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Making a difference: using action research to explore our educational practice

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Making a difference: using action research to explore our educational practice

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This paper describes and discusses an action research collaboration between a multi-disciplinary team of practice educators, a practice development nurse and a university lecturer in order to explore, evaluate and improve a dementia care training package developed for a range of staff providing care for people with dementia. Whilst it is recognised that the findings of this small evaluation study are only of local interest, we believe the approach we took to be of general use for other teams of practice educators as a way of exploring and evaluating their own practice. This paper will therefore focus mostly on the philosophy, methodology and conduct of the study, including our own reflections and learning as novice action researchers.

Keywords: dementia care; practice development; education

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Introduction

The Dementia Care Training (DCT) Team (formerly the Residential Home Advisor Team) at Abertawe Bro Morgannwg University (ABMU) Health Board in South West Wales has been delivering a Dementia Care Training Package over a 10-year period since April 2003. The remit of the DCT team was originally to identify the training needs of care staff that work with people with dementia both throughout the local authority and in the independent care-home sector within the local borough. The team's mandate has since widened to provide training for other staff groups including domiciliary care and daycare centre staff, social work staff, mental health and general ward staff (both registered and non-registered), informal carers, staff working for the Alzheimer's Society and, most recently, for those working in the field of learning disabilities.

It is generally considered that the team was doing well, and written and verbal evaluations and other evidence seem to support this perception. What we as a team required, however, was a more concrete way of proving our worth. We needed answers to questions such as: are we any good; are we making a difference at the 'coal face'; is the care of people with dementia improving as a result of our training; can we do it better; and, perhaps most importantly, how can we do better?

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This paper will outline an action research study designed to address these questions by reviewing our past performance and current approaches in delivering our training package. The purpose of this paper is to outline the philosophy, design and rationale for the study, along with a discussion of some of the methodological and practical issues encountered during the first three action research cycles. Although data analysis is still in process, we will also present some of the findings from the study with the aim of learning lessons to improve our practice.

Developing the study

The training programme always seems to be well received and evaluated by the participants, but over the last eight years we have struggled with whether we were making a substantive difference to dementia care. We have a great deal of anecdotal evidence, both verbally and in written evaluations given at the end of each session, but we felt that we needed something more substantive. We have tried various ways of eliciting this elusive information. For example, at the beginning and end of each training session we ask the staff to complete a knowledge-based questionnaire. It is apparent from analysis of these questionnaires that the majority of participants have benefited from the training, but the question remains as to whether these benefits are being translated into care improvements. Care-home managers were asked whether they had seen any change in the care practice of staff who had received training, and whilst their responses were positive, it remained difficult to provide substantive evidence. The next attempt at assessing the effectiveness of the programme was to determine whether there was any meaningful correlation between the level of training uptake in a care home and the level of referrals to the older adults' mental health referrals coordinator. This exercise also proved inconclusive.

We began at this point to suspect that perhaps we were asking the wrong question, although at this point we were unsure what the right question might be. We were therefore prompted to make contact with the Wales Centre for Practice Innovation at Swansea University, and a senior lecturer from the centre agreed to work with the DCT team in order to explore options for resolving our dilemma. One of these options was action research, and whilst the DCT team had only minimal experience as researchers, we were encouraged by introductory literature such as Jean McNiff's (2002) concise booklet. The central tenet of reflective evaluation appeared to be congruent with our values base and we began to see that action research might be exactly what we required.

Developing research questions

Initially we sought to review the work we do from an educational perspective and to raise questions that would lead to the development of a suitable research/evaluation methodology. The questions we generated appeared self-evident, yet at the same time ambiguous. Some were so broad that we could not envisage collecting and appraising meaningful data. Others were too narrow and the answers to them would not sufficiently inform our nagging doubt about whether the training we were providing was making working practices better and improving the lives of people with dementia. To help us refine useful questions, we determined not to exclude any that were suggested until each had been subjected to an ongoing reflexive review.

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We also participated in free-thinking discussions that raised the following questions:

(1) Do care staff/managers/trainers see a relationship between the training we were providing and improved care practices of staff?
(2) How are these relationships evident and demonstrated as meaningful/purposeful rather than coincidental?
(3) What demonstrable strengths and weaknesses are identified in the training programme, its resourcing, delivery and effects?
(4) What implications are significant and what actions are recommended?

