent theory is compared with and located within the existing literature.

2.4 Non-Committal Literature Review Strategy

In an effort to develop a broad understanding of the substantive area the keywords 'dementia' and 'psychosocial interventions' were used in combinations with a range of other terms such as, 'nursing home(s)', 'care home(s)', 'long-stay care', 'BPSD', 'non-pharmacological interventions', 'policy and 'dementia theory' to the available databases including: EMBASE, MEDLINE, PsychINFO, PubMed, Web of Science, CINAHL Plus, the Cochrane Dementia and Cognitive Impairment Group Database and the Social Sciences Citation Index. Additional literature was accessed by hand

searching relevant journals, following up references within relevant papers and by searching for relevant work via authors and reviewed papers.

2.4.1 Preliminary Review of Dementia Literature

Kitwood's (1987, 1989, 1990, 1993a, 1993b, 1997) body of work is reviewed as it not only questions the dominant bio-medical view of dementia, but it also is important when considering psychosocial intervention use in dementia care and understanding why psychosocial care matters. Kitwood (1987, 1989) argues that ill-being or well-being in an individual with dementia is not a function of brain damage alone, but that the process of the disease is also dependant on individual personality, personal experience and their psychosocial interactions.

Kitwood (1990) uses a psycho-biographical approach to identify that individual psychological factors can result in ill-being both as a consequence of dementia and arising from personal factors that predispose the individual to dementia. In presenting a case study of a lady who developed dementia in later life, Rose; Kitwood (1990) indicates that Rose's life experiences did not allow her to develop relatedness and agency, resulting in her becoming predisposed to dementia in later life. Kitwood (1990) identifies the death of Rose's husband as a trigger for the onset of dementia and in subsequent work Kitwood (1993a) identifies common contributory life events.

By suggesting that pre-disposing social-factors contribute to ill-being and predispose individuals to dementia, Kitwood (1990, 1993a) has been criticised for not acknowledging the societal impact on personhood, making dementia overly individualised (Adams, 2005). Dewing (2008) counters this criticism arguing that personhood as described by Kitwood (1990, 1997) is not overly focused on individual failings or pre-dispositions; it is in fact concerned with the overall social context of the person with dementia. When Kitwood (1990, 1993b) identifies that

human experience; negative, developmental or traumatic contributes to unhappiness and may predispose the individual to dementia he is drawing on the work of Smail (1984, 1993). Smail (1984, 1993) theorises on the nature of unhappiness, based on his practice as a clinical psychologist. He argues that the interaction of the individual with society results in their happiness or unhappiness. Indeed, Smail (1993) argues that the factors resulting in unhappiness, while often identified as personal in nature, are in fact socio-economic and political in nature.

Methodological concerns have been raised over Kitwood's body of work. Adams (1996) notes that Kitwood (1990) draws his conclusions regarding an individual's past predisposing them to dementia from a single case study. Adams (1996) also argues that later research utilising psychobiographies of people with dementia undertaken by Kitwood (1993a, 1995) does not support Kitwood's case for a predisposition to dementia. However, Baldwin and Capstick (2007) argue that while unproven the concept of predisposition towards dementia put forward by Kitwood (1990, 1993a) should not be entirely dismissed. They suggest that when Kitwood (1995) fails to produce sufficient evidence to support his socio-economic/political predisposition theory, he redirected the focus of his later work onto the direct relationship of people with dementia and those who care for them. Therefore, this '*micro-social*' (resident with dementia-staff interaction) understanding of the social impact on well-being in dementia care continues to be enduringly important (Baldwin & Capstick, 2007; Kitwood, 1997, 1998).

Another important area of Kitwood's work concerns the concept of ill-being and well-being in dementia. These related concepts arise not simply from neuropathology, but also as a result of the social interaction that is not person-centred and the nature of the resultant care (Kitwood & Bredin, 1992a). Ill-being is defined as occurring when:

'the individual has lost almost all that remained of self-esteem, agency, social confidence and hope, and withdrawn into terminal apathy and despair'
(p.272)

Well-being relates to the individuals capacity to maintain personhood in spite of even the most severe cognitive impairment. Kitwood and Bredin (1992a) propose that well-being relates to an individual's experience of four separate states of '*sentience*'; personal-worth, agency, social-confidence and hope. This understanding supports the idea that individual well-being and ill-being are states that arise independent of neuropathology, directing carers to attend to their psychological efforts to maintain personhood in residents with dementia.

In addition to introducing the concepts of ill-being and well-being in dementia Kitwood and Bredin (1992b) develop dementia care mapping as a means of observing and recording the quality of care in long-stay settings. Dementia care mapping is used to promote person entered care and as a tool in dementia quality-of-life research (Brooker, 2006; Kitwood & Bredin, 1992b). This approach involves at least one observer, recording the behaviours of up to seven people for up to six hours. Coding every five minutes the observer records activities and rates well-being or ill-being. The observational approach of dementia care mapping was developed in response to criticism of nursing care (Kitwood, 1993a). This criticism identified that nurses were failing to challenge bio-medical models of care in long-stay settings and as such not meeting the holistic needs of residents with dementia. Kitwood (1987, 1993a) argues that by accepting the bio-medical model of care and by failing to develop educationally and professionally, nurses lack the skills and personal qualities required to deliver good care for people with dementia. This criticism of the role of nursing is not diminished when Kitwood et al. (1995) apply dementia care mapping to 224 people in 77 care settings. In this study, use of dementia care mapping identifies failures of psychosocial care in the day to day care of many residents with dementia. Through observation of staff, Kitwood

(1993a, 1995) identifies a duality within care staff as they attempt to care, but persistently apply bio-medical routine in caring for residents with dementia. Doing so is seen to protect staff from the emotional challenge of acknowledging and addressing their inability to deliver care in a person centred manner (Kitwood, 1993b).

Arising from dementia care mapping and observation of care which failed to promote personhood, Kitwood and Bredin (1992a) identify 10 types of '*personal detractions*' which were viewed as detrimental to well-being. These 10 categories were over time added to, becoming 17 personal detractions (see figure 2.1 Malignant Social Psychology) contributing to malignant social psychology (Kitwood, 1997). The concept of malignant social psychology is constructed as means of labelling the poor care that contributes to ill being in residents with dementia (Kitwood & Bredin, 1992a). In this work, Kitwood and Bredin (1992a) are less focused on personal psychology and predisposition to dementia and consider the social processes and interactions that contribute to dementia. This work is clearly influenced by humanistic psychology of Carl Rogers with its emphasis on potential, growth and person-centeredness (Bellchambers & Penning, 2007). This influence contributed to the development of a view of the person with dementia as being capable of stabilisation and indeed where care is of a high standard '*rementia*' that is improvement in function, may occur. Kitwood (1997) outlines the five basic psychological needs that must be met to achieve positive, person centred care:

1. Comfort, the provision of warmth and strength
2. Attachment, the forming of specific bonds or attachments
3. Inclusion, being part of a group
4. Occupation, being involved in the process of life
5. Identity, having a sense and feeling of who one is (p 81).

While these psychological needs are influential particularly in establishing a basis to challenge the standard medical paradigm of dementia care '*rementia*' continues to be a contentious and unproven concept in spite of

evidence that people with dementia can be supported in ways that will improve their quality of life (Bird 2001; Moniz-Cook et al., 2003).

Figure 2.1 Malignant Social Psychology

Treachery: using deception to distract/manipulate/force compliance

Disempowerment: preventing/failing to help the resident with dementia from completing a task

Infantilisation: treating a resident with dementia in a patronising manner

Intimidation: use of threats/power to induce fear

Labelling: interacting with a label (behaviour/condition) rather than the person

Stigmatisation: treating a resident with dementia as a diseased object/alien/outcast

Outpacing: going too fast for the resident with dementia to understand/act

Invalidation: failure to acknowledge subjective reality/feelings of the resident with dementia

Banishment: excluding the resident with dementia physically or psychologically

Objectification: treating resident with dementia as an object rather than a sentient being

Ignoring: carrying on as if resident with dementia were not present

Imposition: forcing resident with dementia to do something without a choice

Withholding: refusing to give attention/meet an expressed need

Accusation: blaming resident with dementia for something they cannot help doing

Disruption: interrupting the resident with dementia's task or activity

Mockery: making fun of the resident with dementia actions

Disparagement: giving the resident with dementia messages that damages their self esteem

These 17 personal detractions represent social interactions and processes that along with neurological impairment contribute to the erosion of personhood. This conceptualisation directly challenges the standard

medical paradigm of dementia, offering one where society contributes to the '*problem*' of dementia. The conceptualisation of these malignant social psychologies represents a change in position regarding the causes of ill-being. Kitwood and Bredin (1992a) are now not simply focused on life-long predisposition to ill-being identifying that poor psychosocial care for residents with dementia can contribute to the development of the difficulties associated with dementia. Kitwood and Bredin (1992a) also propose that approaches to care that position '*them*' (people with dementia) as the problem rather than '*we*' (those providing care) have the potential to compound malignant social psychology. They argue that these approaches can contribute to the positioning of the person with dementia as the problem rather than focusing on the component which is truly problematic, the care providers themselves.

Kitwood and Bredin (1992b) note that the experiences, outcomes and pressures felt by residents with dementia are not unique to them, the staff providing care are also subject to similar difficulties. In considering the influence of Smail (1984, 1993) on Kitwood's conceptualisation of personhood and happiness, it is reasonable to assume that socio-economic and political pressures apply equally to staff happiness. In fact Kitwood and Bredin (1992a) conceptualise a clear mutuality between staff and residents with dementia, a logical conclusion of this is that staff are also subject to socio-economic and political pressures that diminish their ability to deliver person centred care. Delivering care categorised by malignant social psychology then impacts on staff happiness, agency and power.

Another conceptual contribution of Kitwood's work comes as a direct response to the identification through dementia care mapping, that well-being for individuals with dementia was often unachievable without a change in the manner that their core psychological needs were being met (Kitwood, 1998). Accordingly, there is identification that personhood should be addressed via changes in the skills and values of the staff

delivering care (Bradford Dementia Group, 1997). Kitwood (1998) notes this realisation and describes the kind of '*positive person work*' required to attend to the personhood of residents with dementia. Kitwood (1997) argues that true person-centred care should be unconditional. It should provide the resident with dementia with the basic psychosocial need of love, through the provision of five other associated basic psychosocial needs; attachment, comfort, identity, occupation and inclusion (Kitwood, 1997). Such an understanding is of particular value to this classic grounded theory as it represents the ongoing re-conceptualisation of two decades of research and theoretical development and applies directly to staff and their potential to positively influence the lives of residents with dementia (Kitwood, 1998).

In her work Brooker (2004, 2007) adds to the conceptual understanding of dementia by emphasising that the quality of life for residents with dementia is dependent upon quality of care, which is in turn influenced by the social interaction of residents with dementia and staff. Brooker (2004) adds to the understanding of dementia care by explicating the concept of '*dementia-ism*' to explain the discrimination and stigma, experienced by residents with dementia and how this arises from the nature of the social interaction of residents with dementia and staff. Brooker (2004) identifies '*dementia-ism*' as the prevailing state of care in many long-stay settings, identifying that this type of care is applied on an individual level and by the institution as a whole. Building on the work of Kitwood (1997) Brooker (2004) develops a means of conceptualising person-centred care in practice for staff; with the VIPS model comprising four components that promote well-being: Valuing people with dementia as well as their carers interacting with people on an Individual basis, taking the person with dementia's Perspective on the world and ensuring a positive Social environment for the person with dementia (Brooker, 2004, 2007).

The recognition that how carers and society at large relate to people with dementia impacts on the well-being of the person with dementia is an

important concept that has been further developed by contemporary dementia theorists and researchers (Bartlett & O'Connor, 2007; Brooker, 2006). Bartlett and O'Connor (2007) argue that the concept of personhood should be extended into the realms of citizenship, with the poor care received by people with dementia viewed as a function of discrimination. Their case is that the concept of personhood as developed by Kitwood (1997) has helped identify the problems associated with dementia care and changed how people with dementia are viewed and discussed. Unfortunately the widespread acceptance of the concept of personhood has largely failed to result in well-being for people with dementia, this is perhaps due to the over identification of personhood with the individual (Bartlett & O'Connor, 2007). Bartlett and O'Connor (2007, 2010) note the tendency for personhood to be conceptualised as an individual idea that de-socialises and de-politicises the discussion around dementia. This individualised interpretation of personhood can be viewed as marginalising and stigmatising, rather than promoting well-being (Nolan, 2002b; O'Connor et al., 2007).

In fact the conceptualisation of personhood forwarded by Kitwood (1997) promotes interdependence not independence, but it is not always viewed that way (Brooker, 2004). Malloy and Hadjistavropoulos (2004) consider Kitwood's use of Buber's '*I-Though*' relationship as a means of extending the discussion of caring impacting on mutual growth, staff and residents with dementia gaining from each other (Kitwood & Bredin, 1992a; Kitwood, 1997). Malloy and Hadjistavropoulos (2004) talk of '*authentic growth*' within the caregiver arising as a result of delivering care. By associating the '*growth*' of care staff with the quality of care provided Malloy and Hadjistavropoulos (2004) echo the understanding provided by Kitwood and Bredin (1992a). Staff must undertake a fundamental shift from an '*I-It*' view of the relationship with people with dementia, to an '*I-Though*' understanding of the relationship (Kitwood and Bredin, 1992a). Malloy & Hadjistavropoulos (2004) suggest that changing staffs'

understanding to that of shared personhood and citizenship '*I-Though*' is central to the development of personhood and person-centred care.

In considering the contribution and scope of Kitwood's body of work Baldwin and Capstick (2007) summarise the theoretical conceptualisation in three main areas which have developed and changed over time:

- Individual psychological factors resulting in 'ill-being' as a consequence of dementia and precondition for dementia
- 'Ill-being' as a result of social interaction and quality of care
- Positive care resulting in 'well-being'

As noted, the work of Kitwood has been criticised. Methodologically, Adams (1996) notes the inconsistency of method and cautions against sweeping claims derived from small sample sizes. Conceptually there are also identified failings. Baldwin and Capstick (2007) identify the omission of concepts such as individual agency and empowerment in the five basic psychological needs. Nevertheless the concept of personhood as presented by Kitwood (1997) represents an influential and important step in the recognition of the potential for good basic psychological care to impact positively on all aspects of the care and quality of life of residents with dementia. How staff think about and respond to the psychological needs of residents with dementia has a profound impact of residents with dementia and those delivering care (Kitwood, 1998).

Having considered Kitwood's influential body of work this next section will discuss more contemporary dementia literature. Baldwin and Capstick (2007) note that at the heart of personhood is the social interaction between carers and people with dementia, arguing that it is unfair to view Kitwood's explanation of personhood as entirely focused on the individual with dementia. The concept of personhood is intrinsically flexible with social influences both intentional and unintentional, constantly shifting the position and status of the person with dementia. Therefore it is argued

that there is a need to consider dementia from a citizenship perspective (Baldwin & Capstick, 2007; Bartlett & O'Connor, 2007).

The concept of citizenship as applied to dementia care does not supersede personhood rather it is an evolutionary addition to the concept of personhood, accepting the importance of the individual (personhood) along with fundamental influence of power imbalances (citizenship) (Bartlett & O'Connor, 2007). Nolan et al. (2004) make the case for the inclusion of complex societal and professional factors which diminish the willingness of formal caregivers to work with older people. This conceptual work was based upon research that identified that nurses attitudes to working with older people were formed early in their careers while experiencing '*impoverished*' environments where neither the residents nor the carers were valued, and therefore lacked the ability to develop positive caring relationships. When compounded with observed society wide ageism, the perceived low status of such work, lack of resources and lack of training in older people's care, there is clear evidence that the nature of care cannot be accounted for via the conceptualisation of personhood alone (Nolan et al., 2004).

In an effort to reconceptualise the processes that work within individuals and upon individuals, Nolan et al. (2004) develop the Senses Framework to account for the nature of positive relationships that impact upon care. This framework considers security, to feel safe within relationships; belonging, to feel '*part*' of things; continuity, to experience links and consistency; purpose, to have a personally valuable goal or goals; achievement, to make progress towards a desired goal or goals and significance, to feel that '*you*' matter. While not referring directly to citizenship, the Senses Framework represents an effort to expand the focus of dementia care beyond personhood alone and to account for the broader interpersonal and societal factors found to impact upon dementia care. As a concept citizenship directly addresses the power and hierarchy issues touched on by Nolan et al. (2004) offering further extension of the

conceptual understanding. What is clear is that in the areas of research and practice a citizenship conceptualisation offers the opportunity to better understand and address the socio-economic influences on dementia care (Bartlett & O'Connor, 2007).

When Bond & Corner (2004) and Downs (2000) make the case for extending the socio-political understanding of dementia they are also identifying the failure of current conceptualisations to support positive change. These authors along with those specifically promoting a citizenship approach (Baldwin & Capstick, 2007; Bartlett & O'Connor, 2007, 2010) have identified the enduring dominance not only of the bio-medical model of care and the inequities of power contained within this, but of ageism, stigma and discrimination as it applies to dementia. There is evident need for change in the approach to care across all aspects of delivery. Ward and River (2011) articulate the scope of participation required to achieve a citizenship approach to dementia care:

'Effective involvement is most likely co-created; the result of close working between users, practitioners, researchers, provider agencies, policy-makers and other key stakeholders' (p. 19).

This identification of the scope of change required in dementia care mirrors wider sociological discussions. Giddens (2001) considers the question, are individuals' actions and their circumstances individually or socially formed? Extending the conceptual debate around dementia in this same direction is a logical continuation of the theoretical discussion. It is also an opportunity to address some of the failings of an approach to dementia care informed by a narrow view of personhood which focuses on the person with dementia alone.

Bartlett and O'Connor (2007) hold that a citizenship approach to the conceptualisation of dementia with its focus on power and its misuse offers an understanding which develops the concept of personhood. They also note the challenge posed by such a conceptual shift, and cite Kitwood

(1997) in identifying the challenge of the move from personhood to citizenship; a move away from illness focus on individuals towards to personhood within society.

The fact that people with dementia will suffer deteriorating cognitive abilities highlights the need to place personhood, participation and collaboration at the heart of a citizenship approach to dementia care. It also means that those delivering care must be included in any conceptualisation of dementia. Keady and Watts (2010) note a range of recommendations in the form of challenges to address implementation of change in the care of older people. These outline; steps to address societal stereotypes and stigma, a greater role for the participation of older people in service planning and research, along with recommendations that recognise the current lack of preparation of individual care providers and the teams they work within. This extension of the conceptualisation of dementia from personhood as it applies to the individual, towards citizenship as it applies to the person with dementia as a part of society at large, represents the practical development of the theoretical discussion.

2.4.2 Preliminary Review of the Psychosocial Interventions

Literature

Given the focus of this classic grounded theory on psychosocial intervention use with residents with dementia in long-stay care, this next section will provide a preliminary review of the psychosocial intervention literature. This section builds on the Strategies for Dementia Care section in Chapter 1, where psychosocial interventions for residents with dementia were first discussed and the working definition of psychosocial interventions used from the outset of this research, provided:

'everyday therapeutic endeavours involving purposeful human interactive behaviour between staff and residents with dementia'.

In spite of efforts to improve the quality of residential dementia care the consensus is that care often fails to meet the needs of residents with

dementia (Cahill et al., 2012; Murphy et al., 2007; O'Shea, 2007). Clare et al. (2008) identify that the experience of residents with dementia is often one of social impoverishment, characterised by feelings of worthlessness and distress. While there is consensus that psychosocial interventions have the potential to improve the quality of care and outcomes for residents with dementia (Moniz-Cook et al., 2008; Vernooij-Dassen et al., 2010). Little is understood about what psychosocial interventions staff currently utilise, what they know about psychosocial interventions and what they want to learn.

There are numerous psychosocial interventions which have been subject to research and review (Spector et al., 2006; Woods et al., 2005). These include formally trained and delivered approaches such as cognitive stimulation therapy and structured reminiscence therapy as well as approaches with a more general impact focussing on staff attitude and communication in an effort to improve outcomes for residents with dementia (Bird et al., 2007; Fossey et al., 2006).

Consideration of what a psychosocial intervention is and its relationship with the outcomes of residents with dementia reveals considerable debate, but there is a common understanding that staff education in psychosocial interventions is required. Adams (2008) calls for greater investment in training in psychosocial interventions at both pre and post registration nursing levels. This stance holds that that the approach to care delivery adopted by staff is fundamental to addressing unmet dementia care need. Calls for additional training for all long-stay care staff are mirrored in the Alzheimer's Society (2007) report, *Home from Home*. This report, which is based upon the findings of a large survey, indicates that the care delivered in UK care homes is inconsistent and that while there are settings where care is excellent, much of the care delivered is unacceptable. The report particularly notes the lack of planned activity for residents, the failure to address social needs and lack of specific input for the needs of people with dementia (Alzheimer's Society, 2007). The need for education targeted at

long-stay staff to improve their attitudes, psychosocial intervention use and the quality of person-centred care is mirrored in the Irish context with calls for person-centred care supported by improved staff education and training (O'Shea & O'Reilly, 1999; O'Shea, 2007).

Consideration of staff attitude to residents with dementia and its impact on psychosocial intervention delivery reveals a number of attempts to understand and explain the relationship between staff attitude, care and use of psychosocial interventions. As noted in Chapter 1, Sabat (2008) suggests that in practice staff attitudes are influenced by the prevailing theoretical underpinnings for care suggesting that most long-stay care is delivered with reference to the bio-medical model.

Taking a similar stance, Fossey (2008) suggests that where residential care staff lack an understanding of the theoretical basis for nursing care the resultant care delivery will fail to meet the physical, psychological and social needs of residents with dementia. Fossey (2008) suggests that improving staff training and supporting them with ongoing clinical supervision can develop more person centred attitudes in staff caring for residents with dementia. Brooker (2006) takes a similar view and argues that promoting the person-centred care approach of Kitwood & Benson (1995) and Kitwood (1997) to staff is a means of enhancing well-being for residents with dementia. Bowers (2008) argues that knowing about alternatives to the bio-medical model of care is not in itself enough. Suggesting that staff attitude is central to the ability of staff to deliver high quality care that is underpinned by psychosocial interventions and attitude change needs to be addressed through education and institutional support (Bowers, 2008).

In case study research, Sabat et al. (2004) identify the tendency towards '*malignant positioning*' of people with dementia by staff where a bio-medical understanding of dementia contributes to carers' assumptions. Sabat et al. (2004) and Sabat (2008) argue that those caring for people

with dementia benefit from developing an appreciation of biological, social and psychological factors. Such appreciation could make care delivery easier for staff and improve outcomes for people with dementia. Reporting on interviews with people with dementia, Snyder (1999) identifies that people with dementia believe that health professionals demonstrate limited interest in social engagement with residents with dementia along with unwillingness to explore the experiences of those just diagnosed with Alzheimer's disease. Snyder (1999) concludes that this lack of engagement may well stem from therapeutic nihilism, the view that there is no point in engaging, as dementia is progressive and deterioration inevitable. Snyder (1999) concludes that such attitudes risks compounding the communication challenges faced by residents. Snyder (1999) also identifies that residents' awareness of these attitudes in staff compounds their social isolation.

The tendency of staff to avoid social engagement shows the very fundamental level at which psychosocial interventions can impact upon care. Where staff members are supported to change their attitudes and view residents with dementia more positively, they may be better disposed to provide psychosocial interventions that fit with the definition devised for this study '*everyday therapeutic endeavours involving purposeful human interactive behaviour between staff and residents with dementia*'.

A similar theme is taken up by Sabat et al. (2004) who use case study research to identify that the negative attitudes of staff reduce the opportunity to utilise the capacity of residents with dementia. Residents with dementia indicated frustration and embarrassment at their deterioration while stressing that staff had limited time (Sabat et al., 2004). Staff lack of knowledge about residents with dementia and failure to engage with them resulted in frustration and self-depreciation on the part of residents. The lack of psychosocial interventions results in the amplification of behaviours that confirm staff attitudes, resulting in

recourse to medication and further isolation. In later work, Sabat (2008) offers the understanding that psychosocial interventions should be consistently used as part of routine care. This understanding of psychosocial interventions use suggests that their use is linked to staffs' ability to recognise distress and ability to reduce the social isolation of residents with dementia by using basic day to day communication.

2.5 Summary

This chapter has considered the relationship between this classic grounded theory study and the DARES project and the use of literature in a classic grounded theory study. A preliminary exploration of literature relating to dementia and psychosocial interventions for residents with dementia has been presented providing context for the study.

In conjunction with the literature considered in Chapter 1 this preliminary review of the literature has shown that the theoretical understanding of dementia care does influence psychosocial intervention use. Also that psychosocial intervention use has the potential to support personhood through the application of person-centred care. Doing so can improve the quality of life for residents with dementia and the working experience of staff. What is not known is the relationship between the individual and organisational factors that influence psychosocial intervention use. The next chapter will consider the research framework.

Chapter 3: Research Framework

3.1 Introduction

Creswell (2009) describes three components that researchers should include within a research framework; the paradigm, the research strategy and the research methods. This chapter examines the research paradigm and research strategy in detail. Chapter 4 examines methods of data collection and analysis providing a rationale for the overall framework.

A number of possible approaches to paradigm and research strategy will first be presented. Subsequently a rationale will be provided for the use a classic grounded theory strategy. A description of classic grounded theory tenants will be provided, including an explanation of the unique paradigm position in classic grounded theory and the need to explore the historical development of the classic grounded theory before deciding on a research paradigm. This explanation of classic grounded theory will describe the original inception of the research strategy its current forms and the on-going debates over its usage. Finally a rationale for the choice of pragmatism will be provided explaining how that paradigm fits with classic grounded theory.

3.2 Research Paradigms

Kuhn (1970) first used the term paradigm to describe the theoretical and methodological basis that guides research. Parahoo (2006) defines a research paradigm as representing the basic world view being applied to research, or a: *'school of thought'* (Pg38).

Guba (1990) presents a similar definition, describing a paradigm as: *'a basic set of beliefs that guide action'* (Pg17).

Guba & Lincoln (2008) characterise a paradigm as having three elements: ontology (the understanding of the nature of reality), epistemology (how knowledge is developed and the relationship between the researcher and

knowledge), methodology (how research is undertaken relative to question and context). The chosen paradigm therefore influences the researcher's world view and subsequent action, with the choice of research paradigm, in part dependent upon research strategy (Denzin & Lincoln, 2011).

There are numerous sources that define paradigms and their components (Creswell, 2009; Denzin & Lincoln, 2011; Parahoo, 2006). A Review of these indicates a number of paradigms that are often presented as exclusive sets of beliefs. Understanding the differences and, where they exist, the similarities in paradigms, is important if a researcher is to define and justify the approach to any given piece of research (Weaver & Olson, 2006). Five paradigms commonly referred to in the literature will now be presented and explained in terms of ontology, epistemology and methodology (Guba & Lincoln, 2008); positivism, post-positivism, critical theory, pragmatism and constructivism.

3.2.1 Positivism

Creswell (2009) describes positivism as the '*traditional*' form of research with the assumptions of positivism pertaining to quantitative research rather than qualitative, though positivism does have an influence on health and social sciences research (Parahoo, 2006). Denzin and Lincoln (2011) suggest that because of its historical dominance, positivism is the research paradigm that other paradigms are compared against.

Positivists hold that there is an objective reality or '*truth*' that can be identified, observed and understood. This ontological view, '*naïve realism*', (Guba & Lincoln, 2008), accepts that there is only one reality and that this is controlled by natural laws. Positivists view reality as being independent of human perception with identifiable differences between what is '*true*' and what is '*false*' (Denzin & Lincoln, 2011).

Epistemologically, positivism views the researcher as an objective expert who must remain objective whilst manipulating and controlling the object of the research (Parahoo, 2006). Positivists take the empiricist view that only what can be measured is relevant. This rigid view dictates the nature of positivist research inquiry; as only what can be observed, manipulated and measured can be researched (Denzin & Lincoln, 2011). Objects that the researcher cannot observe, manipulate and measure cannot be called truths (Parahoo, 2006). The researcher manipulates (controls) the research conditions to ensure the findings are not influenced by contextual variables. The positivist researcher also believes that this can be achieved objectively; without affecting the researcher or object (Parahoo 2006). Removing the effect of context on objects produces findings that are '*true*' and therefore can be replicated and generalised from (Paley, 2005).

Methodologically, positivism is reductionist, seeking to reduce complex phenomena to simple units to allow observation and measurement; it also utilises verification and replication of findings to discover '*truth*' (Guba & Lincoln, 2008). Parahoo (2006) explains that positivism is deterministic, meaning it accepts the concept of cause and effect. As such positivism uses deduction, a process of knowledge production that formulates theories or hypotheses and then collects data to test them. This approach includes structured experimentation, manipulation of variables' along with objective observation of the results (Denzin & Lincoln, 2011). This approach aims to deductively test hypothesis to produce general laws that allow predictions to be made based upon this scientific enquiry. Findings are usually represented quantitatively and presented numerically utilising statistics (Creswell, 2009).

Over time, positivism has been subject to considerable criticism, specifically in relation to researching social phenomena (Denzin & Lincoln, 2011, Parahoo, 2006). This criticism holds that the understanding that '*reality*' exists entirely independent of human experience is naïve. Kuhn

(1970) explains that dominant scientific paradigms change over time, being replaced by other approaches that become the norm. This process has resulted in positivism, particularly the notion that social phenomena can be observed entirely objectively, being replaced by post-positivism which is now the dominant paradigm (Creswell, 2009; Parahoo, 2006).

3.2.2 Post-positivism

The post-positivist paradigm shares many of features of positivisms regarding controlling variables and empirical testing. Creswell (2009) explains that post-positivism has been influenced by philosophers such as Mill, Durkheim, Comte and Locke. It differs from positivism by accepting that conclusions can only ever be an approximation of the truth due to unobservable influences (Lincoln et al., 2011). Creswell (2009) identifies the commonalities between positivism and post-positivism; both subscribe to verification of hypothesis/theory, reductionism, observation and measurement of research objects. This approach is often referred to as a 'critical realist' perspective. Critical realists understand that truth may only be imperfectly observed and estimated (Guba & Lincoln, 2008).

Ontologically post-positivists represent a move away from the certainty regarding reality that positivists maintain. Phillips and Burbules (2000) hold that post-positivists accept the existence of reality, but take the view that it cannot be found with the means available to us. So while post-positivists agree with the positivist view that objective '*truth*' exists they understand that it can never be fully discovered.

Epistemologically post-positivists aim to improve our ability to perceive reality. Researchers relate to subjects from a modified dualist-objectivist stance acknowledging that they cannot be entirely objective (Creswell, 2009). Post-positivists attempt to address this failing by encouraging ongoing critical scrutiny of research; a process that makes research open, challenging assumptions, but which will never fully achieve the goal of objectivity (Guba & Lincoln, 2008).

Methodologically post-positivists utilise techniques similar to positivists with experimental approaches common (Parahoo, 2006). Post positivists accept that not everything that impacts on research can be observed and therefore cannot be controlled for (Denzin & Lincoln, 2011; Parahoo, 2006). By using a range of methods, including qualitative methods post positivists attempt to compensate for the weakness present in any one approach and endeavour to be as objective as possible. This triangulation of methods allows the researcher to favour the strongest claims and often sets out to test existing theory (Creswell, 2009).

3.2.3 Critical Theory

Critical theory is ontologically based on the belief that reality is virtual, meaning it is constructed from social interactions and historical social imbalances. Critical theory holds that truth is hidden by social factors that develop over time, but in common with positivism and post positivism, still holds that there is truth to be discovered (Guba & Lincoln, 2005). Ontologically it represents a continued step away from the naïve realism of positivism and a continuation of the critical realist outlook (Guba & Lincoln, 2008). Emerging from the Frankfurt School in 1920s Germany, critical theory has its basis in a group of approaches including the Marxist and feminist traditions. For critical theorists knowledge is subject to the relationship (usually unequal) between the researcher and subject and in this respect reflects and replicates the inequalities within society (Gibson, 2007).

Epistemologically critical theory aims to bring about change or produce theory that supports emancipatory change. This relationship between researcher and subject forces the ontological and epistemological components to overlap, as what can be known is based on the power relationship applied during the research (Guba & Lincoln, 2005). The subjective experience of participants is valued so data that represents experience and attitude is favoured (Creswell, 2009). This approach to research is based upon a range of basic assumptions. These assumptions

include the view that research should explicitly set out to emancipate the participants from historical and social power imbalances; that some groups in society are privileged; and that the oppressed often contribute to their own situation through the belief that their lack of status is unchangeable (Kitcheloe & Steinberg, 2008).

Methods used in critical theory range from case studies to qualitative interviews, but do not exclude quantitative methods. Importantly, the research process is seen to be of importance in itself. With the researcher's values and their relationship with the participants impacting upon the emancipatory potential of the research (Weaver & Olson, 2006).

3.2.4 Pragmatism

Pragmatism stems from the work of Peirce in the 1870s. Since then, pragmatism has been advanced by James (1902/1916), Mead (1934), Dewey (1917/1998) and Rorty (1982, 1991). Creswell (2009) notes that pragmatism arises from belief that research should focus upon actions, situations and consequences. In this respect pragmatism represents a move away from the post-positivist focus on antecedent conditions (Creswell, 2003).

Ontologically pragmatism does not favour any single belief or set of beliefs about reality. In fact writers on pragmatism argue that discussions on the nature of truth range from linguistic wrestling to irrelevancies (Bryant, 2009; Rorty, 1991). The world exists in both the critical realist and relativist spheres (Creswell, 2009), but this view is in turn influenced by the need to focus on the desired outcome of the research, not the process. Consequently the relationship between participant and researcher will vary over time. This variation and pragmatism's openness to change is illustrated by Bryant (2009):

'He (Rorty) evokes Neurath's image of our conceptual toolset as a raft on which we are floating; where in the long term we will have to replace all the planks, but only one at a time!'. (p. 15)

Epistemologically and methodologically the pragmatist position stems from the view that any findings are transient and may well need to be revisited over time (Creswell, 2009). Epistemologically, the researcher and participants will engage in whatever manner addresses the research question so pluralism of approaches is favoured. In this sense pragmatism favours mixed methods approaches allowing triangulation of data types and collection styles (Creswell, 2009). This approach allows for both objectivist and subjectivist approaches, accepting that there can be differing researcher participant relationships in an effort to meet the needs of the research as it progresses (Morgan, 2007). Pragmatism acknowledges the influence of the research context and all findings or theory must be considered in light of this context (Rorty, 1991). Methodologically pragmatism is often, but not exclusively, used in mixed methods research where inductive, deductive, quantitative and qualitative methods are likely to be applied to address the question. This openness to getting the job done, using the correct tools is in keeping with what Denzin and Lincoln (2008) call '*bricolage*', a research output created from practical application of a range of methods in reaction to the complexities of the field.

3.2.5 Constructivism

Constructivist researchers seek to produce subjective understanding that arises from the context, historical and social that the research takes place in. Ontologically constructivism represents a move away from the naïve realist and critical realist assumptions of the other paradigm approaches presented. Creswell (2009) explains that constructivist researchers believe reality is a construction created in an effort to understand the world.

Constructivists hold that reality is co-constructed between researcher and subject with the very product of such research being seen not as reality, but a constructed interpretation based upon context and relationships. This stance has implications for the ontology-epistemology relationship as

reality changes at each new viewing (Bryant & Charmaz, 2007). Guba (1990) takes a similar view of the ontology-epistemology relationship of constructivism explaining that the '*relativists*' ontology of constructivism results in a '*subjectivist*' epistemology, meaning that reality is always represented from the perspective of the viewer and that there is no objective '*truth*' to be found. Therefore constructivists seek to represent what is happening, not to produce universally applicable laws or theories (Creswell, 2009). Importantly, constructivists understand that their own understanding and experience influences the outcomes of research. This understanding makes the researcher a participant in the research as well as an interpreter of the data (Bryant & Charmaz, 2007).

The knowledge developed is context-led with meaning applied relevant to the situation, therefore constructivists provide detailed descriptions of context (Charmaz, 2000). The methods used in constructivism are flexible and cannot be mapped in advance of the research due to the collaborative nature of the process, though, in-depth interviews are often used as a starting point (Charmaz, 2006). Regardless of the method the researcher is tasked with presenting the various views of participants and endeavouring to create a construct that is acceptable to the participants.

This section has outlined a number of paradigm options for this research. The rationale for the paradigm chosen will be given after discussion of the research strategy.

3.3 Research Strategy

The second component of an overall research design after paradigm is research strategy (Cresswell, 2009). Cresswell (2009) identifies two broad approaches to research strategy, quantitative and qualitative. This section will briefly outline the decision to use a qualitative rather than a quantitative research strategy before considering the options.

Research conducted using quantitative research strategies generally sets out to identify outcomes, establish facts, test theories and demonstrate relationships (Parahoo, 2006). Quantitative research is particularly interested in the identification of cause and effect relationships and the generalising of deductively identified findings to broader populations (Bowling, 2009). By definition quantitative research deals with quantities and the relationship between defined attributes. Bowling (2009) suggests that this approach is best used where there is pre-existing knowledge around the research area, allowing data collection to be standardised and controlled.

This understanding of quantitative research indicates that such a strategy would not be appropriate for this study. Psychosocial intervention use with residents with dementia in long-stay care have been identified as challenging to measure, due to the current lack of appropriate tools (Vernooij-Dassen et al., 2010). While there is clearly a need to measure outcomes in dementia care, there is also a need to better understand the nature of the social interactions and context within which outcomes occur. This thesis aims to produce such understanding and therefore contribute to the development of appropriate means of measurement in future. Indeed Dewing (2002, 2007) argues that research, as with providing person-centred care for residents with dementia, should take every opportunity to be interactive and ensure the inclusion of residents with dementia. A quantitative approach would not only fail to produce the in-depth understanding of the substantive area sought; it also could potentially repeat historical failings of dementia care research by failing to include the in-depth perspective of residents with dementia and staff (Dewing, 2002) which is crucial to the proposed study. Furthermore, the focus of qualitative research is to explore the quality and in-depth nature of experiences (Creswell, 2009); in this instance to understand the factors that influence the use of psychosocial interventions with residents with dementia. Therefore a quantitative approach was deemed inappropriate.

3.4 Rationale for Qualitative Research

As noted in Chapter 1 this research aims to develop an understanding of psychosocial intervention use for residents with dementia in long-stay residential settings. Qualitative research seeks to describe and understanding participants experiences along with attitudes, opinions and social interactions (Denzin & Lincoln, 2008). Broadly speaking qualitative research endeavours to study phenomena in their natural settings using a range of strategies. Gaining understanding through interaction with the research participants is at the heart of this research from the outset. Denzin and Lincoln (2008) note that there are a growing range of qualitative research strategies available to researchers.

Qualitative research strategies are considered the most appropriate when endeavouring to understand social behaviour and the underlying explanations of that behaviour (Creswell, 2009). Parahoo (2006) supports this view describing qualitative research as:

“Exploration as a means to understand perceptions and actions of participants’ describing the main features of qualitative research as being that it is inductive, interactive, holistic and mainly carried out by flexible and reflexive methods of data collection and analysis’ (p.63).

Understanding why psychosocial interventions are used and not used in long-stay care for residents with dementia requires just such a flexible strategy. Research in this area has shown that residential long-stay settings with similar staffing levels and ratios have very different approaches to psychosocial interventions (Murphy et al., 2007). Therefore, when Parahoo (2006) talks of qualitative research strategies providing understanding of participants ‘*perceptions and actions*’ the resonance with the proposed research is clear. As such a qualitative strategy is best suited for this research as it seeks to develop an understanding of what factors influence psychosocial intervention use for residents with dementia in long-stay residential settings. Using qualitative research strategies allows

the researcher to better understand how behaviour is formed on the level of the individual or via interaction within a group context (Parahoo, 2006).

An analysis of the literature regarding potential qualitative strategies highlighted four commonly used strategies; ethnography, phenomenology, case study and grounded theory (Denzin & Lincoln, 2011; Polit & Beck, 2010, 2013; Silverman, 2006).

Ethnographic research produces rich local description and an insider, '*emic*' understanding of participants' views and behaviours (Denzin & Lincoln, 2011). Ethnography typically focuses on cultural contexts and understanding peoples' views, behaviours and actions in a particular cultural setting. However, the purpose of this research is not to investigate a purely cultural understanding, but to understand all those factors personal, cultural and societal that influence psychosocial intervention use in long-stay care for residents with dementia.

Phenomenology, specifically interpretive phenomenological analysis was also considered for this research. Interpretation of the data looking for similarities and differences across a group of participants offers some clear utility to aim of this research (Brocki & Wearden, 2006). While phenomenology can produce an insider understanding it does not offer in-depth understanding of the personal, cultural and societal influences at work. It also does not provide the level of theoretical understanding of psychosocial intervention use with residents with dementia in long-stay settings aimed for in this research.

While case study research offers the potential to develop understanding of psychosocial intervention use with residents with dementia the aim of this research is to produce theory that is not contextually bounded. This research study aims to develop theory which can transcend the substantive area of interest, producing theoretical understanding that is

applicable to a range of contexts where residents with dementia receive long-stay care.

Grounded Theory (Glaser & Strauss, 1967; Glaser, 1978, 1992), with its emphasis on discovering meaning and producing abstract theoretical understanding from participant data is deemed the most appropriate research method for the exploration of psychosocial intervention use with residents with dementia. Parahoo (2006) suggests that being primarily an inductive methodology grounded theory is best applied where the aim is to explore substantive areas where little known about the social and psychological processes involved. Another benefit of the grounded theory research strategy is that the researcher aims to enter the research setting free from pre-conceived theories or hypothesis with the aim of allowing the data to identify the participants' main concern and means of resolving it (Glaser, 1978).

Therefore grounded theory was identified as most appropriate research design for the current study. The next methodological decision was deciding which form of grounded theory approach would be most suitable. In the following section the historical development of grounded theory in terms of the originators backgrounds, intent and the subsequent development of classic grounded theory will be presented. This background understanding is required to explain the research strategy choice made for this study.

3.4.1 History and Development of Classic Grounded Theory

Grounded theory is a research strategy that utilises inductive approaches to develop theoretical understanding, usually in poorly understood areas of interest (Glaser, 1992). Grounded theory does not set out to describe the area of interest or to test theory its aim is to generate theory from the data. Grounded theory is a general research method that while most often uses qualitative data can utilise any (Glaser & Strauss, 1967, Glaser, 1978). Grounded theory is often considered to be philosophically underpinned by

symbolic interactionism (Cresswell, 2009). However while both originators of grounded theory, Barney Glaser and Anselm Strauss have research backgrounds influenced by symbolic interactionism, grounded theory does not have a prescribed philosophical underpinning. As a general methodology grounded theory is designed to be flexible, open to application of paradigm approaches that suit the research and substantive area of interest (Bryant, 2009; Holton, 2007; Leigh Star, 2007).

In grounded theory data collection and analysis is carried out concurrently. Subsequent data collection, known as theoretical sampling arises from and is directed by the on-going data analysis (Parahoo, 2006). Glaser and Strauss (1967) developed another unique feature of grounded theory, namely constant comparative analysis. This strategy requires the researcher to compare each new instance of data against the others coding data to develop conceptual categories. Constant comparison and theoretical sampling continue until the researcher is satisfied that sufficient conceptual abstraction and understanding has been developed, explaining the similarities and differences noted in the data (Cutcliffe, 2000). Grounded theory has been developing since its introduction in the 1960s with three main schools emerging; classic grounded theory, Strausian grounded theory and constructivist grounded theory (Hunter et al., 2011).

Glaser and Strauss introduced classic grounded theory in the 1960s first with *Awareness of Dying* (Glaser & Strauss, 1965) and then with their '*classic*' text *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Glaser & Strauss, 1967). Glaser and Strauss (1967) were responding to the concern that social research and theory lacked an empirical basis. They argued that contemporary social theory was often based upon research that was not rigorous and whose analysis was not adequately described (Bryant, 2002). The two authors came from different backgrounds; Strauss was noted for his qualitative research being a product of the Chicago School of social research. The qualitative work

coming from this school is exemplified by the symbolic interactionist approach of Mead (1934) along with the work of Blumer (1937) and Dewey (1917/1998). Glaser came from a different tradition having a background in quantitative methods and middle range theory development, working with Paul Lazarsfeld at Columbia University. These different approaches came together in *The Discovery of Grounded Theory: strategies for qualitative research* Glaser and Strauss (1967).

Glaser and Strauss (1967) were critical of social research that developed theories and hypothesis before collecting data. The intention of Glaser and Strauss (1967) was to correct what the authors viewed to be the contemporary emphasis on theory confirmation and verification. In response they outlined a research approach that generated theory directly from data. Classic grounded theory as described by Glaser and Strauss (1967) is a means of generating theory from data that are rigorously collected and analysed to explain and understand social phenomena (Annells, 1997a). It is generally held to be best suited to areas where little research has been undertaken (Cutcliffe, 2008; Glaser, 1978; McCann & Clark, 2003). Classic grounded theory should produce either substantive or formal theory. Substantive theory relates directly to a single area of empirical study, in this case use of psychosocial interventions with residents with dementia. Formal theory further abstracts the conceptual understanding of behaviours applying substantive theory to broader sociological areas; for instance the application of a core category that explains doctors' relationships with patients being applied to law enforcement or business client-provider relationships (Glaser & Strauss 1967). Importantly classic grounded theory does not produce a final complete theory it presents a set of grounded hypothesis that have emerged from the data during rigorous application of classic grounded theory methodology. These hypotheses can then be verified using other means of research (Annells, 1997b; Glaser, 1992).

Since 1967 approaches to grounded theory have developed, diverged and been clarified producing 3 main approaches. The following section will outline the development of 3 main schools of grounded theory methodology: Classic Grounded Theory, Straussian Grounded Theory and Constructivist Grounded Theory.

To understand the divergence since Glaser and Strauss (1967) it is important to understand how that work was developed. Glaser (1998) wrote that he had produced the majority of the Glaser and Strauss (1967) work himself in an effort to capture the essence of the work he and Strauss had undertaken to that point in *Awareness of Dying* (Glaser & Strauss, 1965). So the 1967 book was a retrospective illustration of the techniques the two researchers had used when trying to move qualitative research forward and align their two different approaches to research. This 'discovery' of the grounded theory process was not explicit or exhaustive in its description of data collection and analysis, and did not sufficiently explain emergence of theory (Glaser, 1978). It is perhaps this lack of clarity in the 1967 work that produced the subsequent divergence outlined below.

The first divergence from the classic grounded theory of Glaser and Strauss (1967) was presented by Strauss and Corbin (1998) and Corbin and Strauss (2008). This approach, Straussian grounded theory, set out to address the lack of clear guidance regarding data analysis in Glaser and Strauss (1967). Developed over time, Straussian grounded theory has moved away from the classic grounded theory approach which is primarily though not exclusively inductive, applying understanding of individual cases to the general and abstract (Glaser, 1998). Strauss and Corbin (1998) include deduction, reasoning from the general and abstract to specific instances and abduction. In practice this means that Strauss and Corbin (1998) are verifying findings by applying structured approaches to the data analysis. Straussian grounded theory develops hypotheses that are

then confirmed or not as part of their re-structuring of the data analysis process (Bryant & Charmaz, 2007).

This development of grounded theory has been subject to criticism Glaser (1992). Glaser (1992) argues that the formalised inclusion of abduction and axial coding, as a framework that supersedes constant comparison to verify categories, has resulted in the approach described by Strauss and Corbin (1990, 1998) no longer being grounded theory. Further critique from Melia (1996) and Kendall (1999) raises concerns that the structuring of the data analysis process may be laborious and overly prescriptive forcing the data and producing theory that has not emerged naturally from the data using constant comparison, a key element of classic grounded theory. The differences in approach to data analysis reflect fundamental differences in the proposed product of the research. The developments of Strauss and Corbin (1998) and Corbin and Strauss (2008) reflect a move away from classic grounded theories emphasis on discovery that produces hypothesis ready to be further tested and verified. Instead Straussian approaches develop theory already verified during the analysis process (Annells, 1997b). Bryant (2002), while advocating that grounded theory should evolve, is critical of the direction taken by Straussian grounded theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Bryant (2002) suggests that the approach arrived at it is overly structured to the degree that it mirrors the type of grand theory verifying research criticised in Glaser and Strauss (1967).

McCallin (2003) suggests that the structured approach of Strauss and Corbin (1998) helps new researchers by providing a clear coding process which allows researchers to generate theory while identifying links between them. A key component of Strausian grounded theory is axial coding, (Strauss & Corbin, 1998). This is a means of identifying the relationship between codes using induction and deduction. Strauss and Corbin (1998) and Corbin and Strauss (2008) use this '*coding paradigm*' to consider codes relating to the phenomenon under study, the conditions

relating to it, interactions around the phenomenon and consequences. Strauss and Corbin (1998) acknowledge that this structured approach must be flexibly applied to avoid 'forcing' the data. In spite of this axial coding and the overall '*coding paradigm*' have been criticised as being overly-prescriptive, complex and conceptually limiting (Kendall, 1999; Melia, 1996).

The second alternative development of grounded theory is constructivist grounded theory (Charmaz, 2003). This approach offers much to the researcher who seeks to acknowledge the impact their personal and professional stance has upon the research (reflexive inclusion of self) while treating participants as collaborators in the research (Charmaz, 2003, 2006). For the researcher, as a mental health nurse, reading Charmaz (2006) and Mills et al. (2006, 2007) constructivist grounded seemed very attractive and appropriate for dementia research; aiming for reciprocity with the participants and to produce theory grounded in the experience of both researcher and participants. In this manner it could attend to the inevitable power imbalances present in the research process and it could develop theory directly from co-constructed rendering of data. However, Glaser (2002) provides a defence of classic grounded theory against constructivist approaches, suggesting that the rigorous application of the constant comparative method and inclusion of researcher memos provides reflexive inclusion of self, if not providing full co-construction of theory.

Williams and Keady (2008, 2012) provide an example of constructivist grounded theory. In their research they utilise the collaborative principle outlined by Charmaz (2000), making constructivist grounded theory accessible to participants by developing an innovative narrative approach and by repeatedly interviewing participants over a number of months. Williams and Keady (2008) argue that constructivist grounded theory offers the opportunity to build shared understanding, but within this approach there are also challenges. Whilst attractive and certainly a

research ideal to aim for Charmaz (2000 & 2006) does not provide clear guidance on application of the constructivist approach. This lack of clear guidance along with the level of commitment required to achieve genuine co-construction are practical challenges for the new researcher making the constructivist grounded theory approach extremely challenging to apply. Whilst this approach could have been applied in this research, constructivist grounded theory was viewed to be less well defined than classic grounded theory and as such less appropriate for a neophyte researcher.

Classic grounded theory, Strausian grounded theory and constructivist grounded theory all offer a range of different options in terms of research strategy and paradigm (Bryant & Charmaz, 2007; Cutcliffe, 2008; Hunter et al., 2011; Kendall, 1999; McCallin, 2003; Melia, 1996).

It is clear that the ongoing debate over approaches to grounded theory has had a negative impact on the standing of the methodology and has impacted on understanding of the approach (Stern, 2007). In an effort to clarify grounded theory approaches there is a body of literature that demonstrates the effectiveness and applicability of grounded theory generally and in nursing research specifically (Annels, 1997b; Bryant, 2002; McCallin, 2003; Parahoo, 2006). This literature responds to the methodological confusion by directing researchers to be cognisant of the various choices and suggesting they link their choice of grounded theory approach with the paradigm and research strategy as it applies to their area of study (McCallin, 2003). The next section will explore paradigm as applied to this classic grounded theory strategy and the research aim of understanding psychosocial intervention use for residents with dementia in long-stay residential care.

3.4.2 Paradigm in Classic Grounded Theory

Glaser and Strauss (1967) set out to produce a structured research approach that would address the failings of contemporary research as

they saw it. It is therefore unsurprising that at that time they should place themselves in the dominant positivist tradition to encourage acceptance of their approach. While noting this stance is understandable in the 1960s Bryant (2002) criticises both Glaser and Strauss for failing to alter the perception that classic grounded theory paradigm is positivistic. The impact of this initial paradigm association with positivism has been discussed at length in the literature (Annells, 1997a, 1997b; Bryant & Charmaz, 2007; Bryant, 2002, 2009; Charmaz, 2003). The following section will describe these discussions and the current paradigm position in classic grounded theory.

Much of the positivist critique levelled at classic grounded theory stems from Glaser's insistence on classic grounded theory discovering what pre-exists (Glaser & Strauss, 1967; Glaser, 1978). Rather than classic grounded theory discovering absolute truth classic grounded theory holds that what is discovered is exactly what constructivists seek to produce. Namely, hypothesis that emerge out of the interplay of the researchers influences along with interaction with participants and data through constant comparison, memoing and theoretical sampling (Holton, 2007). These hypothesis are not absolute truth, they are grounded, plausible and open to modification (Glaser, 1978). It would be naïve of a researcher to assume that there is an objective reality free from influence from the interaction of the research process and researcher (Bryant, 2002). It would though, be equally naïve to assume that that positivism is the paradigm position expected of the classic grounded theory researcher. Glaser (1998) explicitly states that classic grounded theory is a rigorous research strategy that is paradigm neutral. Meaning that classic grounded theory can utilise any research strategy and accommodate any data therefore the paradigm position will vary to fit the strategy and the data collected.

Discovery is the key concept both in the title of the seminal Glaser and Strauss (1967) book and in discussing the paradigm in classic grounded theory. In short classic grounded theory seeks to allow the hypothesis

(theory) that pre-exist within the data to emerge (Glaser 1978). Classic grounded theory maintains that far from the researcher constructing theory and hypothesis or co-constructing the theory and hypothesis these pre-exist and will emerge from the data in response to rigorous application of classic grounded theory method. The later work of Corbin and Strauss (2008) and constructivist grounded theory approaches (Ghezeljeh & Emami, 2009) maintain that the interaction of researcher and researched creates hypothesis from the relationship and interaction. This approach assumes there is no pre-existing reality and that the nature of the relationship will produce the subjectively constructed reality (Norton, 1999). The difference between these approaches can be considered in terms of practicality and structure. The practicality of co-constructing theory must be questioned while some participants may have the time and commitment to co-construct theory, but that will not always be the case. It should also be noted that very few people take the time to generate abstract concepts around their personal social situation, even where the researcher and the participants are able to take the time to do this. The ability of the researcher to do this without directing the participants and remaining truly reflexive is questionable (Hall & Callery, 2001).

Classic grounded theory addresses inclusion of participants in the research outcomes in a similar manner to constructivist grounded theory. Reflexivity is included by rendering the researchers thoughts and experiences, through inclusion of observations in the form of memos in the general data set. This achieves inclusion, but does this in reverse order to constructivist approaches, by accepting that the researcher is using the method to discover what is happening rather than constructing a description. Annells (1997b) categorises classic grounded theory as having its basis in positivism, but suggests that classic grounded theory can and indeed should be subjected to changes that suit the requirements of the study and the researcher. Holton (2009) argues for the approaches modifiability stating that classic grounded theory:

“does not fit within established research paradigms whether positivist, interpretivist, postmodern or otherwise; rather, as a general methodology, classic grounded theory transcends the specific boundaries to accommodate any type of data sourced and expressed through any epistemological lens.” (p.268).

