

# Experiences of healthcare assistants working with clients with dementia in residential care homes

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## 1. Abstract

The study aimed to explore the experiences of healthcare assistants working with people with dementia in UK residential care homes. Eight participants completed semi-structured interviews which were analysed by Interpretative Phenomenological Analysis. Data analysis revealed three main themes representing healthcare assistants' experiences: *the importance of relationships*, which referred to the importance of their relationships with clients, families and colleagues as well as their attachment to clients; *something special about the role*, which referred to their perception that their role was unique and rewarding as well as their personal commitment to the job; and *the other side of caring*, which referred to the more difficult aspects of their role, including managing emotions and conflicts within the caring role. The findings indicate that staff should be supported to build strong and supportive relationships within their role and have opportunities to explore their emotional reactions to reduce any adverse impact on care provision. It is possible that this could be facilitated through reflective practice groups or clinical supervision.

**Keywords:** Dementia, experiences, healthcare assistants, residential care homes

## **2. Introduction**

### **2.1 Dementia Context**

There are approximately 800,000 people with dementia in the United Kingdom (UK); a figure which is expected to rise to over 1 million by 2021 (Alzheimer's Society, 2012). In 2008-09, the majority of people with dementia receiving social care services were community-based, with 28% in residential care and 14% receiving nursing care (The Health Foundation, 2011). UK residential care homes provide 24 hour care and support including help with washing, dressing, eating and toileting; with nursing care homes offering 24 hour medical care provided by a qualified nurse in addition to this (Care Quality Commission (CQC), 2016). Bupa, the UK's leading dementia care provider (Bupa, 2016) saw the proportion of people with dementia in their care homes rise from 36% in 2003 to almost 44% in 2009 (Lievesley, Crosby & Bowman, 2011); while a more recent report estimated that more than 80% of care home residents have dementia or significant memory problems (Alzheimer's Society, 2013b).

### **2.2 Quality of Dementia Care**

Improving the quality of care for people with dementia has recently gained priority in the UK healthcare agenda in light of reports highlighting the gap between the existing care provision and high-quality care as indicated by research evidence (The Health Foundation, 2011). However, despite improvements in quality of care being advocated, it has been acknowledged that the health and social care system struggles to provide adequate care for people with dementia (CQC, 2013). In 2013 the findings of a public inquiry commissioned by the UK Government into serious failings at a UK National Health Service (NHS) Trust were

published following widespread media coverage regarding substandard care provision. One of the recommendations outlined called for “an increased focus on a culture of compassion and caring” (Francis, 2013, p.76). Although this enquiry did not focus specifically on the care of people with dementia, the authors acknowledged the potential implications for other sectors (Francis, 2013). Indeed, a recent UK Government Department of Health (DOH) document outlined their vision of high quality, compassionate, person-centred care for people with dementia (UK Government DOH, 2015).

The Alzheimer’s Society argue that staff caring for people with dementia must have sufficient training and support in order to provide good care (Alzheimer’s Society, 2013a). Furthermore, the UK Government have outlined principles for supporting people with dementia, including the importance of ensuring that staff are well trained and supported to meet their needs (UK Government DOH, 2011). However, an independent review of staffing in UK NHS and social care settings found that staff qualifications varied greatly, with almost 40% of staff delivering direct care not having a relevant qualification (Cavendish, 2013). Nevertheless, in April 2015 The Care Certificate was introduced; outlining a set of standards for UK health and social care staff designed to ensure they have necessary skills and knowledge to provide high quality care and support; including training in dementia awareness (Skills for Health, 2016). Whilst its implementation remains ongoing arguably it is important to understand the experiences of staff working with people with dementia to determine what further training or support should be offered.