Our focus was gradually shifting from evaluation of the impact of our training packages on the practice of others to an exploration of our *own* practice in the development and delivery of training and education. In particular, we wished to focus on our attempts at introducing and facilitating a more person-centred approach to care and how we might do it better. Throughout our deliberations, we continued to emphasise the avoidance of simplistic, reductive approaches to ensure that we maintained a practical focus that would lead to demonstrable improvements in care and education practice. We wanted not only to hear staff talking *about* person-centred care but to hear *actual examples* of changes they had made for particular residents in their care that showed a person-centred approach; for example, staff realising that a person is not understanding the words they are saying and so looking to see what non-verbal communication could be used. These approaches reminded us of notions of holism (avoiding reduction) (Altrichter, Posch, and Somekh 1993; Rowan 2001) and the complexity of care. Our challenge at this point was seen as to illuminate and clarify relationships and links between education/training of staff and practice improvement. We did not perceive these links in strictly cause–effect terms, as we recognised that improvements to practice can and do occur regardless of formal educational input. One clear example is of individuals developing their practice through exposure to good role-models.

From all of these ongoing discussions and reflections we eventually identified two very broad aims for our study: firstly, to identify and make clear the strengths and weaknesses in the training provided; and secondly, to use this new understanding to make changes designed to impact positively on care practices of staff and the lives of service users and carers. At this point in our deliberations we finally moved beyond simple evaluation as our primary goal to a fully fledged action research approach in which understanding and evaluation are primarily means to the end of practical change (Carr and Kemmis 1986; Elliott 1991). Despite our growing awareness that the *direct* impact of our work on clinical practice might be difficult to measure, we nevertheless retained the original focus on care outcome because it was perceived as being relevant to the appreciation of interrelationships between training and care practice, and also, importantly, as a precursor to continuing inquiry in later action research cycles that might involve people with dementia and their carers as well as care staff. The purpose of the study was therefore to appraise and improve the impact of the training programme:

(1) through a process of reflective self-evaluation;
(2) by examining course participants' impressions of the teaching methods and educational processes;

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(3) by exploring with them the effects of the programme on the care provided to their patients; and
(4) by examining and improving our own practice as trainers and educators.

The initial meeting

The research team consisted of the mental health nurse and the two occupational therapists from the DCT Team, together with a practice development nurse and a senior lecturer from the Wales Centre for Practice Innovation. The practice development nurse already supported the work of the DCT team and had relevant research experience. In addition, a consultant psychiatrist who was instrumental in the development of the team was asked to play the role of critical friend (Titchen 2003). This decision was based upon his ability to offer an informed view, and it was considered that his opinion of our efforts and findings would be of great value and would give us a different and perhaps more objective perspective on the study.

We first met as a team in the summer of 2009 and organised regular meetings (approximately every six to eight weeks) to plan and undertake the action research/evaluation. Initially, ambiguity seemed pervasive in relation to precisely 'what' and 'how' we wanted to research. An action research orientation matched our wish to 'improve rather than prove' (Hart and Bond 1995), to value action and practice application equally with knowledge and theory, and to work collaboratively as co-researchers (see, for example, Coghlan and Brannick 2005; Jenkins et al. 2005; Koshy, Koshy, and Waterman 2011; Reason and Bradbury 2008). It also matched our wish to learn and adapt as we proceeded, using elements of emergent design (Christie, Montrosse, and Klein 2005, Lincoln and Guba 1985) that allowed for unexpected developments and the use of multiple methods. This was important because healthcare generally, and elderly care environments in particular, are inevitably unpredictable. An action research methodology enabled us to shift the emphasis of our work into an evaluation frame in early 2010 in response to local ethics committee feedback and a review of our timeframe.

Ethical issues

Once we had decided on our methodological approach, we contacted the local health board ethics committee for advice, and were informed that, despite our shift in perspective and methodology, they regarded it as a service evaluation, and therefore formal approval was not required. Nevertheless, the ethical implications for our study were taken very seriously by the team, and these were addressed in respect of our chosen methodology of action research. We identified issues of accountability for choices and actions; informed consent to take part, contribute or withdraw; confidentiality and security of information and records; and protection from harm including sensitivity in managing distress. The ethical issues in action research are often different from those that 'traditional' researchers would face and deal with, not least because of the commitment to sharing private materials and thoughts (Zeni 1998). An obvious example is that of anonymity, since it is difficult to guarantee each co-inquirer will remain anonymous when speaking face to face. It is also difficult to ensure informed consent when so much is emergent and unknown at the outset. Consent therefore becomes more of an ongoing process issue and withdrawing carries ethical responsibilities in respect of confidences being maintained.

