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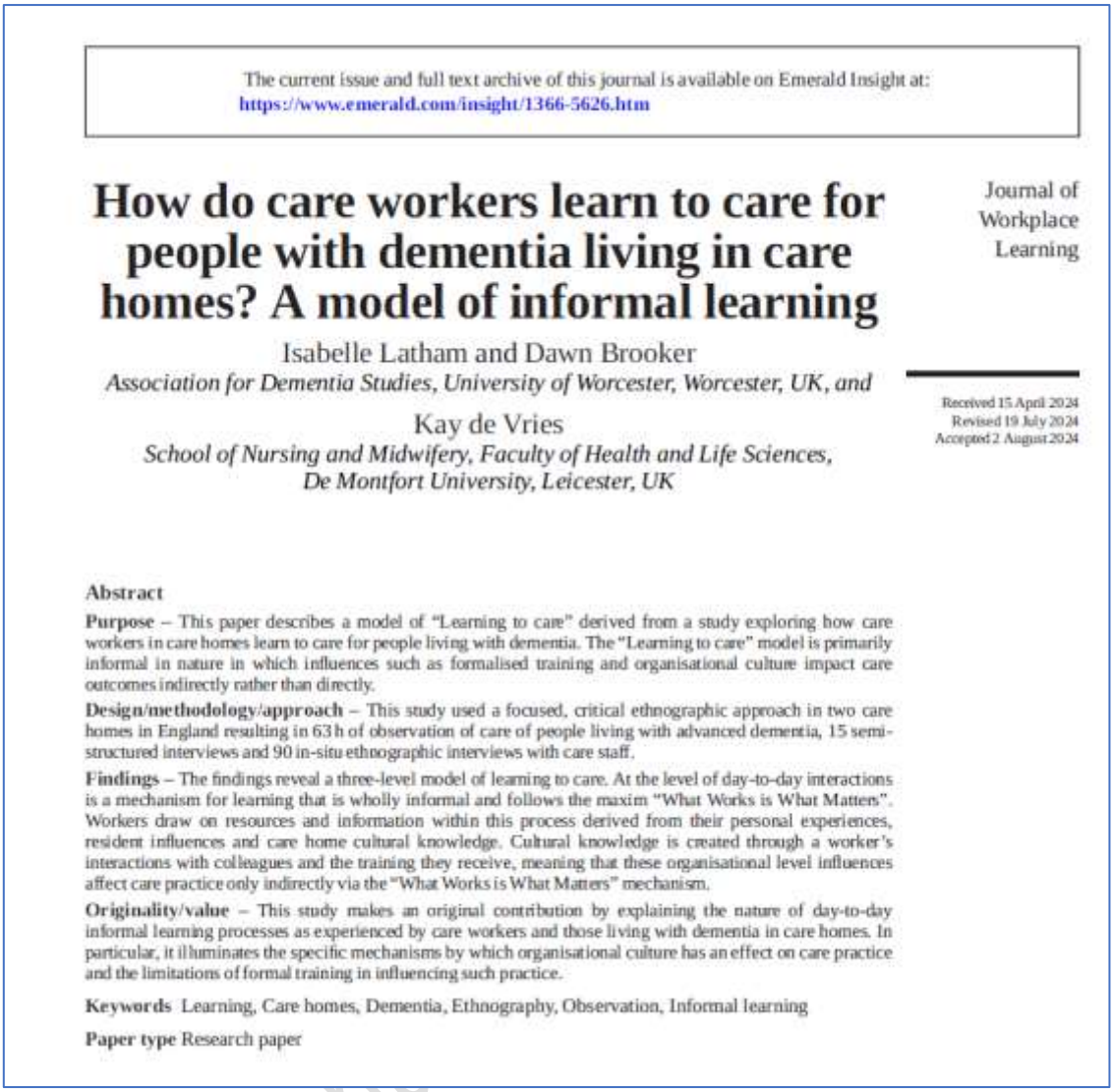

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Isabelle Latham and Dawn Brooker
Association for Dementia Studies, University of Worcester, Worcester, UK, and
Kay de Vries
School of Nursing and Midwifery, Faculty of Health and Life Sciences, De Montfort University, Leicester, UK

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Abstract

Purpose – This paper describes a model of "Learning to care" derived from a study exploring how care workers in care homes learn to care for people living with dementia. The "Learning to care" model is primarily informal in nature in which influences such as formalised training and organisational culture impact care outcomes indirectly rather than directly.