Holton (2009) suggests that the paradigm position adopted in classic grounded theory should fit with the nature of the data collected which in turn arises from ongoing theoretical sampling. This approach is in line with Glaser (1998) who indicates that within any given study the paradigm position of the research, and therefore the researcher may change in keeping with the data collected. Emphasis on the rigorous application of research processes and the modifiability of the paradigm position in classic grounded theory illustrate two of the key strengths in the methodology (Holton, 2009). That said the researcher must state an initial paradigm position that reflects the methods used which in turn must meet the needs of the question or area of enquiry. With this in mind the next section sets out the researcher’s paradigm position on commencing this study which leads to justification of the methods proposed.

3.4.3 Symbolic Interactionism

At this stage in the paradigm discussion symbolic interactionism will be discussed and its relationship with classic grounded theory explored. This theoretical perspective is strongly associated with grounded theory, and is often cited as the paradigm basis for grounded theory studies (Bryant 2009; Stern 2007). Arising from pragmatism with similar roots in the Chicago School, this approach assumes that people develop their view of self, context and others through social interaction (Blumer, 1969; Mead, 1934). Symbolic interactionism assumes that individual’s actions are based upon their interpretations of the actions of others. What people do is based upon the meaning they ascribe to the action of others (Blumer, 1962). This process is mediated largely by symbols. Symbols are a

stimulus with ascribed value accordingly an individual's response is a reaction to the meaning ascribed not the stimulus itself (Stern, 2007).

Kinch (1967) offers three main components of symbolic interactionism:

1. An individual's view of self is based upon their perceptions of the responses of others.
2. The behaviour of the individual is directed by their view of self.
3. An individual's perception of the responses of others in part reflects those responses.

Symbolic interactionist research seeks an explanation of the process by which meaning is arrived at by individuals within their social context (Bryant & Charmaz, 2007). Research utilising a symbolic interactionist theoretical perspective views the individual as being active in their creation of understanding (Charmaz, 2006). Accordingly individuals interpret the actions and behaviours of others and adjust their actions and roles in response.

There is a general misconception that symbolic interactionism is the default theoretical perspective for grounded theory research. Writers on grounded theory such as Glaser (2005), Bryant and Charmaz (2007) and Stern (2007) have refuted this suggestion noting that while grounded theory does not require a symbolic interactionist approach, there is clear applicability. The interpretations and accordant actions made by individuals can only be understood within the context of social interaction and setting. Given that grounded theory places emphasis on the context and social interaction, symbolic interaction provides what Stern (2007) refers to as a useful, backdrop for grounded theory:

"An assumption that people act and react based on their relationships"
(p.121)

This study shares a view similar to Stern (2007) that understanding symbolic interactionism provides the researcher with useful theoretical sensitivity. Individuals ascribe meaning to the actions of others and

respond to symbols and stimuli rather than clear direction. This understanding can be utilised to guide the understanding of relationships between emergent categories (theoretical coding) rather than being the paradigm upon which the entire research rests.

Flexibility and openness to data and approaches as applied to complex areas of enquiry lies at the heart of the discussion when Bryant (2009) argues that grounded theory, in this case a classic grounded theory research strategy can be underpinned by pragmatism. Indeed, historically both classic grounded theory and pragmatism set out to generate data directly from and conscious of context with approaches to analysis critically including the researcher's perspective. Classic grounded theory shares common roots with the American pragmatist movement (Dewey, 1917/1998). Both set out to produce substantive (mid-range) theory as defined by (Merton, 1968), meaning theory that is best derived directly from people, avoiding the unfounded application of pre-existing hypothesis that so concerned Glaser and Strauss (1967). At the outset, given the flexibility demanded by classic grounded theory and the purpose of the study the initial paradigm position is a: pragmatist application of classic grounded theory.

3.5 Rationale for Paradigm

This study set out to develop a theoretical understanding of staff's psychosocial intervention use with residents with dementia in long-term care settings. Classic grounded theory seeks to answer the questions what is going on and why (Glaser 1978, 2002). The starting position in this study is the understanding that there is a problem with the use of psychosocial interventions with residents with dementia in long-stay care. Given this broad starting point for the research detailed consideration was given to the paradigm and strategy choice.

The literature reviewed in Chapters 1 and 2 indicates that currently there is a lack of understanding of the issues that dictate psychosocial

intervention use with residents with dementia in long stay care. Also that the context long-stay care is delivered in may influence the behaviours of staff and residents with dementia.

Positivism does not meet the needs of this study due to its inability to fully explore social and subjective experiences of participants. Post-positivism with its emphasis on producing verified understanding is an attractive stance, but with its emphasis upon testing and control lacks the sensitivity to social phenomenon required for this study. It is also the case that positivism and post-positivism are limited when exploring human behaviours and the emphasis on control and removing context makes these approaches inappropriate.

Given the scale of change required within the substantive area illustrated in Chapters 1 and 2 critical theory was also considered an attractive option, offering, as it does flexibility of approach and sharing common roots with both classic grounded theory and pragmatism. However this study does not have an explicitly emancipatory aim and therefore critical theory was rejected. Constructivism was also rejected, it's firmly relativist stance diminishes the generalisability of the theory developed and its emphasis on co-construction belies the practical challenge of ensuring participant commitment to co-construction.

The review of the paradigm options indicates that the most suitable paradigm for this study is pragmatism. This approach was chosen because of its ability to investigate the research area flexibly in a manner that would provide the best understanding and because of its affinity with the research strategy, classic grounded theory.

3.5.1 Further Exploration of Pragmatism

Rorty (1991) views knowledge derived from pragmatic enquiry to be a framework of understanding, the usefulness and application of which is contextual to the area of enquiry and the person seeking to use it. This

pragmatic stance is at odds to traditional views of research in which a hierarchy of research approaches produce 'truths' which are given weight by methodology. The pragmatic stance allows the researcher to maintain emphasis on the area of interest and what works, using whatever epistemological and methodological approaches suit the context of the research without engaging in rhetorical wrestling (Bohman, 1999; Gibson, 2007; Leigh Star, 2007).

Bryant (2009) argues that not explicitly acknowledging pragmatism as a potential paradigm option for grounded theory opened themselves and the research strategy to methodological criticism. Bryant (2009) suggests that there is still confusion regarding the paradigm position in grounded theory. Glaser (2001) indicates the structure of classic grounded theory ensures all perspectives and data are treated equally in search not of validity or accuracy, rather as a means of producing theory that addresses the concerns of participants and critically includes the researcher's perspective:

'All is data' is a well known Glaser dictum. What does it mean? It means exactly what is going on in the research scene is the data, whatever the source, whether interview, observations, documents, in whatever combination. It is not only what is being told, how it is being told and the conditions of its being told, but also all the data surrounding what is being told.' (Glaser, 2001 p.145)

Glaser (1978, 1992) talks of classic grounded theory being methodologically flexible and open to different theoretical perspectives when analysing the data. The attractive simplicity of this approach fails to address the need for clarity regarding both research paradigm and strategy. Those writers who advocate consideration of grounded theory through a pragmatist lens suggest that statements such as '*all is data*' need to be seen as statements of what is useful rather than what is easily applicable (Bryant, 2009; Gibson, 2007; Leigh Star, 2007).

Pragmatism demands that the researcher use those methods that address the question, one example is the issue of viewing data in a theoretically sensitive manner. Bryant (2009) refers to Peirce's modelling of abduction, the process whereby new conceptual ideas are generated from the data as being analogous to theoretical sensitivity. This issue has caused researchers difficulties when attempting to bring together data, sampling and literature. Induction from the data and deduction, theoretical sampling to 'test' induced categories are both approaches supported by the pragmatist conception of abduction. In this pragmatist reading, the process of theoretical sensitivity outlined by Glaser (1978) is given methodological strength that maintains awareness of the data, the relationship between researcher and participant and the conceptual perspective of the researcher.

Now that the research strategy and paradigm have been selected the chapter will continue with a detailed description of the main tenants of classic grounded theory research, starting with constant comparative analysis.

3.6 Further Description of Classic Grounded Theory Research Strategy

As noted grounded theory is ideally suited to areas of research where there is little understanding of the social processes at work (Glaser & Strauss, 1967; Glaser, 1978). Accordingly, this study set out to develop a classic grounded theory that would enhance understanding of psychosocial intervention use with residents with dementia in long-stay care. The research design and methods described draw upon the work of Glaser and Strauss (1967), *The Discovery of Grounded Theory: Strategies for Qualitative Research* and upon Glaser's subsequent work *Theoretical Sensitivity*, Glaser (1978). While other works such as Glaser (1992) describe and clarify the aspects of research design presented in this chapter Glaser (1978) is the key source that outlines the research strategy used in this research.

The approach to research outlined by Glaser and Strauss (1967) and Glaser (1978, 1992, 1998) endeavours to place theory emergence rather than theory verification at the heart of sociological research. To achieve this, Glaser and Strauss (1967) stressed the need for theory to arise directly from the empirical data. Correct application of classic grounded theory methodology rests upon rigorous adherence to the central tenets classic grounded theory outlined in this chapter. It should be noted that classic grounded theory is a non-linear research approach where application of these tenets overlap and cycle (Glaser, 1978). As such the components as laid out are not ordered rather they should be seen as co-existent and interdependent.

Grounded theory does not produce description or interpretation it produces abstract theoretical understanding. Therefore a classic grounded theory aims to produce a parsimonious explanation of what is going on around the main concern of the participants within the area under study (Glaser, 1978). This is achieved by rigorous application of the process of constant comparison, open coding, selective coding, theoretical coding, memoing, theoretical sampling and developing a core category which is outlined in this chapter.

3.6.1 Constant Comparative Data Analysis

As noted earlier, central to classic grounded theory methodology is the use of constant comparative data analysis. Glaser (1992) described this as the process of comparing incidents or codes (descriptive units) with each other and with concepts (abstract labels for groups of incidents) as the data is collected to produce more abstract concepts. This means comparing data to other data regardless of the nature of the data; sections of interview transcripts, the researchers own thoughts and questions in the form of memos also the literature sampled in response to the developed theory. As part of constant comparison and memoing, discussed below, classic grounded theory accommodates the author's stance and the interaction between researcher, participant during analysis and theory

development. Glaser (2002) in his response to the development of constructivist grounded theory, specifically its claims towards co-construction and the inclusion of self, indicates that classic grounded theory does in fact include the authors' views along with the concerns of the participants in theory development. Inclusion of the author is achieved via rigorous application of the constant comparative method, including the researcher's memos regarding their thoughts, questions and attitudes as data. Participants concerns are included through theoretical sampling; identification of a concern noted during constant comparison being further sampled for and subjected to further analysis to note similarities or differences. As the analysis continues the researcher notes ideas about categories, the core category (discussed later), links between categories and the properties of the categories. Glaser and Strauss (1967) describe four interlinked and cyclic stages to constant comparison.

3.6.2 Comparing incidents applicable to each category

During this process the data is coded and broken into as many categories as possible. Holton (2007) points out that the researcher is seeking to fracture the data to allow as much comparison of the categories and properties that relate to the incidents as possible. During this phase the researcher will record theoretical ideas in memo form as the coding goes on to ensure the memos are as fresh and numerous as possible. The theoretical ideas recorded on these memos are central to the generation of theory and will ultimately form the basis for writing up the theory (Glaser, 1978; Holton, 2007).

3.6.3 Integrating categories and their properties

This is the stage at which the researcher moves from direct comparison of the data, comparing incident with incident; to comparing the new data with categories and properties as they develop (Glaser, 1978; Holton, 2007). Glaser (2005) suggests that this process allows the development of related categories as well as clarification of the properties. Working in this

way the researcher begins to compare and relate the existing categories, gaining a clearer understanding of them and their properties.

3.6.4 Delimiting the theory

Holton (2007) argues that the constant comparative process and coding aim to delimit the theory. This is the process whereby the researcher discards irrelevant categories and properties. In effect the researcher reduces the theory to a clear number of high level hypothesis allowing the emerging theory greater conceptual abstraction and therefore broader applicability (Glaser, 1978; Holton, 2007). This process is a function of theoretical saturation and also supports the development of a core category.

3.6.5 Writing the theory

When the researcher has coded the data, produced categories and properties along with theoretical memos that explain the linkage between the categories the researcher can begin to assemble the theory for presentation. This process is as Glaser (1998) and Glaser (2002) suggests a conceptually complex one. The researcher is required to synthesise the research knowledge gained producing a theoretical rendering that will do justice both to the data and the researcher's own theoretical sensitivity.

3.7 Memoing

Memoing is the on-going process of writing down the researchers' ideas about hypothesis, connections and differences in the categories (Glaser, 1998). This on-going process of recording the researcher's questions regarding the data and on-going data analysis represents the researcher's efforts to raise the conceptual level of constant comparison. Memoing also relates to reflexivity, being the means by which the researcher's pre-conceptions and knowledge are recorded for scrutiny through the constant comparative process, earning a place in the emergent theory (Glaser, 2003). Memoing happens in parallel with data collection, analysis, writing up the conceptual theory and disseminating the work. Initially

memos are likely to be short dealing with the data itself then as the conceptual level raises memos will be longer as they consider the integration of the theory as a whole (Glaser, 1978; Holton, 2007).

3.8 Open Coding

Open codes and selective codes are often referred to as substantive codes (Holton, 2007). Open coding is first stage of data analysis. Glaser (1978) advises the researcher to approach the process with no preconceptions coding for what is found in the data and where possible using codes taken directly from participants words. Constant comparison requires that these codes are revised as analysis continues ensuring that the coding fits with the data (Holton, 2007). The researcher while endeavouring to code as comprehensively as possible avoids simple description of what is happening, seeking at all times to raise conceptual understanding. Glaser (1978) advises the researcher to constantly consider the questions what is happening, what is this data a study of; what category or property of a category does this incident indicate? Open coding continues until a core category emerges. The core category will relate to all of the other codes, be central to the data and will account for much of the variation found in the data. Holton (2007) and Glaser (1978) view this identification of the core category from open coding to be an on-going process subject to development as constant comparison continues, but that identification of even a tentative core category is an indication that the researcher should start delimiting the theory by selective coding.

3.9 Selective Coding

As the name suggests selective coding is the process of using constant comparison to code only for data that can be shown to relate to the core category. Bryant (2009) argues that grounded theorists utilise a mix of inductive and deductive reasoning during this coding process with the innovative component of grounded theory conceptualising arising from abduction, developing new hypothesis from careful comparison of the data. During selective coding the other categories are not ignored, rather their

relationship with the core category is understood and explained (Glaser, 1978). This focus on the core category and its relationship with other categories will in time allow emergence of the theory and theoretical saturation. At this stage the theory can be modelled and understood via theoretical coding.

3.10 Theoretical Coding

Theoretical codes explain how open and selective codes interrelate (Holton, 2007). This is a central component of theoretical development as it fully answers the question posed of the data from the outset, what is going on? By explaining the relationship between all of the categories with each other and the core category a model of what the data is telling us can be produced. This modelling is in effect the production of conceptual understandings that link and integrate the theoretical framework produced. Glaser (1978, 2005) describes a theoretical code as a means of re-ordering and explaining the disparate substantive codes. During constant comparison of open and selective coding memos will be produced considering substantive categories and the interaction of the codes, categories and their properties. These memos must be sorted and different theoretical codes applied to the developing theoretical understanding. Holton (2007) maintains that the researcher must endeavour to know and be open to a range of processes and models applying these to their conceptualisation in search of fit. In his book *Theoretical Sensitivity*, Glaser (1978) outlined 18 coding families and has added to these in subsequent work (Glaser, 1998). Holton (2007) cautions that these are not the only possible theoretical codes and that the researcher must be open to the application of any possibilities always cautious of being seduced or forced into the application of preconceived ideas.

3.11 Theoretical Saturation

This is the point where analysis of the data gives no further categories or properties relating to categories (Glaser and Strauss 1967). Theoretical

saturation is not an end point rather it is the stage at which the researcher perceives categories to be conceptually dense enough to ensure interchangeability of instances (Glaser, 1998). What this means in practice is that although new data can be collected constant comparative analysis of that data will no longer alter the conceptual understanding. Holton (2007) describes this as the stage where the search for '*interchangeability of indicators*' ceases. The emergent theory is deemed to be sufficiently clear and strong with the core category accounting for the variation noted in the data. Importantly the theoretical understanding produced is not an end point it is still open to modification within the substantive area of interest. Were further data collected constant comparison could always modify the emergent theoretical understanding (Glaser & Strauss, 1967).

3.12 Theoretical sampling

Theoretical sampling is the process whereby purposive sampling is undertaken in response to ongoing constant comparative analysis, tailoring the sampling to address the emerging questions (Glaser & Strauss, 1967; Glaser, 1978). The initial coding and categories produced direct the researcher to the next participants and data. This process allows development of the greatest possible understanding of the emergent categories and their properties (Glaser, 1978). For example, which participant or type of participant to interview next as well as the nature of the interview and questions is guided by the emerging analysis and recorded in conceptual memos. This active sampling allows comparisons to be made with existing theoretical concepts arising from the data and helps delimit the scope of the research (Holton, 2007). This process works alongside constant comparison to identify and develop the core category allowing supporting categories to be identified and the properties of these categories to be differentiated. Theoretical sampling allows the researcher to be guided by the data to the next set of data allowing them to identify similarities and differences in the data. Decisions about what participants within sites to sample arise from theoretical sampling along with decisions to sample in different sites (Glaser, 1978). It is important to note that this

variation in sampling is not seeking full description of the substantive area. Glaser (2001) notes that data is not sampled to describe, rather it is sampled to achieve parsimonious theory development. To begin with the data will give the researcher many options, as categories become developed, understood and saturated. The theory should be delimited and the amount of data should reduce as data collection focuses upon the core category. When the core category its properties and related conceptual categories are saturated data collection stops (Glaser, 1978).

3.13 Core Category

The aim of constant comparison and theoretical sampling in classic grounded theory is to develop a core category. The need to control the research scope by delimiting the research is explicitly and repeatedly referred to by Glaser (1978, 1992). The core category is not simply a centre piece that the other categories relate to. It is a frame that allows research to remain ordered and controlled. The core category when developed will be relevant to all the data and all others categories will relate to it. As such the core category is the highest level theoretical construct in any given theory (Glaser, 2001). It is derived from constant comparison of all data and while relating to all of the categories it does not account for all the relationships between categories (Glaser, 1978).

Giske and Artinian (2009) provide a useful example of developing a core category in their classic grounded theory research, exploring how patients in a gastric ward handle the diagnostic process. This research illustrates the process of developing the core category as their conceptualising produced and discarded '*living on hold*', '*striving to get to know*', '*contingency preparation*', '*preparing self for the concluding talk*' and '*preparing for alternatives*' before settling on '*preparative waiting*' as a core category. Almost 12 months in the making, the core category '*preparative waiting*' accounts for how the participants resolve their main concern which is conceptualised as preparing for final interview and life after diagnosis. The other categories that comprise the overall theory, '*handling*

existential threat, *seeking and giving information*, *interpreting clues* and *seeking respite* all relate to the core category *preparative waiting*. When Giske and Artinian (2009) were satisfied that their core category related to the other conceptual categories they then spent 18 months conceptualising and analysing the work developing the theoretical code *balancing between hope and despair* to explain how the other categories interacted with each to allow core category *preparative waiting* to resolve the main concern.

Data and analysis relating to the core category will take longer than others to attain saturation. This category will be more enduringly pertinent with more data referring to it than any other. It will in itself be a component of the substantive area/main concern of the study and as such it will relate to all the other categories in a range of ways. The core category will often, but not always be a basic social process which is identifiable by the presence of discernible stages of development over time (Glaser, 1978).

Recognition and understanding of these temporal elements involved allows the researcher to account for the beginning and end of behaviours and processes over time.

The rigour of classic grounded theory is supported by application of the constant comparative method and theoretical sampling. These components come together to develop a core category. Glaser (1998) described the process as the five Ss:

1. Subsequent: looking to what happens next.
2. Sequential: considering what is happening now and arises from now.
3. Simultaneous: doing many things at once.
4. Serendipitous: open to new ideas that come from the data and elsewhere.
5. Scheduled: work to an overall time plan.

Application of the five Ss requires the researcher to compare data across incidents and settings while memoing to capture ongoing conceptual

understanding. This is done concurrently with planning for the next stage of data collection (Glaser, 1992). This ongoing process informs the emergent theory while directing the next stage of theoretical sampling. Theoretical sampling around the core category is based upon the previous stage of constant comparison of all data including the researchers' memos. The ongoing analytical process is then recorded as theory generation continues. This labour intensive endeavour is potentially endless, limited only by the development of the core category. Until a core category emerges allowing selective coding constant comparison will indicate hundreds more hours of uncertain searching. The emergence of a core category that relates to and accounts for the other concepts directs and limits the research allowing more directed data collection and comparison of new incidents. This process adds to the depth and strength of the core category.

3.14 Theoretical Sensitivity

Theoretical sensitivity concerns ensuring that the researcher undertakes in depth analysis in support of theory. Glaser (1978) states that classic grounded theory aims to generate theory that accounts for an important pattern of behaviour or causes a problem for the participants. This is achieved not through description but through the application of theoretical sensitivity or analytical temperament (Holton, 2007). Analytical temperament is the researcher's ability to tolerate the confusion inherent in the data while allowing theoretical emergence. This is supported by analytic competence, meaning that the researcher must be aware of a range of theoretical approaches and be prepared to apply these. It is only through the application of theoretical sensitivity that the researcher can achieve the main requirement of classic grounded theory, which is identification of a core category and understanding of how this core category develops and changes over time. Interestingly, Glaser and Strauss (1967) are clear that theoretical sensitivity while key to the construction of the core category is not simply a function of analysis of the

data, but it emerges from the researchers experience and their cautious application of existing theory where fit and relevance is identified.

3.15 Quality and Credibility

As with all research classic grounded theory sets out to demonstrate its quality and credibility. Traditionally quantitative research measures the credibility of research against the defined criteria reliability, validity and generalisability (Creswell, 2009). Qualitative research differs as there is no single set of generally agreed criteria for evaluating quality (Parahoo, 2006). The numerous criteria used to evaluate the quality and credibility of qualitative research include reflexivity, relatedness, rigour and transferability (Creswell 2009; Hall & Callery 2001). Parahoo (2006) suggests that given the range of possible criteria for quality and credibility in qualitative research a judgement must be made and the criteria best suited to the research approach used.

Grounded theory is a general methodology which can utilise any data, within any paradigm as such it has unique criteria by which quality and credibility are measured. These arise from the nature of the output of classical grounded theory, namely systematically developed theoretical hypothesis (Glaser & Strauss 1967). Glaser (1978, 1992) defines rigor in classic grounded theory in four domains: *'fit'*, *'work'*, *'relevance'* and *'modifiability'*. These criteria reflect the unique output of classic grounded theory. While other research methods seek to produce verifiable factual results or full descriptions, classic grounded theory produces a systematically derived theoretical framework that explicates the behaviors noted in the data (Glaser & Strauss 1967). The resultant grounded theory does not lay claim to being the correct answer, rather it is intended to be a conceptually abstract explanation that arises from, and is meaningful to the substantive area of enquiry. In addition, it should be conceptually abstract enough to be relevant beyond its substantive area and be open to the addition of further data. The criteria *'fit'*, *'work'*, *'relevance'* and *'modifiability'* are now outlined.

'Fit' relates to the validity of the theoretical framework and ability of the core category to relate to all of the instances and responses to the main problem. Glaser (1978) argues that the researcher must seek to ensure that the developed categories are grounded in the data. This is done by avoiding pre-theoretical categories or forcing the data to fit with preconceived ideas derived from the extant literature (see Chapter 2). Constant comparison of instances in the data is used to ensure that categories emerge from the data, with selective coding around the core category ensuring that the theory *'Fit'* by maintaining conceptual focus (Glaser, 1998). Constant comparison aims to ensure fit and develops over time as the researcher theoretically samples and moves towards theoretical saturation. This process is explicitly detailed in chapters 5-8 as categories changed in response to constant comparison with new data.

'Work' is the ability of the theory to explain the variations identified in the participants behaviors. Described by Glaser (1978) work is the ability of the theory to explain the many ways by which the main concern of the participants, relative to the substantive area are addressed. In doing so, the criteria work describes the ability of the emergent theory to explain what is happening in the area of enquiry over time (Glaser, 1978).

'Relevance' refers to the core category fitting, meaning it fits and works within the substantive area and also to other researchers, participants and practitioners in other fields (Glaser, 1978). Glaser (1998) adds that a relevant classic grounded theory will have *'grab'* meaning it will be recognised by those with knowledge of the substantive or related fields. Where the theory developed is grounded in the data and has been developed through rigorous constant comparison it will be relevant to the area of inquiry.

When a core category achieves fit, relevance and works it should also achieve modifiability by being readily changeable when new data are applied. A classic grounded theory should have the minimum of concepts

that explain the totality of noted variation. Accounting for the emergent theory in the minimum of ways achieves parsimony and scope. This means that all the data (codes, properties and categories) should relate to the core category. The core category should in turn account for what is going on throughout the data.

3.16 Data Collection and Analysis

In this study the collected data included interviews with residents with dementia, staff and relatives and on-going observation within the sites visited. Researcher memos recorded while in the research sites and during analysis are also included within the data. As noted in Chapter 2, literature was tentatively accessed across the research process and once the emergent theory was well developed the extant theoretical, policy, research, education and practice literature from the substantive area was subject to constant comparison to further refine the final grounded theory. In the next section the methods of data collection used within this classic grounded theory will be discussed.

3.17 Interviews

Nathaniel (2008) identifies that in classic grounded theory the one to one interviews as a data collection method serve an important function, namely allowing the participants to tell their story. Glaser (1998) likens the researcher to being a '*big ear*' to which the participants give their stories, specifically their understanding of their main concern. This research aimed to rigorously collect empirical data that would develop theoretical understanding of psychosocial intervention use with residents with dementia. Interviews offer the researcher rich data concerning participant's understandings and motivations, specifically where the information refers to issues that cannot be observed (Cresswell, 2009; Parahoo 2006).

Nathaniel (2008) points out that flexibility around the main concern of the participant is at the heart of undertaking one to one interviews in classic

grounded theory. Simply having a set of questions is not enough, the phrasing of the questions and order must be tailored to meet the needs of the individual participant. Parahoo (2006) explains that one to one, semi-structured interviews allow the researcher considerable flexibility allowing the phrasing of how the question is posed to vary without failing to address the area of interest, making this form of interviewing most appropriate for this study.

3.18 Observation

The use of observation as a data collection tool allows identification and understanding of behaviours within their natural setting (Casey, 2006). Andrews and Waterman (2005) argue that observation is a data collection technique that fits with the inductive nature of classic grounded theory. Parahoo (2006) explains that there are a number of approaches to conducting observations. These include participant, non-participant, structured and unstructured. Participant observation is an approach where the researcher takes an active part in the activities and behaviours of the group being investigated while recording information on context and behaviours. In this research such an approach was deemed inappropriate as the researcher was not known to the participants or in a position to offer care. Therefore, non-participant observation which involves the researcher observing what is happening without active participation was chosen (Parahoo, 2006). Deciding on structured versus unstructured observations was the next challenge. Structured observations involve the use of a frame or schedule to direct the observation of pre-identified phenomena (Polit & Beck 2006). In contrast, unstructured observations involve the researcher observing the phenomena without pre-determined categories, allowing these to emerge from the observation process (Casey, 2006). In the context of the proposed study the aim of the observations was to develop an understanding of psychosocial intervention use with residents with dementia. Mulhall (2003) argues that while researchers using unstructured observation may enter the *'field'* with a limited conception of what is to be observed this

will develop over time. Mulhall (2003) suggests observing broadly in the first instance in order to develop an understanding of the overall context. Therefore, it was felt that a pre-defined structured observation tool might limit the data collected and lead to ignoring potential important factors that governed the use of psychosocial interventions. Given the emphasis on approaching the substantive area in an open manner and the intention to understand the interaction between context and individual action (Glaser, 2005) the observation approach selected was unstructured.

Andrews and Waterman (2005) suggest that the combination of observation and interview data are complimentary in grounded theory research, presenting opportunities for observation to support the ongoing interview data collection. Therefore in this study both interviews and observational data will be collected.

3.19 Summary

This chapter has explored the possible paradigm and research design approaches that could have been applied in this research. An in depth examination of classic grounded theory and the pragmatist paradigm, along with an explanation of the historical development of the classic grounded theory has been presented, providing a rationale for the research approach chosen. Having considered alternative approaches a pragmatist application of classic grounded theory has been identified as the most appropriate paradigm position and research design for developing an understanding of psychosocial interventions for residents with dementia in long-stay residential care. The criteria for quality and credibility in classic grounded theory have been described. Finally an outline of the data collection and analysis techniques used in this research has been provided, with the rationale for the choices outlined. The next chapter will describe the research methods used in this research.

Chapter 4: Research Methods

4.1 Introduction

The chapter will describe the methods used in this classical grounded theory study. It presents an overview of the research phases including accessing research settings and participants (theoretical sampling), ensuring rigor, data collection, data analysis and data management. Prior to this the procedure for gaining ethical approval is described.

4.2 Ethical Approval

Ethical approval for this research was granted along with the DARES Study (University Ethics Reference Number: 08/Sep/05). The Research Ethics Committee of the National University of Ireland, Galway and five hospital-based Research Ethics Committees responsible for the public long-stay units participating in the trial gave ethical approval (see ethical approval letters in Appendix 9). Residents with dementia are a vulnerable population and conducting research with them requires careful attention to their particular needs (Fisk et al., 2007; Slaughter et al., 2007). The following section on maintaining consent will outline how this was addressed in this research.

4.2.1 Consent

Dewing (2007) argues that people with dementia should be given the opportunity to participate in research and that excluding them compounds the difficulties experienced by this group. Therefore there is a need to consider how the capacity of potential participants is gauged (Fisk et al., 2007; Innes, 2002, 2009; Slaughter et al., 2007). Dewing (2007) argues that consent is a social endeavour where the researcher engages the person with dementia face-to-face in an effort to gain and maintain consent. This approach holds that by getting to know the person with dementia the researcher can understand whether the potential participant wishes to take part in the research.

Innes (2009) suggests that researchers must keep in mind the participants autonomy as well as their assumed ability to make decisions for themselves, acknowledging the participants ability to add to the research as well as their right to dissent. This was achieved by the researcher fully applying his clinical background and communication skills. The researcher also made full use of staff and family members as sources of advice, knowledge about the resident with dementia and for introduction before engaging with residents with dementia. Knowing residents likes and dislikes, their ability to engage/concentrate, whether they had trouble hearing, their demeanour on any given day and their cognitive ability were all crucial to the success of the interviews. Being prepared to pace interviews to suit the resident with dementia, take time and be patient was also crucial.

In this study the principle that residents with dementia can give consent, where there is no evidence to the contrary was adhered to (HIQUA, 2009); as was the view that the resident with dementia could remove that consent as the research proceeded (Black et al., 2010). Therefore, the resident with dementia's continued consent to participate was checked at all stages of the research after initial consent had been given. The researcher was conscious of the need to ensure that residents with dementia were engaged in the research to their full potential and free from coercion. Therefore continuous assessment of the resident with dementia participants' consent was undertaken during the interviews. If any participant was felt to be uncomfortable with the interview, showed upset through their body language, or lost interest, the researcher stopped the interview. Some interviews were short (20 minutes) reflecting the fact that participants became tired and disengaged. In these instances, the researcher stopped the interviews, either fully to give the participant a rest before returning or to engage them in another activity, such as discussing what they wanted to or to have a cup of tea. Staff were consulted on these occasions to help judge the participants' consent. Where breaks occurred they varied from 15 minutes to two hours,

returning to the participant when it was felt that the participant was ready to continue, whilst once more re-checking participant consent.

O'Shea et al. (2008) provide useful advice regarding gauging capacity in cognitively impaired individuals in long-stay care, suggesting the need for constant re-assessment of capacity at each interaction. In practice, gaining consent and maintaining assent meant spending a lot of time with residents with dementia, their relatives, and staff to ensure everyone was comfortable with the process. Staff in particular directed the researcher offering advice on when and when not to engage with residents with dementia based upon their experience.

4.2.2 Maintaining Confidentiality and Anonymity

A number of measures were taken to ensure the confidentiality and anonymity of participants. All participants and research sites were given a code, no names of participants or sites were used on transcriptions of interviews, consent forms or demographic information forms (see appendices 2-5). The names of participating long-stay units, residents with dementia, staff and relatives were stored separately from their study codes. All of the site and participant data was securely filed and locked away and will be stored for five years according to university guidelines, at which point they will be destroyed. In accordance with the Data Protection (Amendment) Act 2003 (Government of Ireland, 2003), the interview transcriptions, interview recordings, researcher memos and DARES master coding lists for each long-stay unit, residents with dementia, staff, and relatives were electronically secured with passwords.

4.3 Overview of Research Phases

The data for this study was collected through interviews, observation and sampling the extant literature. As noted in Chapter 3 classic grounded theory is a research strategy where the analysis and data collection take place simultaneously (Creswell, 2009; Parahoo, 2006). This means that while this chapter does describe how the actual research was undertaken,

Chapters 5-7 contain the detailed explanation of the theoretical sampling, data analysis and maintenance of credibility in this research.

Data collection and analysis for the current study took place over four phases between March 2009 and December 2013. Table 4.1 provides an overview of these and the progression of the four phases of data collection, showing that data analysis and theoretical modelling took place during and after the data collection periods. The literature sampling for Phase 4 is detailed in Chapter 8 and the process of theoretical sampling is detailed in Chapters 5-7. The relationship between the DARES project and this classic grounded theory study along with the approach to accessing (sampling) the literature in classic grounded theory was described in Chapter 2.

Table 4.1 Overview of Research Phases

Research Phases 1-4			
Phase 1	Phase 2	Phase 3	Phase 4
4 Sites 11 Interviews March-Sept 2009	3 Sites 18 Interviews May -Aug 2010	3 Sites 38 Interviews July-Sept 2011	Intergrative Literature Comparison May-Dec 2013

4.4 Research Sites

4.4.1 Site Recruitment and Consent

The DARES study employed a project manager. This project manager contacted the nurse managers or the proprietors of eligible long-stay units inviting them to participate (see Chapter 2 for DARES study description). Participant information sheets and site agreement forms (see Appendix 5) were sent to each unit. After this the DARES project manager contacted each nurse manager and/or proprietor by telephone explaining the proposed research and answering any questions. Participating long-stay

units then returned the signed site agreement to participate forms to the project manager.

4.5 Research Participants classic grounded theory study

This section will now describe the inclusion and exclusion criteria, recruitment and consent procedures within the classic grounded theory study.

4.5.1 Residents with Dementia: inclusion/exclusion criteria, recruitment and consent

Residents were included in the classic grounded theory study if they had lived in the recruited long-stay setting for at least one month and were likely to remain there for the duration of the study. The one month time period ensured that the resident with dementia was known to staff allowing the nurse manager to decide if the resident was able to participate.

In response to the noted lack of formal dementia diagnosis in Ireland (Cahill & Diaz-Ponce, 2010) a number of approaches were used to determine whether participants had dementia and would therefore be eligible to participate in the classic grounded theory study and DARES trial. Residents were deemed eligible if they had received a formal medical diagnosis of dementia as determined by DSM-IV (APA, 1994) or ICD-10 criteria (WHO, 1992), or any other diagnosis of dementia by a medical clinician, or if the resident with dementia was prescribed anti-Alzheimer's medications or if in the opinion of the ward manager the resident was likely to have dementia and had documented this.

Residents in Phase 1 of the classic grounded theory study had to be part of the DARES study, but had not received the intervention. Residents in Phase 3 of the classic grounded theory study participants had to have received the DARES intervention.

Residents were excluded from both studies if they had a sensory impairment or a physical illness that the nurses felt impacted on their ability to participate.

Once potential participants were identified the nurse manager introduced the researcher to each potential participant. The researcher explained the purpose of the classic grounded theory study to the resident with dementia and they were asked if they wished to participate. All residents with dementia who were approached consented to participate.

4.5.2 Consent from people with Dementia

The participants were given a study information sheet outlining the purpose of the classic grounded theory study and the DARES study, the process, possible benefits and harms. Participants were given assurances regarding the confidentiality of their data. The participants were reminded that participation was entirely voluntary and that they could withdraw at any stage with no consequences. Participants who indicated they understood the purpose of the research, their liberty to withdraw and that they wanted to participate then completed the consent form (See Appendices 4 & 5). All residents with dementia were able to give informed consent and all next-of-kin were provided with the participant information sheet provided to participants.

If any participants were deemed unable to provide consent directly, consent by proxy could be sought. This was unnecessary as all residents with dementia in the classic grounded theory study were able to give informed written consent. Resident with dementia participants were given at least 48 hours between receiving information and the return of consent.

Although all participating residents with dementia initially gave consent, ongoing participation was not assumed. Ongoing consent, meaning willingness to participate over time was repeatedly re-assessed as the research progressed (Dewing, 2002; Slaughter et al., 2007). None of the

participants withdrew consent, but the understanding was that if they had, they would have been withdrawn from the research immediately without consequences.

4.5.3 Staff: inclusion/exclusion criteria, recruitment and consent

Staff were deemed eligible as participants if they had worked in the long-stay setting for three months and would remain there, caring for residents with dementia, for the duration of the classic grounded theory study and the DARES study. The three month period was deemed the minimum required for a staff member to be familiar with both the residents with dementia and ways of working within the in the long-stay setting. Resident participants were given at least 48 hours between receiving the study information and the return of consent.

Staff recruitment and consent procedures involved the nurse manager identifying potential staff participants (staff nurses and health care assistants). All potential participants were given a participant information sheet and a staff consent form (see Appendix 5). The nurse manager then introduced the researcher to each potential staff participant. At this stage consent was sought from the potential staff participant. The purpose of the interview was explained to the staff member and they were asked if they wished to participate. The participants were given a participant information sheet outlining the purpose of the study process, possible benefits and harms. Staff participants were given assurances regarding the confidentiality of their data. They were also informed of the data collection procedures and commitment required for participation (see Appendices 3 & 5). Staff participants were reminded that participation was entirely voluntary and that they could withdraw at any stage with no consequences. Staff participants who indicated they understood the purpose of the research, their liberty to withdraw and that they wanted to participate then completed the consent form. Staff participants were given at least 48 hours between receiving the study information and the return of consent.

4.5.4 Relatives: inclusion/exclusion criteria, recruitment and consent

Relatives were deemed eligible as participants in the classic grounded theory study if they had a family member who was a resident with dementia participant in the DARES study.

Relative recruitment and consent procedures involved the nurse manager identifying potential relative participants. All potential relative participants were initially approached by the nurse manager and were given a participant information sheet and a relative consent form (see Appendix 5). The nurse manager forwarded the signed relative consent form to the researcher. The nurse manager then liaised with the researcher and a time for a phone interview with the classic grounded theory study researcher was agreed. When phone contact was made, verbal consent was confirmed and the purpose of the interview was explained. The participants were asked if they had read the participant information sheet outlining the purpose of the classic grounded theory study, process, possible benefits and harms. Participants were given assurances regarding the confidentiality of their data. The participants were reminded that participation was entirely voluntary and that they could withdraw at any stage with no consequences. Participants who indicated they understood the purpose of the research, their liberty to withdraw and that they wanted to participate were then interviewed. Relative participants were given at least 48 hours between receiving the study information and the return of consent.

4.6 Theoretical Sampling

Each of Chapters 5-8 gives a detailed description of the theoretical sampling rationale and approach. The two initial interviews were purposefully sampled with experienced nurses who had completed postgraduate diplomas in gerontology at the researchers' university. They were not known to the researcher in advance and both they and their long-stay settings were subject to recruitment and consent in the same manner as all of the classic grounded theory sites and participants.

Analysis of these directed the theoretical sampling and interviews for the rest of Phase 1 (see Chapter 5).

The theoretical sampling approach used in this study is also referred to as a process of 'site spreading' (Glaser, 2001). This was achieved by the researcher and his supervision team considering the data analysis and deciding on the most appropriate next data collection site and participants available from the DARES sites. In total twenty-one sites gave consent to DARES. However three sites were excluded pre-randomisation, following the collection of baseline data as they could not guarantee having 17 consenting residents with dementia. These sites were accessed in Phase 2 of the classic grounded theory.

4.7 Data Collection Methods

Prior to describing the data collection methods an overview of the numbers of sites, number of interviews conducted in each phase is given in tables 4.2, 4.3 and 4.4 (see Appendix 1). Phase 1 included four sites, three resident with dementia and eight staff interviews.

Table 4.2 Phase 1, Sites and Participants

Site Number	Site Type	Residents With Dementia	Staff
1	Urban Private		1
2	Rural Public		1
3	Urban Public	2	1
4	Rural Private	1	4
	Other		1

Phase 2 included three sites, with and eighteen staff interviews.

Table 4.3 Phase 2, Sites and Participants

Site Number	Site Type	Staff
5	Urban Public	6
6	Rural Public	7
7	Rural Private	5

Phase 3 included 3 sites, 11 resident, 22 staff and 5 relative interviews. These 3 sites were accessed after the completion of the DARES structured education programme, while the delivery of the DARES intervention, using reminiscence with residents with dementia was still underway. The details concerning these sites and study participants are outlined in Table 4.4.

Table 4.4 Phase 3, Sites and Participants

Site Number	Site Type	Residents With Dementia	Staff	Relatives
8	Urban Public	4	8	1
9	Urban Public	5	7	2
10	Rural Private	2	7	2

4.8 Interviews

One to one semi-structured interviews were used to interview people with dementia and staff participants. The interview approach and guide was developed as the phases of the research progressed, with the guide adjusted relative to the focus of the questioning and the nature of the participants (residents with dementia, staff nurses, health care assistants, managers and relatives). The initial interview guide was designed to provide understanding of psychosocial intervention use in long-stay settings (see Appendix 7). The content was developed from the initial literature reviewed in Chapters 1 and 2 and agreed with the DARES research study team. It included a definition of psychosocial interventions with the aim of generating broad discussion of the subject area with the participants.

Starting with two initial interviews in Phase 1 enabled the researcher to consider and adjust the interview guide along with interview technique. At the close of each interview the participants were also asked to comment on the interview experience and identify any elements they would add or change. The interview guide was adjusted after the first two interviews, initially in response to the evident lack of psychosocial intervention

use/knowledge and then in response to the ongoing analysis and emerging theory. The definition of psychosocial interventions proved problematic, as participants had very limited experience of them. Accordingly this was replaced by specific questions and ongoing discussion with the participants about what psychosocial interventions meant to them.

These initial interviews provided preliminary codes and categories. These codes and categories provided direction for the subsequent data collection. Feedback from the participants was sought as these initial interviews were also used to develop the researcher's interview approach/skills. Although an interview guide was used to collect the data, the interviews were kept as conversational as possible allowing the participants the flexibility to identify and discuss their main concerns.

As the data collection and analysis process proceeded the emergent categories became increasingly saturated. The development of clearer conceptual categories, specifically the core category, allowed the interview guide to become more focused on the emergent theory, though there was always scope for the participants to add data that could be identified with new codes. The development of the interview guides is detailed in Chapters 5-7. These are provided in Appendices 7-9 which present the numerous versions used across the three phases.

Once at the participating sites the researcher made himself known to the manager who had in advance organised a venue for the interviews. Due to space limitations the venue was typically a staff room, bedroom or empty sitting room. All efforts were made to ensure the participants were comfortable and the interviews were uninterrupted as well as confidential. The choice of setting for resident with dementia interviews was particularly important, here again staff proved invaluable identifying the most suitable setting for these interviews, which typically was in the residents bed room or an identified quiet area. A digital recorder was used

and the researcher took minimal notes to reduce distraction to the participants. More substantial notes in the form of memos were recorded following the interviews and these were included in the constant comparative process. Following data collection, all interviews and memos were transcribed verbatim. The interviews were then listened to whilst reading the transcripts to correct errors and where possible fill in missing data.

It was important to be flexible around the routine of the participants. Doing so facilitated access, developed rapport with the participants to facilitate observation. The combination of interviewing the participants at times that suited their routine, set amongst periods of unstructured, observation (detailed below) allowed observation of the long-stay settings to be reflected upon and resultant questions asked in the interviews. Interviews varied in length across the study between 20 and 60 minutes. The interviews became more focused and shorter as the categories became saturated and the core category emerged. It is worth noting that the resident with dementia interviews varied in length, some short as the individuals grew tired or distracted. Others longer where individuals required more time to articulate their data.

4.9 Observations

The interviews were the primary data source for this research. However observational data was also collected to provide important contextual data and as a means of developing further exposure to and understanding the factors that influenced psychosocial intervention use for residents with dementia in the long-stay settings.

As noted in section 4.10 the researcher had to be flexible in his interview timings to meet the need of the long-stay settings. The observation approach used in this research is described by Parahoo (2006) as unstructured observation, identifying this approach as appropriate where there is little known about the area under scrutiny. Andrews and

Waterman (2005) identify the applicability of this data collection approach, combining interviews and observation, to classic grounded theory. The amount of time spent in each site varied between 4 and 12 hours. This time variation reflects the intent in each site to observe around key times in the day, morning activities, mealtimes, while undertaking all the available interviews. In-between interviews the researcher placed himself in sitting rooms, dining rooms, staff offices and reception areas. Unfortunately time periods for observations could not be pre-specified as opportunities to interview could arise at any moment, decided upon by the nurse in charge/setting routine. Casey (2006) identifies the importance of setting limits on observation to reduce observer fatigue. In this study, from the outset a minimum of 2 hours was allocated for observation at each site at any one time, as it was felt that this would allow the researcher to focus on what was happening without becoming overly fatigued.

Initially observation was used to identify psychosocial intervention use along with the day to day routine (waking and dressing, mealtimes, activities etc.), social interactions and practices. As the researcher became more sensitised to the areas and the emergent theory, the observation became more focused on the emergent codes and categories. For example instances of staff using knowledge of the resident with dementias background in day to day interaction or favouring physical care over social interaction.

In an effort to be as unobtrusive as possible the researcher did not take notes whilst observing, rather he dictated memos when the opportunity arose recording observations and questions. Dictation took place in private areas before or after interviews. This approach of watching, listening and asking questions during unstructured observation supported the interview process by adding understanding and questions. These questions were either recorded as memos or put directly to participants as the interviews progressed. The purpose of the unstructured observation was to explore the manner in which psychosocial interventions were used

within the long-stay setting by viewing staff-resident with dementia interactions. As such the viewing position was mobile allowing staff to be observed at various times and settings (talking to residents with dementia by their beds, activities in day rooms, assisting feeding in dining rooms etc.).

4.10 Ensuring Credibility

The criteria fit, work, relevance and modifiability evaluate the credibility of a grounded theory based upon the theoretical output of the research. Unlike other forms of research these criteria are not applied at the outset of the research, rather they are applied to the emergent theory after its development. Glaser (2003) notes that a credible grounded theory will have '*product proof*' meaning the product of the research itself attests to credibility. In addition, a credible classic grounded theory should demonstrate conceptual abstraction giving it grounded theoretical applicability in its own substantive field and beyond.

In this thesis, credibility is also supported by transparency as Chapters 5 to 8 illustrate what Glaser (2003) refers to as '*procedural credibility*'. These chapters show the systematic use of classic grounded theory procedures to ensure that conceptual development stems directly from the data as theoretical sampling progresses (Glaser, 2003). Theoretical development is central to theory generation and is achieved by systematic application of constant comparison (Glaser, 2005). The following section presents an example of procedural credibility as applied during data analysis in this research.

4.11 Data Analysis

Table 4.5 illustrates the relationship between open codes (initial comments/labels on the data), categories (conceptual groupings of codes) and the core category (the central, delimiting concept). Open codes generated from the analysis of the interview transcripts are grouped under conceptual headings into categories, so the open code 'patience' is

grouped under 'caring attributes'. The three categories at the stage of the analysis in the example then in turn relate to the core category at that time 'flexibility'. The means by which memos arising from interviews and observations are incorporated into the process of theory development is further illustrated in Tables 4.6 and 4.7. These illustrate the data analysis process and provide an example of the progression from actual data to conceptualisation and theory development through constant comparison of incidents.

Table 4.5 Core category, categories and codes

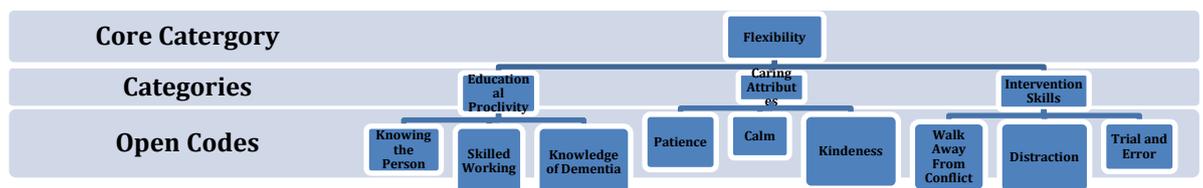
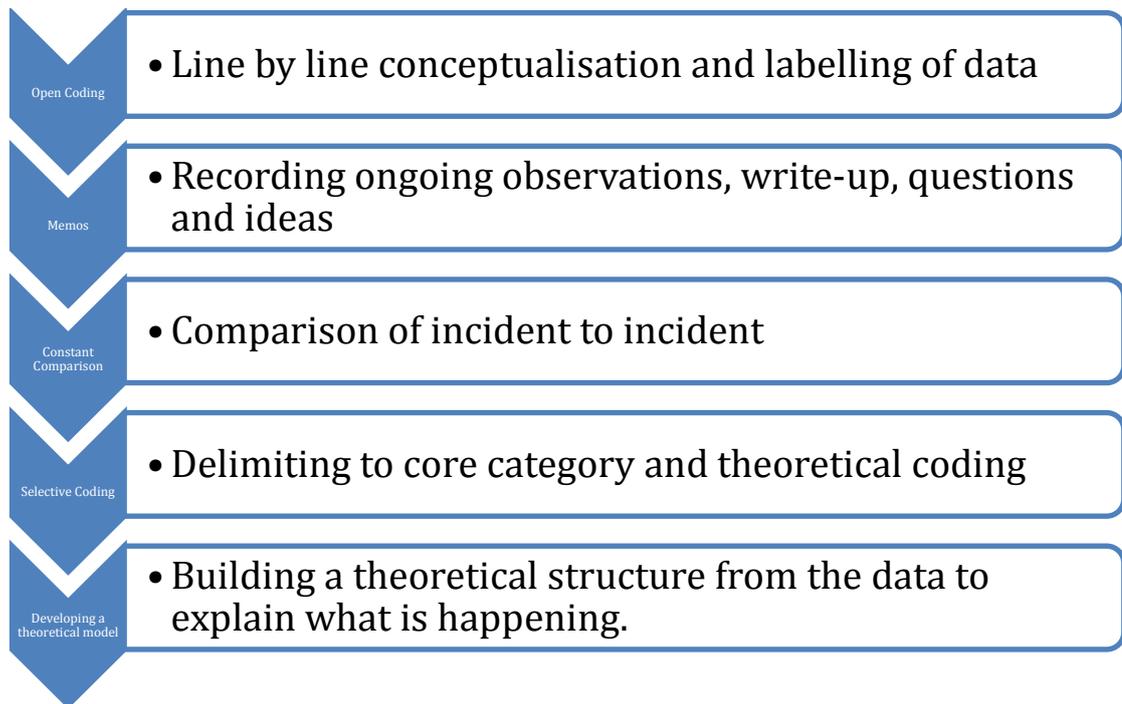


Table 4.6 shows the overall data analysis process as incidents of data conceptually progress, illustrating their relationship with the emerging core category and ultimately with the developing theoretical model.

Table 4.6 Data Analysis Process



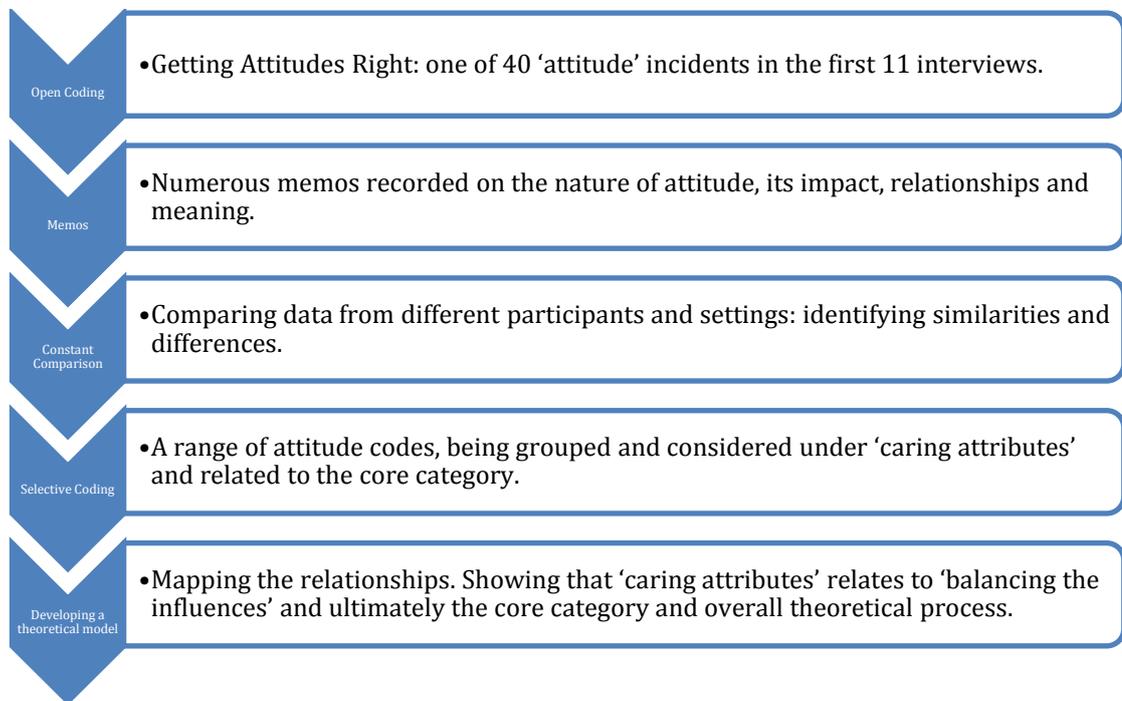
The example of a memo below illustrates how the researcher recorded his questions about the data. Hundreds of these memos were recorded and transcribed across the study. This memo illustrates the growing conceptualisation around the issue of staff attitude and how this memoing process is central to the conceptual credibility of classic grounded theory:

The participants say they want to react positively to behaviours that challenge, such as being shouted at, but lack the time and knowledge to react in a timely and flexible manner. This indicates that there is a link between education, knowledge, attitude to people with dementia and staff action. The link between time and flexibility is clear and also clearly relates to the prioritising physical care over other concerns. I just have time to do a bath not to think psychosocially and I'm not minded to do that because I don't believe/know it will work. Memo 11/02/09

The memo illustrates the ongoing theoretical development that emerges through constant comparison of the data. Table 4.7 shows the actual contribution of data to the theoretical development. In this example a quote from a health care assistant is open-coded, considered in memos, then compared with other data to show differences and similarities. This illustrates that the theory is developed directly from the data through constant comparison of the numerous incidents in the data.

Table 4.7 Example of moving from data to conceptualisation

Healthcare Assistant quote, *‘at the end of the day, this is their home, and the way I’d be looking at it, I’d look at anyone as if it’s my mum and dad, and the way I’d like them to be looked after if they were in a home’*



Tables 4.5, 4.6 and 4.7 illustrate the process of constant comparison used in this study and the constant grounding in the data that keeps the theory close to the data achieving parsimony and scope. Glaser (1992) views parsimony and scope as the central component of theory developed primarily through deduction. Theory that through conceptual abstraction accounts for the variation in the behaviour noted in the data using the smallest number of categories possible.