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Research methods

In keeping with action research methodology, the primary approach throughout was based on critical self-reflection (Altrichter, Posch, and Somekh 1993) and cooperative inquiry (Heron 1996), although a number of more traditional research methods such as focus groups and individual interviews were employed during the second cycle of the study, using a form of triangulation outlined by Williamson (2005) in his Alzheimer's research work. Whereas Williamson (2005) offers a well-theorised account of triangulation, its strengths, weaknesses and application to action research, our approach was designed simply to elicit alternate types of data using a within-method (more accurately, within-paradigm) approach that would serve to supplement, complement and challenge our interpretations and analysis.

Critical reflection

Each member of the research team engaged in first-person inquiry (Marshall 2001; Marshall and Mead 2005; Torbert 2001) throughout the life of the study. This involved each of us moving beyond mere recall and adopting a serious, self-questioning, disciplined approach of critical reflection, supplemented by keeping accurate, detailed records and personal diaries. Marshall (2001) presents an illustrative account of this approach, describing ambitions, aims, struggles and questions about what to notice, why, how and when to focus, and how and when to be more open. We sought to reflect not just on isolated incidents (often labelled 'critical') but on broader associated experiences and responses, picking out words or details that prompted reaction or energised us. Torbert (2001) explains first-person inquiry as the pursuit of the question 'How do we inquire into our everyday actions?' Mostly, we do not pay conscious attention to the present; we simply forget to do so in the hurly-burly of living. Torbert suggests the purposive use of daily activities such as mealtimes, or physical activity such as walking, swimming or exercising the dog as opportunities for a regular focus for thinking and reflecting.

We also employed critical reflection in a more structured group environment as a means of making our own tacit knowledge manifest and sharing it with our co-researchers (Altrichter, Posch, and Somekh 1993), particularly in the first cycle (Beginning) and third cycle (Sense-making and data analysis). As Martin points out:

> In action research, reflection leads to the uncovering of new interpretations and perspectives. As participants engage in inquiry, they are invited to challenge prior beliefs and understandings and reframe what they know. (2006, 168)

The emphasis on reflection as the means of creating knowledge is not without contention. Andrews, Gidman, and Humphreys (1998) highlight that much of what is claimed as reflection is little more than mulling over events (simple recall). Greenwood (1998) found that many UK nursing frameworks for reflection were merely factual recall and quite different to the synthesis, validation and appropriation of knowledge that Boud, Keogh, and Walker (1998) ascribe to the reflective process. Burton (2000) identifies a number of barriers to reflection, including time, accuracy of recall, ethics, emotional issues and privacy intrusion, whilst Jones (1995) argues that reflection is inevitably coloured by 'hindsight bias'. The use of validity

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procedures and recursive recycling is designed to make issues of veracity, dishonesty, misperception, memory errors and ethics explicit as ways of addressing these types of criticisms.

Cooperative inquiry

We were thus mindful of the limitations of self-reflection, not least our own blindness to some aspects of ourselves, including our prejudices and attitudes, and we therefore also included cooperative inquiry (Heron and Reason 2001). Cooperative inquiry is concerned with ordinary people researching together to make sense of practice and each person's self-reflections to enhance collective understanding. Cooperative inquiry has been described as:

> … a way of working with other people who have similar concerns and interests to yourself, in order to: (1) understand your world, make sense of your life and develop new and creative ways of looking at things; and (2) learn how to act to change things you may want to change and find out how to do things better. (Heron and Reason 2001, 179)

Cooperative inquiry also helped us to ensure continuing critical attention throughout the study so that our plausible beliefs were reformulated into well-founded knowledge (Heron 1996). This included a reflexive (critical) appraisal of issues facing the research team, agreeing the extent to which our views were well-informed or ill-informed, and gaining new relevant information to support our collective analysis and conclusions. This is another example of how critical reflection is more than 'mere conversation', but requires particular skills and validity procedures (see Table 1) as means to 'quality-check' inquiry and to ensure that uncritical subjectivity or mere opinion (Heron and Reason 2001) is recognised, appraised and avoided. Without inquiry skills and validity procedures, we are likely to fool ourselves that we are co-creating knowledge when all we are actually doing is confirming/maintaining our own belief systems.