Design/methodology/approach – This study used a focused, critical ethnographic approach in two care homes in England resulting in 63 h of observation of care of people living with advanced dementia, 15 semi-structured interviews and 90 in-situ ethnographic interviews with care staff.

Findings – The findings reveal a three-level model of learning to care. At the level of day-to-day interactions is a mechanism for learning that is wholly informal and follows the maxim "What Works is What Matters". Workers draw on resources and information within this process derived from their personal experiences, resident influences and care home cultural knowledge. Cultural knowledge is created through a worker's interactions with colleagues and the training they receive, meaning that these organisational level influences affect care practice only indirectly via the "What Works is What Matters" mechanism.

Originality/value – This study makes an original contribution by explaining the nature of day-to-day informal learning processes as experienced by care workers and those living with dementia in care homes. In particular, it illuminates the specific mechanisms by which organisational culture has an effect on care practice and the limitations of formal training in influencing such practice.

Keywords Learning, Care homes, Dementia, Ethnography, Observation, Informal learning

Paper type Research paper

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Background

In the UK, an estimated 850,000 people live with dementia with this anticipated to rise to 1350,000 by 2040 (Prince *et al.*, 2014; Wittenberg *et al.*, 2020). Residential care can be the most suitable way to provide support for the person living with dementia at the later stages, when physical and psychological needs require 24-hour attention. Indeed, by 2040 it is estimated that 49% of people living with dementia will live in care homes because of an increase in the proportion of those with severe dementia. This will account for more than 80% of the care home population and contribute to a 300-fold increase in social care expenditure (Wittenberg *et al.*, 2020).

Achieving quality care is therefore necessary, with person-centred care (PCC) established as the desired standard, captured in policy and regulation for care homes (Care Quality Commission, 2017; NICE, 2018). Workforce training is identified as a primary route to achieving PCC, particularly given low pay, low status and high turnover the workforce experiences (Bottery, Ward and Fenney, 2019). Development of induction standards and the Care Certificate (Skills for Care, 2016), indicates that building capacity through training is a key performance indicator. The National Dementia Strategy emphasised the need for specialist training to improve PCC (Department of Health, 2009) and this was followed by research into training practice (Surr *et al.*, 2017, 2019) and development of the Dementia Training Standards Framework (Skills for Health, Health Education England and Skills for Care, 2018).

However, this emphasis on training belies an assumption that learning to care and achieving quality PCC is a process chiefly influenced by training. This assumption sits juxtaposed to both theoretical and practice-based investigations of workplace learning, in which the contexts, relationships and interactions of 'doing work' are identified as highly influential for practice (Eraut, 2004, 2007; Marsick *et al.*, 2009; Billett, 2014a; Gherardi and Rodeschini, 2016; Anvik *et al.*, 2020).

Training and quality dementia care

A rhetoric that positions training as the primary route to improve PCC raises the possibility that both researchers and practitioners uncritically promote training as a solution to the challenges of care quality. Such a strong discourse could influence practitioners and policy-makers over and above that merited by the evidence-base. Thus, it is important to examine the extent to which the large body of international evidence related to training in dementia care explains the learning processes that contribute to quality. The overall message from studies addressing training effectiveness is that the link between training and outcomes is complex, particularly when considering staff behavioural change and impacts on quality of life (Surr, Smith and Latham, 2023). Whilst training is shown to positively impact staff-reported outcomes such as knowledge or confidence (Fukuda *et al.*, 2018; Di Giulio *et al.*, 2019; Scerri and Scerri, 2019; Inker *et al.*, 2020), care practice and subsequent care experiences are much more complex to impact with training demonstrating only qualified success and little consideration of longitudinal impact (Rokstad *et al.*, 2017; Williams *et al.*, 2017, 2020; Yasuda and Sakakibara, 2017). Indeed, successive reviews have shown that whilst certain training approaches can improve efficacy, (Surr and Gates, 2017; Surr *et al.*, 2017, 2019) implementation of learning into practice remains inconsistent and dependent on other, often organisational, factors (Kuske et al., 2007; Surr, Smith and Latham, 2023).

Awareness of these organisational factors is growing, as evidenced by an increased preference for "training-plus" approaches to improving outcomes, in which training is only one component of a multi-part intervention (Surr, Smith and Latham, 2023). Training-plus interventions include staff training alongside components that enable and reinforce the application of training in practice such as introducing 'champions', providing in-practice coaching, or initiating organisational re-structuring. These interventions generally demonstrate qualified success for both staff and care outcomes.(Jessop *et al.*, 2017; Sævareid *et al.*, 2018; Brunkert *et al.*, 2019; Lichtwarck *et al.*, 2019; Oliveira and Sousa, 2020; Reinhardt *et al.*, 2020). However, two noteworthy issues emerge from these studies.