### **2.3 Experiences of Staff Working with People with Dementia**

Care staff working with people with dementia are recognised as having a demanding role (Edvardsson, Sandman, Nay & Karlsson, 2008); with research indicating that it can impact on

staff psychological well-being. For example, researchers in one study outlined that care staff can face stressors including uncooperative or unappreciative clients, families requiring emotional support and working with inexperienced colleagues or in understaffed services; and found that stress, as measured by the Work Stress Inventory, was more often reported by male workers, younger workers and those who had worked for 1-2 years as opposed to longer (Zimmerman et al., 2005). Another study found that approximately 20% of dementia care staff working in NHS facilities and private residential and nursing homes were experiencing psychological distress as measured by the General Health Questionnaire (GHQ-28); with care assistants less likely than nurses to use positive coping strategies such as active coping and planning (Margallo-Lana et al., 2001). A more recent study employing the Caregiver Stress Inventory found moderate levels of stress among staff working with people with dementia in long-term care facilities (Park, 2010). Furthermore, in an American study 61% of unlicensed staff working with people with dementia found the behavioural and psychological symptoms of dementia upsetting and/or bothersome to some degree (McKenzie, Teri, Pike, LaFazia & van Leynseele, 2012).

Another study measured staff burnout using the Mashlan Burnout Inventory whereby participants rate their feelings towards different aspects of their role. The authors found moderate levels of burnout among staff working with people with dementia and highlighted that burnout can impact on staff behaviour towards residents (Duffy, Oyeboode & Allen, 2009). Additionally, Edvardsson et al (2008) found four significant predictors of job strain in nursing staff caring for older people with dementia, including education level, staff age, perceived caring climate and opportunities to discuss difficulties. The authors of these studies concluded that preventing high job strain among staff and improving the quality of

their working lives was important not only for staff well-being but for improving the quality of care provision (Edvardsson et al., 2008; Duffy et al., 2009). However, Brodaty, Draper and Low (2003) found that more than 30% of nursing home staff in their sample felt they had insufficient opportunity to discuss the psychological stress of their role, while more than 55% felt they knew too little about dementia. Arguably, these findings further highlight the importance of staff training and support to ultimately improve quality of care for people with dementia.

## **2.4 Study Rationale**

Existing literature in this area has primarily employed quantitative methodologies. However, there is a need for research utilising qualitative methodology to further explore care staff experiences in order to inform efforts to support them to provide high quality care to people with dementia. Since previous research suggests that less educated staff experience higher levels of strain (Edvardsson et al., 2008) and are less likely to use positive coping strategies (Margallo-Lana et al., 2001), this study explores the experience of healthcare assistants without a nursing qualification. Furthermore, since more people with dementia live in residential care homes than in nursing homes, this study focuses on the experiences of staff in residential care settings.

## **2.5 Aim**

The study aimed to explore the experiences of healthcare assistants working with people with dementia in UK residential care homes.

### 3. Method

#### 3.1 Research Design

Due to the paucity of research addressing the experiences of healthcare assistants working with people with dementia in residential care homes a qualitative research design was utilised. Interpretative Phenomenological Analysis (IPA) was selected as the method of analysis as it offers a phenomenologically focused approach to the interpretation of detailed, reflective, first-person accounts (Larkin & Thompson, 2012). Researchers using IPA firstly aim to understand and describe their participants' world; and then to develop a more interpretative analysis in relation to the wider social, cultural and theoretical context (Larkin, Watts & Clifton, 2006). This research design was deemed appropriate due to the exploratory nature of the research and its focus on the lived experience of this staff group.

#### 3.2 Participants

Participants were recruited from three residential care homes providing 24-hour care using the eligibility criteria outlined in Table 1.

**Table 1. Participant Inclusion and Exclusion Criteria**

Inclusion Criteria	i)	Healthcare Assistant or equivalent
	ii)	Currently working with clients with dementia
	iii)	Currently working in a residential care home
	iv)	At least 18 years of age
Exclusion Criteria	i)	Non-English speaking
	ii)	Has a UK recognised nursing qualification

Two participants were initially recruited for a pilot study and a further eight were recruited for the main study. All participants were White British females whose first language was English. All had a minimum National Vocational Qualification (NVQ) Level 2 in Health and Social Care. Further participant details are provided in Table 2.

**Table 2. Participant Details**

<b>Participant</b>	<b>Age</b>	<b>Length of Experience Caring for Clients with Dementia</b>	<b>Average Working Hours per Week</b>
<b>P1</b>	42	5 years 2 months	Not recorded
<b>P2</b>	56	17 years	35
<b>P3</b>	39	2 years	19.5
<b>P4</b>	49	9 years 1 month	32.5
<b>P5</b>	20	2 years 1 month	28
<b>P6</b>	Not specified	14 years	32.5
<b>P7</b>	20	1 year 11 months	37
<b>P8</b>	32	18 years 7 months	36
<b>Average</b>	<b>36</b>	<b>8 years 7 months</b>	<b>31.5</b>

### **3.3 Procedure**

#### **3.3.1 Ethical Procedures**

Ethical approval was gained from Coventry University Ethics Committee. The research was conducted with adherence to the British Psychological Society (BPS) Code of Ethics and Conduct (BPS, 2009) and Code of Human Research Ethics (BPS, 2010).