Table 1. Validity procedures (see Heron and Reason 2001, 184–185).

Procedures	Illustrative application
Research cycling	Moving through inquiry phases, between action and reflection.
Reflection and action	Balance between 'thinking/articulating' and 'doing' so that the inquiry is neither too 'theory' driven nor too 'action' driven
Divergence and convergence	Recycling different aspects across successive cycles (divergent) or the same issue on multiple occasions (convergent)
Authentic collaboration	Each person acting with equity and all continuing to contribute to decision-making as the research proceeds (domination is anathema)
Challenging consensus collusion	Such as by acting as devil's advocate – challenging and questioning in order to test assumptions
Managing distress	Anxiety is anticipated and co-researchers should allow people time (to recover) and provide the support they need
Chaos and order	Toleration of each is needed to guard against premature decision-making that serves merely to avoid chaos or order as a way of coping with anxiety and difference

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Focus groups and individual interviews

To explore the impact that our work was having on clinical practice, it was necessary to engage in more objective third-person inquiry (Chandler and Torbert 2003) with the course participants in the second cycle. Because we had very limited resources with which to interview a relatively large number of people, focus groups were chosen as the most appropriate and pragmatic data collection method. Focus groups are facilitated group discussions in which an interviewer asks a series of questions of a group (Reed and Payton 1997), and were developed originally as a market research tool (Smith 1995). However, the focus group interview has also been employed as a qualitative research method that allows participants to share ideas and perceptions which may not emerge from other forms of questioning (Krueger and Casey 2008). They have been used as a means to encourage patient participation in the research process (Carey 1995; Carey and Smith 1994; Fuller et al. 1993) and to promote self-disclosure among the participants (Krueger and Casey 2008). Nyamathi and Shuler emphasise that this requires a 'permissive non threatening group environment' (1990, 1288). The groups were conducted by the practice development nurse, who was not a manager to the group members and was not acting in a professional capacity. As a mental health nurse, she brought with her a set of well-developed communication skills and endeavoured to approach the group discussions with openness and transparency.

The focus group method is often used in nursing research (Burnard, Morrison, and Gluyas 2011), and was chosen to allow the participants an opportunity to share ideas and experiences of the dementia care training and to present their views and perspectives. This approach allowed different stakeholders to be brought together to give their views and clarify conflicting perceptions (Parahoo 2006). The focus groups were supplemented with individual semi-structured interviews (Kvale 2007).

In keeping with most approaches to action research, our project comprised a number of cycles, the first three of which will be the focus of this paper.

Cycle 1: beginning

Cycle 1 was exclusively concerned with reflective 'within team' research, and employed critical first-person inquiry and team-focused group discussions. Our first meetings were dedicated to learning about one another, discussing shared research interests, posing questions, and debating how action research could assist our endeavours. We quickly adopted a cooperative inquiry approach with the provisos that we might shift from a research to an evaluation emphasis and also that we envisaged using multiple methods. Records of early sessions include references and choices in relation to organisational and educational action research (McNiff 2002; McNiff and Whitehead 2000, 2002), pragmatic action research (Greenwood and Levin 1998) and appreciative inquiry (Cooperrider and Whitney 1999; Whitney and Trosten-Bloom 2003). We agreed a *modus operandi* that included the ground rules shown in Table 2 (including use of critical questioning and validity procedures), timing, audio and note recording and agreeing notes as confirmation of collective agreement, diary keeping and the use of the consultant psychiatrist as a critical friend (Carr and Kemmis 1986; Myrick and Yonge 2001; Titchen 2003).

Storytelling, humour, metaphor and imagery helped our understanding and our emotional appreciation. Audio recordings of meetings were shared and notes of

Table 2. Ground rules.

(1) Confidentiality, limited by issues of illegality, malpractice or harm
(2) Supportive challenge
(3) Attendance – missing more than two sessions consecutively requires review
(4) Opportunity for everyone to have a voice
(5) Mutual respect
(6) Senior lecturer to facilitate – for review as we proceed (shared facilitation regarded as good practice)
(7) Consultant psychiatrist to act as critical friend (open-door attendance invitation)
Ground rules may be revisited at any time and amended as mutually agreed.