Firstly, alongside positive outcomes are common experiences – regardless of intervention specifics – of challenging implementation, less than optimal impact and concerns regarding long-term sustainability, all of which relate to organisational capacity (Petyaeva *et al.*, 2018; Verreault *et al.*, 2018; Fossey *et al.*, 2019; Griffiths *et al.*, 2019; Kutschar *et al.*, 2020). This reiterates that organisational factors greatly affect training implementation and resulting

quality of care practice. It is highly probable that these factors not only impact a specific intervention but operate continually to affect the learning environment within the care home. Secondly, the non-training components in these interventions have potential to influence the care home above and beyond a specific intervention by altering other (informal) learning in the workplace (Surr, Smith and Latham, 2023). However, currently, this potential is subsumed within considerations of the specific training intervention under evaluation, without thought of independent influence on learning. Gaining an understanding of the dynamics of these issues separated from specific training interventions is therefore important. Overall, whilst knowledge about the impact of training on quality of practice within care home dementia care has increased, there is an obvious gap in understanding: what else is going on that may be affecting the learning that takes place? Thus far, the well-established insights from practice-based research into workplace learning has been under-considered in relation to the learning processes through which quality care is achieved.

Workplace learning

Exploring workplace learning challenges the narrow view of learning-as-training currently dominant within dementia care. It highlights three significant, interconnected features of learning that need to be considered in order to optimise learning towards improved care outcomes. Firstly, learning arises when individuals construct meaning from their experiences and, crucially, this occurs within specific contexts. Therefore, how and what is learned is highly dependent on context (Illeris, 2003, 2011; Rogers, 2003; Jarvis, 2010). Social learning theory posits that all learning is situated, and results from social participation in everyday interactions. As such, any separation of learning from context is limited in insight (Lave, 2009; Wenger, 2009). Exemplifying this is the well-evidenced concept of Communities of Practice (COP) in which learning occurs whenever practitioners share a domain and engage with each other as part of day-to-day action (Lave and Wenger, 1991; Hullick *et al.*, 2022; Noar *et al.*, 2023).

This social and situated nature of learning suggests that, in order to influence learning to care, one must seek to understand the role of care home interactions and organisational context. Indeed, this would appear to be particularly significant when considering the nature

of PCC as an inherently relational activity (Kitwood, 1997; Nolan *et al.*, 2006; Brooker and Latham, 2016). Empirical exploration of learning within a variety of professions, including healthcare settings, demonstrate these social, contextual influences, (Collin and Valleala, 2005; Billett, 2014b; Kuipers, Ehrlich and Brownie, 2014; Gherardi and Rodeschini, 2016), and the increasing utilisation of COP to influence outcomes (Nicolini *et al.*, 2008; Jack, Jones and Hamshire, 2021; Noar *et al.*, 2023; Read *et al.*, 2023). Moreover, the role of organisational culture in creating the contingencies of learning has also been established, (Evans *et al.*, 2006; Ellstrom, 2012; Hauer, 2012; Bridges and Fuller, 2015; Ellström and Ellström, 2018; Anvik *et al.*, 2020).

Secondly, learning viewed in this social way should be considered as an ongoing process, rather than discrete events. Critically, this means learning happens whether intended or not, and this creates possibility that such unintended learning opportunities may be teaching things that we do not account for, do not want, or actively contradict desired outcomes (Rogers, 2003; Billett, 2014a). Conceiving of learning as an ongoing process also emphasises the importance of day-to-day interactions and norms in the workplace in influencing what workers learn (Rogers, 2003; Billett, 2006; Eraut, 2007). Studies of various workplaces, including health and social care, have demonstrated these socialisation-type influences on learning, highlighting that the people, spaces and situations available when "doing" the work are significant to what is learned regardless of formalised training (Boud and Middleton, 2003; Hunter *et al.*, 2008; Avby, 2015; Gherardi and Rodeschini, 2016; Reich, Rooney and Hopwood, 2017; Anvik *et al.*, 2020). Again, this suggests that to fully understand how care home dementia care is learned, one must be open to the impact of all influences rather than focussing down onto specific (training) events.