### **3.3.2 Pilot Study**

A pilot study was conducted prior to the main data collection. A semi-structured interview schedule was designed to ask broad open questions about participants' experiences of working with people with dementia. It was audio-recorded, transcribed verbatim and the data were analysed using thematic analysis; a "method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.79).

### **3.3.3 Materials**

A semi-structured interview schedule for the main study was devised based on the research aim, existing literature and the themes identified in the pilot study. In line with IPA recommendations questions were designed to encourage participants to talk at length with minimal input from the researcher (Smith, Flowers & Larkin., 2009). They aimed to elicit both positive and negative experiences of working with people with dementia as well as experiences regarding particular salient aspects of their work identified through the pilot study.

### **3.3.4 Recruitment**

The researchers wrote to managers of five local residential care homes and contacted them two weeks later to discuss the research. Care home managers then distributed participant information sheets to eligible staff. Eight staff who expressed an interest met the inclusion criteria and consented to participate. The pilot study followed the same process; whereby two participants who met the inclusion criteria consented to participate.

### **3.3.5 Interview Procedure**

Participants were interviewed alone at their workplace. Interviews were audio-recorded and lasted between 17 and 49 minutes (mean 35 minutes). Following the interview participants were de-briefed, reminded of their right to withdraw and given details about sources of support.

## **4. Analysis**

Each audio-recording was transcribed verbatim and then destroyed. Any potentially identifying information was removed. The data were analysed according to IPA methodology outlined by Smith et al. (2009). In accordance with guidelines outlined by Elliot, Fischer and Rennie (1999) for enhancing quality control in qualitative research several measures were used to improve the validity of the analysis. Transcript codings and emerging themes were reviewed by all researchers. One transcript was coded by a peer researcher; following which similarities and differences between the codes and emerging themes were discussed. Where this produced divergent views the differences were reviewed until a consensus was reached. Furthermore, participant quotes illustrating each theme were carefully chosen to reflect the transcript context.

### **4.1 Results**

Data analysis revealed three superordinate themes and several subordinate themes (see Table 3). Themes are discussed narratively in turn with consideration to points of thematic convergence and divergence. Verbatim participant extracts are used to illustrate each theme.

**Table 3: Superordinate and Subordinate Themes**

<b>Superordinate Themes</b>	<b>Subordinate Themes</b>
Theme 1: Importance of relationships	Knowing your client
	Sense of attachment
	Role of support from others
Theme 2: Something special about the role	Feeling important
	Rewarding role
	Personal commitment to the role
Theme 3: The other side of caring	Conflicts with usual caring role
	Dealing with emotions
	It makes you think

#### **4.1.1 Theme 1: The Importance of Relationships**

Participants emphasised the importance of their relationships with clients, families and colleagues which they viewed as crucial to the provision of individualised care but also as an inevitable consequence of providing such personal care.

##### **4.1.1.1 Knowing your Client**

Participants highlighted the importance of getting to know clients, appreciating their life history and being alert to individual needs; rather than treating them as a homogenous group:

*“...getting to know that person. I think if you treat each one as an individual and become part of their life” (P7, Lines 47-49).*

It seemed that this client knowledge helped participants understand how best to provide care and increased their confidence in doing so. They appeared to adapt their approach according to each individual’s needs and focused on being person-centred rather than treating clients based on their diagnosis. Indeed, two participants described forgetting their clients had dementia:

*“You just don’t think about the dementia” (P1, Line 298).*

It seemed that, for these participants, their relationship with clients was based on treating them as individuals with unique needs, qualities and abilities rather than through a diagnostic lens. It is possible that this *forgetting* of diagnostic labels helped them connect with clients in a more human or person-centred way.