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specific sections were made by each co-researcher, and then provided to all the team in advance of the next session so that we could individually and collectively appraise the accuracy and quality of our work. Participation in Cycle 1 led to our making choices in respect of specific questions, methods and actions required for Cycle 2 during Summer 2010.

Cycle 2: using focus groups and individual interviews to gain evaluative data

Cycle 2 involved some more formal data collection methods, including focus groups and semi-structured interviews in order to ascertain the views of care staff who had participated in the courses and to triangulate the findings from our first-person inquiry.

Three focus groups were conducted with care staff from care homes. The first group consisted of nine individuals, the second group of six individuals and the third group of eight individuals. Open-ended questions were devised to guide participants to think about the different aspects of the question and intention of the study. Kitzinger (1994, 1995) highlights the importance of interaction and enabling participants to challenge but also reflect on their understanding of experiences around the discussion. The questions posed to the focus group were as follows:

(1) What did you think of the training?
(2) Did you enjoy the sessions?
(3) Was there anything that stood out as being particularly helpful/unhelpful?
(4) Do you think the content of each session was put across in a realistic way?
(5) What did you learn about dementia that was new?
(6) What does person-centred care/practice mean to you?
(7) Has the training made any difference to the way you work with people with dementia on a day-to-day basis? Can you think of some examples?
(8) Can you tell us about some things you would have liked to change in the care home as a result of the training, but have been unable to? What sorts of things have stopped you from doing this?
(9) Who do you think should attend this training package?
(10) Would an annual refresher training day be useful to you? What do you think should be included?

The literature highlights the importance of conducting a focus group in a place that is permissive and non-threatening (Burns and Grove 2005). Focus groups took place at training venues, arranged at a convenient time and place to suit the groups, taking into consideration space and the acoustics of the room for audio-taping. In order to capture the content of the discussions, the focus groups were audio-taped and written field notes were kept by an assistant to ensure the data could be transcribed as precisely as possible.

The cooperative inquiry approach adopted in Cycle 1 led us to recognise that whilst valuable information would be obtained in the focus groups from participants currently attending training, it was also important to ascertain the views of those people who had previously experienced the whole programme and had subsequently spent time in practice. These individuals would be well placed to provide the research team with views and experiences that would supplement data from other sources and possibly include unforeseen yet significant information. A comprehensive database of all those who had undergone the dementia training programme ($N = 222$) was used to identify a purposive heterogeneous sample of 10 individuals, and one-to-one semi-structured interviews were conducted in private by the senior lecturer from the university (who was not known to the interviewees) in their work settings. Each interview lasted approximately 45–55 minutes, and eight were recorded, with the researcher making extensive written notes of the two where recording was declined. The format involved minimal structure or input by the interviewer, although in most instances, during the earlier parts of interviews, some of the prompts used in the focus groups were introduced. In all interviews, individuals demonstrated increasing willingness to voice their views and make contributions as the sessions progressed. All data were processed as documented scripts for collective review by the research team.

The potential for error and bias in such a small cohort is recognised – our purpose was not to use sampling exclusively to represent the total population as we were obtaining data from other sources. Rather, our action research methodology prompted us to approach individuals who would provide us with as wide ranging a set of responses as possible. To this end, the database was used to select a group of 10 who were more dissimilar than similar in respect of age, gender, nationality, time spent in practice, type of care setting (either local authority or private), status (care worker/manager) and geographical location within the area served by the dementia training team. All were provided with comprehensive information about the project and asked to respond within two weeks without obligation, in keeping with ethical considerations regarding anonymity, consent to record and right to withdraw. Only one person declined and a 'substitute' was identified using the same approach.

Cycle 3: sense-making and data analysis

Each co-researcher had access to all data except personal diary material, and this was shared in co-inquiry sessions. For the purpose of exigency we agreed that individuals would lead analysis of identified elements of the data (e.g. the practice development nurse has most expertise with focus group work and led those elements). These arrangements amounted to an effective 'carving up' of material for the preliminary analysis that was presented at co-inquiry sessions for collective review and agreement. Challenges and alternative views were evident in these

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sessions, providing evidence that we did not simply concur or collude. This process exceeded the time we had planned, not least because of differences of view that required acceptance in particular inquiry sessions followed by ongoing first-person reflection and subsequent collective decision-making.