Thirdly, viewing learning as social and ongoing highlights that it can be both purposeful and intentional, but also informal, unintentional and even unconscious (Reece and Walker, 2007; Marsick *et al.*, 2009; Manuti *et al.*, 2015). Learning may occur when someone is focussed on something else, such as task-completion or problem-solving (Rogers, 2003). Informal types of learning can be hidden and thus taken for granted (Marsick *et al.*, 2009), but this is not the same as being unmalleable; as Clardy (2018) argues, there is a need to understand and take advantage of such opportunities. In health and social care workplaces, informal learning opportunities have been shown to implicate reflection, feedback and managing change

(Skaalvik, Normann and Henriksen, 2012; Hetzner, Heid and Gruber, 2015; Gherardi and Rodeschini, 2016; Sparr, Knipfer and Willems, 2017a; Ryding, Sorbring and Wernersson, 2018; Anvik *et al.*, 2020), as well as applying negative and tacit knowledge (Eraut, 2000; Nicolini *et al.*, 2008; Marsick *et al.*, 2009; Teunissen, 2015; Gartmeier *et al.*, 2017). Therefore, the extent to which different informal opportunities exist in the care home and how they shape what is learned about 'doing care' is vitally important to understand.

Overall, evidence suggests that in order to effectively understand and influence care worker learning, a comprehensive understanding of how that learning occurs, that is practice-based and embedded within the contexts of workplace and relationships, is required. Without an understanding of this process, rooted within perspectives of those who work and live in care homes, it is likely that efforts to facilitate learning PCC will be ineffectual. Furthermore, in a resource-strapped sector such as care homes, failure to understand and utilise existing reserves within workplaces is unacceptable. Therefore, this study aimed to provide this understanding by exploring how care workers learned to care for people living with dementia in care homes.

Design and Data Collection

Methodology

This study was a focussed, critical ethnography. Ethnography is designed to explore typical patterns of interaction, thinking, and meaning-making in communities, whilst retaining the context-specific nature of these activities (Hammersley and Atkinson, 2007; Fetterman, 2010). In this study, ethnography enabled the exploration of learning as a social phenomenon, created by interaction and shaped by the context of the care home. Focussed ethnography is an adaptation to enable investigation of familiar phenomena taking place in complex communities (Lewis and Russell, 2011; Cruz and Higginbottom, 2013; Rashid, Caine and Goez, 2015). It is characterised by shorter-term field visits that prioritise intensity of data collection (Knoblauch, 2005; Liou, 2014), alongside a spotlight on relevant sub-groups (Higginbottom, 2011; Stephens, Cheston and Gleeson, 2012). A critical ethnography – whilst

not differing in method from broader ethnography – meant that this study's orientation was to challenge existing assumptions about learning PCC in care homes and move beyond description towards creating impetus for change (Thomas, 1993; Carspecken, 1996; Kincheloe and Mclaren, 2005; Madison, 2005). This is common within care and health ethnography when the intention is to challenge existing practices and highlight unheard perspectives such as those of people living with advanced dementia (Bransford, 2006; Bourbonnais and Ducharme, 2010; Bambustic, 2011; Deforge *et al.*, 2011; Rashid, Caine and Goez, 2015).

Study context

Fieldwork involved two care homes in Central England. The homes were purposively selected to contrast; a common focussed ethnographic strategy (Spiers *et al.*, 2014). The first (CH1) was home to 34 residents and registered to provide care only. It was owned by a large not-for-profit organisation. The second (CH2) was home to 38 residents and provided nursing care. It was owned by a small, for-profit, local organisation. Fieldwork occurred sequentially in each home across 14 months, with approximately two days a week spent in the homes.

Participant recruitment

Recruitment aimed to represent the dementia care community in each care home, with a particular focus on advanced dementia. As such, processes were concerned with identifying appropriate residents and the staff who worked with them. Resident recruitment utilised these inclusion criteria:

(1) Living with dementia;
(2) Experiencing additional dependency due to physical, communication or behavioural needs;
(3) Met consent/consultee process specified by the approved ethics protocol

Residents who experienced acute mental or physical health challenges were excluded. This resulted in a group of twelve resident participants at CH1 and eight at CH2.

Staff inclusion criteria were as follows:

(1) Had contact with resident participants

(2) Engaged in a care role or had regular contact with participating residents
(3) Provided informed consent

This resulted in a group of twenty staff participants at CH1 and thirteen at CH2

Data collection

This study used an iterative approach to data collection and analysis, applying a variety of methods as described below. Volume and specifics of data is summarised in table i.