#### 4.1.1.2 Sense of Attachment

Linking with the previous theme, participants commented on the inevitability of forming attachments with clients. Indeed, three participants described viewing clients as family members. This sense of attachment was seen as inevitable and as important to the role:

*“You can’t not attach yourself to them” (P1, Lines 226-227).*

*“It makes me do my job better because I really care about them and I want the best for them” (P6, Lines 210-212).*

It seemed that participants viewed attachment as pivotal to providing good care but that it brought with it an experience of loss when clients die:

*“You wouldn’t be in your right mind if you didn’t get attached to them. But it’s hard letting them go. Like I said... It’s like losing a member of your own family” (P1, Lines 226-227).*

However, this was not a universal experience. One participant did not describe the same sense of loss, but instead viewed client death in a more matter-of-fact manner, as an inevitable part of life and something to be expected in this setting:

*“It doesn’t bother me that much. It sounds really bad. But it’s part of... that’s an aspect of life isn’t it? I’m quite prepared for it. This is where I work. They’re all gonna go” (P3, Lines 217-220)*

It seemed that because she did not feel attached she was therefore less affected when clients died. It could be argued that not establishing an attachment acted as a protective mechanism, helping her to focus on practicalities rather than emotions. However, whilst this

seemed to make it easier, it conflicts with the experiences of other participants who saw such attachment as essential to providing effective care.

#### **4.1.1.3 Role of Support from Others**

Participants described feeling well supported in their role. This seemed to be related to the quality of their relationships with colleagues, which were described as positive relationships in which they felt able to seek advice and support:

*“They’re always there for you. And your managers as well. They are always there for advice” (P5, Lines 199-201).*

Furthermore, participants feeling well supported was further indicated by the fact that none mentioned seeking additional support from elsewhere. Indeed, the shared experience between staff and their supportive relationships seemed to negate the need for this:

*“The support from everybody here is enough for me” (P5, Lines 137-138).*

Several participants described the importance of taking time out:

*“You just need a 10 minute break, a change of scenery. Deep breaths. Look at it from a different perspective” P7, Lines 302-305).*

This appeared to be facilitated by colleagues and its usefulness was therefore dependent on the supportive relationships between staff. Two participants also mentioned the importance of their relationships with families:

*“I definitely like working with the families. It’s all part of it. You couldn’t do it without working with the families” (P7, Lines 73-74)*

For one participant in particular the relationships she established with families were described as equally important as those she developed with clients themselves.

#### **4.1.2 Theme 2: Something Special about the Role**

Participants indicated that there was something special or unique about their role. Linked with this was a personal commitment to it and an inability to imagine doing another vocation.

##### **4.1.2.1 Feeling Important**

Over half of the participants seemed to perceive themselves as an expert in their role. This appeared to be related to a perception of themselves and their expertise as important in the overall care of people with dementia. One participant in particular indicated that her knowledge and expertise was at times superior to that of other professionals:

*“We have quite a few people as well I’ve noticed here that are in my opinion misdiagnosed. You know... a lot of GP’s and that will say “she’s got dementia” well not necessarily. There can be lots of other reasons” (P2, Lines 85-88).*

This participant indicated that the nature of her role meant that she was in a better place to understand and diagnose dementia than other professionals working with people with dementia in different contexts. However, all other participants who referred to themselves as experts did so in a context that was appropriate to their role rather than relating to a task ordinarily conducted by other professionals. Linked to this sense of expertise was the idea alluded to by two participants that it takes a certain kind of person for the role:

*“You have to have something somewhere. I don’t know what it is. But this magic ingredient, not a lot of people seem to have it” (P2, Lines 267-269).*

This participant appeared to feel that only a special kind of person, possessing certain unspecified qualities, was right for the role. This therefore seemed to link to feeling important, as she saw herself as being one of only a few people with the right skills and aptitude for the job. For many participants the idea that they were making a positive difference seemed to contribute to a feeling that both they and their job were important:

*“I like to think that we do make their lives a bit brighter” (P1, Line 385).*

For example, participants described making a positive contribution through small gestures such as engaging clients in activities, making them laugh or offering reassurance. Furthermore, three participants mentioned receiving praise from families:

*“Their family come in and say “oh P1 they look beautiful” or whatever, I love that. I love that bit of the job” (P1, Lines 109-110).*

This praise appeared to make participants feel valued and seemed to act as evidence of their important role. It is possible that praise from families was deemed important because it is not always possible for clients to provide such feedback, particularly in the later stages of dementia. This would therefore highlight the importance of positive feedback from families in boosting participants and reinforcing the importance of their role.