4.12 Data Management

The interview data and memos for this study were transcribed and stored using computer assisted qualitative data analysis software (CAQDAS), NVivo 10. Glaser (2003) argues that the use of CAQDAS interferes with the researchers’ ability to conceptualise, producing descriptive accounts rather than conceptualisation. In 2011 the researcher attended NVivo training, satisfying himself that while there were potential problems with the use of CAQDAS these were by far outweighed by the benefits. This

decision was supported later in the research when the researcher attended a classic grounded theory training event in 2012. At this event, Barney Glaser suggested that while he had not changed his view researchers could use such approaches, but must view them as nothing more than a tool, ensuring, constant comparison and memoing are not controlled by the CAQDAS.

Qualitative data analysis requires considerable organisation and NVivo 10 offered this researcher a means of organising the data and ordering analysis effectively. Lathlean (2006) points out that another crucial benefit of the use of CAQDAS is the ability to identify and retrieve data, leaving an audit trail and illustrating the structured approach to the management of data and analysis. That said the software does not reduce the time or analytical focus required to conceptualise from the data (Bringer et al., 2004).

All of the participant interview data and memos from Phases 1-4 were stored and sorted using NVivo 10. Use of *Free nodes* allowed open coding with *Tree nodes* being used to represent substantive coding as the hierarchical relationships between the concepts was developed (Bringer et al., 2004). Screen shots showing the relationship of categories can be seen in Appendix 11.

4.13 Summary

This chapter has presented the actual research process used in this study. Ethical approval, participant consent, data collection methods, theoretical sampling, research credibility, data analysis and data management have been described. The next chapter begins to outline the theoretical development of this thesis, presenting the emergent grounded theory of becoming a person again.

Chapter 5: Phase One Data Collection and Analysis

Oh, has dementia become a psychiatric problem? (Participant 2- Nurse Manager)

5.1 Introduction

This is the first of four chapters that describe the data collection, data analysis and theoretical development of this thesis.

Phase 1 comprises of two cycles of theoretical sampling, constant comparison, theoretical modelling and subsequent theoretical sampling. This process commences with participant interviews 1-2 which are subject to constant comparison, giving access to the area of interest and subsequent theoretical sampling. This is followed by constant comparison, theoretical modelling and subsequent theoretical sampling of all Phase 1 data (participants 1-11). Data collection for Phases 2 to 4 follows on from these initial participants using the same process of theoretical sampling, constant comparison, theoretical modelling and subsequent theoretical sampling. The questions asked in the initial interviews aimed to begin the process of understanding the participants' psychosocial intervention use, what they know about psychosocial interventions, what psychosocial interventions were being used for and how the participants want to develop their psychosocial intervention use.

5.2 Theoretical Sampling (Participant 1-2)

In his discussion of sampling for grounded theory research, Glaser (1992) makes it clear that the nature of the participants (i.e. gender or setting) is secondary to the data that emerges. Accordingly, subsequent constant comparison of data is a process of looking for similarities and differences between codes and categories not between participants or participant types. The intention being, start sampling and let the analysis guide subsequent theoretical sampling. Therefore, the first two participants were purposefully sampled to provide data that would develop understanding of psychosocial intervention use with residents with dementia in long-stay care. These first two participants had considerable

experience working with people with dementia in residential settings as such they were chosen to provide insights for shaping and refining the emergent theory, see Table 5.1 Phase 1 initial Participant Demographics.

The first two participants were interviewed in their long-stay residential work places, one in an office the other in an empty resident bedroom. As with all participants in this study both had been contacted in advance and given information on the study, they gave consent and filled in a short demographic information form. Both were eager to talk but indicated the time pressure upon them, along with the very apparent work load. Both participants made their colleagues aware of where they were and handed their drug cabinet and door keys over before commencing the interviews. In spite of these precautions, both participants were interrupted, features that would be repeated as data collection continued across phases 1-3. The author followed the questions set out in the participant interview guide (see Appendix 7-9).

Table 5.1 Phase 1 Initial Participant Demographics

Participants	Role	Applicable Education	Residential Care Experience	Years in Current Post/Setting	Setting	Age	Gender
1	Staff Nurse	RMN, PgDip Gerontology	10 years	6-10	Private Urban	30-39	F
2	Nurse Manager	RGN, PgDip Gerontology	10 years	6-10	Public Rural	40-49	F

Phase 1 has two sets of sampling, constant comparison, theoretical modelling and subsequent theoretical sampling. Initially participants 1-2 were subject to constant comparison, giving access to the area of interest, allowing initial comparison and subsequent theoretical sampling. The analysis of the two initial participants was subject to open coding with the initial concepts of ‘understanding dementia’, ‘positive caring’, ‘skills and status’ and ‘time and task’ emerging. This is followed by constant comparison, theoretical modelling and subsequent theoretical sampling of all Phase 1 data (participants 1-11).

5.3 Analysis (Participants 1 and 2)

5.3.1 Understanding Dementia

The analysis of these two initial participants reveals much about the participants' understanding of psychosocial interventions with residents with dementia. The quote at the start of this chapter is from participant 2, the nurse manager of a residential setting with ten years of experience working with residents with dementia, she was the second person participant in the study. Uttered with real surprise, the quote came about when the participant realised that she was being interviewed about psychosocial interventions relative to dementia care by a researcher with a mental health nursing background. This quote helps to illustrate and locate the particular world view of this participant, as they had been working with people with dementia for many years and did not consider dementia to be a condition amenable to any approach beyond the medical understanding she worked with. This revelation offered the author an early alert to the potential variation in conceptual viewpoint, philosophical understandings, attitudes and meanings attached to dementia that may arise in the data.

Many insights and questions were generated from these first two participant interviews and the time spent observing the two long-stay settings. Constant comparison of this data revealed conceptual insights regarding the understanding of dementia and the perceived needs of the residents. Both participants speak of nurses in their workplaces having a poor understanding of dementia and not always knowing how to respond to the needs of residents with dementia. As this example of data attests the participants are very clear regarding their colleagues need for more knowledge:

I think staff need to understand that people are losing their social skills they are not doing it to annoy you. They (residents with dementia) are not doing it to make your shift more difficult they are doing it because that's about all they can do really (Participant 1- Staff Nurse)

'Understanding dementia' emerges as an important concept. In addition to identifying the need for more knowledge, actual delivery of care, 'doing',

arose as a concept that was impacted by 'understanding dementia'. As lack of dementia understanding was seen to impact on care delivery:

They (Health Care Assistants and Staff Nurses) think you can just dive in and say 'c'mon, we are going to give you a bath', and I'd say 'you have to go to them 10 mins beforehand and in 10 mins I'm going to come back and get you', and things like that that. These girls mightn't have the understanding for that (Participant-2 Nurse Manager)

The data contains negative and positive examples of how 'understanding dementia' along with knowing the preferences of the resident with dementia combine to explain 'doing', the nature of actual psychosocial interventions delivery. The nurse manager example above describes 'diving in', staff unaware of the need to adopt a more gentle, slow approach. Both participants, while clear about the deficits in 'understanding dementia' present in their colleagues, also held that they and their colleagues possessed innate qualities that provided positive psychosocial intervention care even where educational understanding was lacking.

5.3.2 Positive Caring

The participants were asked about what made staff likely to have positive interactions with residents with dementia. They indicated that personal attributes or qualities, such as kindness and patience, are of primary importance to the provision of positive care as was staff attitude towards residents with dementia. Analysis of the data revealed instances where 'positive caring' was delivered via the use of psychosocial interventions, while a number of instances noted the absence of psychosocial intervention use. The questions arising from the realisation that some staff/resident with dementia interactions involved 'positive caring' and others did not was captured in this memo recorded during analysis:

Participants seem to aspire to 'positive caring' but know it's often missing. What the data from these participants did not tell me is how individuals develop and maintain these personal qualities and positive attitudes. Is it being managed, is it training, time served, luck, even just being naturally good at this work? Need to look at what makes 'positive caring' stick. (Memo 11/02/09)

The emergent understanding the concept 'positive caring' emerges directly from the data. With instances identified by the participants indicating where they could have delivered 'positive caring' and why:

for instance here we had one gentleman here who just suddenly became extremely, extremely difficult out of the blue completely and I said I wonder if that's anything to do with his vascular dementia which now looking back on it I must be the most stupid person ever cos now I realise oh my god of course it was (Participant 2- Nurse Manager)

This nurse manager is very clear that she possesses the 'positive caring' qualities required to effectively care for people with dementia, but indicates that her lack of understanding of dementia inhibited her ability to care effectively. The participant is weighing up her aspiration towards 'positive caring' beside her education and experience in an effort to explain the actual psychosocial interventions delivered.

It is notable that the participants valued education that could deliver greater understanding of dementia and intervention options that could be used when working with people who exhibit behaviours that challenge. At this stage in the analysis the data was unclear regarding the relationship between education and 'positive caring' when accounting for the quality of psychosocial intervention delivery. Constant comparison of incidents around attitudes, attributes and dementia understanding does indicate that 'positive caring' cannot occur without positive application of attitudes and attributes, with education being an important contributing concept. You do not need education to provide 'positive caring' and education does not always ensure 'positive caring', but education in conjunction with experience can alter the application of psychosocial interventions for the better.

5.3.3 Education and Experience

'Education' and 'experience' both emerged as related concepts that impact upon psychosocial intervention delivery. The participants related their attitudes, psychosocial intervention care delivery, and dementia understanding to these concepts. The data relating to education about

dementia and the importance of personal qualities to 'positive caring' revealed complex and at times contradictory relationships. The view that staff education would help people do a better job partially contradicts the participants' initial prioritisation of personal traits. This contradiction indicates that while personal traits are required for effective working, individuals can benefit from educational input. 'Experience' shows itself to be a concept related to 'education' with the previous nurse manager quote indicating that the participants' 'experience' was telling them something was wrong, but that they did not have the knowledge to formulate an understanding of what was wrong or how to act. This data again indicates that while ongoing 'education' is not immediately prioritised by participants it is a required component of effective practice.

There is a contradiction present between the participants' prioritisation of personal qualities over 'education'. The relationship between participants understanding of personal qualities, 'education', 'experience' and skills generated a number of memos seeking to record the questions and complexity of the developing theory:

Is the view that you must possess qualities such as kindness or you cannot function effectively in dementia care tenable? Surely kindness and the skilled approach arising from its application (or the opposite) can be innate but also varies with education and experience. Perhaps the answer is about identifying things that support you to focus on the job in hand, when saying, 'give it your whole mind' (Participant 1) is talking about the realisation (gained via education and experience) that kindness and a positive attitude delivers 'positive caring'. (Memo 11/02/09)

Staff indicated that there is something special about working with people with dementia and awareness of this creates a positive attitude and as such supports good care. I need more data on how a positive attitude impacts on care delivery, how it is fostered and maintained. (Memo 11/02/09)

The questions in these memos show the emergent understanding of a complex conceptual relationship between innate personal qualities, 'education' and 'experience'. The interaction of these concepts impacts on staff understanding, attitude, skills and doing. Constant comparison shows that staff delivery of care varies across people and time. The participants indicate that staff react positively to behaviours that challenge such as;

wandering, shouting and physical violence, if they can attribute the challenging behaviours and changes to dementia. Where this was not the case staff may take offence and react negatively. The link between 'education', 'experience' and attitude was made explicit, with this nurse manager making a distinction between trained staff and health care assistants:

The nurses would have the understanding, but the girls who are training to be nurses aids on FETAC (Irish Further Education and Training Awards Council) courses you can hear them giving out to people and you have to go over and say there is absolutely no point, you're not getting anywhere, just don't do it (Participant 2- Nurse Manager)

That health care assistants berate 'give out' to residents indicates the challenging nature of the work along with suggesting deficits in their educational preparation. This data illustrates another contradiction that relates to 'experience', participants indicated that colleagues can see working with older people as a clinically easy option. This is illustrated by the same nurse manager's comment on her own motivation on commencing residential care work:

can I tell you this and I'm just being honest, but I can remember when I moved here 10 years ago from theatre nursing. I remember saying to myself and maybe just joking with people, oh I'm retiring now do you know what I mean? (Participant 2- Nurse Manager)

This view is supported by this staff nurse when discussing her experience of colleagues' attitudes to work with older people:

I think it was felt that there were very little skills needed. You know it's only now I think that working with older people is even getting any kind of recognition (Participant 1-Staff Nurse)

The participants understanding is that residential care for older people can be viewed as requiring less skill than other areas of health care. This understanding raises numerous questions regarding conceptual understanding of educational need and the impact of 'experience':

This data could be a study of staff's self-view and worth it's not just about patient care? These concepts (doing psychosocial interventions, educational understanding, attitude etc) all influence each other, but if staff think this work is easy or not skilled then this is not all about patient care it's about staff impacts on themselves and each other? (Memo 20/11/09)

These questions raised further questions around the skills required and the status of working with people with dementia.

5.3.4 Skills and Status

Constant comparison of the data shows that the provision of positive psychosocial interventions for residents with dementia is influenced by 'experience', 'attitude' and 'education'. Additionally it is also influenced by existing skill levels and staff members' perception of their own 'status' and the status of the work. Analysis shows that the participants did not routinely appreciate how complex and challenging working with older people can be with this attitude impacting upon their skill use and interest in training. This next comment from a staff nurse on colleagues who were asked to keep a behavioural record for a resident indicates an incident where staff would not develop their 'skills':

People thought that was 'ah for gods sake this is all airy fairy. Now this stuff sure what difference does it make when we fill it in? Like we are still going to have the same problem like'. There was a lady who was biting us and we were asked to fill in record sheets and some of them thought that was complete and utter absolute tripe (Participant 1- Staff Nurse)

This staff nurse's data provides an illustration that some colleagues are not willing to change their approach to care delivery. The perception that working with older people is less demanding and the lack of clarity regarding what the job entails seems to contribute to staff resistance to change. The staff nurse indicated that colleagues viewed the behaviour as inevitable and unchangeable. She suggested that the prevailing view was that the work, while hard, is simple or straightforward so colleagues saw no need to learn and change? This perception is also evident in data regarding the 'status' and 'skill' of the work. Neither participant viewed the job as specialised or skilled, indeed when talking of effective colleagues; health care assistants are referred to as 'girls'. This raises the question of perceived job status and whether this impacts upon care delivery.

When comparing data on job 'status' both participants indicated that a more 'psychiatric' approach to care would improve care quality.

Suggesting that specialist, psychiatry training would alter skills and status:

I think they (nurses and health care assistants) need to train in psychiatry of later life I find people are great when people are very compliant it's at the end stage where its full nursing care it's the bit in the middle that we struggle with (Participant 1- Staff Nurse)

I think we all need to do psychiatric training, I have thought that at times, though I know that's not possible, there are so many conditions that effect the elderly as well you can't just say one study day is going to do it for you, it's not (Participant 2-Nurse Manager)

This data indicates the view that psychiatric training would add to staff ability to deal with behaviours that challenge. In addition both respondents talked of spending constructive time getting to know people with dementia. Approaches they equate with psychiatric training, therefore adding an interpersonal dimension to how staff work and a reduction in their physical care emphasis. While both participants indicated psychiatric training as desirable this view is problematic given the practicality of equating good care with additional psychiatric approaches. This emphasis on a change to psychiatric orientated training raised questions:

The idea that psychiatric training is the way forward is problematic? The view that psychiatric training is something specialised, an elite way of working beyond the function of the 'normal' nurse seems naive as issues of time and capacity exist in all settings. These participants talk about needing to do additional things rather than just doing what they do better or more consistently. This is a real concern as time is already a huge factor, will adding something else may well not help. Memo 09/02/09

This next nurse manager quote illustrates the pressure against adopting a 'psychiatric' approach. She views the organisational culture and work context to be so pressured that physical priorities such as baths are addressed rather than meeting the psychological or social needs of residents with dementia:

It's just so busy and you don't really think. It's not that you do it on purpose, but somebody might not think for a second and like 'I'll grab you and we will go for a bath', like they would with somebody else. Not making the

connection that it's the worst thing you could do with that person.
(Participant 2- Nurse Manager)

This nurse manager while valuing the idea of psychiatric input was clear that any change had to fit with a context where physical care was prioritised.

Another aspect of culture that relates to 'skills' is the data showing staffs' rapid recourse to anti-psychotic medication in the face of behaviours that challenge. This next data indicates medication being the culturally normal response, unchallenged by education in this instance:

ehm we did have a gentleman who just did actually call out all the time and I think you know we were ..the approach was to use a lot of anti-psychotics which seemed a bit unfair because the man wasn't really that psychotic.
(Participant 1- Staff Nurse)

The tension in the data between wanting to take on a psychiatric approach, which was felt to encompass having a less bio-medical focus, flexibility of care and slowing down, verses prioritising physical care is clear. The developing understanding of why staff prioritise physical care and use pharmaceutical interventions rather than psychosocial when faced with behaviours that challenge leads to consideration of staff task choice. This next section will present a discussion of the constant comparison of the data, explaining how staff prioritise the tasks they undertake and decide what is important.

What constitutes success is also an issue that affects 'skills' and 'status'. Participants indicate that success often equates to timely completion of physical tasks. Participants view workplace influences and priorities to be their first responsibility. Completing physical care and medication use in response to behaviours that challenge are examples of what staff viewed to being the normal '*skilled*' activities and responses. The concept of 'time and task' will now be explored as these related concepts arose regularly in the analysis impacting on staff action, their ability to work flexibly and on other concepts.

5.3.5 Time and Task

'Time and task' along with the flexibility to apply psychosocial interventions were regularly referred to in the data, with these concepts impacting on the nature of psychosocial intervention delivery. The data identified time as an important factor in the use of psychosocial interventions, with perceived lack of time used as a reason not to allow flexibility or develop care beyond purely physical tasks. Participants were clear that less time meant less flexibility to apply psychosocial interventions. This staff nurse data maintains that it was in the nature of staff without psychiatric training to rush to complete tasks:

They (Trained General Nurses and Health Care Assistants) tend to look for things to be sorted very quickly. They have a very different attitude ...I think I would like to slow things down a little bit and maybe pare back a little bit and see why someone is wandering (Participant 1-Staff Nurse)

The concept of 'education' in the form of further training that might allow adoption of a different, more flexible approach emerged from the data. While this was held up as an ideal, the comparison showed concerns about prioritising the additional time requirement for training in psychosocial interventions:

well that would be fine if we allocated time to it (training), but I mean all our time.. you should see the stuff I have that's piling under. Things go on the bottom of a pile and it's the last thing I need to do. I mean it's just piling up its just at the minute could you imagine something like that (extensive staff training) happening it would be impossible (Participant 2-Nurse Manager)

The perception of there being no time to do much other than attend to residents' physical care arose clearly from the data. This same nurse manager illustrates the understanding of time pressures and how time related to care priorities within her setting:

you have to get 4 baths done in a day ...they don't get much of a choice they have to be washed somewhere along the way, but that's it you have to get 4 done and the morning particularly, it's just so busy and you don't really think. (Participant 2-Nurse Manager)

Both participants indicated that the culture they worked in was one of prioritising physical care. The data again shows contradictions with staff uncomfortable at the lack of flexibility, but feeling pressured by 'time and

task' within the institutional culture. This is illustrated by this nurse manager's response to a resident who was shouting constantly, clearly distressed herself and causing distress to fellow residents and staff:

The lady just progressively got worse and we just didn't recognise it and I said (to the doctor) 'if you don't get her back on Olanzapine we are all going to end up on it'. Now she doesn't actually have schizophrenia it's just anxiety.
(Participant 2-Nurse Manager)

The nurse manager viewed this situation as distressing for all concerned, but importantly as a drain on staff time that could best be addressed by medication. Both of the initial participant interviews started and ended with a focus on time, the participants were pushed for time, referred to time, and discussed the impact of time on psychosocial interventions delivery. They also suggested the need to be flexible, do things differently within the available time in spite of the many practical impediments.

The participants' understanding that time was limited relates to their prioritisation of physical care. This prioritisation is in part explained by a general lack of knowledge of how psychosocial interventions could be used and a lack of confidence in the ability of psychosocial interventions to get tasks completed in a timely manner. The realisation that staff lacked options and this affected their flexibility of approach and time use prompted the following memo:

The participants say they want to react positively to behaviours that challenge, such as being shouted at, but lack the time and knowledge to react in a timely and flexible manner. This indicates that there is a link between education, knowledge, attitude to people with dementia and staff action. The link between time and flexibility is clear and also clearly relates to the prioritising physical care over other concerns. I just have time to do a bath not to think psychosocially and I'm not minded to do that because I don't believe/know it will work. Memo 11/02/09

When considering the need to change how tasks are completed through education, constant comparison shows that time is seen to be a barrier to day to day practice change. Moreover time or the lack of it emerges as a barrier to efforts to change attitudes to care. Flexible approaches such as 'paring back' meaning taking stock and being less task driven and trying to

'see why someone is wandering' are viewed as potentially effective, but also time consuming. The relationship between the requirements of 'time and task' and the potential of flexibility will be further explored as constant comparison continues.

5.4 Post Participant Reflection and Modelling (Participants 1-2)

Comparison from the data in the first two participants raised a number of key areas for further exploration. Glaser (1978) states that comparison of incidents in the data generates codes, concepts and categories, only through doing so is the next stage of data collection indicated. Glaser (1978) directs the researcher to ask questions; what does the data analysis to date tell me and what comes next? Who do I next need to ask about what? Therefore early stage modelling, reflection and early conceptualisation of categories commences from the outset. This allows conceptual development of categories, their properties and relationships which directs the ongoing research, specifically theoretical sampling and participant scheduling. The tentative categories; 'understanding dementia', 'positive caring', 'skills and status', 'time and task' give an initial indication of how to proceed.

The first two participants were open about the challenge posed by working with residents with dementia and the high variation in ability, attitude and approach to care amongst staff. Analysis indicates that nurses and health care assistants lack knowledge about dementia and about psychosocial interventions that may be utilised when working with residents with dementia. Time is a key concept arising from the data, with residents with dementia requiring a great deal of staff time. Where staff lacked knowledge and flexibility they were dependent on outside expertise and medication when attempting to alleviate behaviours that challenge. In spite of this bleak overall assessment, which included candid criticism of the approaches taken by colleagues, these initial two participants indicated that effective staff possess various innate attributes, positive attitudes and skills that allow them to work skilfully with

residents with dementia. There was also a contradictory emergent understanding that in spite of staffs' emphasis on innate skills and time, there is a need for education that will develop staff understanding of dementia, psychosocial interventions for residents with dementia and support changes in care delivery.

5.5 Building on the Initial Participant Data

The analysis of the first two participant interviews and observation of their long-stay settings raised numerous questions around how staff understand and deliver psychosocial interventions, showing great variation amongst staff approaches. Glaser (1978) suggests that purposive sampling is undertaken to ensure variation in the sample, mindful of the need to identify the core category and directed by the emergent theory. In response, a mix of participants with varied experience of psychosocial intervention use in long-stay care settings with residents with dementia was sought in the hope of eliciting a range of similarities and difference in the data during constant comparative analysis (See Table 5.2 Phase 1 Participant 3-11 Participant Demographics).

Table 5.2 Phase 1 Participant 3-11 Participant Demographics

Participant	Role	Applicable Education	Residential Care Experience	Years in Current Post/Setting	Setting	Age	Gender
3	Nurse Manager	RGN	10 years	1-5	Private Rural	40-49	F
4	Staff Nurse	RGN	10 years	1-5	Private Rural	40-49	F
5	Staff Nurse	BSc, RGN	7 years	1-5	Private Rural	50-59	F
6	Health Care Assistant	Nurses Aid Course	7 years	1-5	Private Rural	40-49	F
7	Nurse Manager	RGN, PgDip Gerontology	30 years	1-5	Urban Public	50-59	F
8	Resident with Dementia	----	----	4	Urban Public	70+	F
9	Resident With Dementia	----	----	7	Urban Public	70+	M
10	Resident With	----	----	2	Rural Private	60-69	F

	Dementia						
11	Clinical Link Facilitator	RGN, MSc	20 Years	1-5	Urban, Rural, Private and Public	50-59	F

The participants were all seen in residential settings and consistently indicated an eagerness to be heard and participate in research. This eagerness to participate was tempered, especially for staff by the ever-present pressure of time. The interviews took place wherever 20-30 minutes of participant time could be secured; in offices, quiet corridors, single rooms and behind the curtains in nightingale wards. As with the first two participants many of these interviews were interrupted as participants balanced their motivation to participate and contribute to the research against the daily routine of the residential setting.

Following reflection and modelling of participants 1 and 2 the participant interview guide was changed. The initial version had a lengthy introduction and explanation of psychosocial interventions, based upon the definition provided by Bates et al. (2004). This explanation was shortened and the questions aimed at gathering participants understanding of, and actual use of psychosocial interventions inserted across the guide. A similar guide was developed to use with residents with dementia (see Appendix 7).

The next section of data analysis comprises constant comparison of all phase 1 data, participants 1-11. Constant comparison is presented under the broad headings that group the conceptual analysis. The constant comparison that emerges under these headings provides greater understanding of participants' current practice, knowledge, need for change and willingness to change:

- Approach to Care and Understanding of Dementia (having knowledge of dementia and a range of approaches to care)
- Educational Needs (need for education and education verses innate skills)

- Care context (current working and need for change)

5.6 Approach to Care and Understanding of Dementia

The data indicates two distinct understandings that relate to the approach to care and understanding of dementia. The first is the understanding that even where staff members are working in an effective skilled manner they do not routinely recognise it as such. The second relates to data that shows that staff lack education in dementia and consequently lack skilled approaches to dementia care. As a consequence staff ascribe successful psychosocial intervention use to innate attributes rather than learned or skilled approaches. Indeed rather than talking about what they could do staff participants tended to downplay their skills and understanding of dementia and focus on their failings or more usually those of their colleagues. The data below illustrates the lack of recognition of skilled working amongst staff. When the suggestion was made that working with residents with dementia was highly skilled the staff nurse smiled and laughed at the thought of anyone telling her colleagues they were skilled: *yeah hmm I think if you told them (other staff) they were very skilled and using all these skills every day that they'd all be very shocked and very surprised and it might be quite good (laughs)* (Participant 1-Staff Nurse)

It is noteworthy that staff nurse, while finding the thought of being described as skilled funny felt that colleagues would benefit from such acknowledgement. She indicated that she and her colleagues do not view their work as comprising skilled interventions that can be formalised and replicated. The memo below considers this understanding:

Staff do not know that what they do is worthwhile outside the immediate moment. If I don't think and am not told that what I am doing is a skill or is useful then surely it's got to be harder for me to plan to do it again never mind make a case to management and colleagues to value the time it takes to purposefully chat or hold hands? Memo 01/07/09

Participants' candid admission of their lack of knowledge about dementia and of approaches to behaviours that challenge prompted consideration of the nature of education required to raise knowledge:

The understanding that people with dementia need stimulation and may not be able to do today what they did yesterday. These participants maintain that many staff do not routinely understand and are not prepared for the changes associated with dementia. I must now explore how the lack of knowledge is affected by education and experience. Memo 01/07/09

In addition to considering the impact of knowledge gained directly from education, the data raises questions about whether knowing the person, impacts on the quality of their care. Constant comparison shows there is a lack of education and knowledge about dementia. Along with a lack of knowledge about the history of residents with dementia and their individual needs. In addition, analysis indicates that a resident with dementia who is known as a person is more likely to receive flexible care:

well it (knowing the resident with dementia's history) certainly helps us because we get to know the person, and you get to know what type of person they were, and so you try and carry on their lives as near to what it was as you can, so in that sense, yes, it helps. (Participant 6- Health Care Assistant)

This health care assistant explicitly links knowing the person to being able to deliver care that included psychosocial interventions rather than 'just sitting in a chair all day', whilst always conscious of the requirement to deliver physical care such as washing and dressing. In this instance, the health care assistant does not view treating the resident with dementia as a person at odds with task completion. By being known to staff the resident with dementia benefits from social interaction, being treated like a person. The quote below from the same health care assistant indicates that her colleagues' lack of appreciation of their own skills directly impacts on the quality of care they deliver. This health care assistant is clear that she is different from her colleagues, having learned how to be skilled when caring for a relative with dementia, skills that she applies at work. In describing colleagues who lack her experience she is suggesting that they have no basis for identifying and delivering skilled interventions:

You know, I wouldn't like somebody to come in to me in the morning and treat me like a child, so it has to be terribly, terribly frustrating. And as I say, people (other staff) don't do that out of malice, but they just don't know any different. (Participant 6-Health Care Assistant)

Not acting out of '*malice*' sums up much of the data regarding lack the knowledge and consequent inability to identify and reproduce effective skilled interventions. This staff nurse notes that colleagues were skilled, but did not realise their capacity:

no I don't think they see themselves as having the skills maybe they are already using them but just no one has put a fancy name on them
(Participant 1-Staff Nurse)

The lack of a '*fancy name*' for skilled intervention is seen as contributing to staffs inability to consistently supply effective skilled care, as skilled approaches are not routinely named, valued and replicated. The data indicates numerous instances where participants note poor care from their colleagues. When participants acknowledge that what they and colleagues do is effective, instances coded as 'positive caring', they tend not to view such interactions as skilled or amenable to replication and planning. Rather participants are clear that 'positive caring' arises primarily from innate ability rather than education and experience. This staff nurse with considerable experience notes effective psychosocial intervention use which she does not attribute to education:

But then you can walk out of the room, and then go back in, and have the clothes all ready, and approach it in a different way, and say 'oh God, so-and-so is coming in today, will you look nice...' and the devil knows what, and then before you know it, they're in the bath. (Participant 5-Staff Nurse)

This staff nurse put her effectiveness down to patience followed by attitude and experience, rather than education. Similarly in this next quote a resident with dementia talks about the importance of staff being natural and having fun. Indicating that staff taking the time to participate in pleasurable activities is a skilled intervention with positive outcomes:

She'd (staff member) get her (fellow resident) up for a bit of a dance and she does seem to like it. I'd do it the odd time myself. I think it's very important. Why wouldn't you? (Participant 10-Resident with Dementia)

This resident was highlighting the importance of simple everyday interactions such as a dance, which the resident did not call skilled, but was aware of as being effective. While some staff participants acknowledged the importance of using simple skilled approaches to care

such as walking away when someone is upset or humming a tune to someone they know likes music. These were viewed as personal strategies comprising innate skills and attitudes along with experience. This next quote from a health care assistant is illustrative of this with qualities such as '*patience*' and being '*a kind person*' consistently being referred to in the data as the qualities that staff required for effective working:

So I think to work with them (residents with dementia), you certainly need an awful lot of patience, you do need an awful lot of patience, and I think you need to be a kind person, and a gentle person, and I think on a one-to-one basis, usually and I know not across the board maybe, but usually on a one-to-one basis, and I find if you make eye contact with them, and if you talk to the person, rather than at them, you'll make great in-roads with them
(Participant 6- Health Care Assistant)

Constant comparison shows that participants view the success or failure of interactions with people with dementia to be a function of an individual's innate qualities; '*patience*', '*kindness*' etc. This belief in innate qualities is in part explained when staff participant demographics are considered. These show no dementia specific training amongst the staff participants. Those participants who offered a view on the style of training required indicated the need for '*psychiatric*' training and knowledge about dementia. Education was viewed as something that can raise awareness and understanding of dementia with successful interaction resting on innate abilities. The data shows a prevalent view that an individual's personal attributes define their capacity, skilled or otherwise. This dependence on innate qualities is made clearer when participants give examples of staff colleagues who are not so well suited to working with residents with dementia and who lack the requisite attributes:

to be honest with you I think there are people who are understanding and people who just aren't. Some people are just better at it than others
(Participant 2- Nurse Manager)

You'd want to be good with people and kind, or get away from the nursing ... Maybe, some people don't do their work so well, but if you go into nursing you'd want to give it your whole mind (Participant 9- Resident With Dementia)

In addition to the data relating skilled working to personal attributes some of the data points to context specific factors. Constant comparison shows that permitting staff to work flexibly and giving them skilled options impacts on staff attitude and therefore skilled working. This analysis indicates that attitude change in staff along with change in practice arises in part from being given managerial permission to change and from education in dementia knowledge and skills. This nurse manager indicated that all staff in her unit worked in a flexible skilled manner:

we don't have that structured 'at two o'clock, the activities staff are coming in' – it's very much built into our day. Everything is an activity, everything has the potential to be an activity, everything has the potential to be reminiscence everything has the potential to be a positive experience
(Participant 7-Nurse Manager)

This nurse manager is eager to show that her own flexibility of attitude impacts on staff, reporting a resultant impact on staff attitudes and their psychosocial interventions. Comparison with other nurse manager data mirrors this view indicating the need to constantly monitor staff approaches to care and re-iterate the need for flexible positive working.

The data indicates the importance of context. In this instance the influence of managerial direction and permission, on staff approaches to delivering psychosocial interventions and staff access to and attitude to education. Constant comparison develops the understanding that skilled psychosocial intervention delivery while influenced by personal factors, such as innate attributes, is also subject to contextual, institutional factors. Managerial direction is clearly a strong contextual influence on psychosocial intervention use. That said both institutional factors and personal ones arise from the data as being more influential than education.

5.7 Educational Needs

Constant comparison of the data indicates that participants view psychosocial intervention delivery as being primarily influenced by individual attributes and contextual factors such as staff culture, managerial direction and experience. The participants deemed education

to be less of an influence on practice, but did suggest that it had a role developing knowledge of dementia and to support interventions, particularly to help address behaviours that challenge. A common response found in the data was for participants not to initially discuss education when asked about what supported good care, choosing instead to highlight personal attributes and contextual or institutional influences. When asked directly about education participants would then enthusiastically indicate their need for greater knowledge:

Well, yeah, I think – yeah. There should be more education for us as to what these people (residents with dementia) need, what their needs are, apart from the obvious. But emotionally – what their needs are, and how it affects them emotionally, and that sort of thing, and what we can do to ease that for them (Participant 6-Health Care Assistant)

When articulating their educational needs staff indicated that their most pressing need is a general understanding of dementia. This is followed by a desire for training in ways of working more effectively with people with dementia, specifically strategies to deal with behaviours that challenge:

I think both (knowledge and skills), because I think if you don't understand how dementia works, then you can't then sort of understand the strategies of dealing with it either (Participant 6- Health Care Assistant)

This prioritisation of knowledge of dementia along with interventions in response to behaviours that challenge reflects the participants' acknowledgement of their limited education. This desire to know more about how dementia affects people reflects staff identification that understanding dementia is an aid to positive attitude change. Staff with more dementia awareness exhibited a more positive attitude along with heightened awareness of the lack of educational preparedness in their colleagues:

In the nursing aide course I did, we would have had lectures on dementia and maybe had a slide show, or something, it was different for me because I would have dealt with my father-in-law, so I would have had some experience. But some of the other participants in the course were horrified to see it, and you know, it had such an impact on them, that they thought 'oh God!' Like they (residents with dementia) nearly think 'God, they were once ok!' (Participant 6- Health Care Assistant)

The statement, 'God they were once ok' is striking with similar comments coming from a number of participants. Staff indicated that they understand people with dementia in terms of their needs and behaviours rather than as people. Participants maintain that individual attributes, primarily attitude vary over time and with experience. They also indicate that willingness to participate in education varies. Attitude to education was identified as important with some staff indicating that they did not feel they, their managers or their teams would make time for education, in spite of acknowledging educational need. The nurse manager data in particular suggests that some staff will continue to prioritise the routine of the setting, in particular physical tasks even where there is education aimed at changing psychosocial interventions use. If education is not supported by managerial support for cultural change, not viewed as supporting staffs' working routine, as well as improving outcomes for residents with dementia, it will not be embraced:

I think telling someone in a formal classroom environment needs to be followed through. We need to bring about a culture of correcting one another, that isn't necessarily done now (Participant 7- Nurse Manager)

Constant comparison indicated that along with cultural factors, time was felt to be a barrier to educationally supported change. Staff participants indicating that the time and effort required were not deemed worthwhile due to the possibility of education not being easily applicable to their workplace:

Maybe if I go (on a training course) the application in work would be different, I don't know. On the practicality side theory is theory but you cannot apply it in work all the time. (Participant 4- Staff Nurse)

In spite of the participants' lack of experience of dementia specific education and misgivings many staff suggested that education does have potential benefits. Participants felt that knowing more about dementia could have a positive impact on their attitude to people with dementia and in turn their ability to deliver psychosocial interventions. In addition being trained in approaches to specific behaviours was deemed to be of practical use:

My view on improving staff attitude to dementia is similar to improving feeding skills. We send staff to be fed as part of training i.e. you can't understand how to feed if you have not been fed. Now I know you can't get better at dementia care by having dementia but understanding it better must improve your skills if you are willing to learn (Participant 5-Staff Nurse)

Significantly this staff nurse while noting the importance of understanding dementia to improving skills, notes the importance of being '*willing to learn*'. This suggests a degree of choice on the part of individuals. This understanding suggests that gaining a conceptual understanding of what makes staff '*willing to learn*' is important to the emergent theory.

Understanding that people with dementia are behaving in challenging ways in response to changes brought on by dementia rather than being intentionally challenging, is a benefit participants feel education can bring. In addition, the realisation that people who due to illness cannot interact and communicate as they once did and that they once had full complex lives seems also to change the attitude of staff, impacting on how staff deliver care. Given the potential contribution of education to improvement in quality of care the question of how to target education and on who was considered:

Some staff in the Phase 1 (participants 1-11) displayed an innate ability to 'slow down' practice when working with people with dementia in spite of receiving no dementia care specific training. Does this suggest that training needs to target that group who do not know how or when to slow down? If so, is it their attitude or knowledge i.e. will telling them about slowing down, telling them about illness processes and telling them about the importance of RDW's slow them down or are there more fundamental attitudinal issues that need to be addressed amongst teams by managers? Memo 20/06/09

Analysis gave some understanding of why individuals seek out education and how they value education. It also raised questions regarding what influences the decision to participate in educational opportunities and once education has been received its application to practice:

you can't expect all staff to think the way you do, so for some education will not work. These people do not care. They come to do the minimum which is good enough to keep the residents safe and clean, but really knowing the

residents and adding that knowledge to their care is above and beyond... A little training goes a long way, staff need introduced to basics that can change their attitude to dementia not detail. Too much detail can put staff off, staff can be scared of dementia and staff share public stigma views to mental health. (Participant 3- Nurse Manager)

Constant comparison indicates that individual staff's understanding of their educational needs is defined by a complex interaction of their experience of care provision, understanding of dementia, existing skills and workplace context. Participants consistently indicated that education does hold potential benefits for care quality, while offering contradictory data which identified pressure from colleagues as well as 'time and task' as barriers to committing to education. Constant comparison also shows that staff attitude to dementia care is also formed by this complex interaction of factors. Conceptually issues of 'care context': managerial influence, institutional capacity to learn and change along with personal approach, and attitude to care are seen to influence educational need. The three sections of data from a health care assistant participant below illustrate the educational need, 'time and task', and attitude based barriers articulated by participants. This data demonstrates the emergent understanding that while education is required it must contend with considerable personal and institutional barriers if it is to impact on 'care context':

Educational need:

I think it needs to be a special course. It needs to be especially about dementia, because it's a different type of care, I feel. You nearly need to deal with psychiatric care as well, because I find it's about eye contact that you are nearly dealing with their (Resident with Dementia) mind, to make things easier for them. I think you have to build an atmosphere around the person, I think it has to be a quiet, peaceful, kind atmosphere, and that you're not rushing them. (Participant 6- Health Care Assistant)

Time and task:

we are over-worked, and sometimes you are rushing, and you're trying to get on to the next person, but if I'm with somebody with dementia, that doesn't work. Even though you might be in a hurry, you can't let them see that you're in a hurry. So I think it's a lot to do with the atmosphere that you do it in. (Participant 6- Health Care Assistant)

Attitude:

I was just talking to one of my colleagues this morning, and it just gives you an insight into what people think... well maybe they're right, I don't know! But just saying about people with Alzheimer's, which is what we have here, well and dementia... but mostly Alzheimer's here, and she was saying 'they should all be put into one nursing home together' you know 'they shouldn't be here' with what she calls 'normal people'. I think it's maybe just good old Ireland, maybe I'm wrong, I mean that stigma was always there with people with psychiatric illness, put them away. I do believe, it's not out of malice, I do believe it is out of ignorance, a lot of it, that people did not know how to deal with people with psychiatric illness, now they do not know how to deal with people with dementia, so if they don't know how to deal with it, put it away. (Participant 6- Health Care Assistant)

Constant comparison consistently shows that participants have considerable educational need along with an appetite for education. It should be noted that none of the Phase 1 staff participants had experienced dementia specific psychosocial intervention education, though they were aware of the educational focus of the research. Within this research context participants indicated a preference for education that would raise their knowledge and awareness of dementia and that would provide practical solutions to behaviours that challenge. While all participants indicated they wanted education they also noted that they worked with colleagues who would be less well disposed to education and that any education would have to be tailored to their needs. Participants indicated that for some attitude to their job, previous experience of education and their perception of the practical applicability and accessibility of education would affect educational uptake and subsequent implementation of training. The next section will explore the importance of cultural context, cultural opportunity and the impact of management on these.

5.8 Care Context

The participant data regularly refers to the care setting with the category 'care context' emerging as a strong influence upon the care delivered. The contextual importance of the prevailing staff culture and managerial direction were regularly referred to by resident and staff participants. The

resident with dementia below is clear about where direction for day to day staff activity stems from:

The matrons too have a great effect on them (staff) and they have to do it (deliver care) the right way (Participant 9-Resident with Dementia)

All the residents with dementia data indicate an awareness of hierarchy within care settings and suggest that nurse managers can set the tone for care delivery. This resident with dementia was interviewed in her room. The room was spotlessly tidy and the lady immaculately dressed and coiffured. As we spoke she held my hand in hers and whispered conspiratorially, telling me how hard a life nurses had. She spoke of how the really good ones were patient and kind and then she told me about the hierarchy in the home and how to respond if you are unhappy about your care, 'tell the matron'. The resident with dementia participants were very aware of hierarchy within the care team and clear about the qualities and tasks they valued amongst staff. This is illustrated in this next data which, as with staff data, values patience and kindness as qualities while being clear that that staffs' primary day to day function was physical care:

I think it's very important for the nurses to be kind. They know what's wrong with you. In all fairness now, I think they're fair enough. They work hard. There's no getting away from it. (Participant 10- Resident with Dementia)

The residents with dementia in Phase 1 talk of being physically cared for, of the pressure of work on staff and of appreciating individual staff who are kind and patient.

I think sometimes they work harder than the doctors....she (the nurse) would put you to bed and help you with your clothes and tell you she would come back. She looked after me very well. (Participant 9- Resident with Dementia)

Residents with dementia do not specifically refer to the lack of time, but are aware of the work load emphasising the physically focused nature of care delivery. On comparison this data supports the same understanding as manager data. That time was not routinely spent being with and communicating with residents outside the completion of physical care. The nurse manager below articulates the pressure excerpted on staff by

colleagues referring staff peer pressure, resulting in rushing to finish a set number of baths or showers rather than spending time with residents.

This data illustrates the nurse managers' understanding that peer pressure to complete physical tasks enforces routine and limits flexibility even where permission to 'ignore' routine is given to staff:

I do not force staff to compete with each other.. to be seen to work hard and enforce rapid regimes without due attention to the patient's needs...this creates problems when in fact sometimes home routine needs to be ignored where people with dementia are concerned. (Participant 3-Nurse Manager)

The understanding that peer pressure amongst staff, enforces 'rapid regimes' and reduces individual flexibility to use psychosocial interventions, further illustrates the complex influences of 'time and task'. Resident participants were not inclined to be critical about their care or the staff delivering it, opting instead to note how hard staff members work. The ability of staff members to develop a context driven set of physical outcomes and tasks in spite of patient need and even managerial direction was striking. This next data from a health care assistant illustrates the conceptual understanding of how care context develops its own rules and values that can conflict with and direct individual values and ways of working. This health care assistant was upset during the interview, mirroring the discomfort and pressure present in other staff data, and illustrating their lack options and obligation to press on with physical care. This quote followed a question about alternative options to forcing a bath or a shower on a resident:

I don't think there is. We've gone around a lot of ways, and she's just one of the people that talking to isn't any good, because she really doesn't even understand what you're talking about even. She doesn't understand the concept of washing. So you know you just try and do it as quick as you can, and put her through as little as you can, and that's basically.... But I find... because you're really doing it against her will, even though I know we have to do it, but I do find that.... (Participants 6- Health Care Assistant)

This health care assistant was confident that with patience, kindness and time she could complete washing in a less upsetting way for the resident with dementia and herself. Unfortunately the impact of care context results in her hurrying to complete the task. As with other staff

participants this health care assistant lacked options and did not feel empowered to go against the context's norms. The nature of care delivery within context proved complex. There was a mixed reaction from staff regarding their ability to change their own practice or influence others. On the whole the health care assistant participants did not feel it was their place to criticise colleagues. Trained staff attitudes to managing health care assistants varied with some comfortable giving guidance and others seeing their role as primarily delivering physical care and medication.

On the whole staff nurse and health care assistant data shows that they are reticent about offering guidance and advice to colleagues. Analysis shows that many staff participants do not feel able to criticise colleagues and while residents with dementia are aware of the hierarchy they were not comfortable commenting on their care, other than to say how good it was. Nurse managers are more inclined to offer guidance than staff nurses, but even where they give advice the lack of education on dementia care results in uncertainty over the effectiveness of the resulting care delivery. This manager was uncomfortable when asked about managing staff. She was loath to criticise them at first stating they are '*all great*'. When she did indicate that she has to intervene with some staff her criteria for intervention is not quality of outcome, but time taken:

Some people are just better at it than others. I know my own staff and they are all great, but some would rubbish the whole science and do everything completely wrong I say it's the way you do it, it took you an hour and it only took them 20 minutes surely you have got to understand that there is something here ... (Participant 2-Nurse Manager)

Quality here is equated to timeliness of task completion. Decisions about approaches to care such as letting residents with dementia wander rather than keeping them in chairs; trying new approaches in response to behaviours that challenge; being prepared to take risks and fail in search of solutions; and having criteria for success that go beyond people looking clean and sitting quietly, were all underpinned by a culture of managerial permission. During analysis a connection between being flexible, practice innovation, and risk taking emerged. Reticence over sharing what works

well with colleagues also arose from the lack of dementia specific education and the resultant lack of confidence regarding interventions.

In the following data a manager describes the approach to care adopted and permitted in their setting:

We don't have a routine – people get up when they get up, they go to bed when they go to bed, we don't have everybody up and sitting for eight o'clock to eat a meal, we allow that flexibility (*Participant 7- Nurse Manager*)

In this care context '*we don't have everybody up*' represents the shared approach to positive care that was communicated to all the staff. Other staff participants indicated their workplaces did not have this cultural context of flexibility and that they or their colleagues would be resistant to changes to their approach to care. This nurse manager gives a bleak characterisation of staff who will not take guidance to change, conceding that while managerial direction can affect the care context it cannot on its own change staff attitude:

They (staff) think you can just dive in and say c'mon we are going to give you a bath and I'd say you have to go to them 10 minutes before-hand and in 10 minutes I'm going to come back and get you and things like that that these girls mightn't have the understanding for that.. they say that's just rubbish they (Residents with Dementia) are being bold and I say you can't just rubbish a whole science like that but people do because they don't understand (*Participant 2- Nurse Manager*)

Comparison of this nurse manager's conclusion that an understanding of the nature of dementia is required to support managerial direction with other nurse manager data prompted the following memo:

While the hierarchy is important and all participants refer to it, managerial direction alone is not a guarantee of attitude and practice change amongst staff. One manager talks of exerting peer pressure on staff that resist change another one calls for more education. Manager data is contradictory indicating that managerial direction alone does not guarantee change of context. Memo 17/07/09

The influence of managers upon context and aspects of psychosocial interventions was varied. Data that referred to allowing the sharing of ideas, the general tone of the setting, access to education, attitude to risk

and criteria for success arose consistently. This data offers conceptual understanding of care context. The influence of hierarchy and collegiate interaction does have an influence on approaches to psychosocial interventions. Some participants indicated that they work the way they want regardless of this cultural context, where they felt patient care would benefit. By contrast, the majority acknowledge that conforming to prevailing care context, getting the job done, as defined by context and attending to physical tasks takes precedence.

5.9 Post Participant Reflection and Modelling

5.9.1 Emergent Categories

Constant comparison of the data shows that staff uncertainty over the nature and efficacy of psychosocial interventions results in a lack of formality in application and replication of success, even where intuitive approaches are deemed effective. Uncertainty over what constitutes a psychosocial intervention results in the view that personal 'caring attributes' and experience define the quality of care, rather than skilled or educationally based psychosocial interventions. An associated concept that emerged from in the data was that of access to education. Participants viewed education as being potentially helpful in respect of knowledge of dementia which was seen to have a positive influence on staff attitude and knowing what to do in response to behaviours that challenge. Staff 'education' is influenced by two sometimes competing factors. Internal decisions, balancing how they currently work against how they want to work and the influence of the setting they work within. Constant comparison of incidents pertaining to education indicates that despite the view that innate attributes and experience are the primary influences on approach to care. All participants accept the need for education, although the data does indicate some reticence over prioritising education over 'time and task'. In response to the desire for education, along with the many influences on educational access and utilisation this category has been re-conceptualised as 'educational proclivity'. Understanding the category in terms of the interplay of categories that influence access to and

utilisation of education gives better understanding to the mechanism that links education, its impact, and psychosocial intervention use.

Conceptualisation of 'care context' has placed 'educational proclivity' subordinate to managerial and cultural factors; what constitutes success, what constitutes a task, break times and being seen to work hard are in practice the factors that define care. Understanding the relationship between 'care context' and 'educational proclivity' allows a clearer understanding of what categories explicate the nature of psychosocial intervention delivery. In practice maintaining appearances, so having residents up out of bed and looking clean is often prioritised over spending time socialising and talking with residents. Participants identified that psychosocial interventions in the form of everyday social interactions when used purposefully could be pleasant for the resident, rewarding for staff and provide a distraction strategy in response to behaviours that challenge. However, most participants did not identify purposive use of a social interaction such as dancing with a resident, or using knowledge of past history to instigate conversation, as psychosocial interventions.

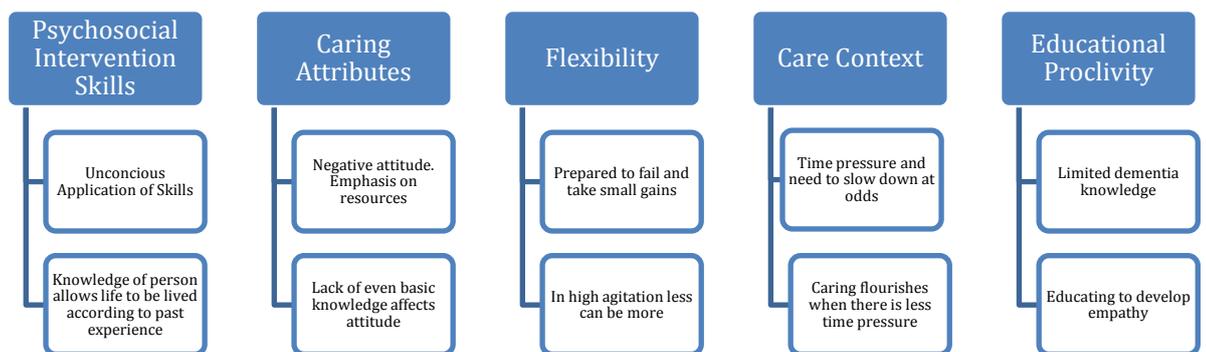
Where tasks are prioritised, participants indicate a culture of appearances being maintained for the benefit of relatives, colleagues, and management, rather than for the resident. In spite of this the staff participants indicated that they are doing a good job given the pressures upon them. Most staff indicated an appreciation of the need for education and change, while defending their approach to care and identifying instances where other staff members were less effective than themselves.

5.9.2 Categories and Codes

The issue of staff not giving optimal care and how to sample for those delivering less than optimal care will be further explored within the Phase 2 theoretical sampling section. The emerging categories, their interrelatedness and the means by which the categories explain positive

examples of care will now be presented and discussed along with the initial theoretical modelling from the Phase 1 analysis. Analysis of these first 11 participants produced a range of open codes 179 open codes arising directly from the data for the first 3 participants alone. During analysis and comparison the open codes were grouped to form the tentative categories: ‘care context’ (the prevailing managerial and colleague culture), ‘educational proclivity’ (experience of and wanting or needing education), ‘caring attributes’ (those qualities that support working with residents with dementia), ‘psychosocial intervention skills’ (planned, effective interventions) and ‘flexibility’ (the ability to try new approaches and apply different strategies). These categories along with some of the sample open codes that comprise them can be seen on Figure 5.1 Phase 1 Exploratory Categories with Sample Open Codes. Grouping open codes under one or more of the categories allows tentative conceptualising and modelling of the findings. These tentative categories arise directly from coding of the data and constant comparison.

Figure 5.1 Phase 1 Exploratory Categories with Sample Open Codes



5.9.3 Theoretical Model

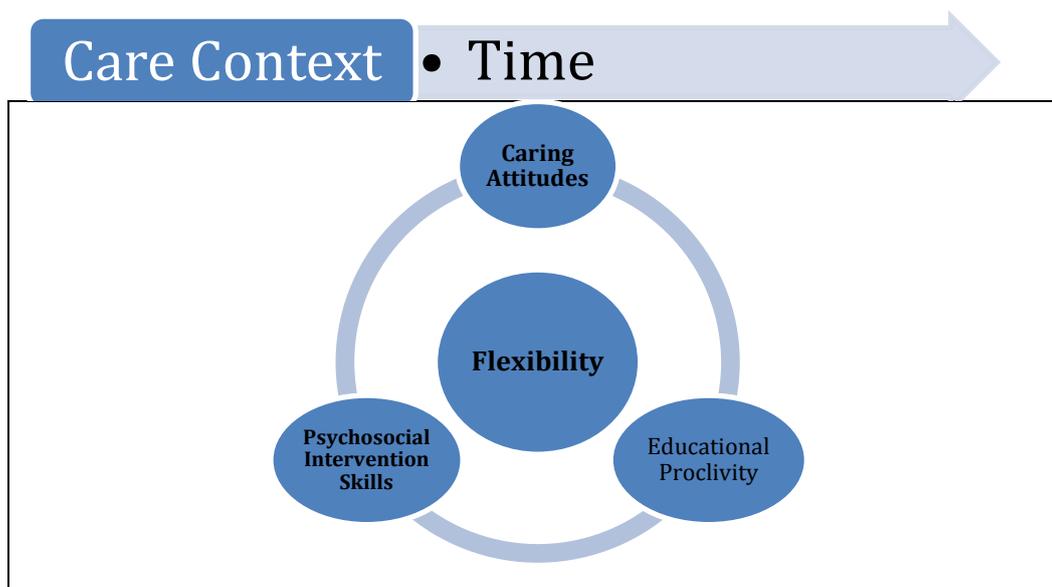
The development of Theoretical Model 1 (Figure 5.2 below) represents the emergent understanding at the end of Phase 1 and gives direction to subsequent theoretical sampling and questioning focus for Phase 2.