Analysis of focus group and interview data involved relatively standard techniques, including reading and re-reading scripts to achieve immersion in the data, followed by thematic analysis (Polit and Beck 2006; Parahoo 2006). Throughout the process of analysing parts of the data, we were mindful of appreciating how each part contributed to others in forming a whole dataset. Analysis ultimately involved interrelating data from different sources and determining in excess of 30 preliminary themes. Ongoing appraisal led to merging, removing and re-merging these themes into two main categories, each with several sub-sections.

The findings generated from this cycle of the study are local, contextual and of limited relevance outside the team. However, they are of vital importance in allowing us to understand and evaluate our practice as trainers and educators, and will inform changes to our practice in subsequent cycles of the action research process.

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Findings

Data from the 'within-team' inquiry in Cycle 1 are concerned mostly with values, processes and personal relationships, and will not be presented in this paper. Similarly, data from the 'within-team' inquiry in Cycle 3 focus on the analysis, validity and reliability of the third-person data collected in Cycle 2, and will be the focus of a separate paper.

The data collected from the focus groups and interviews in Cycle 2 suggested that the training is generally positively valued and influences person-centred practice. Staff spoke about their newly acquired knowledge and underpinning concepts being applied in their places of work. Active learning, the use of experiential tasks, and learning from others in the same role are highly valued and contribute significantly to an ethos of 'practice improvement'. Analysis informed the choice of presenting our findings in two main, although interrelated, categories with a third 'other' category for a small amount of data that fell outside the main two. Each of the two main categories is further divided into sub-categories that are summarised and illustrated from the data. Illustrative examples of verbatim comments of focus group and interviewee participants are identified as 'FG + number' and 'Intv. + number' respectively.

Category 1: knowledge, the training programme and process

The findings presented in the first analytic category mostly address our first broad research aim: to identify and make clear the strengths and weaknesses in the training provided, including our qualities as teachers, the nature and relevance of the course material and the organisation of the programme.

Admirable teacher qualities

Comments from interviews and focus groups highlighted our ability to create an open, learning atmosphere, staff being made to feel comfortable to ask questions and share their experiences, and the use of humour and pointing out our own weaknesses:

> You were at ease, could bring anything up. Yeah you could talk. (FG2)

> Fun loving, mickey-taking – it makes people feel comfortable – they use humour … for example Alison's problems with spelling – big ice-breaker. (Intv.103)

In general it was felt that the teaching was clear. When an annual refresher course was suggested, one interviewee commented:

> they know their stuff inside out, upside-down and back to front. … they put it in a language that the carers understand – it's not highfalutin jargon that can lose a lot of people. (Intv.107)

We as trainers expressed how much we valued team teaching and communication, particularly in less communicative groups, to stimulate interaction. Staff have also commented on the way we work together.

The training is educative, thought-provoking

The programme design begins with directive, 'concrete' and specific knowledge, gradually shifting towards a more facilitative approach to considering principles and abstract ideas in a clinical context. As trainers delivering the package it was exciting to read that care staff had been considering their practice and care approach; seeming to be thinking in a person-centred (not institution-centred) way:

> One of the residents can be agitated. They called the CPN and they increased her sedatives. That's not the answer. She could be agitated because she needs to go to the toilet. It's not always medication. (Intv.103)

Role-modelling

We are only a relatively small team, so it was encouraging to hear that care staff are sharing their learning within the workplace, not only through written information but, more importantly, through role-modelling:

> … people who have the training do quite a lot of role modelling for others, showing how to do things, how to approach people and what they have learned. I think role modelling is a big positive for us. (Intv.104)

Content and method(s)

The data indicated changes to training content and method with emphasis on experiential approaches. Practical tasks play a large role in reinforcing the knowledge we are endeavouring to pass on. The use of storytelling and reflection are valued means of assisting understanding of practice and how it is informed:

> I would welcome use of more videos because they really do make you see things in new ways, caring especially. That would be about it really, I think the formal sessions do have their place but personally, I think the trainers use them with activity type sessions in-between and it works really well. (Intv.104)

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Group constitution

The data showed a spectrum of views in terms of group composition. This ranged from a suggestion that groups should be made up exclusively of individuals from a single care home, to a mix of staff from different work settings. Analysis revealed very few care staff having been in both types of group, so we concluded that more work should be undertaken to determine group composition:

> A mixed group, definitely – a varied group. The students were throwing in a lot of viewpoints … If you've got one set of carers from one care home feeling very comfortable then they are not going to share as openly. (Intv.107)

Refreshers and updating

Data suggested that refresher and updating work is seen as valuable, with whole or half days being suggested. Our reflections during and between inquiry sessions enabled us to consider the best approach. It was clear that a whole day is necessary, with the morning being used to update staff on changes in dementia care, and the afternoon to facilitate a more workshop-type session to encourage reflection and the sharing of good practice relevant to individual care settings:

> Refreshers and maybe better cascading. I also wonder if perhaps updating would be better if staff presented their work experiences, then reflected on them with other staff to try to show how their experience was making them think about their work. (Intv.104)

Suggestions (for improvements)

These included the idea that the training should be made available for informal carers (family members). Staff reported already using our handouts as a source of information for this group. It was also felt that our training may help them to better understand their relative with dementia along with the staff approach and justification for care.

Category 2: person-centred, practice relevance

The findings presented in the second analytic category mostly address the perceived current impact of our educational programme on practice and practitioners, including communication, values, relationships and attitudes. The data highlighted an abundance of examples of the relevance of training to practice, and it was particularly heartening to see examples of person-centred practice in focus groups and interviews:

> knowing each person's likes or favourite things and what they hate of course … I've seen some staff come back and take a new look at how they work with residents and also with relatives too … (Intv.104)

Value of meaningful activity

During focus groups and interviews, staff expressed an understanding of the value of activity and meaningful interaction in the residents' lives, including examples of

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how these activities need to be relevant to the individual. We believe as a team that care does not go far wrong when care staff begin to see the person rather than the dementia:

> I was interested to know as you say that we were doing things with residents that we didn't think were activities but they are you know … You know if you've had a bath that's an activity, helping you put your clothes away that's an activity and we don't have enough space to put it in our profile sheet. (Intv.106)

Communication, relationships, attitudes

We were concerned from the data that staff had sometimes misunderstood a teaching point that could possibly be detrimental to their care practice. For example, we advocate truth telling as best practice when communicating with people with dementia. We qualify this by emphasising the importance of a person-centred approach, taking into account the effect that truth-telling has had with that particular person on that subject before. In the example below we also may have felt that distraction was the best line of action:

> … The truth can be unkind so we need to distract them sensitively. This lady honestly thinks her mum is still alive. Now in the dementia courses … we were told that we had to tell them the truth. How in hell can we tell someone 10 times a day that their mother is dead? (Intv.101)

The data illustrate the value attached to maintaining people's dignity and personhood. Staff are seeking to get to know their residents better, and in doing so are developing relationships that enable them to enhance and personalise their care:

> we need to know what they done years ago like … we got one gentleman here that's a good swimmer he's an athlete … and he worked in the mines. You need to know what to talk to them about don't you? You need some family background you've got to have their background … what are their likes and dislikes you know … yes they might like tea one day might have always drunk tea if you offer them coffee they might taste that. Because some might sugar one day but the next they won't. You have to give them the choice don't you? … every day's different. I mean every morning when they get up it's different. (Intv.106)

Time (as an issue)

A lack of time was cited as the main barrier to improving practice. The data suggested that it was not just insufficient time to care but also to acquire adequate training. The data also identified that more time is needed for refresher training and updating. The issue of available time is related to time management, adapting to revised priorities and recognising the values associated with person-centred practice:

> I wasn't here for the interactions one but just talking to them, you know, it doesn't cost you anything, things like that, there should be more of that, rather than you haven't got time to talk to them. (FG3)

> … It helped me in that way to understand, the only thing was we didn't have the time – you need a lot more time and we didn't have it – nursing needs were given a priority … (Intv.109)

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Discussion

During the course of this project we have gradually integrated an action research approach into every aspect of our work. As its name suggests, action research is concerned with both research and action, with theorising and doing, and we hope that the findings presented above give some small indication of the new knowledge we have gained about our practice as educators, of the changes we have introduced into our teaching processes as a result of our learning, and also, to a lesser extent, of the changes that the course participants have made to their own practice. We discuss some of these outcomes below as 'Effectiveness' and 'Process'. In addition to the changes in thinking and doing in relation to our practice, we have also experienced some less tangible but equally important learning about the action research process and about ourselves, both collectively and individually. These are discussed below as 'Learning'.