#### 4.1.2.2 Rewarding Role

Six participants indicated that their role was particularly rewarding and that they felt privileged to work with people with dementia in this setting. Indeed, several participants described being unable to imagine doing another role:

*“Working with people with dementia is one of the best jobs that I think anyone could have. Obviously that’s just me personally... [laughs] but I just wouldn’t do anything else” (P5, Lines 289-291).*

Furthermore, six participants described feeling privileged to provide end of life care, indicating that there was something special about caring for clients at this time:

*“We care for them all the time, I know that. But it’s that final journey isn’t it?” (P1, Lines 199-200)*

Participants appeared to gain satisfaction and reward from providing end of life care and it was seen as an immensely important time; more crucial to do “correctly” than other aspects of their clients’ care. It is possible that participants felt a greater sense of responsibility because there is only one opportunity to get it “right”.

*“It’s just nice that we can at least carry out their wishes and it’s what they want and what the whole family want as well” (P4, Lines 444-445).*

Participants seemed to enjoy meeting the needs of both clients and their families. However, they also seemed to feel a pressure to get it “right” and to make the experience easier for families; particularly when considering that the majority elect for end of life care to be

provided at the residential home rather than elsewhere. Participants also saw other aspects of their role as rewarding, such as gaining insight into clients' lives:

*"I find it a privilege to learn about people's history. To go through people's photographs. Because some people are quite private and they won't always allow you to do that. But I find it quite a humbling experience and a privilege" (P4, Lines 649-652).*

They appeared to feel honoured to be entrusted with such sensitive and private information. It seemed to further highlight the strength and depth of their relationships with clients and to contribute to participants' sense that their role was special. Seven participants described enjoying noticing little things that clients do, indicating that these experiences were a source of pleasure:

*"Just simple things... you might see them pick up a paintbrush... or even just playing with a pack of cards. Whatever they're doing with it it's just moments like that that are quite nice" (P4, Lines 253-255).*

Furthermore, they also expressed satisfaction when they could make a positive difference:

*"If I can make one person smile in a day then I know I've done my job properly. And that's what it's all about for me" (P1, Lines 377-378).*

Participants seemed to perceive this as a valued part of their role. It appeared to be linked to the idea that their role was a privileged and rewarding one whereby they not only witnessed special moments in their clients' lives but also contributed towards these.

#### 4.1.2.3. Personal Commitment to the Role

Participants indicated that the positive aspects of their role outweighed its negatives. They seemed to want to give a positive impression, with any negatives played down or not afforded as much importance as more positive experiences:

*"I don't think there's much negative. I think it's a lot of positive. I think it gives a lot of positive feelings. I can't... I couldn't think of anything really... I can't think of anything really negative" (P4, Lines 576-578).*

This wish to portray their role in a positive light appeared to reflect a sense of pride and responsibility for giving a positive impression. Although participants acknowledged experiencing negative emotions relating to their role, they tended to brush these aside, indicating that positive feelings carried more weight:

*"The positive feelings outshine the negative ones" (P5, Lines 252-253).*

Participants seemed so committed to their role that they were happy to withstand any negative feelings. Additionally, two participants indicated that their commitment went beyond the call of duty:

*"We're supposed to start at half past 7 so I come in about ten past 7, put the porridge on" (P1, Lines 30-31).*

Another participant reported taking clients out whilst on their break. They seemed to take their role so seriously that they continued to care for clients in their free time. Going the extra mile in this way seemed to link to their attachment and commitment to clients, in that

they felt a sense of responsibility towards them even when they were not working. In contrast, participants also alluded to a sense of 'forced' commitment:

*"If somebody doesn't turn up on that shift then you know you really do have to stand in on that shift if nobody else will" (P1, Lines 149-150).*

It seemed that participants felt they had no option but to step in during colleague absence despite their responsibilities outside work. Furthermore, one participant seemed to feel a sense of responsibility even when she was at home:

*"Even when you're not on shift you might end up coming in for any reason" (P8, Lines 30-31).*

These extracts highlight the different experiences among participants. Indeed, whilst some portrayed their commitment positively as a choice, others felt it was imposed upon them. Furthermore, two participants expressed their anger about how clients were treated and their passion for advocating for them:

*"I still don't feel that people with dementia are treated equally in a lot of aspects. Because I've yet to meet someone with dementia who can't make some kind of decision. You know... even a basic... you know what to eat. They can all do it to an extent. Some more than others. And they're not always given that chance. That I don't like" (P2, Lines 247-251).*

This appeared to link with their sense of commitment as they seemed to feel responsible for doing this and saw it as important to their role.