Theoretical Model 1 is an initial effort to represent the interaction of the

emerging tentative categories and how these influence flexibility within the workplace context.

Theoretical Model 1 is developed from the emergent theory produced from the Phase 1 participants. The emergent understanding indicates that 'flexibility' (that is the ability to make the most of 1:1 time, slow down, use trial and error, fail, take responsibility) is central to staff participants' delivery of psychosocial interventions. 'Flexibility' is in turn directly impacted by the individual's 'psychosocial interventions skills' (application of strategies, most likely not called psychosocial interventions such as effective use of a calm reassuring tone of voice), 'caring attributes' (personal qualities such as patience- this also includes experience and past education) and 'educational proclivity' (do they value or want education, why and in what form?). The interaction of these categories is impacted by the 'care context' over time (colleague culture and managerial environment) such as; permission and support for 'flexibility', support for education, recognition and encouragement of skilled psychosocial intervention application, support or criticism of positive and negative attributes or approaches to care.

Figure 5.2 Theoretical Model 1



5.10 Summary

This chapter is the first of 4 that presents the emergent theory. The chapter has followed the process of; initial data collection (entry to the field of interest), initial open coding and analysis, theoretical sampling, constant comparison of Phase 1 data, theoretical modelling and development of the subsequent theoretical sampling strategy for phase 2. The initial categories 'psychosocial intervention skills, 'caring attributes', 'care context' and 'educational proclivity' have been developed and discussed along with the tentative core category 'flexibility'. Modelling of these categories and their relationship with one another was discussed and this process has produced the theoretical sampling strategy for Phase 2 which will now be presented in Chapter 6.

Chapter 6: Phase Two Data Collection and Analysis

6.1 Introduction

The Phase 2 theoretical sampling and data analysis presented in this chapter stem directly from the emergent theory discovered in Phase 1. With this in mind this chapter will proceed with a description of the theoretical sampling rationale and strategy developed to further explore and understand the tentative core and related categories. This will be followed by on-going constant comparison which is presented under the categories that directed the participants, responses and on-going analysis:

- 'Caring Attributes'
- 'Educational Proclivity'
- 'Psychosocial Intervention Skills'
- 'Care Context'
- 'Flexibility'

6.2 Overview of Conceptual Categories

The initial categories 'psychosocial intervention skills, 'caring attributes', 'care context' and 'educational proclivity' and the tentative core category 'flexibility' generated in phase 1, represent the emergent understanding of the substantive area of interest, understanding psychosocial intervention use for residents with dementia in long-stay care. The clear *what is going on* message arising from constant comparison of Phase 1 participant data is that staff have limited opportunity to deliver psychosocial interventions with analysis indicating a range of reasons why. Staff lack the skills required to purposefully deliver psychosocial interventions and do not recognise when what they currently do does in fact constitute psychosocial intervention delivery. Regardless of nature of 'psychosocial intervention skills' used, constant comparison of the data indicates that staff view 'caring attributes' to be the factor that defines their ability to work effectively with residents with dementia. Participants view these 'caring attributes' to be more influential on the ability to deliver good quality care than education. This understanding diminishes, but does not

entirely remove staff's 'educational proclivity'. The data shows that staff would like education regarding the nature of dementia and how to work effectively with residents exhibiting behaviours that challenge. That said staff do not routinely prioritise educational need with data indicating staff have concerns about prioritising time for training in psychosocial interventions. 'Care context', specifically colleague culture and managerial direction are ever-present, with staff clear that they are influenced by managerial views on what is done and how, along with peer pressure over the timely completion of physical care tasks. The category flexibility regularly accounts for positive instances of psychosocial intervention delivery, where staff participants view themselves as pragmatic and effective.

A key component of the category 'flexibility' is data that was grouped under the open code; making the most of 1:1 time. 'Flexibility' or its absence was seen to be both a function of experience and the interaction of skills, attributes, 'educational proclivity' and 'care context'. As such in June 2009 following discussion with the supervision team 'flexibility' formed the tentative core category and was placed in Theoretical Model 1 Figure 5.2. Glaser and Strauss (1967) view the core category as a means of delimiting or managing the emergent theory. In this instance the tentative core category is likely to be subject to change as further data is compared. Flexibility represents a starting point in modelling the emergent theory, directing further constant comparison of incidents. The next section will outline the theoretical sampling strategy for Phase 2.

6.3 Phase 2 Theoretical Sampling

Analysis of phase 1 data provides emergent conceptual understanding of the various influences on psychosocial intervention delivery for residents with dementia. Residents were loath to criticise their care indicating that hard working staff did their best for them. Staff participants were less reticent; while many had examples of colleagues who were effective most also offered candid criticism of their colleagues' attitudes, attributes and

resultant care delivery. The participants tended to justify the failings they described, but were not consistent regarding the reasons, citing a range of causes including; time pressure, attitude, absence of innate skills, managerial guidance, peer pressure, too little experience, too much experience and lack of education.

Constant comparison of staff data commenting on colleagues psychosocial intervention use shows criticism of those who do not deliver the same type of care as the participants or who possess attitudes to dementia care which are at odds with the participants. Where participants noted negative care quality they tended to refer to other colleagues with few personal admissions of a negative nature. Staff critiqued the care delivered by others, but rarely their own. This is an important emergent understanding, both from the perspective of understanding staff motivation towards psychosocial intervention use and for planning ongoing sampling in Phase 2. The data also indicates that the care quality is potentially transient, with the care quality subject to a range of personal and contextual factors which come together at any given time to impact upon staff attitude and psychosocial intervention use. In considering the rationale for the next phase of data collection the potential for positive change over time resulting in better quality more flexible working must be considered.

6.4 Sampling Rationale

The rationale for Phase 2 theoretical sampling is influenced by the lack of personal admissions of poor care quality delivery in the Phase 1 data. Residents with dementia did not offer criticism of the care they received, while staff talked of '*others*' delivering poor care, not of their own care. The data indicated a desire for change and for positive flexible care that uses psychosocial interventions. Participants indicated that such change is required, indicating that change in attitude was central to positively changing care quality. The following quote illustrates how participants indicated concern at the attitude of colleagues, noting that attitude

dictated the nature of the psychosocial interventions these colleagues delivered:

They (colleagues) say that it's just rubbish that they (residents with dementia) are just being bold and I say you can't just rubbish a whole science like that but people do because they don't understand (Participant 2-Nurse Manager)

I think maybe a lot of people can't deal with it (dementia), you know, themselves, or they're not comfortable themselves with the disease, not that I suppose anybody is, but they look at people with dementia differently maybe to me. I don't look at the person with dementia really any differently than the person hasn't it – they have the same needs, it's a human being, and ... maybe they do look at them differently, now I don't know. (Participant 6-Health Care Assistant)

None of the staff participants admitted to delivering poor care, stating instead that they were doing their best in the face of limited training, lack of time and stretched resources. The fact that most participants could criticise colleagues, but not themselves raises questions around self-awareness, self-protection and how staff viewed the care they delivered. The realisation that staff attitude to self along with their justification of the care delivered is important to the theoretical sampling is captured in the following memo:

I keep on interviewing inspirational managers and positive staff. All participants refer to colleagues who don't want to change and will not learn. Will these staff be interviewed? In any event I am not getting to interview these staff, so assuming they exist I need to get permission to 'drop' into facilities and get data from all the staff who happen to be available? Memo 02/07/09

In response to the realisation that 'others', less positive staff may be avoiding data collection, whole shifts need to be accessed with all staff given the opportunity to contribute data. By interviewing entire teams Phase 2 data collection and analysis aimed to develop further understanding of psychosocial intervention use and those factors that influence individual utilisation of them.

6.5 Sampling Strategy

Building on the theoretical understanding gained and discussion with the supervision team a Phase 2 interview guide was developed (see Appendix 8). This guide asked questions around setting 'care context', the core category 'flexibility' and the three main conceptual categories 'psychosocial intervention skills', 'caring attributes' and 'educational proclivity'. This new interview guide was designed to identify further instances of similarity and difference, collecting data that allowed comparison of incidents against flexibility as a tentative core category. The Phase 2 interviews explore whether the ability of staff to work flexibly varies with their 'psychosocial intervention skills', 'educational proclivity' and 'caring attributes' and how these categories not only influence flexibility as the tentative core category, but each other.

To further explore and understand the participants' consistent identification that their own care quality was good while identifying instances of poor care quality amongst colleagues in Phase 1, the decision was taken that data would be collected, where possible, from all staff on duty on any given day or shift. This pragmatic approach also addressed the need to see staff at times and in places that suited them. Being available to interview full shifts maximised access and also allowed the researcher exposure to context spending the entire day/shift observing the residential setting. It should be noted that only one male staff member was interviewed. This was not part of the theoretical sampling strategy it reflects the gender ratio on duty in the settings, there was only one man. Residents with dementia were not sampled in this phase as the emphasis was on what influences staff use of psychosocial interventions. Two rural sites, one public, one private and one urban public site were selected (See Table 6.1 Phase 2 Participant Demographics). Interviewing the entire shift took between 6 and 12 hours per site, with time and pressure of work again arising as important factors in determining when, where and for how long staff were able to participate.

The first six participants (12-17) took place in an urban public setting. The manager agreed to access to the unit over the entire day. The six participants represent all the staff on duty with the exception of the manager who ‘covered’ as each participant was seen and was not herself interviewed. The next seven participants (18-24) took place in a rural public setting. Again the seven participants represent all the staff on duty with the exception of the manager who ‘covered’ as each participant was seen and was not herself interviewed. The final five participants (25-29) took place in a rural private setting, where all on duty staff were interviewed. Access was negotiated with the manager who was not on duty when the data was collected. Being directed by the Phase 2 interview guide these interviews were shorter than in Phase 1, lasting around 30 minutes each. In between the interviews large amounts of time was spent in the settings talking to staff and observing the settings, while waiting for suitable opportunities to interview. The researcher recorded numerous memos during these periods, reflecting on the settings and the ongoing interviews. These memos were included in the overall process of constant comparison of the data.

Table 6.1 Phase 2 Participant Demographics

Participants	Role	Applicable Education	Residential Care Experience	Years in Current Post/Setting	Setting	Age	Gender
12	Staff Nurse	RGN, PgDip Gerontology	25 years	16-20	Urban Public	50-59	F
13	Staff Nurse	RGN	22 years	16-20	Urban Public	60-69	F
14	Staff Nurse	RGN, PgDip Gerontology	20 years	11-15	Urban Public	60-69	F
15	Health Care Assistant	HCA Training	5 years	1-5	Urban Public	20-29	F
16	Health Care Assistant	FETAC Level 5	20 years	6-10	Urban Public	50-59	F
17	Staff Nurse	RGN	7 years	6-10	Urban Public	50-59	F
18	Staff Nurse	RGN, RMN	27 years	6-10	Rural Public	50-59	F
19	Health Care Assistant	None	10 years	6-10	Rural Public	50-59	M
20	Staff	RGN, RMN	38 years	38	Rural	60-	F

	Nurse				Public	69	
21	Health Care Assistant	FETAC Level 5	4 years	1-5	Rural Public	30- 39	F
22	Health Care Assistant	FETAC Level 5	2 years	1-5	Rural Public	20- 29	F
23	Nurse Manager	RGN	19 years	16-20	Rural Public	50- 59	F
24	Health Care Assistant	FETAC Level 5	7 years	6-10	Rural Public	30- 39	F
25	Health Care Assistant	None	4 years	1-5	Rural Private	30- 39	F
26	Health Care Assistant	FETAC Level 5	7 years	6-10	Rural Private	50- 59	F
27	Health Care Assistant	NVQ 1&2	2 years	1 week	Rural Private	50- 59	F
28	Health Care Assistant	FETAC Level 5	17 years	6-10	Rural Private	50- 59	F
29	Staff Nurse	RGN	5 years	6 weeks	Rural Private	20- 29	F

6.6 The Emergent Theory: Phase 2

6.6.1 Caring Attributes

This section presents the analysis relating to the continued emergence and development of the category 'caring attributes'. Participants were asked to identify and discuss those attributes that supported the effective delivery of psychosocial interventions. Data from staff participants identified 'caring attributes' as a range of qualities and attitudes that influence staff ability to deliver effective psychosocial interventions care to residents with dementia. 'Caring attributes', like the other categories that will be presented in this chapter is a dynamic concept that shifts in response to the influence of the other categories over time. This interplay will be referred to within the category discussion as well as in the post participant reflection and modelling section. Constant comparison of data from Phases 1 and 2 identified two distinct components of 'caring attributes'. The first component is innate qualities, which is made up data grouped under open codes such as; remaining calm, being patient, being kind or making time.

The second component is made up of data grouped under open codes that refer to staff attitude such as; empathising with people with dementia, doing more than basic care and wanting to work in this field.

6.6.2 Innate Qualities

Analysis of data coded under the innate qualities component of 'caring attributes' provides conceptual understanding of those factors that allow staff to deliver care beyond purely physical care. These factors were most often felt to be innate rather than learned or trained. Even where staff recognised such approaches as having a positive psychosocial intervention component they were seen as instinctive:

This health care assistant walked over to her and started chatting. Chat, chat, chat, chat, chat. Didn't give this woman any time to get cross or anything like that. She had refused everything and this girl said, "Maybe I'll try orange juice." She was real friendly, big smile on her face and then the patient started smiling and moved along with that and was chat, chat, chat. Next thing the patient started taking the juice (Participant 24-Health Care Assistant)

The other health care assistant being referred to by this participant, was not identified because of her training or her experience, the participant saw her as naturally able and equipped with innate qualities. These qualities such as 'kindness', 'patience' and being 'calm' are referred to consistently by participants who viewed the presence of such qualities as being fundamental to colleague's ability to work constructively with residents with dementia. The ability to work in a manner that positively distracts and calms residents also relates to staff job satisfaction. In the example of patience below the health care assistant is clear that both they and the resident with dementia benefit by the application of this innate quality. By being patient the staff member avoids the frustration others may experience at repeating the same information and meets the patient's needs, mitigating against potential behaviours that challenge and the associated disruption of the health care assistant's routine:

They (resident with dementia) might say, "What's this tablet for and what's this tablet for?" and you have no problem listing the effects of what it's going to do again for the hundredth time. (Participant 20-Health Care Assistant)

The data shows that utilisation of innate qualities when working with residents with dementia is valued as an approach that allows basic care to be delivered more effectively. Staff recognised constructive use of innate qualities as being time effective, allowing completion of routine tasks and avoiding disruption for both staff and the resident with dementia.

Participants described being patient, calm or kind along with purposeful chatting as approaches that facilitated the timely completion of physical care tasks. In addition to task completion data analysis indicates that both the resident with dementia and the staff member gain a reward. Both participate in a pleasant interaction, free from distress. Constant comparison indicates that the innate qualities that allow 'positive caring' are contingent upon the influence of the other categories ('psychosocial intervention skills', 'educational proclivity', 'care context' and 'flexibility'). The data below records a staff nurse's appreciation of an incident where the quality of a health care assistant's interaction with a resident changed due to context:

She (Health Care Assistant) was off-duty and she was waiting for her lift and she sat with this man in the conservatory, there with a book or magazine in her hands and the two heads together and this man was really interested. She was giving him her total and full attention. Because she was off duty and she was just waiting for her lift to come and she had a few minutes, she just utilised it and I thought it was lovely. (Participant 13-Staff Nurse)

The staff nurse concluded that the quality of interaction observed occurred because the health care assistant was off duty therefore she was free from the pressures of time and context. This incident helps explain how the categories ('caring attributes', 'psychosocial intervention skills', 'educational proclivity', 'care context' and 'flexibility') interact and that a change, in this case in 'care context', can influence the other categories and the resultant psychosocial intervention use. This staff nurse was clear that workplace pressure and priorities can diminish a staff member's capacity to deliver psychosocial interventions. She went on to note that by assigning a member of staff to do just what was observed with this resident with dementia, that is give '*total and full attention*', this man could be freed from the regular angry outbursts and agitation that currently marked his day to day routine. The data illustrates the interaction of

personal and institutional categories. The health care assistant's approach to the resident with dementia changed when work ended allowing her innate qualities to come to the fore, freed from workplace requirements and pressures. This resulted in what the staff nurse observed to be a more recognisably human interaction which was valued as time well spent in spite of the lack of task completion.

Understanding the relationship between the innate qualities and the other categories further develops conceptual understanding of 'caring attributes'. In addition to the direct influence of 'care context', psychosocial intervention application is also influenced by staff experience and education as staff respond to the care they deliver and this understanding interacts with their 'educational proclivity':

I think they (skills and attitudes) are there to begin with, but as they learn more on the job, it comes out more. I think that with education you learn the basics, but it's a different story when you work with them (Residents with Dementia) hands-on. (Participant 22-Health Care Assistant)

This health care assistant was stating her view that staff had the potential to provide psychosocial interventions innately and that this ability was modified by experience rather than education. While every participant in Phase 2 initially stated that staffs' capacity to exhibit these qualities was innate, analysis indicates that individual capacity is more nuanced. In response to the question does experience improve skills, this participant initially responded:

Some people do (improve with experience). Some people have that skill in themselves and some people will never have it. (Participant 17- Staff Nurse)

Later, the same participant when asked about the influence of education and experience, responded:

Education and training come into it a lot, better communication skills and maybe empathy with the person you're dealing with as well. Though some people already have that skill, that knack. (Participant 17- Staff Nurse)

The concept of innate qualities emerges in a number of ways from the data. For instance participants viewed 'experiencing care' to impact upon

individuals existing innate qualities. Over time and through 'doing the job' individuals ability to deliver psychosocial interventions could change, negatively or positively. Almost all of the participants were clear that some colleagues lacked the innate qualities required to work effectively with residents with dementia. In spite of this, the influence of 'experiencing care' in particular determining success within the workplace and the potential influence of education emerge from the data. This understanding contradicts the repeated assertion that psychosocial intervention delivery is primarily based upon innate qualities. Analysis of the data indicates that psychosocial intervention use is influenced by concepts other than innate qualities. Constant comparison shows that 'psychosocial intervention skills', 'care context', 'care context' and 'flexibility' all influence the nature of psychosocial intervention use. As does the second component of 'caring attributes', staff attitude, as psychosocial intervention use is influenced by beliefs and choices individuals make.

6.6.3 Staff Attitude

Conceptual understanding of data coded under the staff attitude component of 'caring attributes' reveals the relationship between 'staff attitude' to residents with dementia and the nature of psychosocial intervention care delivered. Participants indicate that the ability to view residents with dementia as people rather than collections of illness symptoms and physical needs improves the quality of interaction and care delivered:

One day you could be sat in that chair. You treat them (Residents with Dementia) like you would want to be treated. They're human beings. It's not their fault. However bad they are, it's not their fault. (Participant 14-Health Care Assistant)

Staff data consistently shows that achieving and maintaining a positive attitude to working with residents with dementia depends upon a range of factors. Constant comparison shows that incidents coded under 'caring attributes' have a range of different meanings, such as knowing the resident with dementia, knowing why people with dementia act as they do, intervention availability. It is also clear that staff attitude is influenced by

'care context' as managerial directing alters individuals 'caring attributes'. The data indicates that education and experience have roles in changing staff attitudes, but that individuals' innate qualities still impact upon any change. This health care assistant is very clear that wanting to do the work is a staff attitude that supports improvement in psychosocial intervention use over time:

I think you'd really want to do the work. You wouldn't just get the job for the sake of getting a job, or whatever. You want to do it. You do have to be patient and able to learn. You do learn as you go along. Everybody's different. You have to be willing to learn about every individual.
(Participant 22-Health Care Assistant)

As with innate qualities staff attitude emerges from the analysis as a concept with a clear influence on psychosocial interventions delivery. Further interconnectedness of categories is illustrated by the data showing that staff attitude as well as 'care context' influences 'educational proclivity'. This understanding is consistent with the Phase 1 data showing staff '*pooh poohing*' educationally supported psychosocial intervention use. While constant comparison indicates that that education and experience matter, staff considered their colleagues ability to deliver psychosocial interventions to be primarily influenced by innate qualities and staff attitude.

This data helps explain the clear emphasis on physical care and consequent impact on attitude to psychosocial interventions and the nature of the care delivered. Of the first 29 staff participants 15 were qualified nurses of which 3 were registered mental health nurses. Staff participants, including health care assistants had very limited education in dementia care. The health care assistants consistently indicated that they had greater 1:1 access to residents with dementia than the registered nurses. Therefore given the physical focus of the trained staff who oversaw their work the health care assistants viewed completion of physical tasks such as washing, dressing and feeding to be their main task:
Well, we don't have time for much social stuff. In the morning it's very hands-on until about 11.30m (Participant 26-Health Care Assistant)

You've got to get the basics first. You never get a chance to talk, it's usually left to evening staff, so morning staff tend to think it's all graft and you don't get a lot of communication (Participant 28- Health Care Assistant)

This prioritisation of physical care reflects the 'care context' staff work within, but individuals also make a choice regarding the degree to which they conform to the workplace ethos. The data shows that the choice regarding care delivery approach is influenced by staff attitude as well as 'care context'. As a component of 'caring attributes', staff attitude emerges as an important and changeable concept. Attitude varies between staff members and the data suggests that individual attitudes can change over time. Participant's response to behaviours that challenge is clearly impacted by knowledge and experience and when participants are aware of this their understanding of the impact it has is striking:

I was shaving this man and all of a sudden a fist comes up straight in the face. You knew then that he was shocked himself. You could tell from the way his expression was. I said, "It's okay. Don't worry". And then he comes up, "I'm sorry. I'm sorry. I didn't mean to." Obviously, if someone punched me in the face in the street, I wouldn't be very happy about it, but here . . . (Participant 27-Health Care Assistant)

This health care assistant makes a clear distinction between being assaulted outside work and being punched by this resident at work. Her ability to empathise, applying her knowledge and experience influenced her attitude which in turn impacts on outcomes for the man who hit her. She was very clear that her care for and attitude to this man would not be effected by the punch. This view was situational and based upon an attitude developed from her experience of 'care context'. This health care assistant was very clear that in another context her reaction to being punched would not be '*its ok. Don't worry*', she would in fact hit back.

This data illustrates how staff attitude influences psychosocial intervention use. The understanding that 'caring attributes', comprising innate qualities and staff attitude are strong influences on psychosocial intervention use or its absence, but are often not governed by education is important. The realisation that staff actions are often institutionally and

personally defined, free from education, highlights the need for further conceptual understand of the role of education and its uptake in influencing 'caring attributes' and 'psychosocial intervention skills'.

6.6.4 Educational Proclivity

Following Phase 1 analysis and the identification of the lack of dementia specific education amongst the sampled staff, questions arose around education; do staff want education, if so why and in what form? The lack of staff experience of dementia specific education was recorded in memos during data collection and analysis:

On the whole staff do not have much to say about education. Why? Because they do not have any dementia specific education, so lack a point of reference. The sparseness of the educational category requires adjustment of the sampling. If pushed participants say education is important, but put little of their psychosocial intervention activity with residents down to education.
Memo 05/01/2010

Constant comparison of Phase 2 data concerning 'educational proclivity' is consistent with Phase 1 analysis. Two Phase 2 participants were dual trained in psychiatric nursing and two had postgraduate diplomas in gerontology. None of the participants, including these four, claimed any dementia specific education. This lack of dementia specific education could be responsible, at least in part for staff not prioritising education when attributing the factors that influence psychosocial education delivery. Data pertaining to 'educational proclivity' provides an understanding of the influences of 'caring attributes' and 'care context' on staff willingness to participate in and use dementia specific education. Analysis of the staff data illustrates the influence of 'caring attributes', both innate qualities and staff attitude along with 'care context' including staff experience of working with people with dementia. When asked to identify their educational needs participants indicated 3 main areas; knowing more about dementia, knowing how to deal with behaviours that challenge and knowing more about individuals prior to dementia onset. These three areas of identified educational need are discussed under in the next section.

When asked specifically about their educational needs staff data indicated that they needed education that would let them know more about dementia, the different types and likely impact on individuals. The participants were clear that their training as health care assistants or staff nurses did not give them the knowledge of dementia they required. The following are responses to direct questioning around educational need:

Well, I think it would be understanding dementia. You would need to have the education to be understanding of the disease process. (Participant 18-Staff Nurse)

There's no one training us to do that (implement effective psychosocial interventions for behaviours that challenge). Sometimes it's nice to hear, "Yes, that's the line to take. That's perfect" or "You shouldn't have said it that way. Maybe you should have done it this way." We're not trained for this, so you don't know, okay it's working now but next year has that helped them or hindered them? (Participant 24-Health Care Assistant)

The need for greater knowledge of dementia was directly linked to staffs' desire to know more about the causes of behaviours that challenge and knowing why residents with dementia do what they do. Participants indicated that they had no training and therefore were often unsure as to what the correct approach might be. They also indicated a need for feedback, or educational confirmation of the efficacy of the interventions they did use. Being told, *'Yes, that's the line to take. That's perfect'* evidently impacts on staffs' confidence in their 'psychosocial intervention skills' use. The lack of educational confirmation, even where positive care is delivered undermines staff members' confidence in the approaches used. When talking of knowing how to deal with behaviours that challenge staff indicated that while knowing new approaches would be useful, getting confirmation of the approaches currently used would also be beneficial. Participants indicated that educational input regarding why people behave in challenging ways would help confirm and permit effective, experience based care strategies. Staff participants were clear that they did not know if what they were doing was correct or beneficial to residents with dementia. Managerial direction within the 'care context' has a clear role in confirming effective practice along with education. This health care assistant describes her desire for educational support in understanding

and effectively responding to a resident with dementia who may be unpredictably aggressive:

Everyone who has dementia or Alzheimer's has different characteristics every day. Sometimes they can be so nice and helpful and the next day they can be a bit aggressive towards you, so then you've got to sort of like sit down and find out what triggered it off with them. So, it's hard. I think the training is important so you can have more of an understanding. (25-Health Care Assistant)

Faced with uncertainty over their approach to care, participants indicated that education has the potential to build their confidence as well as positively impact on their attitude to people with dementia. Knowing that behaviours stem from illness, rather than as a result of people just being difficult, was regularly referred to as a factor that can impact on staff attitude. Staff participants indicated that having this knowledge allowed more thoughtful, effective and psychosocial interventions in response.

The emergent understanding of the importance of knowing about dementia and residents with dementia shows that 'educational proclivity' is influenced by staff willingness to know 'psychosocial interventions skills' along with their experience of how they may be used in the 'care context'. Participants indicated that they often used approaches that they had learned and practiced on the job rather than ones based on education, but that they viewed education as having the potential to permit and enforce good practice. Part of this good practice was shown to stem from staff having knowledge of individual residents with dementia. Knowing their preferences and their behaviours, with education being seen as having a role in justifying the time spent gaining and utilising such knowledge. The data shows that knowing the resident with dementia supports psychosocial intervention utilisation, but for many staff participants knowing the person and using that knowledge is not prioritised. Focus on physical care, time pressure, staff not recognising the value of such knowledge and limited ability to communicate with people with dementia all served to limit staff's prioritisation of knowing the person. The next section further considers staff proclivity towards educational opportunity.

Phase 1 and Phase 2 data indicates that the participants lack dementia specific psychosocial intervention education. While analysis shows that there is some inclination towards educationally supported psychosocial intervention utilisation, staff proclivity towards education is contingent on the relationship between 'care context' and 'caring attributes'. This next nurse manager data illustrates the influence of context driven barriers to educationally based change, but does confirm the view that education can help:

Of course it (education) helps, but you go back then to the workplace and you're working with a certain limited number of staff and sometimes it's difficult to bring an educationally driven plan of attack. (Participant 23 – Nurse Manager)

Staff proclivity towards change via education is tempered by the lack of staff educational experience and the view that education may not always apply to practice. Participants suggest that education should be enhanced by learning support in the clinical area, which would confirm good practice and support change:

On site, loads and loads of practice. It would be ideal if someone could come in and do a practical thing with people, maybe spend a day. Like they do in the training hospitals, they might come in and work with somebody. I think that might be effective. (Participant 20- Staff Nurse)

Constant comparison shows that participants see education as one means of enhancing psychosocial intervention practice though they consistently link educational developments with pressure for change and change with the need for additional resources. Constant comparison also offers the understanding that education is part of a process of 'care context' change which includes enhancing 'psychosocial intervention skills'. Constant comparison of staff views on 'educational proclivity' and change links educational use in practice with contextual priorities and resources. How much time is there and what tasks are prioritised? The perceived magnitude of change and educational commitment required to effectively implement psychosocial interventions helps to explain the participants' reticence regarding education. Education is seen to be needed, but it is understood to be additional to day to day practice and only a contributory

part of a more general need for change. Not a way to bring about psychosocial intervention use in itself:

if I go on a course at the moment, I'm leaving a unit short. You can understand how some of the staff think, is this course going to add on anything? "Oh, Mary's gone off on another course." You can understand how there would be resentment because they're the ones essentially left holding the baby, trying to manage all these needs of 38 clients in a very, very stressed environment if you have all these needs there that you can't meet.
(Participant 12-Staff Nurse)

This data helps illustrate the ongoing balance between commitment to education and staff perception of day to day service needs. Given the perceived change requirement and the lack of educational experience the service needs are seen as taking precedence. Analysis shows how staff 'educational proclivity' is influenced by 'care context', 'time and task' and 'caring attributes'. Accordingly proclivity towards education exists on a spectrum of educational understanding. At one end staff with no experience of dementia specific psychosocial interventions education including those who are daunted by the level of need and commitment meaningful educational change would require. At the other, staff who view education as having the potential to help them address the very issues raised by 'others' as barriers to education by raising their 'psychosocial intervention skills' level.

6.6.5 Psychosocial Interventions Skills

Phase 1 constant comparison produced the category 'psychosocial intervention skills'. This category was developed to explain the purposive application of psychosocial interventions. The data referred to staff having conversations with residents with dementia and using knowledge about them, but also included touch or strategies such as music or dance. As noted in constant comparison of 'caring attributes' participants consistently hold that innate qualities and staff attitude account for effective application of 'psychosocial intervention skills'. Although used in day to day social interaction 'psychosocial intervention skills' were used primarily as purposeful forms of engagement or distraction to allow the completion of physical care. They are also used in response to behaviours

that challenge, where they are seen as an alternative to or adjunct to the use of medication.

Constant comparison of the data relating to 'psychosocial intervention skills' revealed a complex interaction of personal and 'care context' factors coming together to influence the nature of individual actions. Skilled psychosocial intervention application is influenced by the personal factors including staff attitude affecting decisions regarding care delivery. As well as 'care context' specific factors such as peer pressure and managerial direction. Individual concerns about effectiveness are also influenced by the impact of 'care context' on the prioritisation of effort and time upon physical care.

Constant comparison of the data reveals the use of communication strategies that allow routine to continue. These are often referred to as '*distraction*', communication strategies that allow the completion of physical care and are regarded as skilled by staff participants. Application of 'psychosocial intervention skills' are outcome focused with motivational communication, confident delivery, touch and tone of voice listed amongst a range of effective interventions:

I think the main thing I've noticed with staff is how they divert their (Residents with Dementia) attention to maybe do something else. Maybe saying, "Is this dress yours? I'm just putting away the laundry. Do you want to come and help me?" Something like that. (Participant 18- Staff Nurse)

Constant comparison indicates that where staff recognise the purposeful application of strategies, they are raised from mere socialising to the level of 'psychosocial intervention skills'. This staff nurse explicitly links skilled application of knowing the person to strategies that will allow physical care to be completed:

You have to work finding specific things that will calm that person, so knowledge of your client is huge. One lady, she absolutely is intolerant of people going near her, which she needs because she would have huge physical care needs. She responds very well to music, so I discussed with her family her particular likes in music and I know the songs she likes, so I sing. I speak her name and keep singing and she calms. (Participant 12- Staff Nurse)

Planned interactions that facilitate physical care are highly valued by staff. Such interactions relate to the tentative core category 'flexibility' as they are deemed to be pragmatic, represent a good use of 1:1 time and facilitate completion of tasks. The example of utilising music as a 'psychosocial intervention skill' illustrates the preparedness of staff to be flexible in pursuit of task completion. Flexibility in application of 'psychosocial intervention skills' also relates to effective responses to behaviours that challenge:

I make sure I'm on their (residents with dementia) level first, you know? I keep eye contact. If they're sitting down, kneel down beside them. Try to take them out of that situation and bring them down to their bed. Well, keep talking to them in a calm and soothing voice. Don't raise your voice. Keep the situation as calm as you can. If anything you do isn't working, you can get somebody to help you because you can't be helpful and right all the time. (Participant 22- Health Care Assistant)

These skilled interventions are applied in response to behaviours that challenge which often occur during efforts to complete physical care. Data indicates that when staff are familiar with a resident with dementia they complete tasks by applying strategies they have developed over time, through knowing the resident with dementia. 'Flexibility' impacts on 'psychosocial intervention skills' where a strategy fails to support completion of a task and other approaches are utilised as alternatives or to deescalate the situation. This is another instance of balancing, this time between task and person, with the data above indicating staff preparedness to favour person's needs over the pressures of the 'care context'. In this instance the person not getting upset or agitated, over task completion, 'you can't be helpful and right all the time'. Understanding why staff take the time to apply 'psychosocial intervention skills' goes beyond 'time and task' or even positive outcomes for the resident with dementia. This health care assistant states 'I feel good' and refers to their own achievement along with outcomes for the resident with dementia:

I know it's working (spending time talking) for myself because I feel good because I've achieved what I started that morning. The resident is in a good frame of mind. I haven't upset them too much and they haven't got agitated and they're quite in control. If you can achieve a goal in your work, that's good. (Participant 28- Health Care Assistant)

This health care assistant links making time to talk with resident with dementia directly to addressing their needs and addressing the problems they associate with dementia:

I've done the best I can do and the dementia is in control a bit. They're not upset. They're not getting agitated. (Participant 28- Health Care Assistant)

The reason for applying these 'psychosocial intervention skills' involves the health care assistant's own sense of success. Constant comparison also shows that 'psychosocial intervention skills' even where flexibly applied are not always effective. Staff participants often noted the need for time consuming ongoing 'flexibility' e.g. trial and error and cognisance of the fact that any given psychosocial interventions strategy may not work at any given time. This results in situations where the 'care context', the need to prioritise physical care and address behaviours that challenge, demands that the settings' own criteria for success are met. The data indicated that these criteria shift the balance moving towards the requirements of the 'care context' over the person. This staff nurse comments on the tendency for colleagues to use medication due to lack of understanding when faced with behaviours that challenge:

I think they need oh I dunno I think they just need to understand that people are losing their social skills, they are not doing it to annoy you they are not doing it to make your shift more difficult, they are doing it because that's about all they can do really. They are really struggling you know and I mean a tablet mightn't necessarily be the answer. (Participant 1- Staff Nurse)

While participants indicated a lack of education and formal 'psychosocial intervention skills', constant comparison consistently indicated that staff utilise their available psychosocial intervention options in advance of resorting to medication. However, their options and ability to be flexible are limited. This health care assistant indicated she had no alternative approach and that pressure to press on to complete physical care resulted in upset for the resident with dementia and herself:

We'd say, "We're just going to get you up for breakfast. We're going to take off your nightdress and get your daytime clothes on." She'd always go against you. What can you do then? You can't... We have to do it anyway, and she obviously doesn't want us to do it. She's like that all the time, so you

can't just leave her either. Some people would say that's abuse. (Participant 15- Health Care Assistant)

In this instance the emphasis on 'time and task' results in staff not applying a flexible psychosocial interventions based approach. The health care assistant is aware of the discomfort for the resident with dementia and even asks the question '*what can you do then*'. What is clear is that there is no alternative to completing the task within her 'care context'. There was no 'flexibility' in approach resulting in dominance of 'time and task', institutional needs over the personal. Constant comparison shows that staff lack 'psychosocial intervention skills', showing they often see no alternative to timely completion of physical care while lacking the 'psychosocial intervention skills' to act flexibly or knowledge to challenge the prevailing view of the 'care context'. Analysis also shows that the presence of behaviours that challenge, even where triggered by staff actions are then likely to result in recourse to use of psychotropic medication. The resultant discomfort amongst staff serves to enhance their 'educational proclivity' as the recourse to medication is illustrative of their 'psychosocial interventions skills' not being adequate to meet the criteria for success within 'care context'. Time or the perceived lack of it helps explain the skills used along with the prioritisation of physical care, and the perception of priorities within 'care context'. It is worth noting that participant data did not show them seeking to change the contextual criteria for success, namely timely completion of physical care. There was a general consensus that timely completion of physical care was the main aim of care.

6.6.6 Care Context

Following Phase 1 'care context' was conceptualised as the environment in which care is delivered with workplace culture and managerial direction the key concepts arising from the data. The interaction of individual experience of care, workplace culture, peer pressure and managerial direction influence the use of psychosocial interventions and the criteria for success within any given 'care context'. Taken together these elements

emerge as a balancing set of personal and institutional categories that influence an individual's capacity and inclination to deliver psychosocial interventions. The sampling strategy for phase 2 involved interviewing entire shifts in long-stay settings in the hope of collecting data from 'others' staff who previous data had identified as delivering negative care quality. No such participants or data emerged with all the Phase 2 participants identifying negative care quality in 'others' while noting their own efforts to strive to do their best with limited resources.

Phase 2 participants indicated a lack of psychosocial intervention options within their 'care context' which resulted in their lack of 'flexibility' and their prioritisation of physical care. This prioritisation of 'time and task' is in large part based on staff perception of the requirements of their specific 'care context'. Understanding of psychosocial intervention availability both in terms of education and staff openness to change has arisen within the categories 'educational proclivity' and 'psychosocial intervention skills'. The data from staff participants indicated that individual autonomy and decision making was influenced by their peers, colleague culture and managerial direction. Most participants acknowledge their tendency to prioritise physical care while aspiring to be more flexible:

To be honest with you, I would very much like to have more formal education in managing the dementia care. Even though I'm in the job for a lot of years, I picked up that you can always improve on the services you give...For instance, we have a lady now that really resists physical care, but because she's incontinent, needs the care. That becomes a huge stressor. That's one issue. Another issue is getting her to take her medication. It's a big issue. You can push it. You can do all sorts of things. It can become a challenge.
(Participant 12- Staff Nurse)

The stress for staff, created where the need to complete physical care in the face of limited education and a lack of psychosocial intervention options is common in the data. The following health care assistant data indicates that as with 'psychosocial intervention skills' there was a balance between favouring the personal needs of the resident with dementia and meeting the cultural requirements within the 'care context'. Where participants identify that they are acting in response to pressure of 'care

context' they indicate that colleague and managerial opinion directs their actions:

I can't come as a care assistant and say Mr. Jones doesn't want to get up. He wants to stay in bed until 11.00 O' Clock. To be honest with you, I wouldn't have the courage to say that because there would be someone saying, "Who is she to say that?" I prefer to see a rule come from the top. If it comes from management, it's easy because they are getting paid to lay down the law.
(Participant 16- Health Care Assistant)

Constant comparison indicates the presence of tension between actual staff action and how they would like to act. The influence of 'care context'; managerial and colleague pressures upon care represents an interaction of institutional and personal categories. This balancing of categories results in staff action. In most cases the resolution, care delivered, favoured the prevailing 'care context' an emergent understanding noted in this memo:

Staff want to do what feels right to them, let someone remain in bed, but in practice they act in response to the pressure of categories, the result is care being defined to meet the needs of the context (positive or negative). In the most negative conceptualisation time and local pressures overcome personal responsibility! Memo 15/01/2010

Constant comparison of the data indicates that 'care context' influences psychosocial intervention use in a number of ways. These include the tendency of staff to defer to hierarchy and to conform to contextual norms regarding what kinds of interventions work best. There are positive instances where staff indicated pressure from colleagues along with managerial direction encourage and permit psychosocial interventions. In these examples staff talk of favouring the needs of the resident with dementia over physical care and concerns regarding 'time and task'. Where psychosocial intervention use was part of the culture, participants indicated sharing knowledge and practice in order to make these practices the local norm. This staff nurse data indicates 'psychosocial intervention skills' being passed on, in this case from staff nurse to a student on work experience:

The resident loved a sing-along, so she responded very well to that. So, I try then to pass on all that information to my colleagues. There was one girl (student nurse) who was on work experience and she was fascinated by the

difference in this lady from one day to the next. I felt great, I've taught this girl. Hopefully she'll remember. (Participant 12- Staff Nurse)

This data gives an example of a 'care context' where flexible psychosocial intervention application to care is permitted and acknowledged. This instance differs from most of the criteria for success identified in the data. In this case success was about the resident with dementias needs rather than timely task completion. This positive example stands in contrast to the many instances where success is rated in quiet, timely completion of physical care. The data shows that such criteria for success are regularly not achieved. With pressure to complete tasks at times resulting in behaviours that challenge, upset for residents with dementia and staff and regular recourse to medication. The tentative core category 'flexibility' consistently explains how staff can use available 'psychosocial intervention skills' to overcome the practical pressures of 'care context', lack of time and lack of education. The next section will consider how the tentative core category 'flexibility' developed when subjected to constant comparison against Phase 2 data.

6.6.7 Flexibility

Before further consideration of the tentative core category flexibility it is worth recalling that Glaser (1978) defines the core category as relating to and accounting for all the other categories and properties. The core category therefore delimits and directs the emergent theory while resolving the main concern evident in the data. Constant comparison of the data indicates that the main concern of staff refers to getting their shift completed in a timely manner that fulfils individual and organisational criteria for success. When considering the development of the core category across data collection phases there is a need to conceptualise the main concern (Glaser, 1978). The participants consistently refer to the goal of finishing a shift with a sense of satisfaction at having done the best job they can. The data contains a great deal of variability in defining what outcomes fulfilled personally derived criteria for success. This is

illustrated by comparison of the responses of these two staff when asked to outline how they know they have done a good job:

Well, if they (resident with dementia) are in bed, or whatever, that they're in the right position and that they're turned every two hours and they're in a comfortable position. (Participant 26- Health Care Assistant)

Your own satisfaction, really. You can see the residents look happy and putting on weight, maybe, a little bit. She's eating and drinking. You can tell by looking at her really. ..I worked as a bank official when I was single, when I was younger. I get more satisfaction from this than I ever did sitting behind a computer. (Participant 16- Health Care Assistant)

These two incidents illustrate differing individual interpretations of what constitutes a successful shift. These incidents of data are coded under the heading pragmatic is effective and managerial context with the data explaining how time, local priorities, available skills, personal decisions about what is a good job all impact on care and staff decisions about care delivery. Individuals interpret whether or not the care they deliver fulfils their view of effectiveness. This decision is also based on the influence that the interplay of categories has on them. Data illustrates that how staff go about delivering what they view to be a 'good job', is based on personal decisions that are influenced by the interplay of institutional and personal categories. Individuals indicate that they are responding to 'care context' specific factors, such as perception of lack of time when deciding what kind of care to deliver. Constant comparison identifies that staff are concerned with doing the best job they can within the time available. Resolving this concern is in part to be achieved through 'flexibility'. In this incident the staff nurse is clear that success rests upon knowing the individuals likes and dislikes and being prepared to address these with flexible application of psychosocial interventions:

You get to know that they might like talking to this other lady, or they might like walking down as far as the chapel or walking down as far as the other ward, or walking outside for a few minutes, or whatever. When you're working with them, you know how they tick. (Participant 18-Staff Nurse)

Constant comparison of this data along with other Phase 1 and 2 incidents indicates that the main concern of staff refers to getting their shift

completed in a timely manner that fulfils individual and organisational criteria for success. As indicated in Chapter 2, understanding the main concern is vital to the emergence of the core category and understanding the overall conceptual process that accounts for psychosocial care delivery (Glaser, 1978). At this stage the main concern is conceptualised as 'striving to make the most of time'. With this in mind 'flexibility' developed out of Phase 1 constant comparison with the data showing that the ability to try a range of approaches and to have options gave positive results for residents with dementia. The other categories, specifically 'care context' as it applied to staff criteria for success resulted in great variation in what positive results are viewed to be. This variation makes it difficult for 'flexibility' alone to account for all of the data. With the main concern so highly personalised and variable the core category needs to be able to account for this. Given that the main concern of participants, 'striving to make the most of time', relates to staff getting their shift completed in a timely manner that fulfils individual and organisational criteria for success, the next section begins with re-consideration of the tentative core category 'flexibility' and its ability to account for the main concern. It will then go on to outline the development of the categories 'caring attributes', 'educational proclivity', 'psychosocial intervention skills' and 'care context' into re-conceptualised categories comprising the institutional and personal influences on individuals.

6.7 Phase 2 Reflection and Modelling

'Flexibility' is an important component of successful psychosocial intervention use, but analysis of the data shows that that 'flexibility' is not always present. The data shows incident after incident where participants resolved their main concern, 'striving to make the most of time', by doing what the 'care context' demanded rather than what they felt could or should be done or what residents wanted to do. 'Flexibility', in itself does not account for the variation in response to the main concern over time. It is clear that the interplay of institutional and personal conceptual categories does help to account for changes in individuals' attitudes to and

use of psychosocial interventions. As such these institutional and personal categories have been subject to further constant comparison and refinement. Analysis does indicate participants' desire to change in a manner that resolves the main concern 'striving to make the most of time', while being individually satisfied with the job done. Better understanding the nature and interplay of the emergent categories helps explicate the actions of any individual and their satisfaction at those actions.

The emergent theory must account for individuals' satisfaction or lack of it. Individual satisfaction is conceptually understood to impact on individuals' inclination towards change, often educationally driven, and their inclination towards psychosocial intervention utilisation. Therefore the new and still tentative core category is 'psychosocial intervention utilisation'. This category attempts to account for the variation noted between individuals and over time. Do individuals utilise or not utilise psychosocial interventions? What are the factors and processes that account for this? In this conceptualisation 'flexibility' or its absence becomes a property of the core category. This development of the core category is mindful of the existence of a process with the potential for change. The ability of individuals to apply 'psychosocial intervention skills' changes over time and the current re-conceptualisation of the core category is an attempt to represent the potential for change over time resulting in 'psychosocial intervention utilisation'. As the next phase of data collection progresses there will be consideration of the conditionality of 'psychosocial intervention utilisation'. Constant comparison will seek to understand what elements need to be in place to allow participants to change in a manner that resolves their main concern via 'psychosocial intervention utilisation'.

Analysis shows the lack of dementia specific education amongst staff participants and the influence of this on staffs' understanding of what skills are and what interventions are possible. If not formally taught, skilled approaches are viewed as coming from within, innate qualities or

via experience in response to 'care context'. The staff interviewed in Phase 2 did not have education in specific psychosocial interventions and as such their 'educational proclivity' and consequent skill attribution was affected. For the purposes of Phase 2 reflection and modelling and Phase 2 theory development, where the focus becomes how available education is used, this category will now be referred to as 'using education'. Comparison of the data identifies educational components that staff deem important and are therefore likely to use as; knowing about dementia and its impact, knowing what interventions are effective and knowing the person. The data indicates that these three components can impact on staff attitude, develop their psychosocial intervention options and build confidence resulting in 'psychosocial intervention utilisation'.

The degree to which an individual recognises psychosocial interventions, uses them purposefully, is culturally permitted to use psychosocial interventions or personally wants to use psychosocial interventions explains their individual response to the main concern, 'striving to make the most of time'. Their response to the main concern represents a balance between what the 'care context' will permit them to do, their personal understanding of what constitutes good care in their setting, their ability to deliver psychosocial interventions, their willingness to deliver that care and their appreciation of the needs of residents with dementia as people.

In attempting to understand the balancing of institutional and personal categories it is useful to refer back to Glaser (1978) and his differentiation between substantive and theoretical coding. Substantive coding is the application of labels to related data providing conceptual understanding. This process is primarily concerned with understanding the core category and the categories that relate to it (Holton, 2007). Theoretical codes order the categories establishing links with each other and importantly relating them to the core category (Glaser, 2005). In this research theoretical coding seeks to explain the relationship between the core category and the balance of institutional and personal categories. The interactive balancing

between the institutional and personal categories drives a larger overall basic social process which explains participant resolution of the main concern, 'striving to make the most of time'. The following memo captures the initial realisation that there were basic social processes at work which can be accounted for by theoretical codes:

On re-reading Glaser a number of basic social processes can be seen at work here. The institutional and personal categories interplay over time and impact on 'psychosocial intervention utilisation'. This interplay explains what a given individual does to resolve the main concern. There is an overall process that maps the ebb and flow of care delivery. This process is given momentum by the homeostasis or balancing of personal and institutional categories which is accounted for in the interactive family of theoretical codes. Memo 21/04/10

It is important to emphasise that theoretical coding provides an explanation to the process emerging from the data. Central to the understanding of process is the importance of time and ebb and flow (Glaser, 1978).

Constant comparison now indicates that the initial model provided in Figure 5.2 Theoretical Model 1. Where 'caring attributes', 'educational proclivity' and 'psychosocial intervention skills' interact to produce 'flexibility' there is a more complex interaction of factors taking place in the care context over time to dictate psychosocial intervention use. Following constant comparison of the Phase 2 data the concept of 'balancing the influences' has emerged, providing further development of the concepts 'caring attributes', 'educational proclivity', 'psychosocial intervention skills' and 'care context' as well as the core category, 'psychosocial intervention utilisation'.

'Balancing the influences' is modelled in Figure 6.1. This illustrates the balancing relationship between re-conceptualised institutional categories and personal categories. 'Balancing the influences' is conceptualised as the first stage in the developing understanding of the ongoing social process accounted for by the core category.

Figure 6.1 Balancing the Influences



Constant comparison and theoretical coding has produced this explanation of how the institutional and personal categories interact over time. This interaction produces the starting point of the social process that explicates how participants resolve their main concern, 'striving to make the most of time'. The three institutional categories have emerged from the category, 'care context'. 'weighing up what works', 'psychosocial intervention availability' and 'institutional directing' constantly interact with each other as do the personal categories; 'caring attributes', 'experiencing care' and 'using education'. These balancing groups of institutional and personal categories also interact with each other over time, forming individual staffs' capacity and inclination towards 'psychosocial intervention utilisation'. The interaction of these categories results in 'balancing the influences'. The impact of 'balancing the influences' ebbs and flows over time, with constant comparison of the data indicating that institutional categories have greater influence on balancing than personal in the production of the next stage in the process which is 'individualising status'. The understanding of the importance of staff status as defined by the balancing of institutional and personal factors reveals

another property of the core category, 'capacity and inclination towards psychosocial interventions utilisation'.

The concept of 'individualising status' is illustrative of the emergent understanding of the ongoing balancing of social processes that arises from the data. An individual's use of education will clearly impact upon their capacity and inclination towards 'psychosocial intervention utilisation'. Individual's access to education is influenced by the prevailing balance of institutional categories such as 'institutional directing' and personal categories such as 'caring attributes'. Constant comparison of data pertaining to the personal category, 'using education' largely refers to what education staff would like and why.

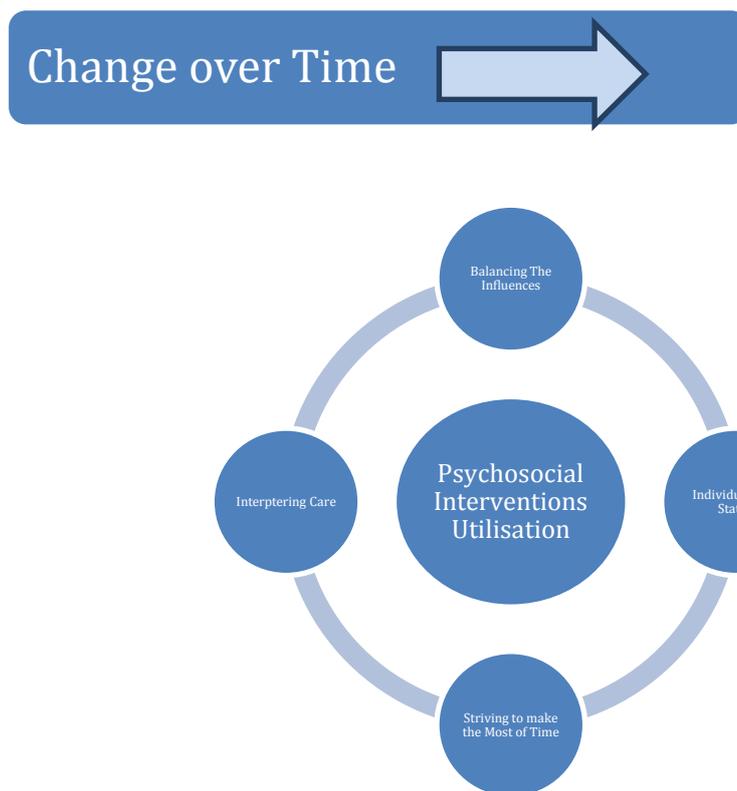
Staff use of psychosocial interventions is dictated by a balance between institutional and personal categories. 'Psychosocial intervention availability' and 'using education' interact, along with the other categories, to produce an individual's capacity and inclination towards psychosocial intervention use. This balance is maintained by 'institutional directing', 'using education' and another balance, between current practice and practice aspiration. What skills do staff possess and are they minded to learn new ones? The new tentative core category 'psychosocial intervention utilisation' emerged in response to staffs' main concern, 'striving to make the most of time'. This memo shows the thought process underpinning ongoing conceptualisation of the main concern:

The workplace pressure on time stated by the participants gives the sense that people are 'striving to make the most of time'. Staff nurses, health care assistants and residents with dementia are all concerned with wanting more resources. The more is more social contact, conversation, education and activity. They all indicate that there are not enough resources and that they prioritise and justify what they do or get in these terms. Memo 17/04/10

The variation noted in the nature of individual 'psychosocial intervention utilisation' indicates the existence of an ongoing process which explains how staff resolve their main concern; 'striving to make the most of time', in a manner that fulfils their conception of 'weighing up what works'. The

interplay of the other categories results in a process which accounts for how individuals decide on success, weigh up what works and the varied application of 'psychosocial intervention utilisation'. It is apparent that for 'psychosocial intervention utilisation' to occur a number of conditions must be achieved and that these occur as part of an ongoing process. This dynamic social process begins with 'balancing the influences' and dictates the nature of how individuals resolve the main concern. The four stages of the social process that begins with 'balancing the influences' moves on to 'individualising status', 'striving to make the most of time' and 'interpreting care' are represented in *Figure 6.2 Theoretical Model 2*. The components of this process will be conceptualised in detail across the next chapter.

Figure 6.2 Theoretical Model 1



6.8 Phase 2 Summary

This chapter has presented the on-going data collection, open coding and analysis, theoretical sampling, constant comparison of Phase 2 data, theoretical modelling and directed the subsequent theoretical sampling strategy for Phase 3. The initial categories 'psychosocial interventions skills', 'caring attributes', 'educational proclivity', 'care context' and tentative core category 'flexibility' have, following constant comparison with Phase 2 data, been re-conceptualised. The core category is now 'psychosocial intervention utilisation', its integration into theory, resolution of the main concern, is explicated via 'balancing the influences' a basic social process conceptualised by the interaction of three individual and three institutional substantive categories (see Figure 6.1). The process that begins with 'balancing the influences', progresses to 'individualising status', 'striving to make the most of time' and 'interpreting care' with these categories constantly interacting to dictate the nature of 'psychosocial intervention utilisation' the tentative core category. What remains to be understood is how the conditions for 'psychosocial 'intervention utilisation' change over time as staff seek to resolve their main concern, 'striving to make the most of time'. Constant comparison to date has allowed the emergence of a basic social process with distinct institutional and personal influences. Chapter 7 (Phase 3 of the research) will present further theoretical sampling, constant comparison and modelling aimed at more fully explicating the overall process of 'psychosocial intervention utilisation'.