<<take in table I here (Source: Authors own work)>>

The default data collection method was ethnographic observation in public areas of the home. This was not full participant observation as care tasks were not undertaken, but a role akin to a volunteer. A contemporaneous research diary recorded events, locations, reflective notes and material aspects of culture such as documents, policies, objects and use of space (Crang and Cook, 2007; Clarke, 2009; Engin, 2011; Silverman, 2011)

Ethnographic observations were complemented by focussed observations using the PIECE-dem (Person, Interaction, Environment Care Experience in Dementia) framework for observing care experiences of people living with advanced dementia and complex needs (Brooker *et al.*, 2013; Killett *et al.*, 2016). This guided attention onto activity known to affect well-being. Such a tool enabled recognition of highly individualised, subtle expressions (such as finger movement or a sigh) available to those with advanced dementia that could be lost in general observation. PIECE-dem was utilised to check tentative conclusions through the perspective of residents living with advanced dementia.

Interviews were semi-structured to ensure focus on key topics, (Rubin and Rubin, 2005; Hammersley and Atkinson, 2007; Fetterman, 2010). Interviews also used vignettes based on observed practice (Wareing, 2010b, 2010a), as these enabled exploration of learning without explicitly mentioning learning; something highlighted as important when informal learning is thought to predominate (Boud and Middleton, 2003; Eraut, 2004, 2007). In both care homes, 'in-situ' interviews occurred alongside observations, replicating interviews in bite-sized conversations necessary when workers could not take time away from work.

Data analysis

The analytic approach had three features. Firstly, in line with focussed, critical ethnography, analysis was iterative. This gradually funnelled data towards areas of emerging interest. (Fereday and Muir-Cochrane, 2006; Hammersley and Atkinson, 2007). Secondly, analysis was inductive, using the data collected to build the model of "Learning to Care". Inductivity is common within ethnographies, (Miles, Huberman and Saldana, 2014). Finally, in line with many care home ethnographies, analysis was thematic (Bourbonnais and Ducharme, 2010; Taylor, Sims and Haines, 2014). Thematic analysis segments, categorises, and summarises data in order to capture significant concepts and describe influential connections (Braun and Clarke, 2013; Vaismoradi, Turunen and Bondas, 2013).

Ethics approval

This study was approved by the Social Care Research Ethics Committee in November 2014, REC reference 13/IEC08/0036. All names/initials used are pseudonyms.

Findings

Data coalesced around three key themes and their subthemes. By exploring these themes and their interrelationship, a multi-level process of how care workers in care homes learn to care for people living with dementia emerged. This "Learning to Care" model (LtCM) is visually represented in Figure 1. Each level and relevant themes will be discussed using typical examples from the data.

<< Take in Fig 1 here- (Source: authors own work)>>

Action Level: Day-to-day learning through 'What Works is What Matters'

<<Take in Fig 2 here - (Source: authors own work) >>

As shown in Figure 2, the Action Level describes the mechanisms for learning that existed within day-to-day encounters of care work with residents living with dementia. This is explained by theme one: **What Works is What Matters;** the most frequent and influential theme evidenced in both care homes. Essentially, learning occurred at this level when a care worker responded to a situation or undertook a task and saw that their action achieved a

successful outcome. When successful, a practice would be repeated and shared. This process could result in different practices being learned dependent on how "success" was determined. The three subthemes describe the circumstances which shaped success for the worker.

The first subtheme; *'seeing results' (1.1)* described how care workers learned by judging if an action achieved a satisfactory result. Satisfactory results were determined by considering three factors: results for residents, fulfilling role expectations and trial and error, the relative importance of which was influenced by the workplace. Considering results for residents generally produced learned practice that was in-line with PCC because an appropriate "result" combined achievement of the intended practical outcome (such as bathing a resident) with achieving an appropriate emotional response from the resident (such as positive feedback or avoiding negative emotion). Contrary to this, fulfilling role expectations could produce less PCC, because an appropriate result required not only achievement of the intended practical outcome but also specific worker behaviour that met expectations of other staff for their role (such as not being seen to sit down or rest). Trial and error influenced learning because care workers often responded to unpredictable situations by trying out different actions and assessing what was successful or not. This was highlighted as particularly relevant when caring for people living with dementia because fluctuating needs and abilities led to unpredictability.