#### **4.1.3. Theme 3: The Other Side of Caring**

Participants commented on the more difficult aspects of their role; including the challenges faced and the impact on their thoughts, feelings and emotions.

#### 4.1.3.1 Conflicts with Usual Caring Role

It seemed participants experienced great frustration and discomfort when unable to make their clients comfortable:

*"You're just trying to make them comfortable. But if they're not comfortable then that's when it's a bit heart-breaking" (P5, Lines 188-190).*

It appeared that being unable to support clients in the way they wanted resulted in a conflict; apparently challenging their sense of role identity, which appeared to include trying to make a positive difference. Related to this, two participants stated they had wondered whether they could have done anything more:

*"I sort of think to myself you know "am I... am I doing enough?" or "should I have done this?" Erm... and sometimes I'll question myself. You know "am I doing the right things here?"" (P4, Lines 626-630).*

It is possible that because of their supportive role, being unable to help meant that they assumed they had not fulfilled their role adequately rather than that there was simply nothing else they could do. Therefore, this indicated that participants experienced a conflict in comparison to their usual caring role. Three participants also expressed how difficult they found witnessing clients' deteriorating:

*"The deterioration...Just seeing them go... every day just a little bit" (P6, Lines 157-158)*

It appeared this was related to their attachment to clients and also represented a frustration at being unable to prevent the deterioration or alter its course. It seemed to be indicative of a conflict between their usual role to help clients feel better, and situations in

which they were unable to do this. Furthermore, participants expressed frustration when administrative tasks took priority over direct client care:

*“I wish I could spend my whole day with them. But unfortunately I can’t because of paperwork and horrible things like that” (P2, Lines 208-209).*

This seemed to create a conflict with respect to participants’ usual caring role because administrative tasks were generally regarded as less important. It appeared to be difficult to balance time spent on such tasks and time spent directly with clients. Nevertheless, participants implied that direct client contact should take priority over administrative duties.

#### **4.1.3.2 Dealing with Emotions**

Participants described their role as both physically and emotionally draining, and reported experiencing a range of emotions:

*“You get so many emotions. So many. It’s... half the time you probably don’t even notice them because it just sometimes can be continuous. You know swapping from one to another...” (P2, Lines 389-391).*

For this participant in particular it seemed that coping had become second nature:

*“Probably because I’ve been doing it so many years... erm... perhaps I don’t know... you don’t get immune to it but you just cope without realising that you’re coping” (P2, Lines 415-418).*

She acknowledged that her length of experience had possibly made it easier to deal with the emotional impact. Indeed, two other participants indicated that their experience had helped, particularly in relation to end of life care:

*“It was every time that I was on shift and... so I had to deal with it and I think that’s why I got so used to palliative care” (P1, Lines 241-242).*

Furthermore, two participants expressed that their training had helped:

*“The training that we have is very good. It’s brilliant. And it does get you prepared” (P8, Lines 255-256).*

However, other participants sought reassurance to help cope with the challenges of the role:

*“You get that sort of positive bit of feedback so that a lot of the time it does actually make you feel better. You think “actually yea... it’s not that bad. I don’t need to be worrying”” (P4, Lines 738-740).*

It appeared that participants were comforted by positive feedback and reassurance from others. However, half indicated that they should just carry on despite their emotions:

*“We’re seeing... residents where they can be very rude. Very very nasty. But like I said that is just part of their condition. You don’t take it personally. You... you do deal with it” (P4, Lines 392-394).*

These participants seemed to believe that their supportive role meant they just had to deal with clients’ behaviour and their associated feelings. They appeared to feel that these emotions were to be expected and therefore not valid or worthy of attention. Their comments gave the impression that whilst their clients needed emotional support, they themselves did not have the same right.