Chapter 7: Phase Three Data Collection and Analysis

7.1 Introduction to Phase 3 Data Collection and Analysis

The Phase 3 theoretical sampling and data analysis presented in this chapter stems directly from the emergent theory discovered in Phases 1 and 2. Phase 3 theoretical sampling strategy will first be presented along with the participant demographics. This will be followed by presentation of the emergent categories and theoretical coding derived from constant comparison of Phase 1-3 data.

7.2 Phase 3 Theoretical Sampling

7.2.1 Rationale

Glaser and Strauss (1967) are clear that the constant comparative analysis aims to delimit the research ensuring data saturation around the core category. Analysis of Phase 1 and 2 data identified that staff participants had not received dementia specific psychosocial intervention education. This finding directly influenced Phase 3 theoretical sampling. Using the hypothesis generating properties of classic grounded theory (Glaser, 1978) a decision was taken to sample residents with dementia, relatives of residents with dementia, health care assistants, staff nurses, and managers, who had experience of dementia specific psychosocial intervention education. This addition to the sampling frame allowed consideration of similarities and differences in the data and helped to answer a primary question in the emergent model, namely in what manner does dementia specific psychosocial intervention education impact on psychosocial intervention use and the social process that explains it.

7.2.2 Sampling Strategy

The participants for Phase 3 (N=37; detailed in Table 7.1 Phase 3 Participant Demographics) had participated in or were relatives of residents with dementia who had undertaken the DARES study (O'Shea et al., 2014). As noted in Chapter 2, the analysis of Phase 1 informed the development of the structured education programme for the DARES study.

As completion of the intervention stage of the DARES study coincided with preparation for Phase 3 theoretical sampling, the opportunity arose to theoretically sample participants who had experience of the DARES study. The educational component of DARES (detailed in Chapter 2) involved staff participants (nurses and healthcare assistants) receiving a structured education reminiscence-based programme and delivering reminiscence based care to an allocated group of residents with dementia. The structured education programme comprised sessions on understanding dementia, working with people with dementia, managing challenging behaviours and reminiscence (Cooney et al., 2013). Participant data was collected in sites, 8-10 (see Appendix 1) following the structured education programme and while the staff were still actively involved in the DARES intervention. The Phase 3 interviews had similar focus to the previous phases with additional questions on the participants understanding of the impact of the structured education programme. See Phase 3 interview guides (Appendix 9). This focus resulted in staff interviews which lasted between 15-30 minutes. Resident with dementia interviews also lasted 15-30 minutes, with some variation dependant on the need to tailor the participant to the individual resident's communication requirements. Relative interviews were longer at between 20-40 minutes. As with the previous phases, numerous memos were recorded during observation, data collection and analysis.

Table 7.1 Phase 3 Participant Demographics

Participants	Role	Applicable Education	Residential Care Experience	Years in Current Post/Setting	Setting	Age	Gender
30	Staff Nurse	RGN	10 years	6-10 Years	Urban public	50-59	F
31	Relative	----	10 years	----	Rural Private	50-59	F
32	Relative	----	5 years	----	Rural Private	60-69	M
33	Relative	----	8 years	----	Urban public	60-69	M
34	Relative	----	4 years	----	Urban public	50-59	M
35	Relative	----	6 years	----	Urban public	60-69	F
36	Resident	----	----	2	Urban	70+	F

						public		
37	Resident	----	----	3		Urban	70+	F
						public		
38	Resident	----	----	4		Urban	70+	M
						public		
39	Resident	----	----	3		Urban	70+	F
						public		
40	Resident	----	----	5		Urban	70+	F
						public		
41	Resident	----	----	5		Rural	70+	F
						Private		
42	Resident	----	----	3		Rural	70+	F
						Private		
43	Resident	----	----	8		Urban	70+	F
						public		
44	Resident	----	----	2		Urban	70+	F
						public		
45	Resident	----	----	4		Urban	70+	F
						public		
46	Resident	----	----	2		Urban	70+	F
						public		
47	Staff Nurse	RGN, PgDip Gerontology	25 years	16-20		Urban	50- 59	F
48	Staff Nurse	RGN	17 years	16-20		Urban	60- 69	F
49	Staff Nurse	RGN	10 years	1-5		Urban	60- 69	F
50	Staff Nurse	RGN	12 years	6-10		Urban	50- 59	F
51	Staff Nurse	RGN	22 years	16-20		Urban	60- 69	F
52	Staff Nurse	RGN,	20 years	11-15		Rural	60- 69	F
						Private		
53	Staff Nurse	RGN, PgDip Gerontology	10 years	11-15		Rural	50- 59	F
						Private		
54	Staff Nurse	RGN	16 years	16-20		Rural	60- 69	F
						Private		
55	Manager	RGN, PgDip Gerontology	20 years	11-15		Urban	60- 69	F
56	Manager	RGN	13 years	1-5		Urban	50- 59	F
						Public		
57	Manager	RGN	17 years	6-10		Urban	60- 69	F
						Public		
58	Health Care Assistant	FETAC Level 5	4 years	1-5		Urban	30- 39	F
						Public		
59	Health Care Assistant	FETAC Level 5	5 years	1-5		Urban	20- 29	F
						Public		
60	Health Care Assistant	None	2 years	1-5		Rural	30- 39	F
						Private		
61	Health Care	FETAC Level 5	7 years	6-10		Rural	40- 49	F
						Private		

	Assistant						
62	Health Care Assistant	FETAC Level 5	2 years	1-5	Rural Private	30-39	F
63	Health Care Assistant	FETAC Level 5	10 years	6-10	Rural Private	50-59	F
64	Health Care Assistant	None	4 years	1-5	Urban Public	30-39	F
65	Health Care Assistant	FETAC Level 5	7 years	6-10	Urban Public	50-59	F
66	Health Care Assistant	FETAC Level 5	2 years	1-5	Urban Public	50-59	F
67	Health Care Assistant	FETAC Level 5	12 years	6-10	Urban Public	50-59	F

Before presenting the constant comparison of each of the phase 3 emergent categories, the context and nature of the data collected should be noted. The data was collected on-site in residential settings, in the case of residents with dementia and staff, and on the telephone for relatives. The researcher made up to 3 visits to each site, spending around 12 hours on each site undertaking observation while conducting interviews. The interviews took place during the 18 week period following completion of the structured education programme, while the participants were still utilising the DARES intervention.

7.3 The Emergent Theory: Phase 3

7.3.1 Core Category Development: Psychosocial Intervention

Utilisation to Becoming a Person Again'

Before presenting the analysis of the individual categories the development of the core category from psychosocial interventions utilisation to 'becoming a person again' will be presented, providing an overview to the analysis of the main categories. From the outset of Phase 3 analysis the core category 'psychosocial interventions utilisation' became subject to conceptual development. Data analysis rapidly showed that 'psychosocial intervention utilisation' did not account for much of the variation in the data. 'Psychosocial intervention utilisation' in a manner

that fulfils participants' desire to resolve their main concern is an end in itself. 'Psychosocial intervention utilisation' explains what is done, but not why, as such it does not account for variation in psychosocial intervention use or for the absence of psychosocial interventions use.

The conceptualisation of 'becoming a person again' transcends the data raising the theoretical abstraction. It accounts for instances where there psychosocial intervention use is present, for barriers to 'psychosocial interventions utilisation' and its absence; explicating the overall basic social process. The core category 'becoming a person again' accounts for how staff view themselves as care providers and what kind of care providers they aspire to become. It also accounts for how they view residents with dementia impacting on how they strive to deliver care. This health care assistant explained how she would endeavour to continue using the knowledge learned from DARES, reflecting the process nature of 'becoming a person again' when endeavouring to resolve her main concern, 'striving to make the most of time':

Oh, definitely, definitely, but like I said to you, it's not a magic wand, but it's a tool for us to understand the behaviour and it's like everybody's home. You want a happy home with harmony, everybody's home. We know some days it doesn't happen, it doesn't happen in your home and it doesn't happen in mine. But instead of feeling extremely frustrated, like oh my god get me out of here, it's like okay we had a bad day so we are just going to try.
(Participant 64- HCA)

In establishing the conditions of the on-going basic social process the core category 'becoming a person again' explains the mutuality of positive change. Having positive attitudes towards residents with dementia, using skills and being knowledgeable also benefits staff. 'Becoming a person again' refers to staff as well as residents with dementia. There is mutuality as the 'long-stay' setting becomes '*everybody's home*'. Finally the core category 'becoming a person again' reflects the temporal component of the basic social process being explained in a manner that 'psychosocial intervention utilisation' does not. Staff and residents are subject to influences over time as they endeavour to resolve their main concern, 'striving to make the most of time'. The gerund (ing) component of the

core category 'becoming a person again' is important to both understanding the basic social process and adherence to the classic grounded theory method (Glaser, 1992). The inclusion of the non-finite verb '*becoming*', in the core category accounts for the conditionality of the process over time. 'Becoming a person again' explains how the changes in the main categories outlined below and also referred to as stages in the process of 'becoming a person again'. Have the potential to positively influence 'psychosocial intervention utilisation' for residents with dementia in long-stay care.

The core category 'becoming a person again' reflects the temporal nature of the basic social process at work and the mechanisms by which individuals' deliver 'psychosocial intervention utilisation' or don't, over time; balancing institutional and personal influences in a manner that brings about change or maintains homeostasis. 'Becoming a person again' explains how the main concern, 'striving to make the most of time', can be attained by staff and residents with dementia, via 'psychosocial intervention utilisation'. Moreover, 'becoming a person again' helps to explain that psychosocial interventions can only ever be truly successful if those using them accounts for individual personhood. This delivers person-centred care in a way which stems from knowing who the person is along with their cultural and relational context. The core category 'becoming a person again' explains an achievable ideal, not always a reality, which is variable over time. The quote below is from a relative talking about staff. It is included to illustrate the existence of an ongoing process, along with the conditionality of care as it ebbs and flows over time. The relative generally considered the staff to be positive and to have benefited from dementia specific education. In this data some staff are seen to be meeting the conditions for 'becoming a person again', but not all and not all the time:

I'd like to think that they, you know, would think of mum as a rounded whole person and I mean, the majority of staff are delightful to her and you know, want to do as much as they can for her, but I do feel that sometimes their priority may be more of a physical nature on a day-to-day basis than anything else. (Participant 33- Relative)

The ongoing development of the core category will be discussed as the categories and theoretical codes are explored. In re-conceptualising the core category to 'becoming a person again' the concept 'psychosocial intervention utilisation' is not discarded, rather it remains as a property of 'becoming a person again', helping to explicate how care is delivered whilst resolving the main concern, 'striving to make the most of time'. 'Becoming a person again' relates to all the other concepts and theoretical codes as it explicates the participants relationship with the main concern. The main conceptual categories form the stages of the conceptual process that emerged from constant comparison of the data. These provide the headings for discussion and explanation of 'becoming a person again' that comprise this chapter:

- Balancing the Influences
- Individualising Status
- Striving to Make the Most of Time
- Interpreting care

Finally, the development of the core category, 'becoming a person again' also conceptualises the positive potential of the process emerging from the data. In Phase 3 staff and relative participants were overwhelmingly positive about the DARES intervention and eager to discuss their experiences. Although residents with dementia showed less awareness of the intervention and their data was not noticeably different from Phases 1 and 2 the positive staff and relative response is evident in the data. These two health care assistants were asked if participating in DARES had changed the way they relate to residents with dementia:

It does. They're more friends, not just an item. It's not just a job you know.
(Participant 58-Health Care Assistant)

It would of course because you get a kind of bond. It's hard to explain but you kind of get compassion towards them, you know (Participant 60- Health Care Assistant)

These responses are typical of the change in favour of 'becoming a person again' that staff identified following the DARES intervention. While the

positive nature of the data did not dramatically change the overall conceptualisation of the basic social process it did impact upon core category and consequently aided understanding of the other categories.

An observation noted in this memo recorded during Phase 3 data collection and analysis:

It is worth noting that on analysis the phase 3 data while mirroring the basic social process structures seen in earlier data there is a more positive relationship between categories. For example while Phase 1 and 2 data show direct opposition between the categories 'using education' and 'weighing up what works'. The conceptualisation in the earlier stages sees institutional priorities such as physical care as dominant to the degree that staff are resistant to education or even 'using education'. Phase 3 conceptualisation shows these same categories are more harmoniously balanced rather than skewed towards the institutional. Memo 11/09/2011

This next section will explicate how the theory of 'becoming a person again' accounts for the variation in the data. Commencing with 'balancing the influences', the stages of 'becoming a person again' will be explored and explained starting with the three institutional categories: Deciding what interventions work, 'psychosocial intervention availability' and 'institutional directing'. This will be followed by explanation of the personal categories: 'caring attributes', 'experiencing care' and 'using education'.

7.3.2 Balancing the Influences

Phase 3 constant comparison commences with consideration of the data relating to the institutional categories; 'weighing up what works', 'psychosocial intervention availability' and 'institutional directing'. The personal categories; 'caring attributes', 'experiencing care' and 'using education' are then considered. Within 'balancing the influences' the institutional and personal categories interact with each other within their groupings and across them. Constant comparison will consider the six categories' interactions and 'balancing the influences' as a whole.

7.3.3 Weighing up what works

'Weighing up what works' is an ongoing mediating process which is based upon an interaction between staff's 'caring attributes' and the norms within their work place. While personal categories do impact on this category, Phase 1 and 2 data revealed that decisions about what is, and what is not, successful are primarily defined by institutional factors.

Weighing up what works as a concept is primarily shaped by 'institutional directing' and balanced by 'caring attributes' as the individual determines the approach to care they take and the success of their interactions.

'Weighing up what works' can have a positive impact upon 'balancing the influences' when the institutional conceptualisation of the category is in balance with the positive personal aspirations of staff. While constant comparison shows that staff are overwhelmingly positively motivated, 'weighing up what works' explains that institutional dominance within 'balancing the influences' can result in the application of approaches that do not fulfil the conditions for 'becoming a person again'.

Some staff indicated what works is completion of task quickly and quietly. Others such as the example below are able decide on success in a manner that establishes conditions for 'becoming a person again' often, clearly influenced by dementia specific education. This health care assistant explains how they applied DARES:

How have I used the training? Well, basically you get to know the patient one-to-one and their past and especially if they kind of get a bit aggravated or upset, you could just talk a bit about their past. And after a while they kind of settle and if they can't speak, they'll gesture or they'll pull something. It relaxes them in a lot of ways. (Participant 52- Health Care Assistant)

In this instance the health care assistant views a '*gesture*' as evidence that her intervention has worked, gaining her in depth knowledge of the resident with dementia from educationally supported life story work. This participant's appreciation of deciding what interventions work illustrates differences in emphasis between Phase 3 data and much of the Phase 1 and 2 data. Staff who had not received dementia specific education consistently viewed timely completion of task as success. In fact much of

the data across the three phases indicates that a good job is equated to completion of task and absence of behaviours that challenge. Identification of the main concern, 'striving to make the most of time', gives conceptual understanding of the potential for positive change and the potential pitfalls faced by staff and residents with dementia. Weighing up what works influences what work is done. Staff members make decisions influenced by their context and the ever present influence of time. Time matters and while it is still an important factor in the Phase 3 data there are identifiable differences to its conceptualisation in comparison with Phase 1 and 2 data. The health care assistant above is representative of staff who following dementia specific education can bring innate qualities and 'institutional directing' into positive balance meeting the conditions of 'becoming a person again'. Only where the health care assistant takes the time to become familiar with the resident with dementia can something as personal as a *'gesture'* be known and acknowledged. The healthcare assistant who has determined that success can be found in a *'gesture'* and that this can be achieved via talking *'a bit about their past'*, has achieved a complex set of conditions. When brought together, these conditions allow both resident with dementia and the health care assistant to benefit from 'becoming a person again'. Time still matters, but the resident with dementia *'relaxes'* and the health care assistant has delivered an intervention that works and is in balance with their 'caring attributes'.

Participants who have experienced dementia specific education are able to ascribe success to interventions learned from or confirmed by education. The staff nurse below indicates how education has changed her understanding of the resident with dementia through utilising life story work. The data also indicates she has been able to change her routine, and spend more time with the resident with dementia:

For me, well I'm (resident's name) named nurse, so it has given me an insight into her background, what sort of life, you know, the hard work she's endured all those years and I suppose it gave me an appreciation, you know to know a bit about her history. Yes. I would sit and talk with her more often than what I normally would have. (Participant 50- Staff Nurse)

Analysis shows that education broadens staff criteria for success beyond task completion. Where education is seen to shift the overall balance in favour of 'psychosocial intervention utilisation', deciding what interventions work is conceptualised as being institutionally determined as well as personally through use of education. In Phases 1 and 2 the participants regularly note that their inclination to apply 'caring attributes' and view success as stemming from these attributes was limited by 'institutional directing' and focus on 'time and task'. In conceptualising balancing between institutional and personal categories it has become clear that often the conditions for 'becoming a person again' are not met. In Phase 3 data, 'weighing up what works' is positively influenced by the concept of 'using education' as it supports change in practice. When managerially supported through 'institutional directing' this gives permission for outcomes arising from 'caring attributes' to be viewed as working.

The following data shows balancing as staff attempt to negotiate towards conditions that allow 'becoming a person again'. Health care assistants are looking for permission to use time differently, seeking time to reminisce. Their means of 'weighing up what works' has changed following education. The health care assistants are seeking to do more than complete physical tasks. Their inclination towards psychosocial interventions utilisation has changed, although their application of this inclination is still subject to managerial direction:

Care assistants especially come to me and say we need time to go and sit down and get the few minutes without bells ringing. I said look, when you're getting them up in the morning, it's not a perfect time to speak to them, but you've got ten, fifteen minutes of valued time and you can reminisce and you know it sets them up the right way for the day...Using the time well
(Participant 49-Staff Nurse)

In directing health care assistants to reminisce while undertaking physical care this staff nurse illustrates the tension existent in 'balancing the influences'. Even where educational change is accepted by staff, in this case reminiscence, there is also a need for 'institutional directing'. This

next data illustrates the ongoing balancing tension between 'time and task' promoted by 'institutional directing' and 'using education'. This tension helps define the nature of 'weighing up what works' and in turn establishes whether the conditions for 'becoming a person again' are being achieved. This manager illustrates the tension between the benefits of psychosocial interventions utilisation and the time this takes:

Well, to me it means it's a lot more individualised because you know so much about them (residents with dementia) and you're giving them very much individualised care. It is worth the time. It is worth doing and it's very worthwhile to do it, but time is a huge element in it and getting to do it properly, because when you were kind of doing it in bits and pieces, you do a bit one day and you do a bit the next day. You're all the time trying to catch up. (Participant 54- Nurse Manager)

While education is important, in introducing means of effective 'psychosocial intervention utilisation' constant comparison shows that it must be supported via 'institutional directing'. Changing staff members understanding of what constitutes success, 'weighing up what works', requires managerial support for education. When this is in place the conditions for 'becoming a person again' can be put in place, but the resultant impact on practice is not only about improving care for residents with dementia. While addressing the conditions that support 'becoming a person again' managers are seeking to get more from patient contact; physical care and psychosocial intervention care at the same time.

Constant comparison also shows that managers identify that health care assistants, in particular, value the additional satisfaction and cache associated with undertaking psychosocial interventions such as reminiscence. This results in them taking ownership of this task as part of their role. Staff participant data indicates that having skills that are recognised along with being able to take satisfaction from positive experience of 'weighing up what works' both balance to the stressful and less satisfying aspects of providing care for residents with dementia. In addition to establishing the conditions of 'becoming a person again', staff development means that managers also have evidence of training which ensures compliance with inspection regimes:

It is the responsibility of all staff on the ward to get involved in this (DARES) and that has been a huge change and it took a lot of persuasion, a lot of meetings, a lot of reassurance and guidance and, you know now there is an onus that it is on everyone. The managers were kind of looking at it from that point of view as well. It's great to be involved in this. It's great for the residents, but in addition it's also great for when HIQA come in to do their inspections. (Participant 56- Nurse Manager)

While education has a role in changing the nature of 'weighing up what works' the data shows that institutional categories have more influence than personal ones. Clearly deciding what interventions work also relates to 'caring attributes'. Where institutional and personal categories are balanced positive psychosocial interventions utilisation is no longer conceptualised in terms of innate qualities alone. A psychosocial intervention becomes more than being kind or being patient, it is a purposeful skill. Dementia specific education establishes a formal understanding of individuals' capacity and inclination which influences institutional and personal categories. The core category 'becoming a person again' relates to 'weighing up what works' as staff value their own use of psychosocial interventions, seeing educationally validated successes stemming from their psychosocial intervention utilisation. Even where psychosocial intervention skills are known; life story work, skilled relationship building, and communication skills all take time and can be viewed as contrary to resolving the main concern of 'striving to make the most of time'. Constant comparison shows that the conditions of 'becoming a person again' are present where both institutional and personal categories are able to balance.

7.3.4 Psychosocial Intervention Availability

The category 'psychosocial intervention availability' while heavily influenced by individual categories is conceptualised as an institutional category as both access to training and its utilisation are primarily defined by 'institutional directing'. 'Psychosocial intervention availability' conceptualises two conditions that need to be present to support 'becoming a person again', what knowledge of psychosocial interventions staff have and what they feel able to use or are permitted to use within

their setting. In Phases 1 and 2 staff consistently asked for more education. Phase 3 data shows that 'psychosocial intervention utilisation' is impacted by dementia specific education with both psychosocial intervention knowledge and utilisation subject to rebalancing following education. The data below gives examples of staff utilising psychosocial interventions within existing 'time and task' frameworks, with their 'psychosocial intervention utilisation' stemming directly from educational experience:

If you use it (reminiscence) in every interaction and as you're doing your daily care delivery on a daily basis, in every activity, it doesn't have to become a time management thing. You know, you could be using it all the time. (Participant 56- Nurse Manager)

Definitely as regards distraction it (utilising reminiscence) would be great. Now, this lady, in the beginning with herself, evening time, she wanted to go home... but once you'd start talking about her mother it completely distracts her from the fact that she wants to go out the door. (Participant 30-Staff Nurse)

In this conceptualisation 'psychosocial intervention availability' is affected by changes in individual views on 'weighing up what works'. Therefore 'psychosocial intervention availability' is influenced by the personal category 'experiencing care', as staff experience psychosocial interventions utilisation. How does psychosocial interventions utilisation feel? What are the outcomes for me personally, within my team and when I experience the resident with dementia's response? These personal considerations are important if the conditions of psychosocial intervention knowledge and utilisation in pursuit of 'becoming a person again' are to be fulfilled. Institutional and personal categories affect the nature of intervention availability in response to dementia specific education. 'Psychosocial intervention availability' clearly gives the opportunity for the personal concept of 'using education' to influence care, but it is dependent on managerial permission via institutional direction. This health care assistant when asked about applying the DARES training provides her understanding of having managerial support to utilise the elements that must be in place to allow psychosocial interventions availability:

Yeah, we actually are able to make the time (to talk to the resident with dementia) and we don't feel guilty. (Participant 58-HCA)

The admission that staff working with residents with dementia would previously have felt *'guilty'* for making time to talk is illustrative of workplace context where the conditions of 'becoming a person again' have not always been met. 'Psychosocial intervention availability' positively emerges when conditions that allow an intervention such as getting to know a resident with dementia are present. Knowing that a particular approach meets criteria for success that are educationally supported and institutionally directed allows psychosocial interventions to become available and utilised.

7.3.5 Institutional Directing

The concept of 'institutional directing' explains the influence of managers and peers upon 'care context' regarding what 'psychosocial interventions utilisation' is acceptable. The influence while found to primarily come from managers also arises from colleagues via peer pressure. The influence of external inspection is referred to in the data, but their requirements are primarily addressed via managerial direction. Relatives and residents with dementia were not referred to as primary influencers of 'institutional directing'. When considering the influence of 'institutional directing' on establishing the conditions for 'becoming a person again' this category conceptualises as highly influential. Where 'institutional directing' shares emphasis with personal categories such as 'caring attributes' positive balancing is identifiable resulting in the conditions for 'becoming a person again' being achieved. This manager is clear that she can influence the 'psychosocial intervention utilisation' of staff in her setting:

You know, I'm emphasising, sit with them. Have a chat with them. If they want anything, get it for them. Maybe take up the paper, if I see them (staff) putting the paper in front of someone that's great. Read the paper for him, he loves it... I'm giving permission. Absolutely, giving permission and allocating that time. (Participant 57- Nurse Manager)

'Institutional directing' defines the nature of 'psychosocial intervention utilisation' with institutional categories taking precedence over personal

ones. Managers decide what 'psychosocial intervention utilisation' is permitted within the care setting with peer pressure also influencing institutional direction. Positive balancing in favour of 'psychosocial intervention utilisation' is largely dependent on 'institutional direction' from managers. Where this occurs 'institutional directing' becomes an important condition in support of 'becoming a person again'. This positive balancing allows personal categories and institutional categories to harmonise in search of the same outcomes. 'Institutional directing' in the form of managerial permission allows psychosocial intervention education to be accessed and utilised. 'Becoming a person again' explicates this positive balancing, where the property of 'becoming a person again', 'psychosocial intervention utilisation' is positively applied, the institutional and personal categories harmonise.

7.3.6 Caring Attributes

The concept of 'caring attributes' conceptualises qualities such as being kind or being patient. 'Caring attributes' is also conceptualised as having positive attitudes that enable staff to care for residents with dementia as individual people, rather than as sets of symptoms and tasks. This relative notes the presence of positive 'caring attributes' in staff caring for her mother:

I mean that can light up your world when you hear that your mother was awake in the middle of the night so they gave her a cup of tea and sat with her and looked through old photographs. You think, well that's lovely and it makes you feel good. Things like that are important, that someone has that personal touch. (Participant 33- Relative)

'Caring attributes' continue to be conceptualised as qualities and attitudes that are innate and where supported by positive balancing are central conditions of 'becoming a person again'. Consideration of the nature of 'caring attributes' and balance between personal and institutional factors indicates that aspiration towards positive 'caring attributes' is ubiquitous, all participants strive to have and utilise 'caring attributes'. In practice staff strive to treat residents with dementia as individual persons, they also attribute value to 'caring attributes' in others. Their application via

'psychosocial intervention utilisation' is dependent on other conditions of 'becoming a person again' being achieved, via 'balancing the influences'. Staff noted their own discomfort when 'balancing the influences' diminishes their ability to apply 'caring attributes'. This failure to meet the conditions of 'becoming a person again' emerges regularly from the data and is conceptualised as negative 'balancing the influences', where the innate urge to act as a person and treat residents with dementia as people is impaired.

Understanding 'caring attributes' and the potential for balance between this personal category and the institutional ones explains the process of formally applying 'psychosocial intervention utilisation'. When being interested in the history and background of residents with dementia, being kind, patient or gentle are valued and permitted, through 'weighing up what works' and 'institutional direction', as skilled approaches to care. Then the conditions of 'becoming a person again' are achieved. The ability to apply 'caring attributes' formally, as supported by the institutional categories confirms and enhances both learned and innately occurring 'psychosocial intervention utilisation'. This purposeful application of 'caring attributes' allows 'becoming a person again' to be achieved for both resident with dementia and staff.

7.3.7 Experiencing Care

Experiencing care explains the impact of time spent in the long-stay residential setting with its practices and influences upon 'individual psychosocial intervention utilisation'. Is the individual 'experiencing care' that meets the conditions for 'becoming a person again' or not? This health care assistant indicates that positive 'experiencing care' can be shared within teams, illustrating the subsequent impact on 'balancing the influences':

We're only doing it (sharing positive experiences of care) that you would pick up from your workmates and yourself, that kind of thing. There's no one training us to do that. Sometimes it's nice to hear, "Yes, that's the line to take. That's perfect." or "You shouldn't have said it that way. Maybe you

should have done it this way.” We're not trained for this. (Participant-24 Health Care Assistant)

It is also worth noting that this health care assistant in spite of participation in DARES articulates the desire for more training and support, putting positive change down to experience. This data indicates a process of reflection on experience influencing future care. Where there is negative balancing and staff have primarily negative ‘experiencing care’ to model their activities on it is unlikely that the conditions of ‘becoming a person again’ will be achieved.

Similar to ‘caring attributes’ the introduction of dementia specific education can impact upon ‘experiencing care’ allowing positive balancing towards psychosocial intervention utilisation. Length of experience was not the only indicator of positive or negative care experience. Staff participants were clear that access to education changed their attitude to care and day to day understanding of ‘experiencing care’. This health care assistant noted a clear change in her ‘experiencing care’ following DARES and the impact on their psychosocial intervention utilisation:

Because if the patient's happy, you're happy. I'm happy because I know they're okay and they like what I'm doing and they're at ease. They're happy and content and they're not agitated, you might get the odd slap, but it won't be as much as you would get. You'll have a conversation with the person, you know. You'll give them their food and you go away happy and they're smiling. (Health Care Assistant 62)

Mutual happiness is clearly a positive response to education and constant comparison shows this health care ‘experiencing care’ has changed, explained in part by education. The category ‘experiencing care’ interacts directly with institutional categories, as ‘psychosocial intervention availability’, ‘institutional directing’ and ‘weighing up what works’ all develop in response to education. This educational influence impacts on ‘balancing the influences’ and the conceptualisation of ‘experiencing care’. Constant comparison shows that ‘experiencing care’ for most staff across the three phases comprises routine physical care in the face of great need, limited staff resource and time pressures. Residents with dementia

continued to be positive regarding 'experiencing care' while noting a desire for social contact and indicating its scarcity due to time pressure.

Another instance of balancing is evident within the conceptualisation of 'experiencing care' as staff and residents with dementia experience mutually balance. Where 'becoming a person again' is evident observed happiness in a resident with dementia becomes a positive determinant of success for staff and in turn directly impacts on staff happiness. Residents want to achieve 'becoming a person again' and are happy when staff know them and socialise with them. In understanding 'experiencing care' it is important to consider the main concern of staff, 'striving to make the most of time'. Staff want to resolve the main concern positively so are open to changes towards positive 'experiencing care' and moving towards the conditions that achieve 'becoming a person again'.

7.3.8 Using Education

Constant comparison of this category shows education alone does not ensure the conditions of 'becoming a person again' are met. For 'using education' to positively occur the conditions for 'becoming a person again' must be established across the institutional and personal categories. The core category 'becoming a person again' explains the degree of 'using education', and provides conceptual understanding of the individual status of staff and the status of the residents with dementia being cared for. Phase 1 and 2 data indicates that even where dementia specific education is present 'institutional direction' and 'determining success' could reduce staffs' proclivity towards 'using education'. Constant comparison with Phase 3 data develops that understanding with 'using education' being shown to depend on enough staff members within a setting being exposed to education with a resultant impact on 'institutional directing' and 'weighing up what works'. This quote illustrates the strategy for implementing educationally based change applied by one manager:

Basically you have to keep encouraging your staff, sitting down with your staff and talking about the benefits of it (Using psychosocial interventions post education). If you can get one person on board with you, if you know

your staff you'll know which one is the best. Get them involved and get them working with the reminiscence and doing life stories with the residents and let them assist you in the converting of the rest, because if it's coming from one of their own, it's going to be an easier pill to swallow as well. (Nurse Manager 55)

The Phase 3 data indicates a willingness to use education where doing so helped resolve the main concern of staff, 'striving to make the most of time'. As indicated the nature of 'using education' was influenced by educationally based cultural changes. Changes in the workplace culture in turn influenced 'institutional directing' and 'weighing up what works', resulting in a rebalancing away from focusing primarily on physical care towards psychosocial intervention utilisation in support of 'becoming a person again'. Following training staff are still mindful of 'time and task'. The change is that educationally supported 'psychosocial intervention utilisation' which facilitates knowing the person, distraction and purposeful 'caring attributes' are also viewed as contributing to ease of physical care delivery. This staff member attributed the changes in her psychosocial interventions delivery directly to the DARES education programme:

It's hard to explain, but you kind of get compassion towards them. Life mightn't have been that easy for them. You just, you get more of a bond with that person. It's hard to explain to tell you the truth. It's just by... by knowing. If they like flowers, you try and have a few flowers around the place...

..when you're doing something with them, as in brushing their hair, they won't be hitting you. They'll be just relaxed about it or maybe even to give them the brush and let them try it themselves. (Participant 62-Health Care Assistant)

This health care assistant illustrates the potential benefits of 'using education' to her and to the resident with dementia. In the constant comparison of Phase 3 data 'using education' clearly allowed conditions of 'becoming a person again' to be achieved via positive re-balancing.

Taken together these six categories interact on individuals, making 'balancing the influences' the starting point for establishing the conditions that comprise 'becoming a person again'. Establishing these conditions is

a complex ongoing process that occurs over time. The process which 'balancing the influences' is conceptualised as beginning continues on with 'individualising status', 'striving to make the most of time' and interpreting care. These four stages are conceptualised as impacting on each other and changing over time. The second conceptual stage 'individualising status' will now be explicated specifically its place in the process and its contribution to 'becoming a person again'.

7.4 Individualising Status

'Individualising status' is the next conceptual stage of 'becoming a person again'. Following on from the interplay of institutional and personal categories in 'balancing the influences' 'individualising status' is formed as institutional and personal influences balance over time to define an individual's capacity and inclination towards 'psychosocial intervention utilisation' and becoming a person again'. Once established following 'balancing the influences' 'individualising status' assumes a degree of homeostasis, it is resistant to change. Comparison of data across Phases 1-3 shows that 'individualising status' while resistant to change is not permanent. A change in any of the categories or properties will affect the homeostasis defining how individuals strive to make the most of time, shifting the balance and continuing the process. Changes in 'balancing the influences' can result in positive or negative homeostasis, with 'individualising status' directing the nature of care delivered. In the quote below a relative of a resident with dementia discusses her experience of staff post education indicating where the conditions of 'becoming a person again' have been achieved and where they have not:

I'm afraid I'm thinking in terms of a particular nurse, you know, it's a job and she does it and that's kind of it and I'm sure that she can walk out the door and not worry about it. Having said that there are other long-term members of staff who are just super and they know the family so well they will tell us all these lovely little bits of information and be really on the ball, but one person who interacts with our mother is an exceptional young girl, gosh, she could only be sort of twenty five or twenty six and she gets on famously with our mum and it's just lovely to see. (Participant 33- Relative)

Given the main concern; 'striving to make the most of time', 'balancing the influences' of the institutional and personal categories produces different forms of capacity and inclination towards psychosocial intervention utilisation. The relative data above shows that similar institutional influences will have different impact on individuals. The following memo uses examples to illustrate this concept of 'individualising status' and how it is given momentum and form by the interaction of personal and institutional influences:

- *Some Health Care Assistants and Staff Nurses are open to redirection. They see themselves at the centre of care but poorly supported educationally and culturally (can't but willing) could have the opportunity if allowed/helped/sold on doing more. Residents are deferentially striving desperate desire for human contact, conversation, company, but deference to cultural context precludes complaint/critique (unless manifest via behaviours in response to unmet need on the part of residents) want to be engaged, understood and known, but need staff to initiate (can't but willing).*
 - *Some Staff Nurses and Managers are engaged in organisation of redirection happy to direct/facilitate physical care while aware of psychosocial interventions potential (can but won't). Bound by 'professional' time priorities re-physical care and safety to not permit psychosocial interventions use in the cultural context.*
 - *The staff member who is untrained in and unaware of psychosocial interventions in dementia care and also lacks the innate abilities kindness, patience etc. identified in the data as key to successful care delivery (can't and won't) likely influenced by their context sees no need to change/improve care.*
 - *The state of capacity and inclination staff and residents strive for (can and will) staff aware of the importance of psychosocial interventions use and permitted to apply their existing skills purposefully.*
- Memo 21/06/2010

The means, by which individuals resolve their main concern, 'striving to make the most of time', stems from 'individualising status', conceptualised by the four sub-categories; can't and willing, can and will, can and won't and can't and won't. A persons 'individualising status', describes their capacity and inclination, and what form of 'psychosocial intervention utilisation' they are able to, or chooses to deliver. Can't and willing conceptualises the status of most staff prior to receiving dementia specific education. Staff in Phases 1 and 2 repeatedly note their lack of knowledge and need for education. Many of the participants noted that they did not

know enough about dementia or about psychosocial interventions to deliver the care they wanted to. While the concept of 'caring attributes' is seen as allowing a degree of 'psychosocial intervention utilisation' this is limited by institutional pressures. Positive balancing is limited by intervention availability and institutional direction that favours physical care and blames lack of time for a lack of 'flexibility'. Following dementia specific education, staff became more aware of the pressures of balancing and the degree to which, prior to education their 'psychosocial intervention utilisation' was influenced by 'institutional directing':

Well, I suppose you weren't necessarily encouraged to sit down all of the time because sometimes you can have a lot of patients and you wouldn't have time. Or you wouldn't want people thinking you were sitting down wasting time. At least now we don't have to feel that. (Participant 58- Health Care Assistant)

Where an individual's 'individualising status' is conceptualised as can't and willing, the main concern, 'striving to make the most of time', indicates that these individuals are open to the idea of gaining capacity towards psychosocial intervention education. Transition from can't and willing, to can and will requires re-balancing of institutional and personal categories. The educational influence on balancing is clear as knowing about dementia, knowing interventions in response to behaviours that challenge, and knowing the resident with dementia better, impact upon staff attitude and action.

To move capacity and inclination from can't and willing to can and will staff not only need knowledge to enact change, but need a workplace culture within which they feel they can practice 'psychosocial intervention utilisation'. Can and will represents the most positive conceptualisation of 'individualising status' where staff have both the capacity and the inclination to deliver positive 'psychosocial intervention utilisation'. Acknowledgement that this status is a part of an ongoing process and is subject to change over time is important in relating status to the core category, 'becoming a person again'. Can and will is not an end point for any individual, it does represent the conditions for 'becoming a person

again' have been met, but it is a status that can vary over time as the basic social process continues and in response to 'balancing the influences'.

Can and won't represents a negative balancing of institutional and personal categories, primarily determining success and 'experiencing care'. This is where individuals who have the capacity to provide psychosocial interventions choose not to apply them. In this category the 'balancing the influences' is understood to favour institutional requirements over those of the individual whether resident with dementia or staff. Even where dementia specific training had been delivered the balance was not always seen to shift positively:

Well, as I say, they just feed her and clean her and change her and take her into the dining room and take her out again and help her. I go down to see my aunt if she's in her room, you just pass by room and room and room of people sitting there alone, you know and their radio is on and they're asleep. They're sort of doped. (Participant 31- Relative)

Some health care assistants talked of not being able to apply training due to continued negative peer pressure and managerial direction. Some trained staff who had received dementia specific education indicated that they did not have the time to use education due to prioritisation of physical care, medication management and administration:

Busy, you're giving them medicines but that's only two minutes with them. It's feeding them, getting them up in the morning, putting them back to bed. They'd be the three main times that you'd be spending more time with them, you know. If we had time we could go in and talk to them, but we just haven't got the time to sit with them. You know, you'd love to, but it's hard to fit in the time like. It's a very busy ward. (Participant 51- Staff Nurse)

'Experiencing care' took on a negative conceptualisation where 'individualising status' resulted in staff favouring physical care at the expense of psychosocial interventions. This negative balancing is also present in the status can't and won't. Can't and won't is a status where both capacity and of inclination are lacking. Lack of intervention availability and negative 'experiencing care' result in can't and won't. This status, while particularly negative, is not conceptualised as impossible to positively re-balance. The process of 'becoming a person again' does

account for change over time as conditions are met and the main concern is positively resolved. That said, in spite of the generally positive responses in Phase 3 data, can't and won't status proved persistent for some even after participation in dementia specific education. Efforts to rebalance can't and won't status positively are conceptualised as attempts to bring about change resulting in positive 'psychosocial intervention utilisation' which achieves the conditions of 'becoming a person again'. Education in the form of knowledge about dementia and of psychosocial interventions is influential, but institutional direction is crucial in addressing can't and won't status:

I think it's basically you have to keep encouraging your staff, sitting down with your staff and talking about the benefits of it. (Participant 55-Nurse Manager)

Lack of skills, lack of knowledge and negative attitudes including unwillingness to change are all identified as factors that define 'individualising status' and are amenable to educational interventions. Such education affects individuals by developing their capacity for psychosocial interventions, but also has the potential to change 'institutional directing' as managers and colleagues become inclined towards change, making 'psychosocial intervention utilisation' acceptable.

'Individualising status' conceptually accounts for the capacity and inclination towards resolving the main concern, 'striving to make the most of time', of any individual. This status is a direct result of 'balancing the influences' and helps us to understand actual 'psychosocial intervention utilisation'. Where 'balancing the influences' results in an individual lacking capacity, inclination or both they are unlikely to fulfil the conditions of 'becoming a person again'. Conceptualisation of 'individualising status' as the second stage of an ongoing process is useful as this acknowledges that there is a potential for 'individualising status' to change as the process continues and repeats. The third stage of the 'becoming a person again', 'striving to make the most of time' will now be discussed.

7.4.1 Striving to Make the Most of Time

'Striving to make the most of time' is conceptualised as serving two functions within 'becoming a person again'. As discussed 'striving to make the most of time' is the main concern of the participants and as such the resolution of this main concern which is explained by the theory of 'becoming a person again'. The second function of 'striving to make the most of time' is as the conceptual stage of the process of 'becoming a person again' where actual care, 'psychosocial intervention utilisation' takes place. In the quote below, a relative outlines how she would like staff to strive to make the most of time with her relative:

How wonderful would it be for you know the head of that organisation to be able to say well actually, you know the staff sat down with your relative the other day and started singing old Vera Lynn songs and your relative was absolutely enamoured with it. He started singing the words himself. For the person at the top of the organisation to actually realise that they can tell families that we've got something special going on here that is different to purely physical caring. It's actually looking at the whole person. (Participant 34- Relative)

This data articulates the benefit to residents with dementia and staff of positive 'striving to make the most of time', conceptualised both as their main concern and actual care delivery. By explaining the actual care delivered as dictated by 'individualising status'; the individual's capacity and inclination being a product of 'balancing the influences'.

Individualising status; can't and willing, can and will, can and won't and can't and won't encompass very different approaches to resolving the main concern and delivering care.

'Striving to make the most of time' is the main concern of residents as well as staff and relatives, with the conceptualisation arising from the understanding that residents '*strive*' to be known and have social interaction. In this data the resident found the thought of more social contact with staff funny. There was irony in the laugh when responding to the question what do staff talk to you about when helping you dress:

Well, not a lot, only tell me to put my arms out here (laughs) (Participant 43-Resident with Dementia).

This next resident identifies time as the reason staff do not talk about his likes and dislikes and then notes how staff use their time:

Ah well, they are busy now like... They haven't that much time... Working and cleaning and cooking and all that. (Participant 36-Resident with Dementia)

Resident participants in this study did not on the whole complain. Their 'striving to make the most of time' can be conceptualised as quiet waiting or manifest via behaviours that challenge. Regardless of how the main concern is resolved 'striving to make the most of time' relates to the core category 'becoming a person again', as individuals and organisations resolve and interpret the care they deliver. These two participants illustrate different approaches to 'striving to make the most of time' following dementia specific education. Both were asked how they used the DARES training:

You're here every day like and you're definitely using it. You know, I use what I do every day because I'm going through them every day and get them up out of bed. We take them for showers and you have the one-to-one time with them. (Participant 58-Health Care Assistant)

Well, to be honest now, we don't really have time because it's very hard here, like you know. (Participant 60-Health Care Assistant)

'Striving to make the most of time' represents the conceptual manifestation, via care, of 'balancing the influences' within and across institutional and personal categories resulting in, 'individualising status'. Constant comparison of data relating to 'psychosocial interventions utilisation' in Phases 1-3 shows how staff identified instances of poor quality care in 'others', but not in themselves. This understanding helps explain the transient nature of 'striving to make the most of time', as care delivery forms a central component of 'becoming a person again'. The theory accounts for how individuals respond to how they 'strive to make the most of time'. The next section explains individual response, conceptualised as 'interpreting care' which explains the constant resolution and re-balancing as the process of 'becoming a person again' proceeds.

7.4.2 Interpreting Care

The concept of 'interpreting care' explains how staff view and respond to the psychosocial interventions they deliver. As with the overall theory of 'becoming a person again' 'interpreting care' is influenced by the interaction of institutional and personal categories which define the individuals' awareness of the process and outcome of the care they deliver. The staff response to 'interpreting care' has the potential to influence the ongoing process feeding into ongoing 'balancing the influences'. 'Balancing the influences' results either in homeostasis with the individual satisfied with their actions; homeostasis with the individual not satisfied with their actions, but unable to bring about change; or in re-balancing resulting in change as the process continues. The example below has a manager 'interpreting care' following the DARES intervention. This data shows that education has in part helped them meet the conditions of 'becoming a person again':

It's (change via education) making them (staff) a better person, a better carer because they're taking more pride in their work. They are more conscientious and when somebody new comes in they are initiating conversations with residents to know their likes and dislikes. One resident will pick at the flowers that are out the back, that's what she loved to do. I think people before were concerned about the fact she was going out and she might be going out and getting wet in the rain or she might hurt herself (Participant 55- Manager)

Following the 'interpreting care' stage of 'becoming a person again' the conceptual model loops back feeding the individuals response to 'interpreting care' back into 'balancing the influences' and repeats its ongoing process (see Fig 7.2 'becoming a person again'), to effect and maintain the overall process. By identifying that something has changed making staff, 'a better person, a better carer', this manager is illustrating positive 'interpreting care'. The conceptualisation of 'becoming a person again' indicates that this understanding can impact upon 'balancing the influences' in a manner that maintains or instigates positive rebalancing as part of the overall process. While there is an ongoing process over time there is no certainty that 'interpreting care' will effect 'balancing the

influences' in a manner that will change status, homeostasis is often maintained as change proves difficult to achieve:

I found it (DARES) very good, but as a nurse in charge I wouldn't do it again because I haven't enough of time to do it and I haven't enough of time to give to do it. I know the other girls found it hard as well to find the time to do it.
(Participant 54-Nurse Manager)

While 'psychosocial intervention availability' has the potential to impact upon 'balancing the influences' it is clear that substantive positive re-balancing in favour of 'becoming a person again' requires a number of institutional and personal categories change. 'Experiencing care' and 'determining success' are directly influenced by 'interpreting care' with all of the other six categories in 'balancing the influences' potentially subject to its effect. If 'institutional directing' and 'weighing up what works' are also subject to change then the personal categories 'caring attributes' and 'using education' will harmonise and re-balancing in favour of 'becoming a person again' can occur.

7.5 Becoming a Person Again: Phase 3 reflection and modelling

Phase 3 sampling focused on participants who had experienced dementia specific education. This sampling strategy has allowed constant comparison of data across all of the phases. This analysis has developed conceptual understanding of the theory of 'becoming a person again', allowing emergence of its four stages: 'balancing the influences', 'individualising status', 'striving to make the most of time' and 'interpreting care'.

The theory of 'becoming a person again' is conceptualised as a cyclical four stage process which repeats over time explaining how participants address their main concern, 'striving to make the most of time'. As the main concern the concept of 'striving to make the most of time' also represents the stage in the overall process where care is delivered. 'Becoming a person again' is not a static outcome and should not be viewed as an end point. The process of 'becoming a person again' explains the achievable ideal of staff utilising psychosocial interventions, producing

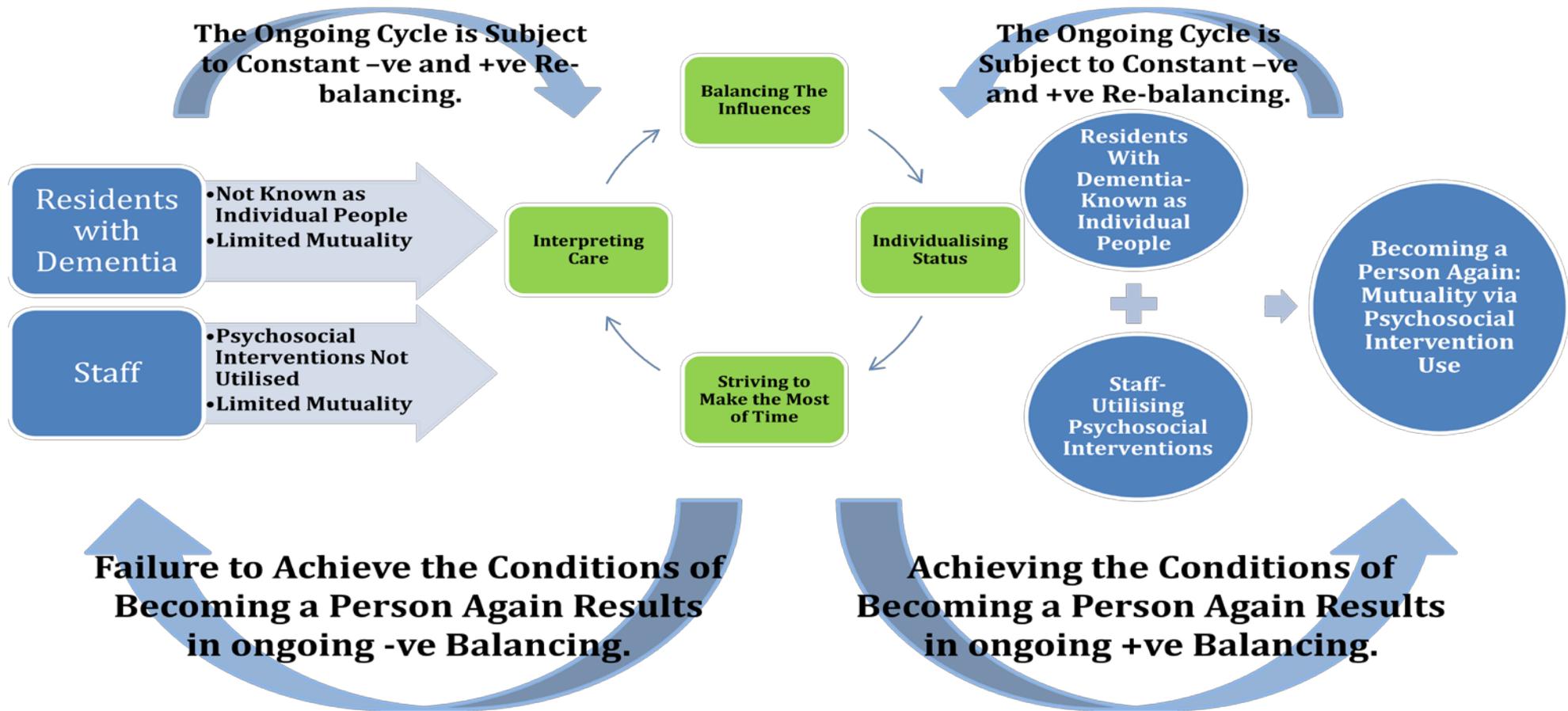
improvements in quality of life and experience for both residents with dementia and themselves. As such the cyclical process accounts for positive re-balancing towards becoming a person again and for negative re-balancing where residents with dementia and staff do not achieve the reciprocity of quality of life and experience described under the term mutuality.

Constant comparison of Phase 3 data (section 7.3) provided numerous examples where staff directly linked their ability to provide psychosocial interventions with improved outcomes for residents with dementia. In addition staff link residents' positive experiences with their own experience of providing care. This understanding establishes positive mutuality as a condition of becoming a person again. Staff participants also indicate that the mechanism of mutuality, whereby the provision of psychosocial interventions results in mutual positive experiences results in continued psychosocial intervention use.

Figure 7.1 'Becoming a Person Again' models how the cyclical interaction of the four stages over time accounts for both positive and negative re-balancing. In the most positive case accounting for 'the conditions of 'becoming a person again' being achieved mutually via psychosocial intervention use. The four stages 'balancing the influences', 'individualising status', 'striving to make the most of time' and 'interpreting care' as described in detail in this chapter, represent the resolution of the on-going conceptual process. 'Becoming a person again' accounts for psychosocial intervention use which is influenced by long term factors, such as societal influences as well as short term ones, such as the changing managerial ethos. Accordingly, the theory of 'becoming a person again' accounts for both the nature of 'psychosocial intervention utilisation' delivered by individual staff at any given time and for staff willingness to learn and use psychosocial interventions.

Figure 7.1 'Becoming a Person Again'

Becoming a Person Again: Cyclical Interaction of Concepts Accounting for Mutuality and Psychosocial Intervention Use Over Time



7.6 Summary

Following constant comparison across the three phases of data collection 'becoming a person again' emerged as the core category. This core category accounts for the overall conceptual process explaining psychosocial intervention use with residents with dementia. The theory of 'becoming a person again' is conceptualised as a four stage process that explains the mechanism by which psychosocial intervention utilisation changes over time. Central to the understanding of this conceptual process is the identification that staff and residents experience mutuality in 'becoming a person again' Constant comparison of the data shows that where 'individualising status' enables staff to utilise psychosocial interventions as part of person-centred care they are happier in their work and experience more satisfaction in their jobs.

'Balancing the influences' represents the stage of where the interplay between personal and institutional categories *'fuels'* the basic social process for an individual. This balancing defines 'individualising status' accounting for the individual's capacity and inclination towards 'psychosocial intervention utilisation'. This status then dictates actual psychosocial intervention use as individuals resolve their main concern, 'striving to make the most of time'. As the process of 'becoming a person again' continues individuals respond to their 'psychosocial intervention utilisation'. This 'interpreting care' stage accounts for the individuals response to the care provided with institutional and personal factors, along with understanding of mutuality impacting on the individuals' view of how they resolved their main concern. The response to 'interpreting care' then feeds back into 'balancing the influences' as the process cycles over time and continues.

Chapter 8: Phase Four Comparison with the Extant Literature

8.1 Introduction

This chapter will compare the theory of 'becoming a person again' with the existing literature. This chapter presents the theoretical sampling strategy and subsequent constant comparison of the conceptual stages of the theory of 'becoming a person again' with the extant theoretical, policy, research, education and practice literature. The analysis shows that the theory of 'becoming a person again' contributes to the theoretical understanding of psychosocial intervention utilisation for residents with dementia, displays similarity and applicability to the sampled literature, and identifies areas for refinement of the existing conceptual model. Firstly, this chapter will present an overview of the emergent theory of 'becoming a person again'.

8.2 Becoming a Person Again: Overview

The theory of 'becoming a person again' has emerged from rigorous constant comparison of the data. As such it offers a new theoretical understanding of how psychosocial interventions are defined by the mutual interaction of residents with dementia and staff to institutional and personal influences. These influences establish the capacity and inclination of staff towards psychosocial intervention use and explain individual resolution of the main concern, 'striving to make the most of time'.

This chapter now compares the theory of 'becoming a person again' against the extant literature in five key areas; theory, policy, research, education and practice. This process of comparison with the literature identifies the differences and similarities of understanding between the extant literature and the theory of 'becoming a person again' as articulated in Chapter 7. This process will allow the emergent grounded theory to be refined and provide identification of the unique contribution of this grounded theory within the substantive area.