Effectiveness

Questions about the effectiveness of our work were the original motivation for the study, and the analysis of our findings tends to support our hopes and expectations that our education and training programme is positively valued and influences person-centred practice. The participants applied new knowledge and concepts to their care practice, and active learning from other participants was reported as being highly valued and contributed to an ethos of practice improvement, with demonstrable examples of high-quality care practices and the identification of factors that impede practice improvement. This latter point is indicative of carers' awareness of what should be done combined with the recognition that on some occasions the ideal thing to do is not possible, entailing a compromise to practice. These compromises were not generally presented by staff as a lack of understanding or willingness to carry out good practice but rather as a resource or attitude issue, such as when people in or with authority insist on particular courses of action. However, as the study progressed, the focus of our attention shifted from evaluating the effects of our input to an exploration of our educational processes and practices.

Process

The second broad research aim we set ourselves was to use the data from this study to make changes to the programme in order to impact positively on care practices of staff and the lives of service users and carers. Caring for people with dementia requires thoughtful person-centred approaches that take account of the particular, the context, the individual, relevant circumstances and resources (Brooker 2004, 2007; Edvardsson, Winblad, and Sandman 2008; Epp 2003). This in turn demands thoughtful, person-centred educational processes. Ongoing reflexive analysis has resulted in changes to the programme and its delivery during the duration of the research/evaluation, such as adopting more use of videos and activity-based sessions. Plans to improve the programme in negotiation with relevant managers and partners include beginning with more broad and general issues during initial study days/sessions, before moving gradually to the specifics/particulars. Refresher and update work will be designed to review need and knowledge without duplication (seen as a demotivator), leading to more experientially oriented sessions

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using case work and reflection to ensure application links. The challenge for us as facilitators and educators (rather than 'trainers') is to ensure a smooth transition from a directive and concrete approach at the outset towards developing facilitative styles, promoting learning that is meaningful rather than rote, and thoughtful and contextualised rather than rule based and universal (Gibbs 1988; Kolb 1984; Freire 1972).

Making these changes in teaching style will be a personal challenge for each of the facilitators/educators, but can be achieved at a relatively low financial cost. However, if we wish to widen our remit to include regular education with family and other informal carers, we will require more teaching hours than is possible given our present team size. As dementia care is a growing concern in the United Kingdom (Banks, Searle, and Jenkins 2011; Dementia UK 2007), we believe that long-term investments of this type could empower informal carers to manage for a longer period of time and in a more effective way, thus postponing the date at which residential care is needed, and could also add quality to the care given within the care-home sector (National Dementia Action Plan for Wales 2009).

Learning

Although the substantive findings and tangible outcomes of the study have made an important contribution to developing our practice, the early stages of the process before we began the formal collection of data were in many ways the most productive and informative. It was during the first cycle, as we began to explore and develop a *modus operandi*, that we came to know ourselves and each other better as individuals and also as a team. It was in this team-building phase that a great deal of tacit knowledge was surfaced and shared, and a collective understanding of our role and function was developed and agreed. This first cycle also taught us the invaluable lesson of taking the time to formulate the right research questions. During the early stages of the study we shifted our focus from evaluation of the effects of our training on dementia care practice to a critical self-examination of our beliefs, attitudes, knowledge and practice as educators; that is, from outcome to process questions. Indeed, it was the growing awareness that we were asking inappropriate questions that led us to action research in the first place, and the dual processes of formulating the research questions and developing the research methodology have continued to feed off one another symbiotically in a reflexive cycle.

We now believe that the importance of asking the right questions in the right way, not only as researchers but also as educators and practitioners, cannot be overstated. Doing this project has taught us not to be afraid to ask complex questions that might not deliver clear and unambiguous answers; it has shown us that the knowledge gained from posing the question can sometimes be more valuable than that gained from the answer; and it has taught us to trust the process – that if we ask the right questions in the right way, the right answers will follow.

Overall, taking our first steps as action researchers has led to an added confidence in our roles as educators and in the validity of the package we have developed. It has also given us an experience of the world of research that has raised our knowledge and skill base such that we would be eager to use action research to continue to evaluate other projects that we are working on at present.

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