#### **4.1.3.3 It Makes You Think**

Three participants commented that their work had challenged their preconceptions about older people and people with dementia:

*“I used to have the impression that old people are a bit... stuck in the mud” (P4, Lines 667-670).*

They indicated that their perceptions had changed positively since working in this setting. However, some participants reported finding it difficult and upsetting to envisage themselves as clients and to contemplate having dementia:

*“You just think “how could you just forget that if you do it every day?” (P5, Lines 230-231).*

Nevertheless, two participants indicated that they felt that people with dementia cannot be truly happy or that their quality of life is somehow worse than other people:

*“Hopefully they can lead... well it is a normal life... as possible” (P4, Lines 170-171).*

Furthermore, two participants expressed that they did not want to have dementia in the future:

*“I don’t particularly want to end up that way” (P3, Lines 267-268).*

It appeared that although they did not want to envisage having dementia, their role nevertheless made them consider this possibility. Indeed, two participants described drawing parallels with their own life:

*“Scary. When you think about what’s ahead [laughs] and you think “I wonder whether I’ll ever end up like that. I wonder what my family would be like, my children, if I was like that?” It makes you think. (P7, Lines 224-226).*

Their experiences seemed to give new meaning to what participants might expect from later life in comparison to what they might have envisaged prior to working in this field, in that they had to confront the future possibility of dementia whether or not they wanted to do this.

## **5. Discussion**

### **5.1 Discussion of Study Findings**

Data analysis revealed three superordinate themes. The first theme *‘importance of relationships’* referred to the importance of participants’ relationships with clients, colleagues and families as well as their attachments to clients. Forming relationships with clients and families was considered extremely important, consistent with previous research in which staff working with people with dementia have described such relationships as essential to person-centred care (Edvardsson, Fetherstonhaugh & Nay, 2010). Participants generally viewed attachment to clients as inevitable and important for quality care but nevertheless acknowledged the emotional difficulty this could cause. However, one participant did not feel the same attachment, highlighting differences in participants’ relationships with clients. It is possible that not forming attachments may have acted as a protective mechanism for this participant. Interestingly, it has been suggested elsewhere that such detachment or emotional distancing from clients by healthcare professionals can

help them carry out their role (Oakley & Cocking, 2004). Indeed, in a recent study researchers found that although care home staff caring for people with dementia at the end of life found it difficult to remain detached, they did so to protect themselves from grief (Vandrevala et al., 2016). Furthermore, participants described relationships with colleagues as a significant source of support. This is consistent with previous research conducted in inpatient settings, which indicated that relationships between staff acted as an important coping mechanism (Schneider, Scales, Bailey & Lloyd, 2010).

The second theme '*something special about the role*' referred to the rewarding aspects of participants' role such as making a difference and feeling important, and their commitment to their job. Overall, participants gave very positive accounts of their experiences and tended to minimise the negative aspects of their work. This is consistent with previous research which found that healthcare assistants working with people with dementia in inpatient settings used, in addition to other positive coping strategies, a psychological strategy they termed 'desensitisation' to tune out negative stimuli whilst focusing on the rewarding aspects of the role to enable them to work effectively (Schneider et al., 2010, p.44). Participants in the present study appeared to gain a sense of pride and enjoyment from their work and indicated that it was both rewarding and satisfying. Furthermore, participants' commitment to their role and inability to imagine doing another vocation seemed to further reflect their satisfaction. These findings are consistent with previous research indicating that staff working with people with dementia in long-term care report good levels of job satisfaction. For example, in one study employing a staff satisfaction questionnaire scores were clustered around the middle to high end of all subscales; indicating good levels of job satisfaction (Moyle, Murfield, Griffiths & Venturato, 2011).

The third theme, *'the other side of caring'*, referred to the more difficult aspects of participants' role including conflicts with the caring role, dealing with difficult emotions and facing the reality of dementia. Despite these challenges participants generally indicated that their emotional responses were not important to address but rather an expected part of their role. Indeed, participants did not mention seeking specific support to help them cope with the emotional impact of the work. This finding may be partly explained by participants' supportive relationships with their colleagues; consistent with previous research which found that staff managed their emotional responses by seeking support and comfort from their colleagues (Schnieder et al., 2010). It may also simply reflect participants' expectations of their role, as suggested above, however; it is noteworthy that research elsewhere found that care assistants were less likely than nurses to use positive coping strategies (Margallo-Lana et al., 2001).