8.3 Sampling Strategy and Structure of Comparison with the Extant Literature

As indicated in Chapter 2, classic grounded theory endeavours to minimise exposure to literature in the field of interest prior to data collection and analysis. This allows the extant literature to be considered once the grounded theory has emerged from the data. This comparison of newly developed grounded theory to the existing theoretical literature aims to develop and extend the theoretical understanding of the substantive area (Glaser, 1978). This '*integrative placement*' (Glaser, 1978, p.138) of the new grounded theory allows development of the existing theoretical understanding. Chapter 2 of this thesis explains how the literature in a classic grounded theory study is accessed in a phased manner, as indicated by the practical needs of the study and by theoretical sampling. As noted in Chapter 2, Urquhart and Fernandez (2013) outline a structured approach to the use of literature in classic grounded theory. This is made up of a noncommittal phase, in which literature is initially accessed allowing the researcher to develop theoretical sensitivity to and understanding of the research area. Followed by an integrative phase during which a thematic and theoretical comparison of literature against the emergent theory takes place. The non-committal phase in this study is made up of the discussion of the literature in Chapters 1 and 2. The integrative phase will now be presented.

The means by which the integrative phase of accessing the literature is undertaken is not clearly stated in the methodological literature. There is though general agreement that in classic grounded theory the substantive sampling and comparison of the literature must be delayed until the end of the analysis process allowing it to be directed by the emergent theory (Glaser, 1978; McCallin, 2003; Urquhart & Fernandez, 2013). While adhering to this guidance as far as possible, the literature is not entirely avoided. During the non-committal phase, described in Chapter 2, literature was identified and noted as potentially valuable. These sources were stored for possible inclusion and future comparison. This bank of

literature was added to over the life of the study. As the research progressed literature was searched for using the emergent concepts as key words utilising the databases outlined below. Sampling sought to ensure that the literature sampled was applicable to contemporary practice, accordingly apart from a number of seminal sources only literature published after 1995 was included.

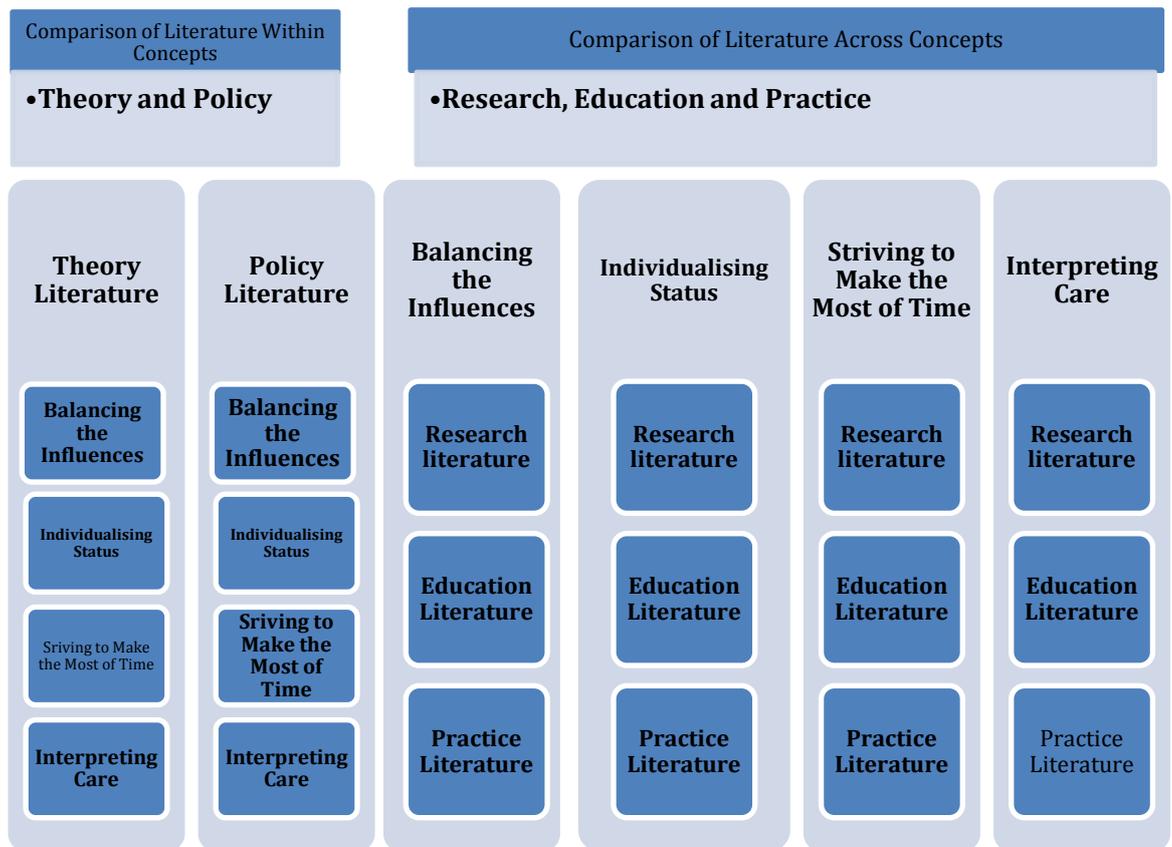
Relevant literature was also identified by extracting references from literature that had already been considered. Key to this process is the understanding that the literature is being identified stored for later inclusion, with its relevance for inclusion determined by the emergent theory. In addition to this phased identification of potentially applicable literature, following discovery of the emergent theory a database search was carried out using search terms arising from the emergent categories. Databases accessed for this search included: ERIC, MEDLINE, PsychINFO, PubMed, Web of Science, CINAHL Plus, IBSS and Social Sciences Citation Index.

A range of search terms were used derived from the conceptual categories and their properties (for example; balancing, long-stay care, peer pressure, managerial influence, dementia, education, staff reflection, psychosocial interventions in a range of combinations). Abstracts were read to identify relevance with the emergent categories. At this stage, the inclusion criteria were that the sources showed relevance to the emergent categories and that the sources were of good quality, that is peer reviewed in the case of research, education and practice literature; and utilised peer reviewed sources in the case of policy, theoretical and discussion literature. Some sources were rejected due to lack of relevance while others were found to have relevance to numerous categories. Sources with relevance to more than one category were stored and subsequently analysed by category. This process produced a sample of sources for each category which were then stored on NVIVO 10 according to the literature type theory, policy, research, education and practice (see Appendix 11).

To ensure clarity and brevity the constant comparison of the sampled literature is presented in two different manners. The theory and policy literature samples are constantly compared individually across the conceptual categories while the research, education, and practice literature are constantly compared as a group within the four conceptual categories that comprise the stages of 'becoming a person again'. This approach minimises the tendency for repeated reference to individual sources within concepts, which occurs with the theory and policy literature in particular. This also allows the comparison against the literature to be presented in a more structured and concise manner. The policy literature aims to influence and direct future practice while the theory literature seeks to offer conceptual understanding of the substantive area. Therefore, these two samples are subject to individual constant comparison across each category of the theory of 'becoming a person again' in turn, see figure 7.1.

By contrast the sampled research, education, and practice literature have a narrow focus, identifying and reporting on individual aspects of care provision; whether reporting on '*usual care*' or findings of interventions. The narrow focus of the education, practice and research, is more readily applied within the each conceptual category rather than across them. Simultaneous constant comparison of the sampled research, education, and practice literature against each of the conceptual categories in turn reflects the commonality of emphasis across these samples see figure 8.1.

Figure 8.1 Structure of Discussion and Comparison with the Literature Samples



Across the literature comparison sampled literature will be subject to analysis based on two questions:

1. How is the theory of 'becoming a person again' refined by constant comparison with the literature sampled?
2. What additional conceptual understanding does the theory of 'becoming a person again' offer the literature sampled?

This comparison will allow recommendations for the application of the key theoretical findings to the literature in the theoretical, policy, research, education, and practice domains. This comparison with the literature in the five domains will explore the conceptual contribution of the theory of 'becoming a person again' to the extant literature. As well as identifying any refinements to the theory following comparison.

8.4 Discussion and Comparison with the Theory and Policy

Literature

The theory and policy literature samples will now be applied individually to the conceptual categories that comprise the theory of 'becoming a person again'. The four stages 'balancing the influences', 'individualising status', 'striving to make the most of time' and 'interpreting care' represent the resolution of the on-going conceptual process of 'becoming a person again'.

8.4.1 Theory Literature

As previously highlighted in Chapter 2 personhood in dementia and person-centred dementia care are concepts that are regularly referred to in the sampled literature. Therefore, this constant comparison of the literature will first compare the conceptual categories comprising the theory of 'becoming a person again', with the extant theoretical literature pertaining to 'psychosocial intervention utilisation'. The literature in this area was initially accessed during the noncommittal phase (Urquhart & Fernandez, 2013) prior to development of the emergent theory. This was discussed in Chapter 1 noting that there are numerous definitions and conceptualisations of personhood and person-centred care across the health care literature (McCormack & McCance, 2006). Integrative placement of the theory of 'becoming a person again' begins with comparison against the theoretical understanding of personhood in dementia and person-centred dementia care. These concepts arise from the work of Kitwood that was discussed at length in Chapters 1 and 2 (Kitwood, 1990, 1997; Kitwood & Bredin, 1992a). Kitwood's conceptualisations of personhood in dementia and person-centred dementia care are regularly cited within the literature both in an effort to direct good practice and as a proposed outcome of good practice (Cahill et al., 2012; NICE, 2007, 2013). In Chapter 1, there was a discussion of the development of the concept of personhood in dementia and person-centred dementia care. This explained that Kitwood's theoretical writing was in part an explication of personhood in dementia and person-centred

dementia care that was developed over time across three main phases.

Baldwin and Capstick (2007) articulate these phases as:

- Individual psychological factors resulting in 'ill being' as a consequence of dementia and precondition for dementia
- 'Ill being' as a result of negative social interaction and poor quality of care
- Positive care resulting in 'well-being'

The theory of 'becoming a person again' provides emergent understanding of the processes that help staff to use psychosocial interventions with residents with dementia, making its scope is more limited than Kitwood's work. Nevertheless, this next section will show that there are considerable areas of similarity along with differences in focus.

8.4.2 Comparison with Personhood and Person Centred Care

Literature

In Chapters 1 and 2, personhood is identified as an enduringly important concept in dementia care. The concept was defined by Kitwood (1997) as a, *'standing or status that is bestowed on one human being by others in the context of particular social relationships and institutional arrangements'* (p.7).

This conceptualisation of personhood in dementia offers an alternative to the bio-medical modes of dementia (Sabbat, 2008). The definition of personhood given by Kitwood (1997) also provides an interpersonal understanding of the experience of dementia pointing to the interdependence of the resident with dementia and staff. This conceptualisation states that personhood can be maintained through the application of person-centred care. As also discussed in Chapter 1 person-centred dementia care endeavours to maintain and enhance personhood and attends to the individual's basic psychological needs, free from the negative influences of malignant social psychology (Kitwood, 1997).

Kitwood and Bredin (1992a) developed the concepts of ill-being and well-being as indicators of the maintenance or erosion of personhood in dementia. As with the theory of 'becoming a person again', Kitwood and Bredin (1992a) identify that personhood is impermanent, subject to changes created by the nature of care delivery. Bartlett and O'Connor (2007) further developed this idea identifying cause and effect between the nature of care and personhood in dementia. They note that well-being stems from the maintenance of personhood in individuals with dementia. The understanding that well-being, relates to personhood in dementia which is supported by person-centred care is a culturally transformative idea in dementia care (Bartlett & O'Connor, 2007). This view of cause and effect resulting in improvements in well-being is similar to the identification of the potential for change explained in the 'balancing the influences' component of the theory of 'becoming a person again'. Institutional and personal factors were both found to be susceptible to the realisation that personhood in dementia could be achieved. Conceptualisation of 'interpreting care' also showed that education could support positive change. The data sampled for this study and the general literature indicate a degree of pessimism present in staff, specifically around their understanding of the progress of dementia (Edberg et al., 2008; Rewston and Moniz-Cook, 2008; Ward et al., 2008). Given that this pessimism in part stems from a lack of knowledge it is likely that staff can be educationally supported to positively change their attitude and subsequent 'psychosocial intervention utilisation', positively re-balancing organisational and personal factors in their ongoing effort to resolve their main concern, 'striving to make the most of time'.

Consideration of the psycho-biographical approach of Kitwood (1990) reveals some similar, and some different conceptual understandings to those contained in the theory of 'becoming a person again'. While the theory of 'becoming a person again' does not focus on predisposing psychological factors, the Chapter 1 discussion of the psycho-biographical approach as described by Kitwood (1990) suggests that the process of

gaining a detailed understanding of a person's life story has positive psychological implications for the resident with dementia and for staff. The belief that mutual relationship building and understanding can enhance person-centred care does resonate with the conceptualisation of 'becoming a person again'. While the participants who contributed the data from which the theory of 'becoming a person again' emerged were not constructing psycho biographies, those staff who took the opportunity to get to know residents, conceptualised through the personal category 'using education' within 'balancing the influences', reported satisfaction and positive change in attitude.

The understanding that staff who get to know the person are fulfilling a condition of 'becoming a person again' has resonance with the concept of '*biography*', the term that Kitwood (1993a) used to refer to life history or life story. Since the work of Kitwood (1993a), other writers have highlighted the importance of staff getting to know the stories of the people they are working with (Baldwin, 2009; McKeown et al., 2010; Nolan et al., 2006). While knowing who the person you are working with, their history and preferences would seem to be a fundamental component of person-centred care it is clearly not something that staff routinely do. Nolan et al. (2006) identified the need to change the way staff work and the degree to which they know the people with dementia they are working with. When they discuss the importance of the person with dementia having a '*sense of significance*' they are also referring to the importance of staff knowing about and recognising the individual's significance in a manner that impact upon their care delivery (Nolan et al., 2006). This recognition of the person is also referred to by Baldwin (2009) when discussing the importance of staff awareness of the overall '*narrative*' of the person with dementia. In this conceptualisation, Baldwin (2009) refers to the importance of staff having an alternative view of the person with dementia, specifically where the person with dementia is at risk of being reduced to problems or behaviours that challenge. It is interesting to note that McKeown et al. (2010) advocate implementing life story work in

conjunction with ongoing staff support and education. They caution that without this life story work could become another task, diminishing the person-centred value and impact (McKeown et al., 2010). The emergent theory in this thesis also accepts that getting to know the person is a staff activity that requires ongoing support; adding that a key condition of 'becoming a person again' is the recognition of mutuality of experience between residents with dementia and staff. 'Interpreting care' explains that a condition of 'becoming a person again' is being person-centred; so knowing the resident with dementia and that by doing so makes the job easier and more fulfilling for staff.

In the analysis it was noted that residents with dementia wanted to be known, equally staff participants consistently noted changes in their attitude to people with dementia and subsequent care when they got to know them. Knowing family history, occupational history or even that someone had a *'hard life'* contributed to positive re-balancing in staff as knowledge contributed to the resident with dementia 'becoming a person again'. The conceptual understanding that staff and residents are connected in a shared progression towards personhood as articulated in Kitwood and Bredin (1992a) mirrors the mutual process of 'becoming a person again' outlined in this thesis. In chapter one it was also noted that Kitwood (1998) identified education as a driver towards enhancing well-being for staff and residents with dementia, a theoretical stance that resonates with the identification of education as a potentially positive factor in 'balancing the influences'.

As noted in chapter one, Kitwood and Bredin (1992a) outlined the impact of psychological and social processes that affect the progression of dementia. Kitwood (1997) then went on to develop his theoretical explanation of personhood in dementia. This explanation holds that the well-being of people with dementia responds to changes in their social and psychological conditions. The high standards of care provision and moral development of staff referred to by Kitwood (1997) and Kitwood (1998)

are similar to the changes in staff reflection and 'psychosocial interventions utilisation' brought about by 'interpreting care' and the subsequent re-balancing that can take place as part of the process of 'becoming a person again'. In developing the theory of 'becoming a person again' constant comparison noted the potential for educational and managerial changes to impact on 'balancing the influences' as well as 'interpreting care', enhancing the influence of personal categories such as 'using education' and 'caring attributes'. The conditions brought about by this process show commonality with the five basic psychological needs outlined by Kitwood (1997) as discussed in chapter one. Kitwood (1997) identified 'attachment, the forming of specific bonds or attachments' (Kitwood, 1997, p81).

This understanding provides a very specific area of similarity between the conceptualisation of person-centeredness provided by Kitwood (1997) and the theory of 'becoming a person again'. As the theory of 'becoming a person again' emerged staff participants who had participated in the DARES programme were found to positively alter the manner in which they resolved their main concern, 'striving to make the most of time'. This occurred due to changes in 'individualising status' as staffs' capacity and inclination altered. This allowed them to form positive mutual relationships with residents with dementia who had, for them, 'become a person again'. The conceptualisation of attachment provided by Kitwood (1997) arose from dementia care mapping. By contrast constant comparison of the data in this study showed that staff became more aware of what they were doing in terms of 'psychosocial intervention utilisation' following education and associated institutional change. Knowing about dementia and taking life histories were found to have a mutually positive impact on both staff and residents as 'attachment' was formed. Constant comparison of the staff data in this thesis shows many instances where change in care, specifically psychosocial intervention utilisation, can be explained by the introduction of dementia specific education and consequent managerial permission to change. While not undertaking

dementia care mapping staff participants were supported via the DARES programme to engage in self-observation and reflection. Where positively applied the conceptual stage of 'interpreting care' shows resultant positive re-balancing and subsequent change in their 'psychosocial intervention utilisation'.

This section explores the comparisons that can be drawn between literature that has conceptualised personhood in dementia and person-centred dementia care with the theory of 'becoming a person again'. In Chapters 1 and 2 the concepts personhood in dementia and person-centred dementia care were explored in depth and their development over time discussed. Kitwood (1990, 1997) explicitly identified personhood as psycho-social in nature, this awareness offers individuals and society at large the opportunity to reconsider and adapt their approach to people with dementia and provide person-centred care. In practice where staff apply an understanding of personhood the resultant person-centred care can put the person with dementia at the centre of the care-planning process and the care they receive, respecting their wishes and needs as individuals. Brooker (2004) discussed the complexity of this task when she describes the four elements of providing person-centred care; valuing the person with dementia and those who care for them, treating people as individuals, looking at the world from the perspective of the person with dementia and a positive social environment in which the person living with dementia can experience relative well-being. This conceptualisation of person-centred care explains that each element is based on the interdependence of the resident with dementia and staff. Brooker (2004) also acknowledges the dangers of under or over emphasising any element of person-centred care and notes the complexity of trying to meet individual needs within institutions.

Woods (2001) sums up the contribution of the concept of personhood in dementia care when he suggests that awareness of personhood and the resulting acknowledgement by staff of the perspective of the person with

dementia and awareness of their lived experience are significant steps forward in dementia care. Woods (2001) offered a simple explanation of what personhood represents for staff; suggesting it is the ability to recognise who the person is and what their history is. This explanation is in keeping with the conceptual understanding of 'becoming a person again' explained in this thesis. In addition the theory of 'becoming a person again' explains the biological, social and psychological complexities involved in recognising personhood, both from the perspective of the person with dementia, and from the perspective of the individual attempting to incorporate personhood into their world view to deliver person-centred care. The discussion of personhood presented in Chapters 1 and 2 shows that the theoretical understanding of personhood and person-centred care continues to evolve. Although personhood is open to interpretation as a concept it does offer an understanding of dementia care that can act as an alternative to the dominant bio-medical view of dementia.

A particular criticism of personhood as a precursor of person-centred care as defined by Kitwood (2007) is the suggestion that relatives and staff do feature prominently within the conceptualisation (Adams, 1996; Nolan et al., 2002b). As noted in chapter one, this criticism is not entirely accurate. Dewing (2008) made the case that Kitwood did encompass all those involved with the person with dementia in his conceptualisation of personhood, but failed to offer a structure for delivering this understanding into person-centred care in practice. The conceptualisation of the theory of 'becoming a person again' offers further understanding around this area. 'Becoming a person again' explicitly accepts mutuality of process and outcome, whereby both residents with dementia and staff have the potential for 'becoming a person again' when the correct conditions are met. These conditions include staff developing an understanding of personhood which can be translated into their person-centred care delivery. This emergent understanding is similar to that developed by Dewing (2008) and McCormack et al. (2011) when exploring the challenge of providing person-centred care within workplace context

that accounts for the physical and temporal reality of care. The concept of 'balancing the influences' offers an understanding of how intervention in institutional and personal conditions may impact on 'psychosocial intervention utilisation', providing person-centred care that responds to the many factors that affect personhood including the physical reality and pressure of time.

8.4.3 Theory Literature Summary

Comparison of the theory of 'becoming a person again' with the concepts of personhood in dementia and person-centred dementia care discussed here and in earlier chapters shows that the theory of 'becoming a person again' provides new insights that enhance some of the understandings in the existing literature. Appreciation of the mutuality between resident with dementia and staff along with ability of the theory of 'becoming a person again' to account for complexity advances theoretical understanding and offers utility to practice.

By identifying the main concern of participants 'striving to make the most of time', the explanation of the complexity of the overall process of 'becoming a person again' delivers understanding of how change can be achieved in a manner that addresses that main concern. Having an understanding of personhood and being person-centred matter, but without clear theoretical applicability to staff's main concern, will not change how they utilise psychosocial interventions. While 'becoming a person again' shares conditions with person-centred care it acknowledges that it is not a static outcome or an end point. This realisation offers conceptual understanding of the evident variation in care quality along with hope for positive change. By accounting for both the nature of psychosocial interventions care delivered by individual staff and for staff attribution of and application of psychosocial interventions the theory of 'becoming a person again' explains the mechanism by which an appreciation of personhood can be applied to care and how care can be

made person-centred through support for ‘psychosocial intervention utilisation’.

8.4.4 Policy Literature

The sampling strategy described in Section 8.3 identified primarily UK and Irish government policy documents, service frameworks and guidelines. In addition literature relevant to policy which presented conclusions of reviews of current practice and discursive literature seeking to influence future policy was also sampled. The following section will explore the similarities, differences and utility of the theory of ‘becoming a person again’ to the extant policy literature. It will identify the contribution of the theory of ‘becoming a person again’ to the policy literature and any refinements made to the theory following comparison.

The aspiration towards person-centred dementia care underpinned by an understanding of personhood in dementia is ubiquitous in the policy literature, as is the understanding that current provision is not always underpinned by person-centred dementia care (Cahill et al., 2012; Commission on Dignity in Care for Older People, 2012). Numerous sources in the theoretical and policy literature indicate that staff can only be person centred if they attend to their own personhood as well as the personhood of those they are caring for (Commission on Dignity in Care for Older People, 2012; Health Foundation, 2011; Kitwood & Bredin, 1992b; McCormack & McCance, 2006; RCN, 2012). The theory of ‘becoming a person again’ explains the process by which both residents and staff can experience positive ‘balancing of the influences’ as the balance of institutional and individual categories are altered allowing the correct conditions to be met. Mutuality of change between residents with dementia and staff is central to how the theory of ‘becoming a person again’ explains the change process towards positive ‘psychosocial intervention utilisation’. Understanding that residents with dementia will not receive the ‘psychosocial interventions utilisation’ required for

person-centred care without attending to the conditions of 'becoming a person again' is a key contribution of this theory.

As noted the bulk of the policy literature is aspirant and underpinned by the understanding that change is possible as well as desirable. The theory of 'becoming a person again' offers conceptual understanding of the mechanism by which institutional and personal factors interact offering the possibility of positive change through 'balancing the influences'. There are numerous examples of policy literature which call for change, specifically person centred care via 'psychosocial intervention utilisation' underpinned by an understanding of personhood in dementia (Commission on Dignity in Care for Older People, 2012; DoH, 2012; Lakey et al., 2012; NICE, 2013). Much of this policy focuses on specific components of change such as management structures or enhancing 'psychosocial intervention availability' via staff education. In addition there is also a growing appreciation within the policy literature that the attitude to and understanding of dementia amongst society at large has to be addressed and improved (DoH, 2012; Lakey et al., 2012). This next section will consider the promotion of specific components of care along with the promotion of improved attitude to and understanding of dementia amongst society at large in the policy literature. In doing so the contribution of the theory of 'becoming a person again' will be noted along with the theoretical refinement that comparison with this literature suggests.

Literature seeking to direct practice implementation such as Guidance for Commissioners of Dementia Services (Eley et al., 2012) and A NICE-SCIE Guideline on supporting people with dementia and their carers in health and social care (NICE-SCIE, 2006) are just two examples of dementia care policy guidance. Both specific elements of care provision and general care aspirations such as person-centred care, underpinned by an appreciation of personhood are argued for. The theory of 'becoming a person again' offers this policy literature and future writers of policy understanding of

the fundamental links between institutional and individual factors and the need to balance these factors in a manner that can effect positive change.

Even when the aim of the policy is positive, such as the reduction of anti-psychotic medication, the theory of 'becoming a person again' shows that policy aspiration without clear understanding of the interaction of institutional and individual categories will not result in the desired change. The Care Quality Commission (2010) in their position statement, highlight the policy goal of reducing the prescribing of anti-psychotic medication to people with dementia. Care Quality Commission (2010) identifies that the anti-psychotic medications are being prescribed in response to behaviours that challenge, causing difficulties for the resident with dementia, fellow residents, and staff. The conceptual understanding of 'balancing the influences' shows that reduction in prescribing only changes the institutional direction component of the existing balance. Without other interventions residents with dementia are likely to continue exhibiting behaviours that challenge. While the Care Quality Commission (2010) in common with much policy draws attention to the need for change, application of such guidance would benefit from the theoretical understanding contained in this thesis.

The concept of 'balancing the influences' shows that decisions about how to respond to behaviours that challenge are influenced by a range on institutional and individual factors. In the example above, removing medication must be balanced by identification of those factors causing the behaviours that challenge along with investment in psychosocial intervention education that will support staff to respond without medication. Failure to attend to the full range of balancing factors; education, managerial permission, staff support, staffing levels around any change in the process of care delivery can result in unintended change or diminished effectiveness. Requiring staff to become less dependent on medication as an intervention has resource implications, changing managerial direction without a balancing increase in resource will not

necessarily result in improvements in care. In fact it may result in further recourse to medication as behaviours that challenge are not being addressed via psychosocial interventions. In addition, constant comparison of Phase 3 data showed that both staff education and changes in managerial direction are required to underpin such change.

While much of the policy literature emphasises the need for individuals to change their practice, other examples acknowledge the complexity of change and the need to manage change. Cahill et al. (2012) and The Commission on Dignity in Care for Older People (2012) noted the need for a managed process to enact changes in individual use and receipt of psychosocial interventions. In these examples, calls for educational change are balanced against consideration of skill mix, managerial influence and specialist residential dementia care provision. This view of process and the impact of institutional and personal factors beyond education shares understanding with the conceptualisation of 'balancing the influences', often calls for change are precipitated by identification of poor practice. In response education is regularly promoted as the sole means of change. Cahill et al. (2012) and Commission on Dignity in Care for Older People (2012) identified that educating staff in psychosocial intervention approaches without consideration of local culture, resources and management will not in itself change attitudes and therefore will not change care for people with dementia.

In addition, policy calls for the attitude to dementia care across society to be addressed, to positively change organisational culture and to consider the impact of staff status and staffing levels (Care Quality Commission, 2012; DoH, 2012; NICE-SCIE, 2006; O'Kell, 2002). What is evident in much of the current policy literature is an awareness of the many elements that impact on change. The theory of 'becoming a person again' explains the interaction of the many factors that impact on care and demonstrates the importance of strategies that address these, such as supporting education in the workplace with managerial permission for change. Much of the

change proposed in the sampled policy literature is based upon research evidence with policy makers attempting to underpin their direction with evidence. Consideration of the research literature in detail will show that the concept of balancing arises regularly within the research literature as authors attempt to account for the complexity of their findings (Chang & Lin, 2005; Edberg et al., 2008; Keady et al., 2012).

Constant comparison of the policy literature shows that the individual and institutional components that comprise 'balancing the influences' are not only influenced within the care context, but are impacted by broader societal influences. Literature that comments on the nature of current care seeking to bring about policy change in both Ireland and the UK, calls for changes in the quality of dementia care to be achieved at an individual, institutional and societal level (Cahill, 2010; DoH, 2012). The understanding that residential dementia care quality can be effected by building a dementia friendly society, suggests that the process explained by the theory of 'becoming a person again', while accounting for how staff resolve their main concern in practice is not only effected by the residential setting. The emphasis of policy on attitude to and understanding of dementia amongst society at large adds to the theory of 'becoming a person again'. This understanding broadens the conceptual utility of the theory showing that societal factors influence the process within residential settings.

Cahill (2010) identifies an ongoing process in Ireland where societal awareness of dementia and investment in dementia care lags behind the need for service development. Recognising that individual care can be improved by the implementation of psychosocial interventions and that societal attitude as well as individual attitude to residents with dementia has to be addressed shows the complexity of this area. In this sense reviews of policy and literature that aim to influence service provision such as Cahill et al. (2012), The Prime Ministers Challenge on Dementia (DoH, 2012) and the National Dementia Strategy, (DoH, 2009b) share the

aspirant nature of the theory of 'becoming a person again'. These policies promote change towards person-centred care that will not become reality unless numerous conditions; societal, institutional and personal are addressed. The theory of 'becoming a person again' while sharing this aspiration also explains the process via which such change can be achieved.

When considering the contribution of this theory to the policy domain and to change management it is worth re-visiting the work of Baldwin and Capstick (2007). In their critique of Kitwood's work on organisational culture in dementia care, they ask a question that should concern policy makers, *'it is not clear what comes first-better individual caregivers or better organisations for them to work within'*, (p.273). The theory of 'becoming a person again' offers service commissioners the understanding that staff action is defined by 'individualising status'. By explaining that individual capacity and inclination towards 'psychosocial intervention utilisation' is derived from a balance of individual and organisational factors the theory of 'becoming a person again' indicates that the answer to the question posed by Baldwin and Capstick (2007) is you need both; better individuals and better organisations, and that developing one will impact on the other. Integration of this literature offers refinement of the theory of 'becoming a person again'. The view that staff wishes and therefore actions are subordinate to that of the institution was strongly present in the data. Balancing does not refer to being in balance or to equality between the institutional and personal categories. Rather, within the context of residential dementia care, 'balancing the influences' refers to a care delivery context which remains balanced and stable, not equal, as institutional influences tend to be dominant. This suggests that better organisations ultimately must come first and that re-balancing occurs as the institutionally dominant categories develop allowing the individual categories to exert a more dominant influence.

Striving to make the most of time is the stage of the process of 'becoming a person again' where actual care is delivered, and participants resolve their main concern. Policy ultimately seeks to influence this point of care delivery, but as noted when considering 'balancing the influences' policy often seeks to do this through statements of aspiration towards person-centred care or through direction towards individual interventions. The nature of day to day life lived by and the care delivered to residents with dementia identified in this research is carried out according to an institutionally directed routine of washing, toileting, dressing, feeding, medicating and where possible socially interacting. This understanding of the rhythm of day to day life and care while emergent from the data in this study is also recognisable within some examples of policy literature (Care Quality Commission, 2010; DoH, 2012). The theory of 'becoming a person again' offers policy makers further empirically based understanding of the pressures on staff and their main concern, conceptualised in this research as 'striving to make the most of time'. Using this theoretical understanding to undertake policy guidance and operational planning with an awareness of the complex nature of change should allow positive psychosocial interventions utilisation to become more attainable. Striving to make the most of time is an aspiration which is mutually agreed by stakeholders; residents with dementia, relatives and staff. Incorporating this understanding into operational planning would allow a stakeholder led development of how to achieve person centred care.

In guidance for service commissioners, the Joint Commissioning Panel for Mental Health (2012) sets out a policy approach aimed at raising awareness across society, helping residents with dementia 'live well' and be in receipt of 'personalised' care. This policy aspiration directs service commissioners to resources such as the NICE (2010) quality standards, with its myriad of evidence based resources and links detailing implementation. The understanding of staff 'psychosocial intervention utilisation' provided by the conceptual understanding of 'striving to make the most of time' indicates that staff are primarily concerned with 'time

and task'. Residents with dementia are also 'striving to make the most of time', and view resolution of their concern to be social interaction and being known. The majority of staff encountered in this study viewed 'striving to make the most of time' as the completion of physical care with little thought of psychosocial interventions or personhood.

Conceptualisation of the main concern shows that on those occasions where staff meet the conditions of 'becoming a person again', 'balancing the influences' to include 'psychosocial intervention utilisation' in their day to day care they make the most of time. There is also a mutual response where residents can, make the most of time resolving their main concern by being known and socially interacted with. The theory of 'becoming a person again' explains that psychosocial intervention utilisation occurs subject to considerable practical and institutional pressure including; perceived lack of resources, managerial direction and peer pressure. Even where education is received these other balancing factors can result in psychosocial interventions not being utilised. The pressure created by 'balancing the influences' to complete the tasks deemed acceptable by 'institutional directing' can inhibit psychosocial intervention use. Even where individuals received dementia specific education their 'psychosocial intervention utilisation' was subject to complex 'balancing the influences' before the care was delivered and to 'interpreting care' afterwards. Phase 3 data indicating that often education did not change the institutional focus away from physical 'time and task' emphasis.

The policy literature will now be considered as it applies to 'interpreting care', the final stage of the process of 'becoming a person again'. The individual verses organisational discussion that has just been applied to actual care delivery as conceptualised under 'striving to make the most of time' also applies to how individuals view their psychosocial intervention utilisation and how they feed this awareness back into the process. The emergent theory shows that a condition of 'becoming a person again' is change in staff attitude. This needs to be achieved before change in

'psychosocial intervention utilisation' can occur. This understanding offers an important contribution to the reading of the policy literature and is similar to that argued by Davies and Nutley (2000) when considering educational support for policy driven change in organisations. Davies and Nutley (2000) supply a useful framework for considering the relative influence of the institution and the individual in healthcare. They suggest that the organisation must transmit a clear vision and that individuals must be given learning opportunities that move them towards that goal. In this conceptualisation of changing individual and organisational approaches to care Davies and Nutley (2000) caution that the organisational culture must be one that encourages and retains individual learning. It is interesting that Davies and Nutley (2000) view a robust organisation as being one that enhances and retains individual capacity. This view is in keeping with the understanding of positive 'interpreting care' in this thesis, as the ability to identify the presence or absence of good practice along with the need for change. Davies and Nutley (2000) argued that a learning organisation is one where individual skills and understanding must be favoured and utilised in pursuit of a clear vision such as promoting the conditions of person-centred care.

When the policy literature is compared with the concept of 'interpreting care', plausibly justifying actions after the event, the literature as a whole argues the need for change in the manner care is delivered and the need for education towards that end. The National Dementia Education Project (2012) provides a model for educational development in Ireland emphasising the requirement for change in staff and organisational awareness of and attitude to dementia. The Commission on Dignity in Care for Older People (2012) presented a similar approach suggesting that the individual and organisation must change in harmony. This approach identifies the need to improve care generally, but adds the need for a level of individual understanding and responsibility. This policy suggests that all staff must challenge poor care in themselves and in others. The Commission on Dignity in Care for Older People (2012) takes an

institutional and individual approach suggesting that both organisations and individuals need to avail of educational input to help develop standards of care. Other policy such as HSE (2010) takes a more pragmatic approach attaching goals directly to interventions and suggesting that where goals are not achieved staff must review their approach.

'Interpreting care' explains that where individuals and organisations identify, the need for change, positive 'interpreting care' this realisation is part of an ongoing process that can result in positive re-balancing and a change in the manner in which individuals' main concern is resolved. Another approach showing similar understanding to the concept of 'interpreting care' is provided by NICE-SCIE (2006). These proposals recommend staff education in the social model of dementia. Primarily intended to improve the quality of care directly, this approach does have resonance with the concept of 'interpreting care'. NICE-SCIE (2006) suggested that such training would engender attitude changes in staff that will impact on care and 'improve staff responsiveness' (NICE-SCIE, 2006, p275) resulting in more positive attitudes to people with dementia, improved job satisfaction and improved patient outcomes. Identifying staff responsiveness indicates that NICE-SCIE (2006) has a complex view of change similar to that identified in this thesis, specifically in the area of 'interpreting care', where staff consider and respond to the care they have delivered. This thesis offers stakeholders seeking to implement policy the understanding that positive 'interpreting care' must be supported by the conditions of 'becoming a person again' such as 'using education' and institutional direction. This will allow positive changes in 'balancing the influences' and 'psychosocial intervention utilisation'.

8.4.5 Policy Literature Summary

Comparison with the theory and policy literature has highlighted the contribution of the theory of 'becoming a person again' and has allowed some refinement of the theory. The policy literature sampled endeavours to influence actual 'psychosocial intervention utilisation' by promoting

broad aspirations such as personhood and person-centred care as well as providing a vision for the implementation of individual care components. By identifying that 'psychosocial intervention utilisation' occurs subject to considerable practical and institutional pressure, such as lack of resources, managerial direction and peer pressure. The theory of 'becoming a person again' offers stakeholders a means of interpreting policy and putting policy guidance into practice. Comparison shows that this theory offers policy makers a means of directing operational planning which can link these individual and organisational policy aspirations. The complexity of 'becoming a person again' accounts for the mechanism of change for both individual elements of care and the overall aspiration towards personhood and person-centred care. Along with this conceptual linkage the theory of 'becoming a person again' accounts for the mutuality of experience between residents with dementia and staff. By doing so the theory of 'becoming a person again' offers stakeholders an operational planning structure for managing change in 'psychosocial intervention utilisation' as well as theoretical understanding of the likely effects of changes at any point in the process.

This comparison with the theoretical and policy literature has further refined the theory of 'becoming a person again'. Identification of the policy aspiration towards person centeredness highlights the need to reconceptualise a stronger influence for organisational change categories, specifically where they influence attitude to and awareness of dementia. In addition where previously the theory of 'becoming a person again' accounted for institutional and individual balancing when considering the overall process it is clear that similar processes are taking place on a societal level. Indeed the hierarchy of priorities needs to be reflected within 'balancing the influences' as it is clear the process of 'becoming a person again' is driven by the interaction of institutional and personal factors that exist in balanced stability not equality. Just as individual categories can only be favoured through the positive re-balancing of institutional categories the hierarchy of influence present in context must

be acknowledged. When resolving their main concerns residents are subordinate to staff who are in turn subordinate to the institution. Previously the societal influences were considered to be factors that influenced the nature of the existing institutional and individual categories. Societal influence is now viewed as having greater impact on all categories. Conceptualisation of the core category now acknowledges that there is a societal impact on 'balancing the influences' and upon 'interpreting care'. Where the conditions of becoming a person are met 'striving to make the most of time' is resolved in a manner which is mutually beneficial for residents with dementia, staff and the institution. Such change in 'psychosocial intervention utilisation' is influenced by societal influences on institutional priorities and staff awareness, with the mechanism of impact on actual care explained through the overall process. The emergent model shows the potential for this positive resolution of the conditions of 'becoming a person again' along with the means by which these same factors interact to inhibit 'becoming a person again'.

8.5 Discussion and Comparison with the Wider Literature

Having compared the sampled theory and policy literature against theory of 'becoming a person again' this section will now consider the research, education, and practice literature. The integrative stage of the phased literature review, outlined above produced a sample comprising research, education and practice literature with considerable overlap in focus. Sampling the research, education, and practice literature produced sources ranging from research reports on the impact of specific psychosocial interventions, systematic reviews of research in related areas (psychosocial interventions in dementia, staff training, non-pharmacological interventions, communication strategies) of dementia care, research reporting on current psychosocial interventions practice, reports of psychosocial interventions specific educational interventions, policy documents recommending education in psychosocial interventions approaches, literature reviews of the efficacy of educational interventions, government and stakeholder organisation reports on current practice,

reviews of practice and research articles reporting on the nature of practice. Given the scope and overlap in focus of the literature the research, education, and practice literature will be applied concurrently to the main categories that form the theory of 'becoming a person again'; 'balancing the influences', 'individualising status', making the most of time and 'interpreting care'. Each section will begin with a brief recap of the conceptual category to illustrate the concepts that the conceptual category relates to.

8.5.1 Balancing the Influences

Within the theory of 'becoming a person again' 'balancing the influences' is the conceptual stage which accounts for the interaction of personal and institutional factors. 'Balancing the influences' explains the complex interaction of institutional and personal categories and the means by which this interaction 'fuels' the ongoing process. This stage of the ongoing process explains how the status of individuals both staff and residents with dementia is established relative to psychosocial interventions utilisation. This section will consider a range of issues that arose from the sampled literature: education as a fundamental component of change, the dominance of institutional factors over personal, the mutual interdependence of staff and residents with dementia.

When considering how the research, education and practice literature relate to the concept of 'balancing the influences' it is important to establish the influence of education as a proposed means of improving dementia care. The policy literature, discussed earlier, while different in emphasis draws heavily upon the research, education, and practice literature when making the case for service development. As indicated there are numerous sources, primarily policy and practice guidance that propose education as a means of improving quality of care, specifically via training in psychosocial interventions. Cahill et al. (2012), Puurveen and Drance (2009), O'Kell (2002), O'Shea (2007), and RCN (2012) all promote staff education as a means of improving outcomes for residents with

dementia. This literature also acknowledges that over time the process of positive change while potentially influenced by education will be subject to a range of other factors. Not least amongst which are negative attitudes to and poor understanding of dementia amongst staff and society in general. Similarly, The Health Foundation (2011) provided comprehensive educational guidance indicating the need for society wide education in dementia to address attitudes and stigma.

The National Dementia Education Project (2012) and RCN (2012) represent recent attempts to address the care deficits noted in the research, practice, and policy literature. These reports have recommendations for experiential learning that support formal education of staff to allow change to become rooted in practice. The National Dementia Education Project (2012) in keeping with much of the education literature is focused on the qualities it seeks to produce in the recipients of education. In a research based example Bird et al. (2007) reported on a controlled trial of psychosocial intervention approaches to behaviours that challenge. They conclude that as an adjunct to specific skill development staff require greater awareness of dementia to positively change attitudes towards residents with dementia. These sources show affinity with 'balancing the influences' with their suggestion that staff education must include awareness of dementia, improve attitude to dementia and promote staff wellbeing; as a means of ensuring improved outcomes for the resident with dementia. This approach is further explained within the conceptualisation in this thesis, that education availability and staff use of education are merely components of 'balancing the influences'. It is the interaction of these educational components with the other institutional and personal components that can influence the process of positive re-balancing resulting in the conditions of 'becoming a person again' being achieved.

While being in receipt of education can contribute to an individual achieving the conditions of 'becoming a person again', it does not

guarantee change in the manner staff use psychosocial interventions or the institutional context on its own. In their content analysis of focus group data from 35 nurse participants, Edberg et al. (2008) considered the factors that influence educational uptake, utilisation and its impact on practice. This research concludes that factors such as staffs' moral strain, job satisfaction and workplace environment impact on both educational uptake and utilisation. Skog et al. (2000) presented an ethnographic study considering the impact of specialist dementia care education in three different settings. This research provides a similar view of the influence of individual and organisational factors on 'psychosocial intervention utilisation'. Nurses working in three different settings; day hospital, supported accommodation, and residential care were given the same practical dementia care training. In the day hospital setting staff utilised the education in a manner that was person-centred, reflecting their desire to deliver care in a holistic individualised manner. By contrast, the supported accommodation staff focused their care on illness types, differentiating care relative to the staffs' perception of illness and need. In the residential setting organisational and managerial factors took precedence further limiting the application of education and reducing the person-centeredness of the care delivered. In Cochrane reviews considering cognitive rehabilitation training and reminiscence training, Clare et al. (2003) and Woods et al. (2005) noted the influence of context on the staff uptake of education and application of the psychosocial interventions skills learned.

These studies conclude that institutional factors can limit access to education and once training has been received can limit the application of the training. When considering the impact of educational interventions on individual staff the theory of 'becoming a person again', specifically 'balancing the influences' offers understanding of the impact of institutional context on individuals. Kusk et al. (2007) and Vasse et al. (2010) in systematic reviews of literature reporting on educational interventions, raised concerns over the quality of educational research

both in terms of methodological rigour and scope suggesting that educational programmes often fail to consider the organisational context. Kuske et al. (2007) reviewed 21 in-service interventions for caregivers of persons with dementia in nursing homes. Vasse et al. (2010) considered 19 studies looking at the effects of communication enhancing interventions for the care staff and residents with dementia in residential settings, and the effects of these interventions on the symptoms of dementia. Both reviews concluded that the considerable methodological challenges and failings noted in the literature resulted in their being no clear evidence for the efficacy of educational interventions. That said both reviews indicate the need for education to be supported by ongoing training, managerial and contextual support in an effort to change staff and resident behaviour.

Conceptualisation of 'balancing the influences' explains the complex interaction of factors resulting in psychosocial interventions care delivery. 'Balancing the influences' models how other factors especially institutional ones can dominate the balancing process resulting in educational interventions failing to make an impact in practice. The literature sampled, in response to the emergent categories, produced numerous studies that drew conclusions concerning the use of staff education as a means of improving outcomes for residents with dementia. These include studies that consider a range of issues from agitation, reduction of medication and training needs. Ballard et al. (2001) drew conclusions following application of dementia care mapping to explore the quality of life with 112 residents with dementia: McKeown et al. (2010) reported on four detailed case studies exploring the impact of life story work; Fossey et al. (2006) report the findings of a cluster randomised control trial considering anti-psychotic use following training in 12 nursing homes; and the RCN (2011) provided findings from a survey exploring dignity in hospital care with 712 participants. Varied in emphasis, size, and methods these studies all justify their educational focus by highlighting the ineffectiveness of current care provision. These studies also note that

without support for change within the practice areas educational interventions alone will not succeed in changing practice.

Bird (2001) used case study design to consider the impact of a psychosocial intervention cued recall, on behaviours that challenge. Bird et al. (2007) undertake a randomised control trial considering the impact of cued recall on behaviours that challenge. In both of these studies the authors conclude that the effectiveness of psychosocial interventions is defined by a number of factors which interact with the training to define actual psychosocial interventions application. The findings of Bird et al. (2007) show limited evidence of difference in effectiveness when comparing a primarily psychosocial interventions approach to behaviours that challenge verses psychotropic medication alone. The authors conclude that given the relative merits and costs of the two approaches a predominantly psychosocial intervention based approach can be justified over medication alone. Bird et al. (2007) argued that non-pharmacological approaches to behaviours that challenge must consider a broad range of factors including staff ability to be flexible in their approach along with skilled use of basic communication and engagement skills. While the theory of 'becoming a person again acknowledges the importance of flexibility and skilled communication, 'balancing the influences' offers the additional understanding that institutional categories are dominant in the balancing process. Flexibility and skilled communication will not be utilised if the institutional conditions do not allow them.

While the conceptualisation of 'balancing the influences' notes the dominance of institutional factors some researchers have explored the fundamental impact of personal factors. Edberg et al. (2008) identified the interaction between the needs of residents with dementia, staff needs, other residents' needs and the needs of the institution. This research views the interaction between these factors as potentially creating a conflict between staff values. Staffs' urge to do the best for residents with dementia verses the many practical constraints that prevent them such as

staffing levels, lack of education and limited time. Edberg et al. (2008) viewed staff strain as being caused by limited personal ability to undertake the nursing care staff wish to perform. Edberg et al. (2008) concluded that staffs' ability to deliver care is a personal factor that is influenced by practical institutional pressures such as staffing levels and training. The impact of failing to deliver the care staff wanted, staff strain, was found to be a personal consequence of their powerlessness.

An approach showing similar awareness of the influence of competing factors on care is provided by Chang and Lin (2005). They discuss the findings of their quasi-experimental study designed to explore the impact of education on staffs approach to feeding residents with dementia who require help. The skills required are placed in the context of a range of other factors including staffing levels, managerial influence and staff attitude. While not using the term balancing Chang and Lin (2005) interpret their educational intervention within a broad framework whereby feeding skills are affected by a range of factors including education. They view change in staff understanding of dementia and attitude to residents with dementia to be required if staff approaches to feeding are to be modified. In this study, staff were trained to take more time during feeding. In addition, the researchers consider staffing levels, managerial influence and staff attitude to be key components of change. Chang and Lin (2005) discuss their findings within the context of staff resources and organisational structures.

Both Edberg et al. (2008) and Chang and Lin (2005) endeavour to highlight the personal factors that influence care delivery. These studies display common understanding with the concept of 'balancing the influences' by referring to institutional factors that influence staff use of psychosocial interventions and the application of education. 'Balancing the influences' contributes understanding to educational researchers by illustrating the mechanism by which institutional factors impact on

psychosocial intervention delivery and modelling the means by which positive re-balancing can occur.

The link between context, individual uptake of education and actual care delivered conceptualised as the progression from 'balancing the influences' to 'individualising status' to 'striving to make the most of time' allows those designing educational interventions to map the linkage between balancing factors, educational uptake and utilisation of the education proposed. In a pilot study, Egan et al. (2007) used a single subject, repeated measures design with qualitative participants to investigate the impact on aggressive behaviour from residents with dementia of staff knowing their life history. This research discusses balancing as being a relationship of potential gains derived from taking the time to know the person, balanced against the numerous risks associated with aggression for both the resident with dementia and staff. It is worth noting that the work of Egan et al. (2007) builds on earlier research that identified the importance of staff knowing the life histories of residents with dementia (Cohen-Mansfield et al., 2000), and that in spite of the evidence for the benefits of knowing life history Egan et al. (2007) found the level of knowledge amongst staff was still poor. Egan et al. (2007) found decreased incidence of aggression from residents with dementia where life history was known by staff. In addition, the research found that knowledge of life history positively changed staff attitudes towards the participating residents with dementia. Similar findings are present in a RCN (2011) survey of 712 staff working with residents with dementia in acute settings which reports on the means by which the dignity of residents with dementia is promoted and practice improved.

This research identifies a willingness amongst staff to develop psychosocial interventions approaches and notes that institutional factors such as workload and staffing inhibit staff ability to undertake basic psychosocial interventions such as getting to know residents with dementia. Constant comparison of this literature once more illustrates the

contribution of the concept of 'balancing the influences' to researchers and educators. By explicitly linking the interaction of factors that allow the conditions of 'becoming a person again' to take place this theory offers researchers and educators a framework upon which they can hypothesise the potential outcomes and effects of proposed interventions.

Conceptualisation of the theory of 'becoming a person again' offers understanding of the institutional and personal interactions that can result in staff being resistant to participation in psychosocial intervention education and delivery. Concern over additional work, worries about being evaluated, peer pressure and individual reluctance to change can all impact on educational participation and psychosocial interventions utilisation.

When subjecting the research, education, and practice literature to constant comparison against the concept of 'balancing the influences' the seminal influence of the research of Kitwood and Bredin (1992b) and Kitwood et al. (1995) needs to be considered. This research contributed to development of an empirically based understanding of the concepts of personhood in dementia and person-centred dementia care, emphasising the need for maintenance of personhood via person-centred care, an idea which is often referred to in dementia research. What emerges when this work is subject to constant comparison is the importance of the concept of mutuality between residents with dementia and staff to personhood and person centred care. Kitwood and Bredin (1992b) used observation to empirically develop 12 indicators of relative well-being for people with dementia. As part of this research they identify the vulnerability of people with dementia and their dependence on staff who are in turn impacted on by the priorities of and nature of the institutional setting. Kitwood and Bredin (1992b) identified that staff must address their own needs before being able to effectively work with residents with dementia and identify a process of interdependence between residents with dementia, staff, and the institution. Similarly when Kitwood (1995) drew conclusions about

the diverse nature of personhood from case study research he was drawing the reader's attention to the complexity of influences, including mutuality between residents with dementia and staff who are equally subject to the interplay of institutional and personal factors. The concept of 'balancing the influences' shares this understanding of interdependence between residents with dementia, staff, and the institution. This understanding further explains the primacy of the institution in defining the nature of resident and staff interdependence as part of the overall process of 'becoming a person again'.

Understanding the mutual processes at work offers researchers and service developers a mechanism for change based on enhanced understanding of their research and practice based observations. In literature commenting on service quality many practice areas are identified as failing to deliver person centred care resulting in poor outcomes for residents with dementia (Health Foundation, 2011; O'Shea, 2007). This literature identifies care that is physically orientated, not person-centred and viewed to be damaging to quality of life for residents with dementia, staff morale, and staff self-worth. The conceptual understanding of 'balancing the influences' with its explication of the interaction between staff attitude and 'psychosocial intervention utilisation' offers additional understanding of the negative attitudes and practices observed in research, education, and practice literature. Overall, the theory of 'becoming a person again' shows that where staff view the resident with dementia to be a unique individual, regardless of their cognitive deficits, they view their job as important and therefore view themselves as important. When these conditions of 'becoming a person again' are achieved both the resident with dementia and the staff member positively experience the process of care.

In an ethnographic study observing physical and social interactions between staff and residents with dementia Campbell (2012) found that while often physically focused the nature of care is found to be strongly

influenced by the interpersonal and power relationships between the staff member and resident with dementia. Norbergh et al. (2006) used questionnaires to gauge the attitudes of nurses working with residents with dementia. This research analyses data from 181 nurses working with residents with dementia and identified a predominance of neutral to negative attitudes towards residents with dementia. They also identify that interpersonal relationships between staff and residents with dementia are central to the nature of care, defining the quality of 'psychosocial intervention utilisation'. Norbergh et al. (2006) concluded that for nurses there is considerable risk that the experience of caring itself will result in the development of negative attitudes to residents with dementia and that this attitude negatively impacts on psychosocial intervention delivery. Both Campbell (2012) and Norbergh et al. (2006) link care delivery to staff attitudes towards residents with dementia with their attitude to the worth of the job they are undertaking.

The conceptualisation of 'balancing the influences' offers a structured explanation of the mutuality of outcome between staff and residents with dementia. Importantly the theory of 'becoming a person again' illustrates the means by which the dominant influence of institution, over staff and residents with dementia can be understood and positively re-balanced. 'Becoming a person again' is conceptualised as being attained when residents with dementia and staff mutually attain positive re-balancing, achieving the conditions of 'becoming a person again' for one group being mirrored in outcomes for the other. An example arising from the data for this study illustrates this; staff and residents with dementia consistently talk of not spending enough time socialising with each other. Clearly if either group achieves this condition of 'becoming a person again', spends more time socialising and experiences the benefit, there will be mutual benefit for the other group. This ongoing process of mutuality begins with the interplay of personal and institutional categories explained through 'balancing the influences'.

The research, education and practice literature provides a number of sources that have explored this mutuality with many identifying that staff attributes such as attitude impact upon the experience and outcomes of residents with dementia. Other examples in the literature indicate that the ability of staff to deliver the care they want to is influenced by levels of individual staff empowerment. Ward et al. (2008) developed a conceptual understanding based on videos of care interaction with 32 staff and 28 residents with dementia. In their three year qualitative study of communication between staff and residents with dementia they identified that there is a mismatch between the tasks staff prioritise and the social needs of residents with dementia. Bird et al. (2007) in their randomised control trial of psychological approaches towards behaviours that challenge noted the importance of staff variables such as attitude when determining outcomes. Ward et al. (2008) and Bird et al. (2007) both refer to resident outcomes being impacted by staff decisions about what tasks to undertake. These authors conclude that the tasks decided upon are defined by the priorities of the workplace in interaction with staffs' own skills and sense of empowerment.

Building on the understanding of factors that affect staff empowerment, Edberg et al. (2008) recommended that staff must 'balance' competing pressures to enable them to deliver practice they deem to be appropriate. Edberg et al. (2008) concluded that if staff are to change their practice they must engage in an ongoing ethical discussion where they reflect on their own experience of care delivery. This ethical discussion would be supported by staff experiencing empowerment and agency over their work and being supported to do so in their workplace. The need for staff to experience empowerment was also taken up by Campbell (2003) in analysis of participant data from 14 staff and residents on the topic of staff empowerment. Based on this data Campbell (2003) developed an understanding that staff and patients require a companionate and caring environment where staff are empowered via education and management to develop meaningful relationships with the residents they work with.