A care worker at CH1 demonstrated results for residents as her guiding principle when learning whether to tell the truth to residents who asked about absent family:

> *"If you know that they are going to completely break down, don't tell her no lies but just go along with it. Whereas, with (Resident F) very much tell her straight because…she can take the truth. (The aim is) just to keep them settled, I think. Regardless of what you say (Resident O) seems happy whereas potentially you could lie to (Resident F) and it would make the situation worse" (Interview, CH1)*

Contrastingly, the following observation at CH2 illustrated that fulfilling role expectations of completing tasks on time often governed learned practice:

> *"Resident N is sitting in the lounge watching TV, a nurse is sat with her. (Carer J) comes in and the nurse tells her that Resident N likes Emmerdale. (Carer J) replies "she's going to bed". Nurse replies "oh, okay then but put it on in her room, she likes it" (Observation, CH2)*

The second sub-theme that helped determined "success" related to *'negotiating conflicting pressures' (1.2).* Care workers identified that much of their work occurred in situations where it was not possible to achieve everything, because of conflict between resources and need. Therefore, a practice was learned if it helped to balance such pressures in-line with *seeing results (1.1).* Higher levels of flexibility and autonomy for care workers in managing time, tasks and resources increased the likelihood of PCC in these situations. The contrast between attitudes to providing activity during times of reduced staffing illustrated the different outcomes to this negotiation in the two homes:

> *"Put everybody back to bed, then there will be activities going on if we've got enough staff. We'll allocate one of them to do quizzes or reminiscence" (Interview, CH2)*

> *"Staff do not seem stressed even though they are short-staffed, exchanges are still meaningful. Later on, when chatting to (Carer V) about being short-staffed, she says 'you can still interact with them can't you?' There seems to be a rule here that even when they can't do everything, just being with people is important" (Observation, CH1)*

The third sub-theme care workers applied when considering success could be characterised as *'being thrown in at the deep end' (1.3).* Feeling under-prepared was identified as an inescapable part of the job, connected to both dementia and care work generally. Therefore, being willing and able to respond and adapt in these situations was seen as an essential component of learning. A care worker at CH1 described how she first learned to interact with Resident J, a lady with perseverated speech which could be hard to interpret:

> *"They literally just did this: 'Here's Resident J!" and I was like, I don't know what to do with her…(but) I realised that if you walk down the corridor and go 'alright, J!' she smiles at you and makes noises at you and (the noises) somehow make sense! It's weird, but you just have to do it." (Interview, CH1)*

Resource Level: Skills and knowledge applied in day-to-day learning

<<Take in Fig 3 here - (Source: authors own work)>>

The Resource Level is shown in figure 3 and demonstrates that, when formulating applicable actions within the "**What Works"** learning process, care workers drew on information and skills from three, increasingly important, resources: personal experiences, resident influences and cultural knowledge. These resources created a conduit through which other factors such as training and colleagues could influence learning but, crucially, this influence was indirect: something was learned if it 'worked' but was dismissed if it did not.

Personal Experiences were the least influential input and affected a worker's overall approach. Care workers applied their values alongside previous work or life experience to their current work and this helped them consider different actions available:

> *"I've done this for 12 years, you get to know the look of someone's face, the way their hands are acting, either they've had a good or bad night. You just have to adjust to everything you see" (Interview, CH1)*

Knowledge related to *Resident Influences* played a role in shaping care workers learning in two ways. Learning *from* residents occurred when a worker received personal feedback (whether verbal, physical or emotional) from the resident, with actions that were perceived by the worker to enhance the quality of relationship being repeated. Learning *from* most often resulted in PCC. Learning *about* residents outside of direct contact (e.g., from care plans) was less influential because care workers experienced this information as being static and thus less useful to resolving day-to-day situations:

"Carer J explains that she knows she does the right thing by (Resident K) because once, when she said in passing 'oh, I do love you, K', he replied 'I know you do'. This meant a huge amount." (Observation, CH1)

Cultural Knowledge was by far the most influential resource that care workers utilised in their learning and thus it strongly shaped resulting practice. It comprised two themes; **Interactions with Colleagues** (theme two) and **Formal Training** (theme three), which connected the Resource Level with Organisational Level influences.

Organisational Level: Structurally determined aspects of cultural knowledge

<<Take in Fig 4 here - (Source: authors own work)>>

Figure 4 illustrates the contributors to *cultural knowledge* resource available for care workers to draw on in their day-to-day work. It was heavily circumscribed by the organisational context of the individual care home. Thus, organisational influences at this level, such as management decision-making, division of work and boundaries of different roles shaped learning and subsequent practice. Crucially, *cultural knowledge* was not applied directly, rather it was utilised through the "**What Works"** process. This meant that the effect on learning of both **Interactions with Colleagues** and **Training** was indirect.

Interactions with Colleagues emerged as the second most influential theme affecting how care workers learned. Four types of interaction with colleagues, shaped by existing relationships and circumstances in the care home, created the subthemes, providing opportunities for guidance that the care worker would apply within their day to day "**What Works"** learning.