## **5.2 Clinical Implications**

The findings highlighted that participants not only valued their relationships with clients, families and colleagues but viewed them as essential to care provision. This suggests that care staff should be encouraged to build strong and supportive relationships within their role. However, managers must also recognise that staff may become attached to clients and therefore find the emotional impact of their loss or death difficult, highlighting the importance of staff having access to adequate sources of support. Additionally, participants were clearly very motivated to engage with clients and keen to make a positive difference. However, some commented negatively about administrative tasks taking over. Therefore, in order to improve the quality of care for people with dementia and their families, as well as

staff satisfaction, the balance between direct contact and administrative duties could be reviewed when planning dementia care in such settings.

Furthermore, participants tended to disregard their feelings and in particular any difficult emotions experienced. Nonetheless, it is important that staff have opportunities to discuss and process their emotions to reduce any adverse impact on care provision. Managers could model the importance of this and support staff to do so by embedding it into training and practice. For example, this could be facilitated through reflective practice groups or clinical supervision. Although there is limited evidence regarding the effectiveness of reflective practice interventions for healthcare assistants in long-term dementia care there have been positive indications of its usefulness. For example, researchers found that a training programme for ward-based dementia healthcare assistants, which incorporated reflective exercises following self-study modules and 12 facilitated group discussions, had a positive impact on their confidence and competence, with one participant in particular commenting that they had learned to reflect on the potential impact of their actions (Chapman & Law, 2009). Furthermore, researchers investigating healthcare assistants' experiences of dementia care mapping and reflective practice in residential care found that all participants acknowledged the benefits of reflection in order to enhance the quality of care provision (Mansah, Coulon, Brown, Reynolds & Kissiwaa, 2014).

### **5.3 Study Limitations**

Participants were all White British females whose first language was English. Although the majority of staff working in UK residential care homes are female (Eborall, Fenton & Woodrow, 2010); there is also "a rich nationality and ethnic mix among care home staff, with a high proportion speaking English as an acquired language" (Luff, Ferrerira & Meyer,

2011, p.4). This indicates that the sample was not representative of the general staff population in such settings. Additionally, due to the methodology employed the sample size was small. These sample characteristics limit the transferability of the findings. Similarly, opt-in participation for care home managers and staff could have biased the results towards staff who were more enthusiastic or had more positive experiences. Furthermore, data analysis was conducted at the end of the data collection phase and participants were not asked questions outside the interview schedule. However, it is possible that the study findings may have been enhanced by concurrent data collection and data analysis and by asking follow-up questions to encourage participants to elaborate on certain points raised.

#### **5.4 Future Research Directions**

The study highlighted the paucity of qualitative research exploring the experiences of staff working with people with dementia in residential care homes. Future research could usefully build on these findings by exploring the experiences of qualified nursing staff working in such settings. It is possible that they may have different experiences given the differences in their role, training and educational background. Furthermore, it would be interesting to explore and compare the experiences of staff working with people with dementia in nursing homes or inpatient settings. Future research could also explore the experiences of clients or family carers to ascertain whether their perceptions match those of the participants. Additionally, observational data could be employed to ascertain whether healthcare assistants' perceptions match the care delivered.

Additionally, as the study focussed broadly on healthcare assistants' experiences, future research could focus more specifically. For example, the theme '*the other side of caring*' could be further investigated to clarify the specific aspects of their role that healthcare

assistants find more difficult. As previously highlighted, staff may benefit from clinical supervision or training to help them process their emotional responses. Therefore, further research exploring *difficult* experiences may be beneficial in helping to provide clearer recommendations for staff support.

## **5.5 Conclusion**

Semi-structured interviews were employed to explore the experiences of eight healthcare assistants working with people with dementia in UK residential care homes. Data analysis using IPA revealed three main themes: *the importance of relationships*, which incorporated their relationships with clients, families and colleagues as well as their attachments to clients; *something special about the role*, which referred to their perception of their role as unique and rewarding, as well as their personal commitment to the job; and *the other side of caring*, which referred to the more difficult aspects of their role including dealing with emotions and conflicts with the caring role. The findings have important clinical implications, particularly regarding the use of clinical supervision and training to help support such staff in providing a high quality of care to people with dementia.

## **6. Declaration of Conflicting Interests**

The authors declare that there is no conflict of interest.

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