Figueiredo et al. (2013) analysed focus group data after delivering psycho-educational sessions to six staff working with residents with dementia. This research found that education and institutional support could result in a virtuous cycle of change, where staff development of competence would result in increased well-being for residents with dementia and in turn this would confirm a sense of well-being and accomplishment in staff. In both these examples staff empowerment is explicitly linked with the goal of improving the quality of care for residents with dementia. By discussing and accounting for the numerous components that comprise care Campbell (2003) and Figueiredo et al. (2013) both develop an understanding of the interdependence of residents with dementia, staff and the institutional setting. 'Balancing the influences' illustrates the interplay of institutional and personal factors and their influence on the mutuality of outcome for residents with dementia and staff. This models the overall process explaining the interactions that account for 'psychosocial intervention utilisation'.

Finally 'balancing the influences' offers an important theoretical understanding of the priorities that influence 'psychosocial intervention utilisation' in the context of limited time, poor training, and staff shortages which are commonly referred to in the literature (O'Kell, 2002; RCN, 2010). While literature reporting on practice has identified growing evidence of poor care quality this evidence in itself has not been influential in improving clinical practice (HIQUA, 2009; O'Kell, 2002; O'Shea & O'Reilly, 1999; O'Shea, 2007). 'Balancing the influences' offers stakeholders an understanding of the great complexity which contributes to the lack of change in long-stay care provision for residents with dementia. Understanding of the interplay of institutional and individual factors will allow practitioners and commissioners of services to respond to the clear need to manage change.

There are examples of other research that has endeavoured to broaden the conceptual understanding of dementia with the aim of influencing practice.

By developing a bio-psycho-social-physical model, Keady et al. (2012) demonstrated similar conceptual awareness to that which allowed conceptualisation of 'balancing the influences'. Keady et al. (2012) used collective case study research producing evidence for the development of a physical domain that would complement the existing bio-psycho-social model of dementia re-stating the centrality of the physical domain. Keady et al. (2012) acknowledge the importance of the physical care as part of what they view to be an overall re-balancing that explains and supports the reconceptualising of the physical domain in a manner that offers theoretical utility when planning practical care. Utilising case studies, Keady et al. (2012) developed a theoretical understanding of the experience of living with dementia. The authors identify five physical components: (1) physical well-being, (2) physical health and examination, (3) physical care, (4) physical treatment (5) physical environment. This research achieves a conceptual re-balancing of priorities towards holism in the understanding of dementia. In developing a bio-psycho-social-physical model Keady et al. (2012) argue that the physical domain should be balanced alongside the other priorities that staff have when delivering care.

Similarly, Heath (2012) develops a conceptual understanding that includes balancing when reporting on an observational study of registered nurses working in care homes. This research considers the contribution of nurses in residential settings faced with limited time, poor training and staff shortages. Heath (2012) refers to balancing when attempting to understand the impact change will have, acknowledging that changes will have balancing consequences. The conceptual development of 'balancing the influences' as part of the overall process of 'becoming a person again' helps explain the interaction of the factors that define the nature of psychosocial interventions. This understanding helps those with an interest in developing care to understand the likely outcome of any change to the existing nature of care delivery.

8.5.2 Individualising Status

Within the theory of 'becoming a person again' 'individualising status' is the stage accounting for individual capacity and inclination towards 'psychosocial intervention utilisation' following 'balancing the influences'. This stage represents an important conceptual 'bridge' between the interaction of institutional and personal factors which define the status of an individual and how they then go on to resolve their main concern. In this sense 'individualising status' describes the ability of the individual accordingly how the main concern is resolved. While applicable to residents with dementia and to staff the nature of 'individualising status' conceptualised in this thesis primarily explains the product of 'balancing the influences', defining how staff will go about resolving their main concern, 'striving to make the most of time'. This section will consider two key issues arising from the sampled literature: understanding capacity and inclination towards psychosocial intervention delivery as a bridge between education and actual care delivery, and the mutual impact of 'individualising status' on residents with dementia and staff.

The conceptual understanding of 'individualising status' offers explanation of an important conceptual stage between 'balancing the influences' and psychosocial intervention delivery. Single balancing factors alone are unlikely to define how staff resolve their main concern, 'striving to make the most of time'. Changing the balancing conditions that define 'individualising status' does impact upon actual care delivery. In the literature sampled, individual capacity and inclination towards 'psychosocial intervention utilisation' are not regularly referred to. Most of the literature discusses and describes observed staff actions or outcomes in response to educational interventions. The National Dementia Education Project (2012) in keeping with much of the literature focused on describing the qualities it seeks to produce in the recipients of education. Case study research by Bird (2001) found that rather than receiving formal psychosocial intervention training. Staff would be better prepared to address behaviours that challenge in residents with dementia

if education targeted their awareness of dementia. This would positively change staff ability and attitude in a manner that affects their care delivery. By identifying the need and explicating the means by which capacity and inclination in staff is developed the concept of 'individualising status' offers stakeholders a crucial '*bridge*' between institutional and personal balancing factors and actual care delivery.

Ward et al. (2008), described under 'balancing the influences' (Section 8.5.1), explored communication patterns in long-stay settings for residents with dementia. This research mirrors Kitwood (1997) in identifying that the predominant discourse and culture within residential settings serves to fix the status of staff and residents with dementia relative to the nature of care delivery. This research concludes that the dominant and often unchallenged position of the bio-medical model in dementia care results in staff lacking inclination to change their ways of working, and lacking the capacity to meet the psychosocial needs of residents with dementia. Ward et al. (2008) recorded extremely low levels of communication between residents with dementia and staff. This was attributed to lack of resource and a workplace cultural focus on completing physical tasks. Ward et al. (2008) concluded that staff are too willing to label residents with dementia as unable to communicate. This results in staff failing to view residents with dementia as complete human beings with physical, psychological, and social needs. The concept of 'individualising status' offers understanding of this observation. Where staff have a limited sense of their own ability to communicate effectively and hold views about care priorities that limit their actions then the capacity and inclination towards 'psychosocial intervention utilisation' are reduced. This conceptualisation also offers understanding of the relationship between staff attitude and 'psychosocial intervention utilisation' as noted in some of the research literature.

Campbell (2003) and Figueiredo et al. (2013) in two qualitative studies explored staff empowerment and the impact of psycho-educational

sessions on staff. They conclude that where staff are empowered they will feel greater commitment to their workplace and provide better quality care for residents. 'Individualising status' explains the outcome of 'balancing the influences' where investment in staff such as education and managerial support, result in improved capacity and inclination; a step towards more positive psychosocial interventions delivery, 'striving to make the most of time'. This understanding of 'individualising status' offers enhanced understanding of the findings of Campbell (2003) and Figueiredo et al. (2013); that staff who receive support and education become more competent, are able to change their attitudes, work better in teams, cope better with challenging situations and value the job they are doing.

Fossey et al. (2006) in their randomised control trial of an educational intervention to reduce neuroleptic medication use with residents with dementia, develop understanding of the need to address staff status through education. Fossey et al. (2006) directly link enhancing staff status, staffs view of themselves and their role, with the psychosocial intervention use they wish to promote. Fossey et al. (2006) sought to reduce neuroleptic medication prescribing via staff education and by changes within the care setting as a whole; the care environment, the nature of psychosocial interventions delivered, and staff attitude. This study establishes that care delivery, 'psychosocial intervention utilisation' to address behaviours that challenge as an alternative to neuroleptics, is a result of changing the status of staff through a range of interventions, not simply a result of altering individual components such as training. The concept of 'individualising status', as the bridge between 'balancing the influences' and 'striving to make the most of time' where actual care is delivered provides an achievable product of 'balancing the influences'. This conceptual understanding offers researchers, educators and practice developers a goal, in terms of the kind of staff they are seeking to produce. Staff capacity and inclination can be positively influenced and must be

considered when planning a research or educational intervention aimed at improving person-centred care via psychosocial interventions.

The understanding that recognition of personhood varies relative to staff action is offered further explication by the theory of 'becoming a person again'. The on-going process explains how 'individualising status' is defined with the resultant impact on actual care which in turn bestows status on the resident with dementia. Norbergh et al. (2006) in their study of staff attitudes to dementia, (described in section 8.5.1) identified the aim of staff who aspire to person centred care as being the maintenance of 'the self'. In their analysis, Norbergh et al. (2006) discussed the interaction of staff ability, staff attitude to people with dementia and staff's self-worth. They view this as an interaction between the aspiration to maintain 'the self' and those attitudes and actions that reduce staff effectiveness. The conceptualisation of maintaining 'the self' offered suggests that in practice staff members who feel ineffective reduce their social contact with residents with dementia and stop instigating therapeutic interactions with a resultant negative impact on outcomes for the resident with dementia.

The understanding that staff skills, beliefs and attitudes affect the nature of psychosocial intervention use and care generally was also presented by Kitwood (1997). As discussed previously the theoretical stance offered by Kitwood (1997) holds that the resident with dementia has a 'standing status' that is bestowed by staff. Norbergh et al. (2006) share the view linking staff and resident with dementia status as does Cohen-Mansfield (2003) when discussing why non-pharmacological psychosocial intervention approaches for psychosis are not used in residential settings. Individualising status offers a clear 'bridge' between 'balancing the influences' and 'striving to make the most of time'. Understanding the importance of status of staff and resultant status of residents with dementia offers researchers, educators and service developers an achievable goal. By targeting staff status, their psychosocial intervention use and consequent person-centred care delivery will be enhanced in a

manner that targeting interventions alone will not. This conceptual understanding holds that where the conditions of 'becoming a person again' are not met, capacity and inclination towards psychosocial interventions utilisation is reduced. This less favourable staff status also serves to fix the status of residents with dementia as the options for psychosocial interventions and subsequent person-centred care are limited.

Staff who do not attain the conditions of 'becoming a person again' are themselves subject to a range of stressful influences as they endeavour to rationalise the care they provide. This understanding of mutuality and the setting of status derived from the literature does warrant some refinement of the theory of 'becoming a person again'. While mutuality is reflected in 'becoming a person again' the strength of the mutual status setting interaction between staff and residents with dementia needs to be acknowledged across the overall process.

8.5.3 Striving to Make the Most of Time

Within the theory of 'becoming a person again' the concept of 'striving to make the most of time' represents how individuals, resolve their main concern. As noted 'striving to make the most of time' explains how care is delivered by individual staff. Residents with dementia are also 'striving to make the most of time' viewing resolution in terms of social interaction and being known. Conceptually this stage describes actual psychosocial intervention use or absence in response to the on-going process of 'becoming a person again'. 'Balancing the influences', establishes 'individualising status' which then defines how the main concern is resolved, 'striving to make the most of time'. This section will consider how the interplay of a range of factors defines the nature of actual care.

It is clear from the conceptualisation that emerged from the data analysis in chapters 4-6 that staff want to do the best job they can with the available time and resources. Individuals create their version of 'best'

continually 'striving to make the most of time'. The resolution of staffs' main concern is perhaps most clearly illustrated when compared to examples of positive and negative care delivery within the literature. McKeown et al. (2010) used multiple case study research to explore the impact of training staff in life story work on the delivery and outcomes of care. This research identifies that training in life story work must also be supported by practice development including staff facilitation, support and supervision. This study identified that institutional change in culture as well as education in life story work enhanced staff ability, made the attitude of staff towards dementia care more positive and resulted in desirable changes in the nature of actual care delivery. In other research Ward et al. (2008), (described in section 8.5.1) identified the consistent failure of staff in their study to meet the communication needs of residents with dementia resulting in residents spending much of their time alone without social contact or pleasurable activity. Their research concludes that institutional changes such as improving staffing levels, changing emphasis away from the bio-medical model and educational input would all be required to positively change the nature of actual psychosocial interventions utilisation, in this case communication, in the study settings.

The review of evidence aimed at influencing dementia care practice presented by The Health Foundation (2011) Spotlight on Dementia Care Report, is one of many sources which views education to be a primary means of bringing about change in the nature of dementia care. Their vision is that education will change the care given in terms of: quality, effectiveness, capacity and patient-centeredness. The understanding of 'striving to make the most of time' that has emerged in this thesis shows that education alone will not bring about positive changes in 'psychosocial intervention utilisation'. While the other sampled literature identifies a role for education in bringing about change in care delivery. There is also a suggestion that the link between education and change in the nature of psychosocial intervention delivery is difficult to clearly establish (Clare et al., 2003; Kuske et al., 2007; Vasse et al., 2010; Woods et al., 2005). Vasse

et al. (2010) in their systematic review of educational intervention literature, (described in section 8.5.1) identified a number of factors which they suggest will aid adoption of psychosocial interventions in practice. These include personal feedback on education, interactive learning, ongoing support after training, linking the psychosocial interventions utilisation with daily care, and making set times to deliver the interventions. Kuske et al. (2007) in their systematic review of educational intervention literature, (described in section 8.5.1) went further recommending that there must be organisational change, ongoing support, and post intervention evaluation of change in both staff and residents with dementia. The caution evident in reviews of educational literature suggests that even where methodologically robust, the plethora of other factors that impact on practice makes establishing a cause-effect relationship between education and practice difficult. Constant comparison of data from participants who had received education for this thesis shows that while actual care delivery can be impacted by education, the conditions for positive 'psychosocial intervention utilisation', 'striving to make the most of time', do not occur through education alone.

A common feature of the research, education and practice literature is the identification of resources or their absence as having an impact upon psychosocial intervention delivery and care generally (Heath & AIGNA, 2010; Heath, 2012; O'Kell, 2002). This literature identifies that staff perception of lack of resources has an impact upon staff attitude and care delivery. The Care Quality Commission (2011) highlighted lack of training and resources within dementia care residential settings. This report identifies that 55 out of 100 hospitals fail to meet the standards set, including measures of respecting and involving residents with dementia. Heath and AIGNA (2010) in a report on nursing practice in residential settings links perception of resource shortage with task orientated approaches to care which in turn reduce the use of psychosocial interventions. Other examples indicate that where factors such as negative staff attitudes, staff shortages, and lack of time are addressed then

psychosocial interventions can be provided with positive outcomes for residents with dementia and for staff (Figueiredo et al., 2013; Norbergh et al., 2006, Ward, 2008). Pulsford (1997) in a review of practice research suggested that there is a relationship between these factors and the nature of psychosocial intervention delivery. Pulsford (1997) argued that ultimately the values staff hold define the nature of the care they deliver. This suggests that addressing factors such as staff shortages and lack of time alone will not necessarily result in positive changes in 'psychosocial intervention utilisation', staff beliefs and understanding of their role needs to be addressed. It is evident that individual components such as staffing levels or personal decisions about applying training interact and define the status of individual staff resulting in actual care delivery. As indicated 'striving to make the most of time' represents actual care delivery in response to the on-going process of 'becoming a person again'. As 'balancing the influences' defines 'individualising status' which in turn directs the nature of actual care delivery. This understanding offers stakeholders an empirically based view of how staff capacity and inclination towards psychosocial interventions are formed and of how actual 'psychosocial intervention utilisation' is established. The explication offered in Chapters 4-6 explains the institutional and personal conditions that result in actual care delivery, conceptualised as resolving the main concern, 'striving to make the most of time'. In this conceptualisation the process from 'balancing the influences', through 'individualising status' to 'striving to make the most of time' can result in care which is positive or negative in terms of 'psychosocial intervention utilisation'. The next section considers how staff participants respond to their individual resolution of the main concern.

8.5.4 Interpreting care

'Interpreting care' is the stage which conceptualises how staff make sense of, justify and respond to the manner in which they have resolved their main concern. As with the overall process of 'becoming a person again' this stage is influenced by a balancing of personal and institutional factors.

'Interpreting care' serves two functions within the ongoing process of 'becoming a person again'. The first is explaining and representing individual staff's view of the appropriateness of the psychosocial intervention care they provide. This of course relates to individual awareness, understanding and attitude meaning that staff may or may not be able to identify the presence or absence of appropriate psychosocial intervention delivery. The second function is explaining and representing staff reaction to any such identification and their subsequent response. Where staff identify the need for change and react to that realisation 'interpreting care' has the potential to impact upon 'balancing the influences' and the other stages of 'becoming a person again' positively. This occurs where an individual identifies the presence or absence of good practice and brings this knowledge to bear on 'balancing the influences'. This section will consider a range of issues arising from the sampled literature: change in staff values and attitudes, staff experience of strain, mutuality (between residents with dementia, staff and society), impact of 'interpreting care' on psychosocial interventions utilisation and 'interpreting care' as a component of resident with dementia and staff empowerment.

As noted 'interpreting care' has the potential to have a range of impacts. It can perpetuate current 'balancing the influences' where there is no change, illuminate failings resulting in positive balancing or illuminate failings resulting in strain with no positive effect. The conceptualisation of 'interpreting care' offers researchers, educators and service developers understanding of the mechanism linking staff awareness of positive psychosocial interventions utilisation and efforts to apply this change systematically. 'Interpreting care' can help improve psychosocial interventions utilisation where staff positively apply their understanding, affecting change to the nature of 'balancing the influences', with a consequent impact upon psychosocial interventions utilisation. Egan et al. (2007), (described in section 8.5.1), suggested that when staff utilise life history knowledge and realise that doing so reduces the incidence of

behaviours that challenge this realisation changes staff values, attitudes and actions along with outcomes for residents with dementia. Davies and Nutley (2000) in their discussion of organisational change in health care, noted the requirement for staff and organisations to 'unlearn' allowing wholesale change in institutional customs, ways of working and processes. They acknowledge that such change is difficult to achieve in the face of individual investment in and comfort with continuity. Davies and Nutley (2000) show an understanding that individuals must identify the need for change and act upon this identification. This conceptualisation offers stakeholders the understanding that positively 'interpreting care' can contribute to 'psychosocial intervention utilisation' changing over time. The understanding of 'interpreting care' also offers stakeholders a means of considering and reflecting upon the mutual, individual and institutional impact change, specifically educational interventions. Understanding the potential impact of 'interpreting care' on 'balancing the influences' and 'psychosocial intervention utilisation' shows that supporting staff reflection in conjunction with educational interventions can enhance the potential for lasting positive impact on psychosocial intervention use and care.

Some of the sources included in this analysis raised the influence of societal views on dementia upon the concept of 'interpreting care'. A pilot study by Alzheimer's Australia (Phillipson et al., 2011) examined the views of 614 adults between 40-65 years of age, 89.9% of whom knew a person with dementia and 21.8% of whom were the primary carers of someone who had dementia. This study found that 34% admitted to finding people with dementia irritating and over 50% felt they could not have a meaningful conversation with a person with dementia (Phillipson et al., 2011). Similar negative attitudes towards residents with dementia have also been identified in staff members. In their 3 year observational study Ward et al. (2008), (described in section 8.5.1), concluded that where education was not supported by managerial approaches that focused on refreshing staff values and attitudes to care there was a tendency for staff

to resort to less positive communication and more limited interaction. Ward et al. (2008) identify that where staff have no alternative view, care will be delivered uncritically with limited scope for change. Positive change will not occur where staff are not able to challenge their negative attitudes of residents with dementia. Constant comparison of these sources indicates the need to include societal influence to dementia in the understanding of 'becoming a person again' and specifically 'interpreting care'. This addition offers the understanding that research and education needs to account for the tendency to adopt negative attitudes towards people with dementia amongst society at large and that this impacts upon staff.

Much of the research, education and practice literature endeavours to resolve the question of what staff do with and for residents with dementia. The theory of 'becoming a person again' offers understanding that staff action, ongoing psychosocial interventions delivery, is in part dependent upon staff reflection. The process by which staff reflect upon the psychosocial intervention care they have provided; maintaining or challenging negative ways of working and attitudes is explicated within the concept of 'interpreting care'. In their research, Brodaty et al. (2003) undertook a self-completion questionnaire survey of 253 nursing home staff considering strain and satisfaction. This was subject to cross sectional analysis against behavioural assessments of 647 residents with dementia. Brodaty et al. (2003) argued that there is a link between staff reflection and actual care delivery. This study suggests that lack of education, workplace pressures, and personal concerns result in poor understanding of care, subsequent negative attitudes to residents with dementia, and resultant lack of psychosocial interventions utilisation (Brodaty et al., 2003).

There are other examples of research education and practice literature that discuss the interdependence of staff values, attitude and psychosocial intervention utilisation. Cohen-Mansfield (2003) discussed the need to

develop an etiology based approach to psychosis in dementia to replace diagnostic approaches that result in over use of medication. The identification of causation followed by an etiology based response is discussed. Cohen-Mansfield (2003) argued that where staff are struggling to meet their own physical and psychological challenges and are working in poorly resourced care settings where they lack power, they may take the easiest option. Easiest meaning anti-psychotic medication when faced with behaviours that challenge, rather than identifying the cause and applying psychosocial interventions. The idea that staff psychosocial intervention delivery is defined by their knowledge of dementia along with values and attitude to dementia was also taken up by Douglas et al. (2004) in a review of non-pharmacological approaches to behaviours that challenge. They conclude that while psychosocial interventions have a place and can impact on the quality of care. Staff understanding of and reflection on dementia along with the care they deliver clearly impacts upon their future psychosocial intervention delivery. Norbergh et al. (2006) (described in section 8.5.1), also concluded that staff caring behaviours stem directly from their attitudes and efforts should be made to enhance staff self-awareness and reflection. They concluded that staff who consider their own contribution to be ineffective will avoid attempting potentially therapeutic psychosocial interventions with residents with dementia.

The relationship between the psychosocial interventions staff deliver and their attitudes as explicated by Norbergh et al. (2006) identified that the practice of staff is directly impacted by their attitude to the people they work with and their reflection on the psychosocial interventions care they deliver. Norbergh et al. (2006) described a reflective process amongst staff that where unchallenged and uninformed results in mutually negative consequences for staff and residents with dementia. If the people I am working with are worthless, then is not the job I do worthless and by extension am I worthless? Brodaty et al. (2003) considered staff attitude, strain and work satisfaction. They also identify the tendency for negative

attitudes towards people with dementia to feed into how staff reflect on care. Brodaty et al. (2003) and Norbergh et al. (2006) identified that staff are affected by institutional and personal factors when reflecting on the care they have delivered.

The Parliamentary and Health Service Ombudsman (2011) concluded that poor staff communication, lack of staff empowerment, negative attitudes, and habitual practices are maintained if staff are unable to reflect on their practice. In research into the nature of nursing practice in residential older peoples' settings Heath and AIGNA (2010) and Heath (2012) (described in section 8.5.2), noted the importance of staff reflection and empowerment on changing practice. This research into nursing contribution to dementia care acknowledges that workplace cultural factors will influence nurses perceptions regarding deciding what interventions work. The concept of 'interpreting care' explains that where staff with sufficient knowledge, support, skill and expertise can reflect on the care delivered, this positive 'interpreting care' can influence the ongoing process and feed into 'balancing the influences'.

'Interpreting care' offers the understanding that the development of staff understanding of dementia and psychosocial intervention use impacts on their future care delivery. The conceptual understanding of the overall process of 'becoming a person again' explains how the attitudes and values of individual staff are formed subject to a process which ultimately defines staff decision making relative to 'psychosocial intervention utilisation'.

'Interpreting care' explicates their response to the care they deliver and why this response may or may not positively influence the ongoing process of 'becoming a person again'. In a review of evidence for the use of therapeutic interventions in dementia care, Pulsford (1997) goes so far as to suggest that staffs' values are more central to the nature of care delivered in this area than any other care setting. In highlighting the centrality of staff values, Pulsford (1997) argued that regardless of external influences staff have to take personal responsibility for their

values the resultant care they deliver. Pulsford (1997) acknowledges the importance of factors such as education and institutional pressures, but ultimately stresses the importance of individual decision making based on values. As individuals make decisions about the nature of the care they deliver. The importance of staff decision making and reflection on their own care is also referred to by Edberg et al. (2008). Their content analysis of focus group data identified the concept of moral strain as staff struggle with the morality of and quality of the care they were able to deliver. Edberg et al. (2008) differs from Pulsford (1997), offering a view of staff values and attitudes that is influenced externally rather than personally as education and workplace affect staffs' responses. This produces 'moral strain' in staff as a response to being unable to deliver the care they would wish to. They give the example of staff knowing that a resident with dementia is anxious but choosing not to sit down and comfort them, because they lack the emotional strength to do so. The authors conclude that making such day to day decisions produces 'moral strain' which negatively impacts on staff well-being and induces apathy towards care delivery which has negative impacts for residents with dementia.

Another conceptualisation of 'interpreting care' is that it can result in strain in staff as they identify a gap between their caring expectations and the reality of care. Cahill and Diaz-Ponce (2011) in a qualitative study considering the quality of life of 61 residents with dementia noted that the majority of these felt isolated and lonely and that while experiencing cognitive impairment could still communicate their views and preferences. These findings are supported by studies that show a mutual dissatisfaction in 'psychosocial intervention utilisation' amongst staff and residents with dementia. In their study, Edberg et al. (2008) used the term 'experience of strain' to describe staff response to working in residential settings. In this conceptualisation staff experience is impacted upon by a divergence between the actual care provided and their caring aspirations. Edberg et al. (2008) concluded that staff faced with managerial pressure, poor team support, inadequate training and a problematic home-work balance will

suffer from 'experience of strain' which in turn negatively affects the nature of care provided and can result in poor staff retention as staff resolve their strain by leaving their job. Edberg et al. (2008) link staff empowerment to their ability to make decisions which improve care delivery. They recommend a combination of emotional support for staff and supporting staff to increased control over their own working practices.

Consideration of the means by which education may have a lasting positive effect on practice supports further refinement of the theory of 'becoming a person again'. This refinement acknowledges that if education is to have a lasting positive effect the strong societal impact on 'interpreting care' must be represented when modelling the overall theory of 'becoming a person again'. For education to change 'psychosocial intervention utilisation' the influence of societal awareness and attitude to dementia must be included in the overall process model. Cahill and Diaz-Ponce (2011) and Edberg et al. (2008) note the need for concerted long-term commitment to education on a personal and institutional level that acknowledges the influence of negative attitudes to dementia along with poor understanding of dementia amongst society in general. Within the literature considered, there have been numerous efforts to evaluate the quality, impact and nature of educational interventions (Clare et al., 2003; Health Foundation, 2011; Kuske et al., 2007; NICE, 2007; Vasse et al., 2010; Woods et al., 2005). A common feature of this literature is the identification of failings in education or the methodological challenge of educational evaluation. Most commonly these identifications are reflected upon and fed back into the research or policy discourse, most often in the form of recommendations for future research or education. Davies and Nutley (2000) offer a useful understanding which mirrors the understanding of mutuality present in 'becoming a person again' and is specifically applicable to the concept of 'interpreting care'.

Changing the way individuals view their care delivery with the resulting change in practice requires long-term and ongoing commitment from both

organisations and individuals (Davies & Nutley, 2000). Baldwin and Capstick (2007) noted that when considering the skill level required for staff to enhance personhood, Kitwood himself developed a growing appreciation of the degree of challenge over time along with an understanding of the impact of societal values on staff values and attitudes. In later work, Kitwood (1998) identified the need for ongoing supportive education which would allow staff to reflect upon and influence the care they deliver in order to overcome the numerous personal and organisational challenges presented when endeavouring to enhance person centred care.

The variation in the nature of 'interpreting care' noted acknowledges that reflection on 'psychosocial intervention utilisation' does not always occur. Where it does occur this is viewed as a positive manifestation of 'interpreting care'. Sumner (2010) in a discussion of nurses' ability to critically reflect on their practice describes this ability as moral maturity. This moral maturity is developed through a combination of experience and expertise and is impacted by contextual influences such as hierarchy within institutions. Sumner (2010) related this developing moral maturity to the stages of mastery outlined by Benner (1984) with the outcome of mastery being nurses' ability to display enlightenment, emancipation and empowerment. Benner (1984) conducted numerous research studies with nurses to develop an understanding of their mastery and critical reflection. The understanding developed explains that; nurses can undergo a process of skilling over time which allows them to move beyond routine practices. Nurses can achieve a status, including recognition of their ability, which can impact positively on the quality of care delivered. Also that while nurses are subject to situational influences they can work to refine their skills and practice. Benner (1984) also recognises mutuality of process between nurse and patient; the power relationship between nurse and patient along with nurses' ability to tolerate risk being central to this conceptual view.

In another example of practice literature that considers the decisions staff make about care, Vernooij-Dassen et al. (2005) and Iliffe et al. (2005) reported the findings of a modified focus group approach with 23 purposively sampled dementia care experts. Each participant participated in four focus groups following circulation of pre focus group information and commented on the generated themes post data collection. Vernooij-Dassen et al. (2005) identified the potential for stigma beliefs to limit staffs' inclination towards caring, reducing residents with dementia to collections of problems. This research concludes that stigma belief impairs the ability of staff to identify dementia symptoms and diminishes their subsequent psychosocial intervention use. Iliffe et al. (2005) identified the impact of stigma on actual care delivery viewing staff to be complicit in reducing the quality of person-centred care. Iliffe et al. (2005) argue that there is a need for active reflection and action from staff to re-frame how dementia is viewed on a public level as well as on the level of the individual professional. In a review of concepts of caring applied to nursing practice, Matsuoka (2007) defined caring and care delivery as a process through which carer and cared for both have their human needs met acknowledging that personal experience, skills, and context all impact on an individuals' ability to care in a manner that is humanistic. Matsuoka (2007) also noted that without attendance to the interaction between carer and cared for effective human caring cannot be demonstrated.

Finally, Sumner (2010) used the terms self-reflection and moral maturity to describe positive changes in staff self-worth and empowerment. Noting that while desirable this level of empowerment and emancipation is rare amongst nursing staff. Sumner (2010) also argued that staff who have not attained the required level of self-reflection avoid critical self-reflection with the result that poor care continues unchallenged. Sumner (2010) holds that while hard to attain '*self-blossoming*' is possible with the result that:

'Practice can then be truly autonomous, free of the governmentality that controls ritualistic, habitual practices' (Pg.161).

The research, education and practice literature notes numerous negative examples of care. This thesis offers an understanding of the process by which staff engage in 'interpreting care'. This that shows they often have not been aware of or have not acted to address negative care. While 'interpreting care' can be negative or fail to result in change, explication of the overall theory of 'becoming a person again' shows how 'interpreting care' can be harnessed as a means of positively influencing staff attitudes to the people they work with and to the work they deliver. 'Interpreting care' offers further understanding of how individuals can become aware of negative practice and act to address such care. Awareness in itself is evidently not enough to modify 'balancing the influences', but the action it stimulates is an importance component of change.

8.6 Becoming a Person Again: Phase 4 post analysis reflection and modelling

Comparison of the conceptual stages of the theory of 'becoming a person again' with the extant research, education and practice literature shows areas of similarity, applicability to the sampled literature and identified areas for refinement of the existing conceptual model. Constant comparison shows that the conceptual stages and process of the theory of 'becoming a person again' offer researchers explication of the mutuality of outcome between staff and residents with dementia. The research literature regularly refers to the need for greater understanding of the factors that enhance the efficacy of educational interventions. Research also connects outcomes for residents with dementia with staff needs such as empowerment. The mechanism of empowerment is accounted for within 'balancing the influences' as institutional and personal concepts interact. As such empowerment is a mutually experienced condition of 'becoming a person again' that can be realised by residents with dementia and staff together.

The literature sampled indicates that there is a clear mutuality and interdependence between staff and residents with dementia. In re-

conceptualising the model this relationship is reflected across the overall process. Equally the importance of staff experience, conceptualised as 'experiencing care', whilst present in the model, should be re-emphasised beyond 'balancing the influences' to the 'interpreting care' stage of the process. Reflection on the impact of psychosocial intervention use and the mutuality of experience, reciprocity between staff and residents with dementia does impact upon positive re-balancing. This theoretical understanding also explains the influence of staff values and beliefs on the delivery of psychosocial interventions, and models the interaction and impact these factors have on educational uptake, utilisation and efficacy. It explains that education alone cannot deliver person-centred care via psychosocial interventions. In addition, the importance of time as it impacts on staff experience as a factor in achieving the conditions of 'becoming a person again' is now conceptually understood to have an impact on the entirety of the model. Finally, re-conceptualisation must acknowledge the influence of societal awareness and attitude to dementia, specifically stigma on educational efforts to change 'psychosocial intervention utilisation'.

8.7 Phase 4 Summary

The literature sampled describes and considers practice focussing on psychosocial intervention delivery, use of time, staff resources, staff attitudes, staff-resident status, staff abilities and decision making. The theory of 'becoming a person again' offers stakeholders the understanding that care context, capacity and inclination of individual staff, actual psychosocial intervention care delivery and staff's recognition of and response to the care they deliver are connected as part of an ongoing process. Also that education is only a single component whose application is subject to a range of influences. Underlying these considerations is a general understanding that services are not meeting the needs of residents with dementia. The clear explication of the relationship between staff attitude and 'psychosocial intervention utilisation' in the theory of 'becoming a person again' offers stakeholders understanding of the

negative attitudes and ways of working observed in the practice literature. The theory of 'becoming a person again' models the process by which institutional and personal conditions interact resulting in actual psychosocial intervention delivery. The mutually dependent status of staff and residents with dementia identified models a reciprocity of interaction between staff behaviours, beliefs and 'individualising status'. Comparison with the literature considering staff decision making also shows the utility of the concept of 'interpreting care' as staff consider and justify their practice over time. The overall process of becoming a person explains how this can be part of a positive process that can bring about 'psychosocial intervention utilisation'.

The next chapter presents the concluding comments and findings of this thesis.

Chapter 9: Thesis Conclusion

This chapter concludes this thesis commencing with a discussion of the contribution to knowledge of this research. The quality of the research will then be discussed along with concluding comments on the main findings of this research; comprising research limitations, practice implications and recommendations for practice.

9.1 Contribution to Knowledge

The theory of 'becoming a person again' provides insight into the complexity of the under researched area of psychosocial intervention use with residents with dementia. In addition it offers theoretical understanding that builds upon the extant knowledge in the substantive area. There is growing evidence raising concerns over the quality of care provided for residents with dementia (Cahill & Diaz-Ponce, 2010, 2011; Murphy et al., 2006). The Irish Action Plan for Dementia (O'Shea & O'Reilly, 1999) calls for long-stay care to be more person-centred with more emphasis on individual needs. Such change will require implementation via staff education in psychosocial intervention provision (Brooker, 2007; Keady et al., 2004; O'Shea, 2007). This research adds to the understanding of the issues and processes involved in implementing such change.

The central contribution of this thesis is the understanding that the conditions of 'becoming a person again' are achieved mutually for residents with dementia and staff. The theory of 'becoming a person again' explains the mutuality of experience of the two and how facilitating psychosocial intervention use has a mutually beneficial effect, meeting staffs' aims as well as the needs of residents with dementia. This knowledge offers a means of encouraging staff skill attribution and application. Moreover the theoretical understanding suggests that where staff begin to understand and use psychosocial interventions their capacity and inclination for continued and enhanced use increases.

The concept of 'balancing the influences' provides an understanding of the opportunity staff, specifically managers, have to positively adjust the conditions that affect the workplace. This balancing of institutional and personal factors influences staff capacity and inclination towards psychosocial interventions over time. By conceptualising how the capacity and inclination of individual staff is achieved the actual nature of psychosocial interventions provided can be understood and therefore modified. This systematic explication of how the relationship between institutional and personal factors impacts upon staff capacity and inclination towards 'psychosocial intervention utilisation' models a mechanism by which change can be managed.

The understanding that over time staff interpret their psychosocial intervention use in a range of ways and that their ability to reflect ultimately affects their care delivery offers further means of managing change psychosocial intervention use. This research shows that staff reflection on their action is poorly developed and where present often results in strain with no change.

By explication of how these incidents of balancing and mutuality of experience effect the process of 'becoming a person again' this classic grounded theory offers understanding of how resident with dementia and staff aspiration towards 'psychosocial intervention utilisation' can be mutually achieved by meeting conditions of 'becoming a person again'.

Finally this research provides an example of how classic grounded theory methodology can facilitate the emergence of complex theoretical structures. It offers an example of a how a structured approach to literature sampling in classic grounded theory allows the researcher to strike a balance between being so familiar with the literature that conceptualisation is forced, and being so unfamiliar with the field that understanding as well as access are diminished.

9.2 Research Quality

The classic grounded theory approach is detailed at length by Glaser (1978, 1992, 1998) and outlined in Chapter 3. Utilising constant comparison of data relating to psychosocial intervention use, along with the ongoing development of codes and conceptual categories this method emphasises the need to move beyond mere description. The aim is to achieve abstraction of participants, setting and time to develop theory that is applicable beyond the substantive area. The systematic presentation of methods and findings presented in this thesis provides two main contributions that relate to research quality. The first is the detailed illustration of the full complement of classic grounded theory components: constant comparison, memoing, the use of extant literature, theoretical sampling, theoretical saturation, substantive coding, theoretical coding, and application of theoretical sensitivity. By relating the rigorous structured application of the full complement of classic grounded theory components this thesis provides an accessible resource for readers of the research and researchers new to the methodology. In addition, given that classic grounded theory does not apply audit trails as evidence of trustworthiness, Chapters 5-8 provide evidence of fit, work, relevance, and modifiability illustrating the credibility and logical progression of the theoretical development.

In keeping with classic grounded theory procedures, the researcher made every effort to avoid application of preconceived ideas to the emergent theoretical framework. Glaser (1998) acknowledges that remaining open is an ongoing effort and the researcher cannot be expected to approach the research entirely free from beliefs and theoretical understandings gained from the literature or from professional experience. Rather the researcher must minimise the impact constantly asking, what category does this data indicate and what is this participant's main concern? As noted in Chapters 2 and 8 accessing the literature in the substantive area was undertaken in a phased manner which provided context and general understanding in the first instance, only undertaking detailed critical reading and constant

comparison of the literature once the theoretical framework was well developed. All efforts were made to acknowledge and question pre-existing professional understandings. Constant comparison and the memoing process ensured that any data derived from pre-existing knowledge earned its place in the research along with other data (Glaser, 2003).

As discussed in Chapter 3, classic grounded theory does not use the standard measures of quality and rigour utilised in qualitative research. In classic grounded theory quality and rigour are measured against the emergent theories' fit, work, relevance and modifiability. Classic grounded theory does not set out to produce accurate description and verifiable results. Classic grounded theory is used to develop a theoretical framework that while not designed to be verified as right or wrong shows relevance, applicability, and modifiability within the substantive area (Glaser 1978). Accordingly the credibility of a classic grounded theory study rests on the degree to which the emergent theoretical framework displays conceptual integration, addresses the participants' main concern and is abstract enough to be generally applicable out-with the substantive area.

9.2.1 Fit

The conceptual criteria fit relates to the validity of the emergent grounded theory. This is the degree to which the the developed categories are grounded in the data and as such relate to the behaviour under investigation (Glaser, 1978). In this thesis Chapters 5-8 demonstrate that constant comparison of the participant data along with the sampled literature allowed identification and understanding of the main concern, 'striving to make the most of time'. This concept emerges directly from the data outlining the practical challenges along with institutional and personal pressures that bear on 'psychosocial intervention utilisation'. Use of the constant comparative method ensures that the main concern fits. It is shown to have developed from theoretically sampled data achieving

theoretical saturation. This main concern shows fit when compared to the extant theory, policy, research, education, and practice literature. As such the theory of 'becoming a person again' can be seen to fit the data as a means of resolving the main concern. This has been achieved by allowing the concepts to emerge from the data rather than forcing them with preconceived hypothesis or concepts. As such the theory of 'becoming a person again' explains the patterns that are present in the data.

9.2.2 Work

Work is the ability of the theory to explain the many ways by which the main concern is addressed. In doing so the work criteria describes the theories' ability to explain over time what is happening in the area of enquiry (Glaser, 1978). The main concern, 'striving to make the most of time' and the other behaviours conceptualised in the theory of 'becoming a person again' were developed from rigorous application of constant comparison as such they are grounded in the data. The work of this theory is also apparent in the applicability of the conceptual concepts to the extant literature relating to psychosocial intervention use as evidenced in Chapter 7. It is also the case that the theory of 'becoming a person again' works in terms of explaining and predicting the behaviour of staff relative to their psychosocial intervention use.

9.2.3 Relevance

Relevance refers to the core category fitting and working to the view of other researchers, participants and practitioners (Glaser, 1978). The theory of 'becoming a person again' explains how the participants resolve their main concern relative to psychosocial intervention use, 'striving to make the most of time'. Relevance has been ensured by maintaining iterative and rigorous application of constant comparison, theoretical modelling, and subsequent theoretical sampling. Limiting initial access and phasing access to the literature as outlined in Chapters 2 and 8 served to ensure that the main concern and core category emerged directly from the data. Relevance was also maintained by constantly working to avoid

forcing the data along with copious memo writing to capture the researchers' perspective. Consideration of the relevance to the literature sampled in this thesis suggests that the theory of 'becoming a person again' is of relevance to areas of service provision beyond the substantive area where staff are balancing institutional and personal influences in pursuit of care delivery. Glaser (1978) argues that having the potential for formal theory development suggests that a core category is relevant. In this thesis there is sufficient conceptual grab to indicate the possibility of this theory being used as part of the development of a formal theory which would explain the nature of care delivery in the context of imbalances between institutional and personal influences.

9.2.4 Modifiability

Finally the theory of 'becoming a person again' has modifiability. The conceptualisation of the theory allows easy comparison with data arising from other research. This is apparent in Chapter 7 where the theory was compared to the extant literature. This suggests that were new relevant data subjected to the same classic grounded theory process it could modify the existing theory. Such application of new data and development of new hypothesis would not diminish the existing theory; rather they would increase its density and scope. That said Glaser (2003) is clear that while a classic grounded theory does not produce finished, final theory there must be an end point to data collection and analysis. The theory of 'becoming a person again' presented in this thesis is theoretically robust enough. It shows fit, work and relevance to the substantive area whilst being open to further modification. This potential to be modified makes the theory of 'becoming a person again' enduringly relevant and useful.

9.3 Research Limitations

This section will identify the research limitations of this classic grounded theory. Systematic application of constant comparative analysis and consequent theoretical sampling resulted in the majority of data being collected from staff participants. On reflection it may be the case that

theoretical sampling favoured the clarity and accessibility of staff data. The relative lack of resident with dementia data could be viewed as replicating the nature of long-stay settings, where institutional considerations take precedence over those of residents with dementia. Accordingly it should be acknowledged that obtaining more data from residents with dementia would have allowed further comparison of incidents and may have altered the overall conceptualisation. However the resident with dementia data collected in Phases 1 and 3 did earn its place into the analysis by showing fit, work, and relevance which allowed it to contribute to the saturation of the emergent concepts and resultant theoretical modelling.

Chapter 2 describes how this research used NVivo 10 software to manage the data used in this research. Classic grounded theorists are advised not to use such software to manage data for fear that use of computer assisted data analysis software (CAQDAS) will interfere with constant comparison. Glaser (2003) argues that doing so will diminish the researchers own inductive processes which should arise from non-linear sorting of memos and concepts. In practice the researcher developed knowledge of NVivo 10 concurrently with his developing knowledge of classic grounded theory methodology. This resulted in a clear understanding that the CAQDAS is a tool utilised to fit the requirements of the methodology not the other way around. In practice this means that the constant comparative process is not dictated to by the structure of the CAQDAS. Codes and concepts were developed only in response to connections and patterns in the data. There was no use of pre-formed codes or automatic coding. CAQDAS allowed the researcher to store all of the data, memos, codes and categories in an organised and accessible manner. Also by creating separate overlapping NVivo projects across the research phases, the developing process of coding and conceptualisation was readily illustrated and accessible. This use of CAQDAS facilitated ordered storage of participant data, researcher memos and literature. It also resulted in applicable instances of data being easily accessed during theoretical sorting and writing. This thesis shows

that any potential drawbacks of CAQDAS can be avoided and are outweighed by the clear organisational benefits of its use.

Classic grounded theory research requires that the emergent theory should be subject to constant comparison against other examples of theory in the literature. The theory of 'becoming a person again' may benefit from further comparison against wider theoretical constructs. These might include *street level bureaucracy*, considering the actions of public service workers (Lipsky, 1980); *structuration theory*, considering the relationship between individual agency and society (Giddens, 2001) and *McDonaldization*, considering the impact of societal rationalisation on the interaction of institutional and personal factors in care giving (Ritzer, 1994). In practice given the great wealth of theoretical writing directly relating to dementia care accessed and outlined in Chapters 1 and 7, the decision was taken not to extend the theoretical comparison beyond the theoretical writing relating directly to dementia, personhood, and person centred care. There is no doubt that further theoretical comparison would raise the level of theoretical abstraction achieved in this thesis. However, the resultant theory of 'becoming a person again' presented is complete enough demonstrating fit, work and relevance following comparison with the theories relating directly to the substantive area.

The potential for further theoretical development will be addressed in recommendations for future research below. Similarly it should also be acknowledged that the theory of 'becoming a person again' is conceptualised around behaviours relating to education and psychosocial intervention use. There are no doubt other priorities, interactions and processes at work within long-stay residential settings. That these other concerns did not impact upon the emergent theory is a reflection of their not demonstrating sufficient fit and relevance to the theory presented here. There will be other main concerns that future research can identify within the substantive area.

9.4 Practice Implications

Developing this classic grounded theory has allowed the identification of a number of practice implications relating to the delivery of psychosocial interventions for residents with dementia. These practice implications relate to three main areas: supporting 'caring attributes' towards 'psychosocial intervention utilisation', staff access to and use of education and institutional influence on psychosocial intervention use.

9.4.1 Supporting Caring Attributes Towards Psychosocial Intervention Utilisation

The theory of becoming a person, specifically 'balancing the influences' conceptualises the way the 'caring attributes' of staff are balanced against a range of other factors and how this process influences the use of psychosocial interventions. This thesis supports the assertion that staff possess positive 'caring attributes' such as patience, and that purposeful application of these enhances psychosocial intervention delivery, positively addressing staff's main concern, 'striving to make the most of time'. In addition staff are understood to be open to further learning about 'psychosocial intervention utilisation' and are willing to use psychosocial interventions, if supported to do so. Unfortunately conceptualisation of 'balancing the influences' shows that staff capacity to utilise psychosocial interventions is regularly unbalanced by institutional factors. The understanding that the nature of the long-stay setting ('institutional directing', 'weighing up what works', and 'psychosocial intervention availability') impacts on staff capacity and inclination towards psychosocial intervention use is an important finding of this research. 'Balancing the influences' models the institutions ability to encourage or inhibit the delivery of *'every day'*, psychosocial interventions through purposeful application of 'caring attributes'.

9.4.2 Staff Access to and Use of Education

The theory of 'becoming a person again' explains that although education alone will not achieve change it is an important component in developing

'psychosocial intervention utilisation'. In addition the conceptualisation of mutuality between the resident with dementia and staff present in this thesis offers implications for future education. Staffs' inclination towards education falls into two main areas. The first is a general desire for more knowledge about dementia. This thesis explains the positive relationship between staff understanding of dementia, psychosocial intervention use and increased self-worth and feelings of empowerment amongst staff. The second area of educational inclination is towards understanding behaviours that challenge and strategies to address them positively. The institutional category 'weighing up what works' shows that staff favour interventions that are timely and minimise distress for the resident with dementia and staff. Purposeful application of psychosocial interventions to complete physical care, de-escalating difficult situations or spending pleasurable time in social contact represent use of education that supports meeting the criteria for 'weighing up what works'. Psychosocial intervention education should provide staff with the skills to resolve their main concern positively, by doing so the concerns of staff and residents with dementia can be mutually resolved. Such education must be applied across teams to ensure equity of understanding of 'weighing up what works' and application of psychosocial interventions.

9.4.3 Institutional Influence on Psychosocial Intervention Utilisation

This thesis identifies that institutional factors are a strong influence on the manner in which psychosocial interventions are delivered. Actual care delivery is conceptualised as staffs' resolution of their main concern, 'striving to make the most of time'. The balance of influences in any given setting dictates whether spending time getting to know a resident with dementia is deemed a valuable use of staff time or not. As noted purposeful application of psychosocial interventions is not simply a function of education. 'Balancing the influences' explicates how institutional factors 'weighing up what works' and 'institutional direction' critically influences the potential for 'psychosocial intervention utilisation'. Staffs' own understanding of the psychosocial interventions they deliver

conceptualised as 'interpreting care' is also influenced by their colleagues and crucially managers' direction. Staff participants routinely talked of looking for permission to use psychosocial interventions within their institutions. Changing an environment from one where 'weighing up what works' relates to colleagues ensuring that the correct number of residents with dementia are showered, to one where success includes collegiate support for taking time to talk and getting to know residents with dementia requires both managerial oversight and permission.

9.5 Recommendations

This thesis supports a number of recommendations for policy, education, practice, future research and theoretical development.

9.5.1 Policy

- National and local policy should be encouraged to reflect the need to raise staff awareness of and improve staff attitude to dementia. Such policy cannot focus purely on educational responses but must acknowledge the balance of institutional and personal factors when promoting psychosocial interventions.
- Given the positive response to life story work noted in this research and in the literature. National and local policy should be encouraging the integration of life story work in long-stay settings.
- As an adjunct to life story work, national and local policy should encourage long-stay settings to strive to facilitate more personalised living environments which reflect mutual understanding of the '*person*' between staff and residents with dementia
- Given the evident need to develop staff attitudes to dementia, institutional approaches to person-centred care and staff knowledge of dementia policy should encourage an improved inspection regime, specifically focussing on the educational and practice recommendations outlined below

9.5.2 Education

- Educational programmes should be encouraged to target staff self-worth and empowerment rather than interventions alone.
- Integration of the findings of this research into the curricula (undergraduate and postgraduate) for nurses and health care assistants can help develop knowledge and critical awareness in the workforce.
- Staff can be helped to realise the value of their contribution to the care of residents with dementia via education. Education should emphasise the complexity of their social, psychological and physical contribution to the care. Training schemes should explicitly challenge the hierarchical dominance of the institution, peer pressure towards physical care and the bio-medical approach to dementia care.
- Staff require educational support to modify their ethos of care towards one that views successful management of behaviours that challenge in terms of psychosocial intervention use rather than recourse to narcoleptic medication.
- Staff training should explicitly note the importance of staff empowerment. Positive change should be explicitly linked with that of residents with dementia as a means of enacting change in psychosocial intervention delivery.

9.5.3 Practice

- The theory of becoming a person again provides a staged mechanism and model by which service providers, specifically managers can direct change in 'psychosocial intervention utilisation'. Practice change will be supported by disseminating these theoretical understandings for use by managers. This will introduce the understanding that they have the opportunity to support changes in person centred care via 'managerial direction' and providing permission for staff to engage in everyday psychosocial interventions.
- Entire teams must be supported to implement psychosocial intervention use. All staff involved in the care of residents with

dementia should be supported by colleagues and managers to reflect upon their psychosocial intervention use. Staff status and reciprocal resident with dementia status, specifically attitude towards residents with dementia should be openly addressed within practice settings.

- Along with the importance of staff attitude the understanding of mutuality between residents with dementia and staff should be placed at the core of practice change in long stay residential settings. All staff, residents with dementia and relatives should be made aware of the mechanism of mutuality and the potential for reciprocity. Whereby psychosocial intervention use by staff with residents with dementia can improve the experience and outcomes for all those involved with care.
- Service providers should be given guidance (and education) regarding understanding the causes of behaviours that challenge, unmet need and applicable psychosocial interventions.

9.5.4 Future Research and Theoretical Development

- Further research into the relationship between psychosocial intervention education and institutional influence on educational access/application is required. Multi-site research which considers institutional support for educational change in practice should be considered.
- No research has been identified that examines the long-term, post intervention impact of psychosocial intervention education on staff application of skills and upon overall sustainability of educationally driven change. Further research is required to explore the relationship between outcomes for residents with dementia, staff application of psychosocial intervention skills over time and the sustainability of institutional change.
- The identification that institutional factors are dominant within 'balancing the influences' indicates a need for further classic grounded theory research around the concept of 'interpreting care'. Further modification of this classic grounded theory would provide better

understanding of how to support the positive aspirations of staff. This would be supported by sampling out with the substantive area, in areas such as acute medical care, to offer the concept greater density and generalisability.

- Given the continued efforts to theoretically explicate the place of dementia in society, further theoretical sampling around ‘individualising status’ the concept of mutuality and the identified reciprocity between residents with dementia and staff is indicated. This would develop knowledge of how mutual disempowerment of staff and those they care for impacts upon the outcomes for residents with dementia.
- Develop a formal theory to explicate the broader implications of staff ‘striving to make the most of time’ influenced by the imbalance of institutional and personal factors.
- A number of concepts (hypothesis) have emerged from this research that present areas for further research and would benefit from further testing. The concept of ‘balancing the influences’ emerged as the starting point of the overall process. The relative influences of institutional and individual factors merits further research.
- Individualising status and the degree to which links can be drawn between changes in staff status and the outcomes for residents with dementia is clearly worth further study.
- Striving to make the most of time, conceptualised as the main concern of participants is fundamental to ‘becoming a person again’. Developing greater understanding of why staff undertake the psychosocial interventions they do offers a means of enhancing care.
- Further research considering ‘interpreting care’ offers greater understanding of the potential for individuals to reflect upon care and influence change in practice. It may be that within this category lies the active ingredient for developing psychosocial intervention utilisation for residents with dementia.

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Appendix 1: Site Descriptions

Site 1- Urban/Private, 27 places, catering for a mixed resident group. Large re-developed building on two floors. Single en-suit or four bedded shared accommodation. Doorways and toilets were brightly coloured. Residents were encouraged to eat in a shared dining area some remained in their bed area. Open spaces available to residents included two day rooms, a conservatory and a garden. Most residents congregated in one day room with a television, with some routinely remaining in their rooms/bed areas. There were daily and weekly activities such as music groups and newspaper groups. Care provided on the whole by health care assistants.

Site 2- Rural/Public, 55 places, provides long and short-term residential care, including palliative care and short-term respite care to the local community. A single-storey building opened in 1978 as a welfare home. It developed into a residential centre for older people as the dependency levels of residents increased. A twenty-bedded extension was added in 1998. A mix of four bedded, eight bedded or single en-suit accommodation. Bed areas were personalised with pictures and belongings. Most residents ate in the shared dining area. Much of the residents time was spent in the dining area or communal sitting area (chairs around the edge of the room) There was no evidence of dementia specific environmental modification. There are a range of planned activities and an activities co-ordinator (health care assistant). It has a secure garden with seating with a water feature and a second garden used for growing vegetables.

Site- 3 Rural/Public, 95 places, provides continuing care, rehabilitation, palliative and respite care. Built in the 1900s and Part of the building dates from 1842 and converted/modified over time. All residential accommodation is in four bedded or six bedded rooms. These rooms had an institutional, 'Nightingale' feel in spite of personal belongings being evident. Residents mostly ate by their beds, though there was the option to eat in a dining area. DARES participants were based in three different units. There was no evidence of dementia specific environmental modification. There was little evidence of structured activity staff were clearly familiar with residents pausing to chat as the daily routine was attended to.

Site- 4 Rural/Private, 44 places, provides long-stay care for a mixed group of residents. A purpose built two story building, all accommodation is single en-suite. There were pictures to indicate eating areas and toilets. Residents were encouraged to eat in the communal dining area. Residents spend most of their day in one of two lounges. There was an activities coordinator (health care assistant) who organised a rota of activities such as walks, bingo, music and quizzes. The trained staff and other health care assistants noted that they concentrated on physical care leaving activities to the dedicated staff member.