The first subtheme of **Interactions with Colleagues** related to being *formally shown or told (2.1)* in which routines instituted by management provided opportunities to instruct or demonstrate desired practice. These routines included daily events such as handovers and mandatory 'shadowing' of more experienced staff within a worker's induction. However, whilst all care workers recalled these routines and their influence, it was acknowledged by all to be an imperfect process, highly dependent on the organisation of work and teams and

often compromised by staffing issues. The influence of this compromise was most noticeable at CH2, as care workers operated as two distinct staff teams, with little crossover between them or with other roles in the home, resulting in rigid, routinised and non-PCC practice:

> *"(for induction) they would normally go with the team leader. They are the most experienced. My guys, because they're in two teams they will work with that team and learn from their peers as they go along" (Interview with manager, CH2)*

> *"To be honest, we don't tend to have a lot to do with (carers induction)" (Interview with Nurse, CH2)*

This can be contrasted with the CH1 approach which resulted in more PCC practice:

> *"I'll pick the best one that I've got on. There's very few that I wouldn't, they're generally the more old-fashioned carers that I don't want them picking up habits… It makes or breaks whether someone wants to work here" (Interview with Deputy Manager, CH1)*

This contrast was reiterated within the homes' induction paperwork, with CH2's listing a series of tasks and CH1's prompting discussion about the home's ethos of 'being-with' residents. Handover routines also contrasted. In CH1, these were discursive and interactive involving most staff. In CH2, care workers never attended, with only their team leader receiving instructions from the nurse.

The second subtheme of **Interactions with Colleagues** was *asking and being given advice (2.2).* This comprised frequent, informal exchanges between colleagues. Care workers sought out advice from those who were available when they were uncertain about a situation, choosing to ask experienced and well-thought of colleagues, rather than deferring to seniority:

> *"You're always learning off people. If there's a situation I'm not used to and it didn't go particularly well… then I would go to (Carer Y) because she's here 5 days a week, so she knows them inside out." (Interview, CH1)*

Care workers also gave unsolicited advice to colleagues when deemed necessary, usually to correct practice:

> *"I explain all these things to them as I'm working… if you can pass on knowledge and experience that makes for better carers and company" (Interview, CH2)*

These interactions resulted in different care practice dependent on the variety of colleagues available to a particular worker. Where the organisation of daily work meant a care worker encountered a range of different colleagues and roles, they had a wider variety of people to seek advice from, resulting in more flexible PCC. This was the case at CH1, due to overlapping teams, shift patterns and responsibilities. Contrastingly, at CH2, the static shift teams and rigid boundaries between roles meant that care workers only had a limited range of colleagues with whom they could exchange advice.

Observing others (2.3) was the third subtheme of **Interactions with Colleagues** and another informal process, distinct from officially facilitated shadowing. It occurred frequently with the worker choosing who to observe and learn from based on their personal opinion of the colleague. Again, the range of colleagues available to a worker appeared to influence the flexibility of practice learned. In addition, relationship quality mattered because it determined whether a colleague would be deemed worthy of learning from:

> *"I get disapproving looks every time (I dance). Some people are just so set in their ways. I'm hoping that some of the other carers will take note; (Carer V) for instance. She was so stuck working with people who were square that now somebody has gone in and said 'let's party' she's (realised) I can do that!" (Interview, CH1)*

The final subtheme of **Interactions with Colleagues** related to *Communication and categorisation (2.4)* in the home. These practices sent implicit messages about boundaries and expectations of care work alongside literal meanings. These messages were then incorporated into the "**What Works"** learning process. Communication and categorisation occurred through several means: written documents (e.g., memos, care records); the

environment (e.g., identifying areas of the home as 'hard work'); and management talk (e.g., phrases used to describe care work). For example, at CH2 there was a strong message of care work as busy, hard work that offered little opportunity for 'sitting down':

> *"Conversation with Carer J as I sat observing in the lounge. I said I was tired and J laughed, asking if I want to swap saying that she would like to "sit around taking notes" whilst I ran around. Being busy is definitely the order of the day here" (Observation, CH2)*

The shorthand care workers used when communicating amongst themselves also served to send these implicit messages about their work. Shorthand occurred whenever a task or resident was spoken about in a non-literal way. This took the form of phrases such as *"I am going to do Mrs R"* instead of *"I am going to help Mrs R to get dressed"*. Shorthand influenced learning because, in order to understand it, the care worker had to intuit what it meant from previous experiences. The use of frequent shorthand, when not interspersed with more detailed descriptions, resulted in less PCC practice because it offered no opportunities for nuance or clarification.