Site- 5 Urban/Public 22 places, provides long-stay care for a mixed group of residents. A single story purpose built building, built as a welfare home in the 1970s. Accommodation consisted of 20 single and six three bedded rooms. Residents ate in a large dining area, with some choosing to eat by their beds. There was no evidence of dementia specific environmental modification. A large dining area with an open fire and 'traditional' kitchen range; there were also a range of seating areas including a conservatory overlooking an enclosed garden. This was a busy setting with an attached day centre. The rooms were laid out around a circular corridor, with residents observed to move around the setting at will. There were reminiscence groups weekly in the dining room. Little other activity.

Site- 6 Rural/Public, 24 places, though mixed, most residents were reported as having dementia. It is a two-storey re-developed. All the residential accommodation is located in two 'Nightingale' wards on the ground floor. Residents had the choice to eat by their bed area or in

the dining room. There was no evidence of dementia specific environmental modification. The bed areas were personalised with residents' belongings and pictures. There is an entrance hallway, large day room, dining room, smoking room, conservatory and other seating areas in hallways and alcoves. There are well maintained grounds with comfortable garden furniture and an outdoor bowling green. The observed and reported dependency level was high with limited activity within the setting. Residents deemed able to could attend the attached day unit on weekdays.

Site- 7 Rural/Private, 38 places, though mixed the majority of residents were reported as having dementia. A two-storey re-developed building with all accommodation in 4, 6 or 8 bedded rooms. Bed areas were clean and tidy with very little personalisation. There was no evidence of dementia specific environmental modification. Meals were taken in a large shared dining area. Much of the day was taken up with getting residents in and out of the dining area. All of the residents other than those deemed to physically unwell spent their day in one large sitting area. There was no organised activities observed or reported, the staff (1 staff nurse and 4 health care assistants) reported pressure of work limiting their opportunity for social interaction/activities.

Site-8 Urban/Public, 74 places rehabilitation, respite care, long-term care or who have dementia care or enduring mental health problems. Large re-developed workhouse, comprising four separate units with their own communal space, bathrooms and toilets. There was some evidence of dementia specific modifications (pictures on some toilet doors, but not all). Accommodation was in a range of single and 4, 6 or 8 bedded rooms. Residents ate in bed areas or in a shared dining area. Staff did not engage in social activities. Volunteers and relatives offered some activities such as bingo. Otherwise there were few organised activities. Some residents remained in bed with the majority in day rooms with televisions or radios, turned on. There were outside spaces but access was limited due to limited staff time.

Site- 9 Urban/Public, 82 places, long-stay residential care for a mixed group of residents A large hospital built in the 1840's now providing day hospital services, clinic services and residential care services. The residents lived on four different wards. There was no evidence of dementia specific environmental modification. Most residents ate by their bed areas. Accommodation was in a range of single and 2, 4, 6 or 8 bedded rooms. Staff indicated there were very limited opportunities for excursions. There were no organised activities or access to outside spaces. Some residents bed areas or rooms were highly personalised others featureless. The residents spent their time either in or beside their beds or in one of the day rooms with televisions or radios, turned on.

Site - 10 Rural/Private, 50 places, long-stay residential care for a mixed group of residents. A purpose built two story building, accommodation is single en-suite and one double room. The upper floor accommodation used for people deemed to have higher dependency. Each floor had its own dining room and dayroom. Residents spent the majority of their day in the dayrooms. Resident bedrooms were highly personalised with bedding, belongings and decoration individualised. Staff encouraged residents to eat in the dining room and there was evidence of spontaneous activities, singing or group discussion in the sitting room. Activities were arranged during the day by activities coordinator (health care assistant). Other staff participated in these. Staff reported a range of activities both one-to-one and group ranging from bingo, dominoes, arts and crafts and organised day trips.

Appendix 2: Participant Demographic Forms

DARES Study

Site code: Participant Code Date T1 or T2

Care Assistant Demographic Information

1. Gender:

Male 1 Female 2

2. Age

<21 years 1 41-50 years 4

21-30 years 2 50+ years 5

31-40 years 3

3. Have you completed a Health Care Assistant Programme?

Yes 1 No 2

a. Please give the title and level of the programme you completed:

4. Number of years since completing this programme.

< 1 year 1 21 – 30 years 4

1 – 10 years 2 31 - 40 years 5

11 – 20 years 3 41 – 50 years 6

Not relevant 7

5. Number of years working with older people:

< 1 year 1 21 – 30 years 4

1 – 10 years 2 31 - 40 years 5

11 – 20 years 3 41 – 50 years 6

6. Other educational qualifications (Tick all that are appropriate)

Diploma Postgraduate Diploma

Degree Masters

Higher Diploma PhD

Other If yes, please specify below

7. Have you completed a specialist qualification in gerontology?

Yes 1 No 2

a. Please give the title of the programme you completed:

b. Please indicate the duration of the programme you completed:

8. Have you completed an education programme on dementia?

Yes

1

No

2

a. Please give the title of the programme you completed:

b. Please indicate the duration of the programme you completed e.g. a two-day programme:

9. Have you completed an education programme on reminiscence or on any other psychosocial interventions e.g. Sonas?

Yes

1

No

2

a. Please give the title of the programme you completed:

b. Please indicate the duration of the programme you completed e.g. a two-day programme:

10. What is your Ethnic or Cultural background?

(Please choose one section from A to D then ✓ the appropriate box)

A White

Irish

31

Any other White background

Irish Traveller

2

B Black or Black Irish

African

54

Any other Black background

C Asian or Asian Irish

Chinese

76

Any other Asian background

D Other, including mixed background

Other

8→ (please describe below)

Appendix 3: Staff Demographic Form

DARES Study Staff Demographics

Site code: Participant Code Date T1 or T2

Registered Nurse Demographic Information

1. Gender:

Male 1 Female 2

2. Age

<21 years 1 41-50 years 4

21-30 years 2 50+ years 5

31-40 years 3

3. Professional qualifications (Tick all that are appropriate):

Registered General Nurse Registered Midwife

Registered Psychiatric Nurse Registered Sick Childrens Nurse

Registered Nurse Tutor Registered Public Health Nurse

Registered Intellectual Disability Nurse:

4. Number of years since first registration

< 1 year 1 21 – 30 years 4

1 – 10 years 2 31 - 40 years 5

11 – 20 years 3 41 – 50 years 6

Not relevant

5. Number of years working with older people:

< 1 year 1 21 – 30 years 4

1 – 10 years 2 31 - 40 years 5

11 – 20 years 3 41 – 50 years 6

6. Educational qualifications (Tick all that are appropriate)

Diploma Postgraduate Diploma

Degree Masters

Higher Diploma PhD

Other If yes, please specify below

7. Have you completed a specialist qualification in gerontology?

Yes 1 No 2

c. Please give the title of the programme you completed:

d. Please indicate the duration of the programme you completed:

8. Have you completed an education programme on dementia?

Yes 1 No 2

c. Please give the title of the programme you completed:

d. Please indicate the duration of the programme you completed e.g. a two-day programme:

9. Have you completed an education programme on reminiscence or on any other psychosocial interventions e.g. Sonas?

Yes 1 No 2

c. Please give the title of the programme you completed:

d. Please indicate the duration of the programme you completed e.g. a two-day programme: _____

10. What is your Ethnic or Cultural background?

(Please choose one section from A to D then ✓ the appropriate box)

A White

Irish 1

Irish Traveller 2

Any other White background 3

B Black or Black Irish

African 4

Any other Black background 5

C Asian or Asian Irish

Chinese 6

Any other Asian background 7

D Other, including mixed background

Other 8 → (please describe below)

Appendix 4: Resident with Dementia Demographic Form

Site code: Participant Code Date T1 or T2

1. Date of birth: _____
2. Gender: Male Female
3. Date of admission _____

Inclusion criteria

4. Over 65 years ₁ Yes ₀ No
5. Lived here for a least 1 month ₁ Yes ₀ No
- Dementia as determined by (tick all that apply):
6. Formal diagnosis as per DSM IV or ICD10 ₁ Yes ₀ No
7. Any other diagnosis by a medical clinician ₁ Yes ₀ No
8. On anti-alzheimer’s medication e.g. Aricept (donepezil), Ebixa (memantine) Exelon (rivastigmine) ₁ Yes ₀ No
9. Nursing records /nurses judgement ₁ Yes ₀ No

Exclusion criteria

10. Has a sensory impairment that, in the judgement of the nursing staff, impairs their ability to participate ₁ Yes
₀ No
11. Has an acute physical illness that, in the judgement of the nursing staff, impairs their ability to participate ₁ Yes
₀ No

12. Ethnic or Cultural background

(Please choose one section from A to D then ✓ the appropriate box)

A White

- Irish ₁
- Irish Traveller ₂
- Any other White background ₃

B Black or Black Irish

- African ₄
- Any other Black background ₅

C Asian or Asian Irish

- Chinese ₆
- Any other Asian background ₇

D Other, including mixed background

- Other ₈ → (please describe below)
- _____

Appendix 5: Resident with Dementia, Staff, and Relative Information Sheet, and Consent Forms

Using Reminiscence with Older People – Staff Information

The National University of Ireland, Galway is being funded by the Health Research Board to undertake an important study, called DARES, on the impact of a reminiscence-based education programme for staff on the quality of life of people with dementia.

What is the study about?

The purpose of this research study is to examine whether the use of reminiscence in day-to-day caring within the care home makes a difference to the quality of life and behaviour of residents with memory problems and the care burden of staff caring for people with dementia.

Reminiscence involves prompting people to remember and discuss past events, positive experiences and activities from their lives by using materials such as photographs, life history, historical items and music or archival videos. The aim is to increase resident-staff interaction, enhance resident's quality of life, including their overall mood and well-being, and reduce the care burden of staff.

What will the study involve?

When 17 residents with dementia and 10 staff from this care facility agree to take part in the study, a care facility is included in the study. Long-stay facilities in the study will be randomised into two groups: a control group, where care continues as usual, and an intervention group.

If your facility is randomly selected for the intervention group, a number of staff nurses and health care assistants in this care home will attend a three-day training programme preparing them to use reminiscence. Each staff nurse will be paired with a health care assistant and each pair will be caring for 3 or 4 residents with dementia who have agreed to participate in this study. The staff will use the knowledge gained from the programme to learn more about each resident's past and their likes and dislikes, and this information will be used to plan their person-centred care.

To examine the impact of reminiscence, the research team will also complete some questionnaires with residents and staff at the start and at the end of the study and will look at care practices. In addition, the research team will check the medical records of each participating resident, to see if the resident is on medication for memory problems. The research team will also interview a small number of staff and resident participants, to explore their experience of using reminiscence. These interviews will be recorded and transcribed and then the audio tapes will be destroyed.

If your facility is randomly selected for the control group, where care continues as usual, then you will not receive the intervention, that is, the structured education programme, but the research team will complete some questionnaires with residents and staff at the start and at the end of the study and will look at care practices. All facilities, whether intervention or control, will be given access to the education materials when the study is complete. The results of this study may lead to new practical approaches to caring for people with memory problems in long-stay care settings.

What we guarantee

The privacy and confidentiality of staff, residents and the care centre will be safeguarded and in no way will you be identifiable in this research. Participation is strictly voluntary, and staff and residents can withdraw at any time.

Who do I contact to find out more?

Should you require any more information or have any queries, please contact the Director of Nursing, in the first instance.

Site code: Participant Code Date T1 or T2

Reminiscence Study Staff Consent Form

The Director of Nursing in the care home has suggested to us that we invite you to take part in this study. We are therefore asking you to consent to be involved in this study.

What we guarantee

Your privacy and confidentiality will be safeguarded and in no way will you be identifiable in this research. Participation is strictly voluntary, and you can withdraw from the study at any time.

Who do I contact to find out more?

Should you require any more information or have any queries, please contact the Director of Nursing.

CONSENT

This study has been explained to me and I am happy to take part.

Printed name of the staff participant

Signature of staff participant

Date

Using Reminiscence with Older People – An Important Study Begins

My name is _____, from NUI Galway. The nursing staff in this care home think that you might be interested in being part of a research study. Research is a way to test new ideas and helps us to learn new things. Our study, called the DARES study, looks at whether a training programme for staff improves how they look after people with memory problems.

So I am asking you to take part in a research study. It is your choice whether or not you wish to be in this research. You can say yes or no. Whatever you decide is OK.

What is the study about?

We have been asked to look at how the use of reminiscence affects the care of people with memory problems. Reminiscence is about talking about the past, maybe using photographs or music from the old days. We think that reminiscence may help improve the quality of your care but we are not sure and would like your help to look at this.

What will happen during this study?

Long-stay care homes who are taking part in this study will be divided into two groups. This home may be in the group where a nurse and care assistant who care for you will attend a special training programme. They will want to ask you about what matters to you, about your past and what interests you. They will use all this information to plan care that meets your needs. Or this home may be in the group where everything continues exactly as usual.

Being part of the study means that a researcher will ask you some questions and look at your care plan. We will also check your medical records to see what medication you are on. We will not intrude and at any time, you can ask us to leave if you feel uncomfortable with us being there.

The research team might decide to talk to you about the study, if that is OK with you. They will use a tape recorder to make sure they don't forget what you say. After they have typed up what is on the tape, they will get rid of the tape recording.

What else should I know about the study?

You do not have to answer or do anything if you don't want to.

What will we learn?

We hope to learn more about the best way to look after people with memory problems.

What if I don't want to be in this study?

You do not have to be in the study if you do not want to. If you don't want to be in this study, you will continue to be cared for as normal. Even if you say yes now, you can still change your mind later. You can stop being part of the study at any time. It is up to you.

Who will know I was part of this study?

If you choose to take part, what you tell me or what is observed will be held as strictly confidential. You will not be named and nothing you tell me will be reported in a way that could identify you.

Who should I ask if I have any questions?

Ask me anything you like about the study. I am here over the next few days and will check with you how you are getting on. If you have further questions, you can us call 091 495938. You should also talk to your next of kin or relative(s)/carer(s) about the study.

Site code: Participant Code Date T1 or T2

Reminiscence Study Resident Consent Form

The DARES study has been explained to me and I understand what is involved. I know that I can leave the study at any time without having to give a reason.

Participant: Date:

Time:

If the process of signing is too difficult the researcher should document here that the consent has been obtained verbally.

.....
...

If the participant is unable to give consent the following should be recorded:

In my opinion, this participant cannot give consent.

Reason(s):

.....
...

Name of researcher:Date:

Time:

Seek proxy consent if the person assents to participating in the study.

Using Reminiscence with Older People – An Important Study Begins

My name is Andrew Hunter, from NUI Galway. The nursing staff in this care home think that you might be interested in being part of a research study. Research is a way to test new ideas and helps us to learn new things. Our study, called the DARES study, looks at whether a training programme for staff improves how they look after people with memory problems. So I am asking you to take part in a research study. It is your choice whether or not you wish to be in this research. You can say yes or no. Whatever you decide is OK.

What is the study about?

We have been asked to look at how the use of reminiscence affects the care of people with memory problems. Reminiscence is about talking about the past, maybe using photographs or music from the old days. We think that reminiscence may help improve the quality of your care but we are not sure and would like your help to look at this.

What will happen during this study?

Being part of the study means that a researcher will ask you some questions, if that is OK with you. They will use a tape recorder to make sure they don't forget what you say. These interviews will be recorded and transcribed and then the audio tapes will be destroyed.

What else should I know about the study?

You do not have to answer or do anything if you don't want to.

What will we learn?

We hope to learn more about the best way to look after people with memory problems.

What if I don't want to be in this study?

You do not have to be in the study if you do not want to.

Who will know I was part of this study?

If you choose to take part, what you tell me will be strictly confidential. You will not be named and nothing you tell me will be reported in a way that could identify you.

Who should I ask if I have any questions?

Ask me anything you like about the study. If you have further questions, you can us call 091 495823.

Site code: Participant Code Date T1 or T2

Reminiscence Study Relative Consent Form

The DARES study has been explained to me and I understand what is involved.
I know that I can leave the study at any time without having to give a reason.

Participant:

Date:

Time:

Appendix 6: Long Stay Care Facility and Consent Form

DARES Information Sheet – Long-Stay Care Facility

Your long-stay care facility is invited to take part in an important research study. Before you decide, it is important that you understand why the research is being done and what it will involve. This information sheet tells you about the purpose, benefits and implications of this research study. If there is anything that you are not clear about, we will be happy to explain it to you. Thank you for reading this information.

Are all long-stay care facilities eligible to take part in DARES?

A long-stay care facility can take part in DARES provided:

- There are 17 residents with dementia in your facility who meet the study criteria and are willing to take part in the study. Previous experience indicates that we will need approximately 24-26 residents with dementia in your facility to ensure that 17 residents are available to participate in the study.
- There are at least 5 nurses and 5 healthcare assistants interested in taking part.
- A dyad (a nurse and healthcare assistant pair) will work together to offer reminiscence, so it must be possible to pair each nurse with a healthcare assistant.
- Each dyad will use reminiscence with 3 or 4 residents with dementia for the duration of the study. This means the dyad needs to work in the same unit as 3 or 4 residents with dementia who have agreed to take part in the study.

Taking Part – What it involves for your long-stay care facility

If you agree that your long-stay facility will take part in the DARES study, a research assistant will visit your facility to recruit 17 residents with dementia and 10 staff into the study. The research assistant will collect baseline data from both residents and staff and will review the care plans of participating residents. The research assistant will also look at their medical records, to see if they are on medication for memory loss.

Long-stay facilities will then be randomised into two groups: a control group, where care continues as usual, and an intervention group. If your facility is randomly selected for the intervention group, then 10 staff from your facility will attend the DARES reminiscence-based dementia education programme, delivered over 3 days in, or at a venue close to, your long-stay care facility. Each pair of staff will then use reminiscence in the care of 3 or 4 residents with dementia who have agreed to take part in the study. Ongoing support will be provided to staff in the intervention group. 20-22 weeks after randomisation, post-intervention data will be collected from your facility.

If your facility is randomly selected for the control group, where care continues as usual, then you will not receive the intervention, that is, the structured education programme, but final data will be collected from residents and staff 20-22 weeks after randomisation. All facilities, whether intervention or control, will be given access to the education materials when the study is complete.

How long is the study?

From the time we first contact you to the end of the study will be approximately 6 months.

What are the benefits of taking part?

The DARES study has the capacity to positively impact both the residents with dementia and the staff in your facility. DARES delivers a reminiscence-based dementia education programme to your staff, free of charge, in, or close to, your facility. Participation in this programme will help to up skill your staff, improve their knowledge and understanding of dementia, and improve the care delivered to residents. It will also demonstrate to the regulatory authorities, e.g. HIQA, and to potential clients and their families your commitment to training and development for the betterment of both residents and staff. It is anticipated that participation in this programme will reduce the care burden of staff caring for people with dementia.

Reminiscence can help staff to know residents better and supports the delivery of person-centred care. If the DARES intervention is successful, care staff will be able to communicate better with residents with dementia, understand more about their needs and wishes and incorporate this into their care plan.

Taking Part – What to do next?

If you would like your long-stay facility to take part in the DARES study, please sign the enclosed *Agreement to Participate* form and return in the enclosed pre-paid envelope to NUI Galway. If you have questions, please contact the project manager, Edel Murphy on 091 495938

DARES

Long-Stay Care Facility Agreement to Participate

Name:	
Title:	
Email address	
Long-stay care facility:	
	<p>I have received and read the <i>DARES Information Sheet – Long-Stay Care Facility</i>.</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>I agree that this long-stay facility will participate in the DARES study.</p> <p>Signed: _____</p>

Appendix 7: Phase 1 Interview Guides

Phase 1 Resident with Dementia Interview Guide

Note the objective of these interviews is to inform programme design.

Focus	Cue questions
Context	How does your memory problems affect you? What kind of things help? Are there any kinds of things that you do that help? (for example, keeping a diary or making notes)
Content educational programme	We are trying to write a training programme for nurses to help them to better care for people with memory problems. What kinds of things do you think staff need to know? What kind of things do you think staff need to know about you to care for you well? What do you think is important?
General	Is there anything else that I haven't asked that you think is important? Or anything else you'd like to say?

Phase 1 Staff Interview Guide A

I am Andrew Hunter from the school of Nursing and Midwifery NUIG. I am a researcher and I am interested in learning about how you care for people with dementia and about your thoughts regarding ongoing training. I am particularly interested in your emotional, psychological, social and behavioural work with people with dementia i.e. social interaction, activities and other structured or unstructured ways of helping. (**Psycho Social Interventions definition- 'psychosocial intervention is defined as a therapeutic endeavour involving human interactive behaviour between therapist(s) and client(s) throughout the course of the intervention.'**)

Caring for people with dementia is a challenging job and as you are an expert I am asking you to share your experience with me, allowing me to improve my understanding. Your responses will be used to develop my knowledge of how you work, if there are any changes you would make to the way you work, what kind of training would help and how to make that education effective and accessible?

Tell me about your experience of working with people with dementia?

- Can you tell me what issues arise around emotional, psychological, social and behavioural needs when you are working with people with dementia?
- What are the psycho-social needs of the people with dementia you work with?
- Can you describe an example of one of your patient's psycho-social needs?
- PROBE: From the example tell me what you did to address their psycho social needs?
- Is what you were able to do in this example typical or would you do other things with other patients?
- Have you any other examples of PS issues arising in the people with dementia you work with and what you do?

Can you tell me about your experience of working with the family/carers of people with dementia?

- What work do you do with family and carers to meet the PS needs of people with dementia?
- Can you describe an example of working with family and carers to meet the PS needs of a person with dementia?
- PROBE: From the example tell me how did you work with the families and carers to address the people with dementias psycho social needs?
- Is what you were able to do in this example typical or would you do other things with other patients?
- Have you any other examples of working with families and carers to meet the PS needs of people with dementia
- What are family/carers PS needs?
- Tell me what work do you do addressing family and carers PS needs?
- Can you describe an example of addressing family and carers PS needs?
- PROBE: From the example tell me what you did to address family and carers PS needs?
- Is what you were able to do in this example typical or would you do other things with other families and carers?
- Have you any other examples of addressing the PS needs of family/carers

Given your experience how do you feel about working with the psycho-social needs of people with dementia and their families/carers?

- Tell me how would you change the way you work?
- Have you specific examples of what would you do differently?
- Have you received any training that helps you work with people with dementia and their families/carers?
- What training do you think you need to work the way you want to?
- What would help you access training (is online an option)?
- What would get in the way (is travel a barrier)?

On a scale of 1-10 rate your dementia care expertise?

- Do you have experience of using PSIs?
- Do you have experience of using R?
- Do you know anyone who has used PSIs or R?

Summarise- check for understanding

Is there anything else you think is important about working with people with dementia, their family/carers that we have not discussed? **Complete Demographic Sheet**

Phase 1 Staff Interview Guide B

I am Andrew Hunter from the school of Nursing and Midwifery NUIG. I am a researcher and I am interested in learning about how you care for people with dementia and about your thoughts regarding ongoing training. I am particularly interested in your experience of and expertise in emotional, psychological, social and behavioural work with people with dementia i.e. social interaction, activities and other ways of helping. Your responses will be used to develop my knowledge of how you work, if there are any changes you would make to the way you work, what kind of training would help and how to make that education effective and accessible?

Context and demographic Information

- How many residents are there in this unit/home?
- How many have dementia?
- Do these residents have a diagnosis?
- How is the diagnosis arrived at?

Definitions/understanding of reminiscence

- What is a psychosocial intervention
- Do you use any psychosocial interventions with people with dementia (for example music, arts and crafts, life story books, story telling)?
- What do you understand by reminiscence? Do you use reminiscence with people with dementia? How is it used?

Tell me about your experience of working with people with dementia?

- **(4 questions behaviour last)** Can you tell me what big issues arise around **emotional, psychological, social and behavioural** needs when you are working with people with dementia?
- How do you usually manage disruptive behaviour, for example, agitation, persistent wandering?
- What are the psycho-social needs of the people with dementia you work with?
- Can you describe an example of one of your patient's psycho-social needs?
- **PROBE:** From the example tell me what you did to address their psycho social needs?
- Is what you were able to do in this example typical or would you do other things with other patients?
- Have you any other examples of PS issues arising in the people you work with and what you do?
- What would you describe as the focus of care?
- How would you describe care? e.g. task centred, individualised, person centred, routinised.
- Is there an individualised plan of care for each resident?

Can you tell me about your experience of working with the family/carers of people with dementia?

- What work do you do with family and carers to meet the PS needs of people with dementia?
- Can you describe an example of working with family and carers to meet the PS needs of a person with dementia?
- **PROBE:** From the example tell me how did you work with the families and carers to address the people with dementias psycho social needs?
- Is what you were able to do in this example typical or would you do other things with other patients?
- Have you any other examples of working with families and carers to meet the PS needs of people with dementia

Educational needs

- Given your experience of working with people with dementia-specifically their PS needs- what would you like to do differently? Have you specific examples of what would you do differently?
- What would you like to see included in a programme for staff aimed at helping you to care better for people with dementia? What do you need to know?
- What do you need to be able to do?
- What do you think is the most important area of content for an education programme?
- Have you received any training that helps you work with people with dementia and their families/carers?
- What training do you think you need to work the way you want to?
- What would help you access training (is online an option)?
- What would get in the way (is travel a barrier)?
- On a scale of 1-10 rate your dementia care expertise?

Is there anything else you think is important about working with people with dementia, their family/carers that we have not discussed? **Complete Demographic Sheet**

Appendix 8: Phase 2 Interview Guides

Phase 2 Staff Interview Guide A

I am Andrew Hunter from the school of Nursing and Midwifery NUIG. I am a researcher and I am interested in learning about how you work with people with dementia and about your thoughts regarding ongoing training. I am particularly interested in your experience of and expertise in emotional, psychological, social and behavioural work with people with dementia i.e. social interaction, activities and other ways of helping. Your responses will be used to develop my knowledge of how you work.

Skills

- When do you get to do 1:1 work with people with dementia
- What difficulties (comms/behaviour) r u working with
- What do you do to deal with these difficulties
- Does knowing the persons background help
- How do you know about the person
- How do you share what you know (past Hx and things that work) with other staff
- How do you know what you are doing works? (look out for compliance)
- Does anyone tell you that you are doing a good job
- How do group activities help you do your job

Attributes

- What personal qualities do you think it takes to work with people with dementia?
- What do you do particularly well when working with people with dementia?
- Have you worked with anyone who is really good at working with people with dementia?
Why were they good?
- Did your training prepare you to work with people with dementia
- Do you think attributes or training are more important

Educational Proclivity

- Given your experience of working with people with dementia-specifically their PS needs- what would you like to do differently?
- What would you like to see included in a programme for staff aimed at helping you to care better for people with dementia? What do you need to know?
- What training do you think you need to work the way you want to?

Environmental/ Managerial Context

- How does the team and your manager help you to work effectively
- Do you get critiqued if things go wrong
- Do you get encouraged if things go badly
- Is education supported

Is there anything else you think is important about working with people with dementia, their family/carers that we have not discussed? **Complete Demographic Sheet**

Phase 2 Staff Interview Guide B

I am Andrew Hunter from the school of Nursing and Midwifery NUIG. I am a researcher and I am interested in learning about how you work with people with dementia and about your thoughts regarding ongoing training. I am particularly interested in your experience of and expertise in emotional, psychological, social and behavioural work with people with dementia i.e. social interaction, activities and other ways of helping. Your responses will be used to develop my knowledge of how you work.

Skills

- When do you get to do 1:1 work with people with dementia
- What difficulties (comms/behaviour) r u working with? What do you do to deal with these difficulties
- Does knowing the persons background help
- How do you know about the person
- How do you share what you know (past Hx and things that work) with other staff
- How do you know what you are doing works? (look out for compliance)
- Does anyone tell you that you are doing a good job
- How do group activities help you do your job

Attributes

- What personal qualities do you think it takes to work with people with dementia?
- What do you do particularly well when working with people with dementia?
- Have you worked with anyone who is really good at working with people with dementia? **Why were they good?**
- Did your training prepare you to work with people with dementia
- Do you think attributes or training are more important

Educational Proclivity

- Given your experience of working with people with dementia-specifically their PS needs- what would you like to do differently?
- What would you like to see included in a programme for staff aimed at helping you to care better for people with dementia? What do you need to know?
- What training do you think you need to work the way you want to?

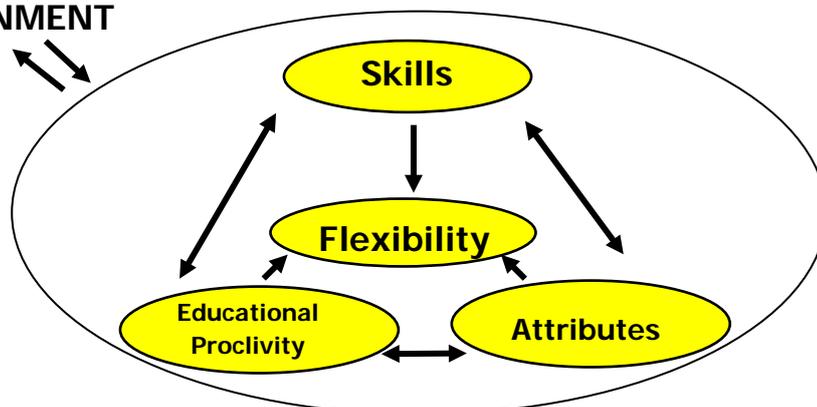
Environmental/ Managerial Context

- How does the team and your manager help you to work effectively
- Do you get critiqued if things go wrong? Do you get encouraged if things go badly?
- Is education supported

Is there anything else you think is important about working with people with dementia, their family/carers that we have not discussed?

Kindness, patience, knowledge of dementia and time. I need to be looking out for these and thinking again and again how do they fit into my model

ENVIRONMENT



Appendix 9: Phase 3 Resident with Dementia, Staff, Manager and Relative Interviews

DARES

Phase 3 Resident with Dementia Interview Guide

Note to interviewer:

The aim of the staff interviews is to identify residents' interests, how staff reminisced with residents (e.g. used a memory box, used pictures or talked) and what staff perceive to have made most difference to the person.

(Staff name) has been working to get to know you a little better over the last few weeks. S/he will have asked you to tell him/her a little about your life, what is important to you and what interests you. I am interested in talking to you about how you found that.

What kind of things has (staff name) done to get to know you better?

Did you enjoy talking to (staff name) about your life?

Are staff talking to you about the things you are interested in? (Prompt using examples given in staff interview, for example, likes to talk about the seaside, interested in farming). Do you enjoy talking about (example)?

Are staff doing ... ? (Prompt using examples given in staff interviews, for example, hand massage, watching videos, going for a walk) Do you enjoy this?

Are staff doing anything different? (Prompt time you go to bed, get up in the morning, things you like to eat, things you like to do, talking to you more)

Has anything changed? (Prompt how staff talk to you, time staff spend with you, what staff do)

Do you feel you can ask for more time with staff?

Do you get enough time with staff to talk (if not why not?)

Anything else you'd like to tell us?

Phase 3 Staff Interview Guide

How have you used reminiscence with residents? Could you tell me what you did? How did residents respond? (Seek specific examples in relation to each resident allocated to the registered nurse/health care assistant).

Has reminiscence, particular collecting the person's life history, helped you to know the person better? (Seek specific examples in relation to each resident allocated to the registered nurse/health care assistant).

Has knowing more about the person impacted on how you understand or respond to them? (Seek examples in relation to each resident allocated to the registered nurse/health care assistant).

Has knowing more about the person impacted on how you care for them? (Seek examples in relation to each resident allocated to the registered nurse/health care assistant).

Has knowing more about the person impacted on how other staff understand or respond to them? (Seek examples in relation to each resident allocated to the registered nurse/health care assistant).

Has knowing more about the person impacted on how other staff care for them? (Seek examples in relation to each resident allocated to the registered nurse/health care assistant).

Has knowing more about the person changed the person's quality of life? (Seek examples).

How have you found introducing reminiscence to your setting? **Will you continue using reminiscence beyond the study?**

What made RT Hard/easy to use?

Has the time and effort to get life histories and do reminiscence paid off? (differentiate between Life Hx, formal, informal)

Do you differentiate between the ways HCAs and SNs use RT?

How would you change the training?

Anything else you'd like to tell us?

DARES

Phase 3 Interview Manager

How have your staff used reminiscence with residents? Could you tell me what you/they did? How did residents respond? (Seek specific Examples).

Can you tell me what the overall impact of DARES has been. (staff/residents)

Have staff used continued to use reminiscence? (if not why not?)

Where they have continued to use it how has it been used (seek examples)

Has use of DARES reminiscence, particular collecting the person's life history, helped staff to know the person better? (Seek specific examples).

Should staff continue to use it? If yes, what would support the continued use? If no, why not?

Has knowing more about the person impacted on how other staff care for them? (Seek examples). How is information shared with other staff?

Has knowing more about the person changed the person's quality of care? (Seek examples).

How have you found introducing reminiscence to your setting? Will you continue using reminiscence beyond the study?

Has the time and effort to get life histories and do reminiscence paid off? (differentiate between Life Hx, formal, informal)

Do you differentiate between the ways HCAs and SNs use RT?

How would you change the training (content, organisation, any aspect)?

In your opinion is it worth continuing to use reminiscence? If yes, what would facilitate that? If not why not?

How will you get staff to keep doing RT?

Anything else you'd like to tell us?

DARES

Relative Interview Guide

How have the staff caring for your relative used reminiscence with them? Could you tell me what you/they did? How did residents respond? (Seek specific Examples).

Can you tell me what the overall impact of DARES has been. (you/staff/residents)

Have staff used continued to use reminiscence? (if not why not?)

Where they have continued to use it how has it been used (seek examples)

Has use of DARES reminiscence, particular collecting the person's life history, helped staff to know your relative better? (Seek specific examples).

Should staff continue to use it? If yes, what would support the continued use? If no, why not?

Has knowing more about the person impacted on how other staff care for them? (Seek examples). How is information shared with other staff?

Has staff knowing more about your relative changed their quality of care? (Seek examples).

How have you found the introduction of reminiscence to your setting? Will the staff?continue using reminiscence beyond the study?

Has staff and your time and effort to get life histories and do reminiscence paid off? (differentiate between Life Hx, formal, informal)

Do you differentiate between the ways HCAs and SNs use RT?

How would you change staff training (content, organisation, any aspect)?

In your opinion is it worth continuing to use reminiscence? If yes, what would facilitate that? If not why not?

How would you get staff to keep doing RT?

Anything else you'd like to tell us?

Appendix 10: Ethical Approval Letter



National University of Ireland, Galway
Ollscoil na hÉireann, Gaillimh

20th November 2008
Ref: 08/SEP/05

Professor Eamon O'Shea
Irish Centre for Social Gerontology
Top Floor, Cairnes Building
NUI Galway

RE: Ethical Approval for "The impact of a Dementia Education Reminiscence Programme for Staff on the agitated behaviours of residents with dementia, their quality of life and on staff attitudes towards residents with dementia and perceived care burden. (DARES project)"

Dear Prof O'Shea

I write to you regarding the above proposal which was submitted for Ethical review. Having reviewed your response to my letter, I am pleased to inform you that your proposal has been granted **APPROVAL**.

All NUI Galway Research Ethics Committee approval is given subject to the Principal Investigator submitting an annual report to the Committee. The first report is due on or before 30th September 2009. Please see section 7 of the REC's Standard Operating Procedures for further details which also includes other instances where you are required to report to the REC.

Yours Sincerely

A handwritten signature in blue ink, appearing to read "Saoirse Nic Gabhainn".

Dr Saoirse Nic Gabhainn
Chairperson
Research Ethics Committee



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE West,
Mid-Western Regional Hospital,
Dooradoyle,
Limerick, Ireland

Tel: 00353 (0) 61 301111
Fax: 00353 (0) 61 301165
Website: www.hse.ie

20th May, 2010.

Ms. Edel Murphy,
DARES Project Manager,
School of Nursing & Midwifery,
National University of Ireland,
GALWAY.

Re: Protocol Title
The DARES study: A cluster randomised trial on the effectiveness of a structured education reminiscence-based programme for staff on the quality of life of residents with dementia in long-stay unit.

Dear Ms. Murphy,

I wish to thank Dr. Declan Devane and Dr. Adeline Cooney for attending the Research Ethics Committee meeting on the 19th May, 2010 in connection with your study.

I wish to advise that the Committee has now approved your study. However, you should note that your study cannot commence until you also receive Risk Management approval. This approval will be issued to you shortly.

You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

I wish you every success in your study.

Yours sincerely,

Marie Hickey Dwyer,
Consultant Ophthalmic Surgeon,
Chairperson, Ethics Research Committee.



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE West,
Mid-Western Regional Hospital,
Dooradoyle,
Limerick, Ireland.

Tel: 00353 (0) 61 301111
Fax: 00353 (0) 61 301165
Website: www.hse.ie

03rd June 2010

Ms. E. Murphy
DARES Project Manager,
School of Nursing & Midwifery,
NUI,
Galway.

Re: Protocol Title
The DARES Study: A cluster randomised trial on the effectiveness of a structured education reminiscence-based programme for staff on the quality of life residents with dementia in long stay unit

Dear Ms. Murphy,

The Ethics Research Committee at the Mid-Western Regional Hospital, Limerick has received a submission for ethical approval for the above study.

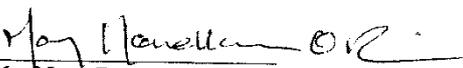
The following documents were reviewed and approved by the Ethics Research Committee:

<i>Application to the Research Ethics Committee</i>	<i>Approved</i>
<i>Participant Consent Sheet</i>	<i>Approved</i>
<i>Participant Next of Kin Consent Sheet</i>	<i>Approved</i>
<i>Participant Questionnaire</i>	<i>Approved</i>
<i>Participant Information Sheet</i>	<i>Approved</i>
<i>Staff Consent Sheet</i>	<i>Approved</i>

This approval is valid for one year from the date(s) accepted above unless otherwise noted on this document.

From an insurance perspective, please note that cover does not extend to those parties not employed by the Health Service Executive (HSE), or non-HSE Institutions.

Yours sincerely,


Ms. Mary Donnellan O'Brien
Business Manager, Medical Directorate,
(For and on behalf of the Ethics Research Committee)



Reidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Research Ethics Committee
Sligo General Hospital
The Mall
Sligo
Chairman Dr. John Williams
Adm. Mette Jensen Kavanagh

Prof. Eamonn O'Shea
ICSG
Top Floor
Cairnes Building
NUI Galway
Galway

June 9th 2010

Re. Research Ethics Application

Dear Prof. O'Shea,

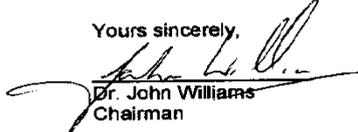
The Research Ethics Committee (REC) at Sligo General Hospital has received the revised submission of the study *"The DARES study: A cluster randomised trial on the effectiveness of a structured education reminiscence-based programme for staff on the quality of life of residents with dementia in long-stay units"*, which was first reviewed at the REC meeting May 19th 2010. The revisions / clarifications meet the requirements of the REC and the REC Chairman has given a **favourable ethical opinion** for the above study.

Documents reviewed:

- REC Application Form
- Protocol
- Principal Investigator C.V.
- RCT Staff Information Sheet version 4, June 1 2010
- RCT Staff consent form version 4, June 1 2010
- RCT Long stay facility information sheet version 6, June 1 2010
- RCT Long stay facility consent form version 6, June 1 2010
- Relative information sheet version 4, June 1 2010
- Relative proxy consent form, version 4, June 1 2010
- RCT Resident information sheet, version 4, June 1 2010
- RCT Resident consent/assent form, version 4, June 1 2010
- Letter to REC dated June 3rd 2010
- Insurance Certificate
- Interview guides, staff & residents

The REC requires that approved studies submit an annual report to the REC. The annual report for the above study is due on May 19 2011.

Yours sincerely,



Dr. John Williams
Chairman

cc. Edel Murphy, DARES Project Manager, School of Nursing and Midwifery, NUI Galway



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
KB/MH

Western Area,
Health Service Executive,
Mayo General Hospital,
Castlebar,
Co. Mayo,
Ireland.

Tel: (094) 9042000
Fax: (094) 9021454

Dictated: 4th July 2010
Typed: 13th July 2010

**Ms. Edel Murphy,
DARES Project Manager,
School of Nursing and Midwifery,
National University of Ireland,
Galway.**

Rc: A cluster randomized trial on the effectiveness of a structured education reminiscence-based programme for staff on the quality of life of residents with dementia in long-stay units.

Dear Ms. Murphy,

This letter will confirm that the DARES research proposal was considered at our Hospital Research Ethics Committee Meeting which took place on Monday, 31st May 2010. I am writing to confirm that our Committee has granted ethical approval for the research study to take place at Mayo General Hospital and affiliated hospitals in County Mayo.

Our Committee felt that it was important that the next of kin should be involved in the consent process where appropriate.

You may wish to correspond therefore with two people in particular. I might suggest Dr. Elaine Walsh, Consultant for Old Age Psychiatry. I also mention the name of Ms. Marian Kilcoyne, Clinical Nurse Manager, Grade 3 who is in charge of St. Ann's Unit at the Sacred Heart Hospital in Castlebar.

If you have any further questions or concerns, please feel free to contact me at Mayo General Hospital.

Many thanks.

Yours sincerely,

**Mr. Kevin Barry, MD, F.R.C.S.I. (Gen Surg), F.A.C.S.
Consultant Surgeon.**



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



University Hospital Galway
Ospidéal na h-Ollscoile, Gaillimh
GALWAY UNIVERSITY HOSPITALS

Clinical Research Ethics Committee
Unit 4
Merlin Park Hospital
Galway.

23rd July, 2010.

Professor Eamon O'Shea
Director Irish Centre for Social Gerontology
ICSG
Cairnes Building
NUI
Galway.

Ref: 11/10 - The DARES study: A cluster randomized trial on the effectiveness of a structured education reminiscence-based programme for staff on the quality of life of residents with dementia in long-stay units

Dear Professor O'Shea,

The above project was considered and approved at the Clinical Research Ethics Committee meeting on Wednesday 21st July, 2010.

Yours sincerely,

Dr. Shaun T. O'Keeffe
Chairman Clinical Research Ethics Committee.

c.c. Ms. Edel Murphy, DARES Research Project Manager, School of Nursing & Midwifery, National University of Ireland, Galway.

University Hospital Galway, OSPIDÉAL NA H-OLLSCOILE, GAILLIMH,
Galway, Ireland. Tel: 00 353 (0)91 524222 / 544544

Research Ethics Committee
HSE – Midland Area
HSE Area Offices
Arden Road
Tullamore
Co. Offaly

Telephone: 057 9359894 Fax: 057 9359906

10th December 2010

Ref: 051010EOS

Professor Eamon O'Shea
Irish Centre for Social Gerontology
National University of Ireland
University Road
Galway
Co. Galway

Re: DARES study (Dementia Reminiscence-based Education programme for Staff)

Dear Prof. O'Shea,

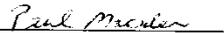
Thank you for your correspondence in relation to the above research proposal that was received on the 16th of November.

Please accept my apologies in the delay in getting a response to you. The Chairperson has reviewed your clarifications and is now satisfied that all ethical considerations have been met.

Therefore, I am pleased to inform you that research ethical approval has been granted to the above piece of work.

Wishing you all the best with your research.

Yours Sincerely,

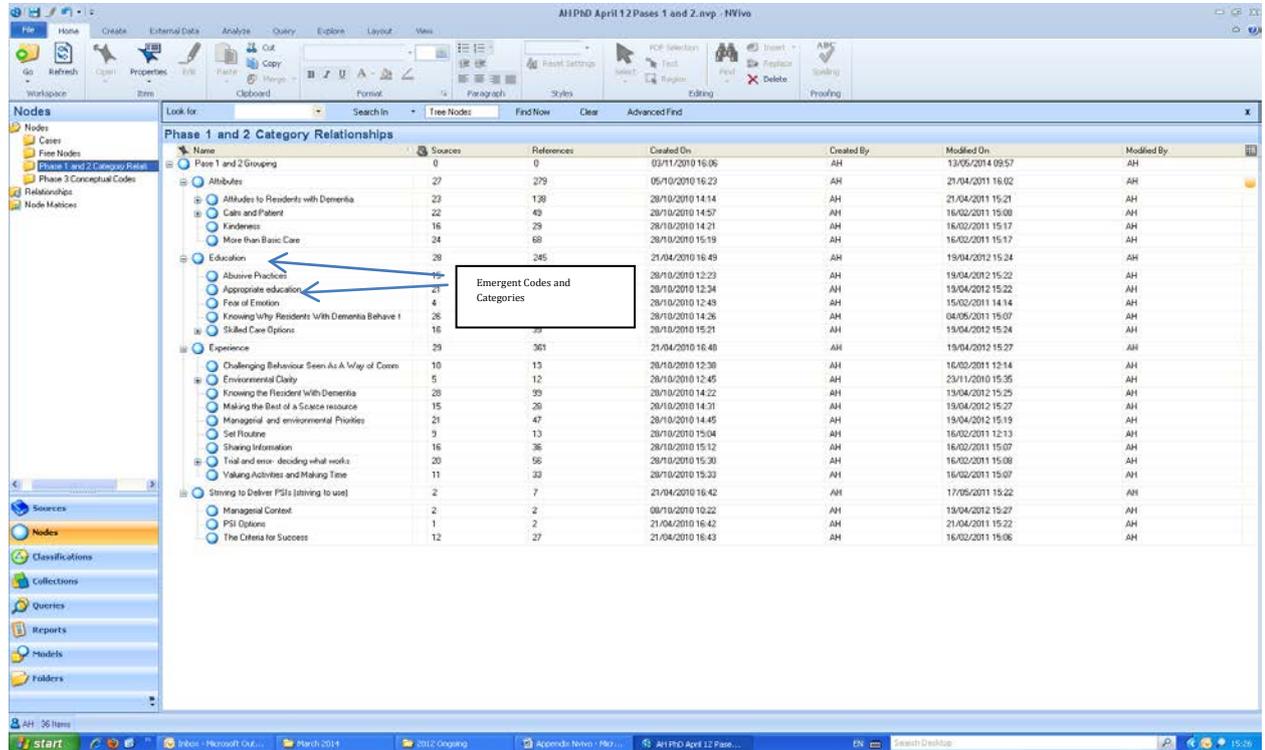

Paul Marsden
Secretary – Research Ethics Committee
On behalf of
Dr. Una Fallon
Chairperson – Research Ethics Committee

A favourable ethics review from the Research Ethics Committee (REC) is not the same as permission from the relevant HSE manager to proceed with the study. Authorisation from HSE management must be sought separately.

Appendix 11: Examples of NVivo Category Structure and Hierarchy

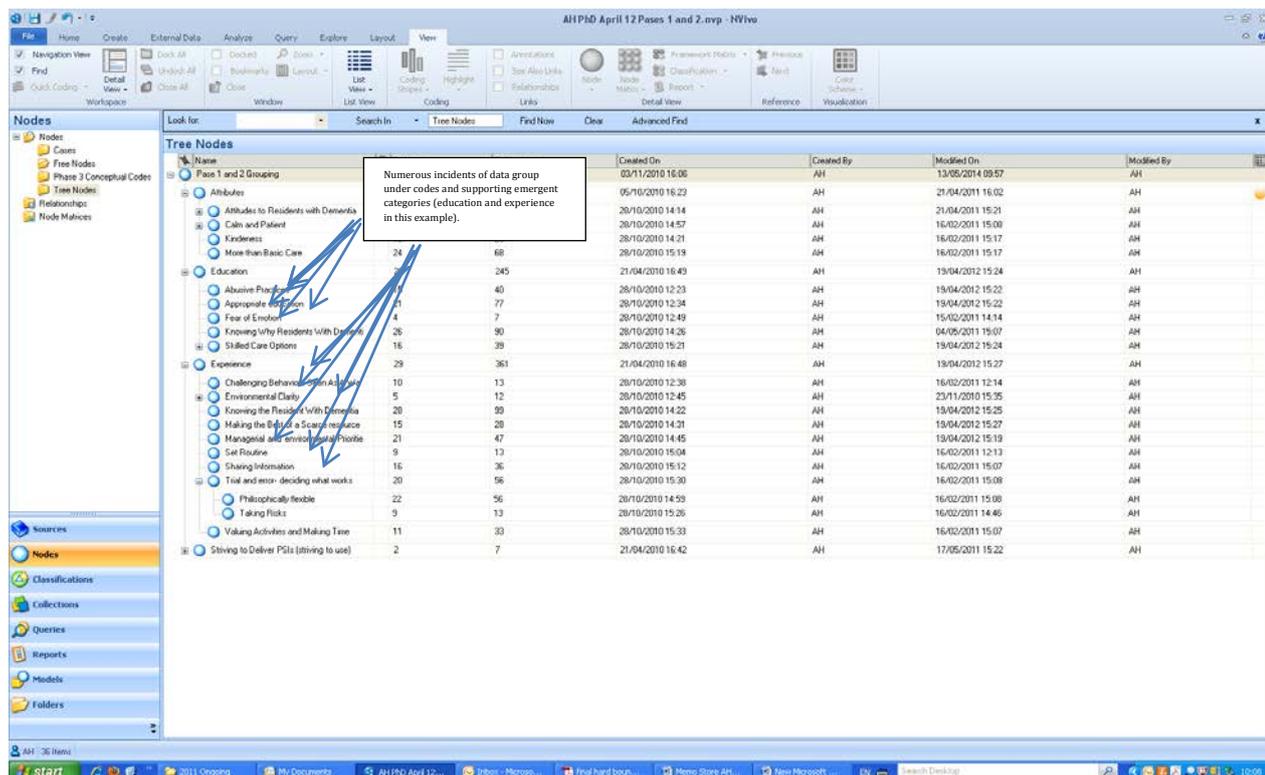
Phase 1 and 2 Conceptual Categories in Tree Nodes

Codes were developed based on the emergent code-category relationship emerging from constant comparison of data and memos.



Phase 1 and 2 Open Codes and Categories in 'Child' and 'Parent' Nodes

Open codes for Phases 1 and 2 shown supporting their categories.



Start of Phase 3 Conceptual Categories and Memo

Illustration of the relationship and coding for Phase 3 categories and 'becoming a person again'. With inserted memo showing 'interpreting care' conceptualisation.

Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
Resolving the main concern (strivingApplication)	26	92	24/10/2012 12:09	AH	10/12/2012 12:49	ANDREW
Integrating Care	30	93	24/10/2012 12:10	AH	13/06/2014 13:30	AH
Institutional and Personal Categories (balancing the influences)	28	72	24/10/2012 12:08	AH	15/05/2014 15:33	AH
Using Education (P)	16	32	17/01/2013 11:14	AH	04/04/2013 13:43	AH
Intervention Availability (P)	11	19	17/01/2013 11:17	AH	25/03/2013 12:29	AH
Institutional Directing (P)	11	21	17/01/2013 11:07	AH	17/01/2013 11:54	AH
Experiencing Care (P)	5	13	17/01/2013 11:14	AH	04/04/2013 13:45	AH
Determining Success (P)	9	11	17/01/2013 11:06	AH	17/01/2013 11:55	AH
Caring Attributes (P)	6	8	17/01/2013 11:06	AH	17/01/2013 11:49	AH
Individualizing Status	30	70	24/10/2012 12:09	AH	13/05/2014 13:31	AH
Becoming a Person Again	29	91	24/10/2012 12:10	AH	10/12/2012 12:50	ANDREW

Memo 25/07/2011- 'Interpreting' Relatives

Relatives would appear to be as likely as staff to take a 'stance' on what is being done, (PSI use). For example 1 relative spent the interview pushing for change and improvement while relatively happy and philosophical about the care (her rationalization was to be good by always pushing for improvement). Another relative was very clear that the care was good and the staff were using her to benefit her relatives care, but was also desperate to confirm that the care of her relative (that she was choosing to have) was of the finest quality (her interpretation was that she will support the staff who are carrying out her will).

Phase 3 Full Code-Category Relationship

Using tree nodes, conceptual category related in hierarchy with supporting categories and codes. This reflects the conceptual process as data is coded, sorted into categories and related to the higher level concepts and core category. The '-' sign denotes the relationship between concepts.

Phase 3 Conceptual Codes

Name	Sources	References	Created On	Created By	Modified On	Modified By
Striving to Deliver PSIs (striving to use)	2	7	24/10/2012 12:57	AH	17/05/2011 15:22	AH
The Culture for Success	92	92	24/10/2012 12:57	AH	16/02/2011 15:06	AH
PSI Delivery	11	33	24/10/2012 12:57	AH	21/04/2011 15:22	AH
Managerial Control	20	56	24/10/2012 12:57	AH	19/04/2012 15:27	AH
PSI Options	9	13	24/10/2012 12:57	AH	16/02/2011 15:08	AH
Managerial Context	22	56	24/10/2012 12:57	AH	16/02/2011 15:08	AH
Sharing Information	16	36	24/10/2012 12:57	AH	16/02/2011 15:07	AH
Set Routine	5	13	24/10/2012 12:57	AH	16/02/2011 12:13	AH
Managerial and environmental Priorities	21	47	24/10/2012 12:57	AH	13/04/2012 15:13	AH
Making the Best of a Scarce resource	15	28	24/10/2012 12:57	AH	13/04/2012 15:27	AH
Knowing the Resident With Dementia	20	39	24/10/2012 12:57	AH	13/04/2012 15:25	AH
Environmental Clarity	5	12	24/10/2012 12:57	AH	23/11/2010 15:35	AH
Focus on Physical Care	22	42	24/10/2012 12:57	AH	16/02/2011 14:10	AH
Challenging Behaviour Seen As A Way of Communicating	10	13	24/10/2012 12:57	AH	16/02/2011 12:14	AH
Education	28	245	24/10/2012 12:37	AH	19/04/2012 15:24	AH
Skilled Care Options	16	39	24/10/2012 12:37	AH	19/04/2012 15:24	AH
Options Other Than drugs	13	26	24/10/2012 12:37	AH	15/02/2011 14:51	AH
Knowing Why Residents With Dementia Behave the Way They Do	26	90	24/10/2012 12:37	AH	04/05/2011 15:07	AH
Fear of Enolion	4	7	24/10/2012 12:37	AH	15/02/2011 14:14	AH
Appropriate education	21	77	24/10/2012 12:37	AH	13/04/2012 15:22	AH
Abusive Practices	15	40	24/10/2012 12:37	AH	13/04/2012 15:22	AH
Attributes	27	279	24/10/2012 12:56	AH	21/04/2011 16:02	AH
More than Basic Care	24	68	24/10/2012 12:56	AH	16/02/2011 15:17	AH
Kindness	16	29	24/10/2012 12:56	AH	16/02/2011 15:17	AH
Calm and Patient	22	49	24/10/2012 12:56	AH	16/02/2011 15:08	AH
Giving time and space	14	35	24/10/2012 12:56	AH	21/04/2011 16:02	AH
Attitudes to Residents with Dementia	23	138	24/10/2012 12:56	AH	21/04/2011 15:21	AH
Wanting to do the Work	17	36	24/10/2012 12:56	AH	16/02/2011 15:18	AH
Empathy	11	21	24/10/2012 12:56	AH	21/04/2011 15:21	AH

'Balancing the influences' categories grouped by their many supporting codes.