The third and least influential theme related to **Training.** Its influence on practice was indirect as a component of the *cultural knowledge* that care workers employed within the "**What Works"** learning process. Three aspects of training were particularly relevant to this indirect process and form the subthemes.

Gatekeeper tasks (3.1) related to specific tasks that could not be performed without prior mandatory training, such as moving and handling people. This meant that, without such training, a person could not carry out tasks considered fundamental to the care worker role and therefore were not viewed by others as being a "proper" care worker. However, despite this differentiation, the influence of such training was still primarily informal, because it was overridden in practice if it was deemed to fail the **"What Works"** mandate. Learning from training could fail if it did not produce the desired result, or if other mechanisms of learning (such as interactions with colleagues) did not reinforce it.

> *"As a new carer its hard, because you should know from the manual handling training, because they tell you…but if I work with someone who is an old carer, I gently remind them, you know there's (equipment) there," (Interview, CH2)*

This conditional impact of **Training** was emphasised further by the subtheme *knowing the job, not care (3.2).* Care workers identified that much training was experienced as being relevant to the job, but disconnected from the act of caring itself. This meant that whilst training was viewed as necessary in order to be a care worker, it was not what differentiated good and poor care. Training was seen as an unavoidable hurdle rather than essential to shaping practice. Instead, the "doing" of care was the significant experience.

> *"It's frustrating to have to sit and watch, because (you learn) hands-on. It has to be hands-on because everyone is different. You learn from interacting and learning their triggers. It has to be hands-on because it's about people and relationships with them" (Interview, CH2)*

The final **Training** subtheme, *application (3.3),* illustrated that it was the way that training was utilised that often determined any influence on practice. This required conscious effort from management to enable the application of learning from training. This occurred by explicitly integrating training experiences into other systems in the home, such as supervisions and handovers, pairing staff, and encouraging staff ideas. When this sophisticated thinking about activating training occurred, training was more likely to influence practice and that practice was more likely to be person-centred.

> *"You can inherit staff (who) can be old fashioned in the way that they do things... So quite often when we do training we'll be careful about who we'll put them with. We'll put them in with the (staff who have) new ideas" (Interview, CH1)*

Describing the operation of the three themes of the LtCM across the levels of day-to-day action, utilisation of resources and organisational influences demonstrates that learning to care is essentially and inevitably a model of learning to care *in this particular place*. The

same themes and processes occurred in both care homes but they resulted in different care practices because Organisational and Resource Level factors are drawn into the Action Level learning process of **What Works is What Matters.** The Resource Level enables individual workers to utilise knowledge and skills shaped by their *personal experiences, resident influences* and *cultural knowledge* as they participate in the day-to-day **What Works is What Matters** learning. Thus, the utility of these resources is based on their ability to help a care worker practice care that "works" in the context of the particular care home. Organisational Level influences (such as division of work tasks, team composition and role boundaries) are imported into the learning process as *cultural knowledge*; a resource determined by the highly significant **Interactions with Colleagues** and the less consequential **Training**. Again however, their utility is determined by the extent to which they provide successful solutions to daily work through the **What Works is What Matters** process.

Discussion

The LtCM is an original description of the day-to-day mechanisms of learning to care for people living with dementia from the perspective of those who live and work in the care home. By articulating this in full, the aim is that those interested in affecting achieving PCC are able to develop interventions and approaches to learning that: (1) move beyond simply delivering knowledge to care workers, (2) incorporate the reality of how dementia care practice is learned, and, (3) transfer the wealth of knowledge about learning that already exists in other disciplines to the dementia care field. Therefore, this discussion addresses how the LtCM connects with broader understandings of learning in the workplace, and the practical implications of this for improving PCC in dementia care homes.

The significance of care home culture for learning to care

The pervasive effect of organisational culture on care quality in care homes has been explored empirically (Caspar *et al.*, 2013; Killett *et al.*, 2016). It is known to be influential because it provides useful solutions to the problems workers face day-to-day and thus is self-reinforcing (Killett *et al.*, 2016; Schein, 2017). Features of organisational culture have

also been identified as significant to facilitating learning, (Evans *et al.*, 2006; Bridges and Fuller, 2015; Ellström and Ellström, 2018; Anvik *et al.*, 2020). By describing the specific mechanisms through which learning occurs, the LtCM affirms the importance of organisational culture to achieving PCC in dementia care homes and demonstrates for the first time precisely *how* it is drawn upon within the learning process. With this understanding comes an ability to shape that influence towards improving care practice.

Aspects of organisational culture such as decision-making about configuration of work tasks, composition of teams and prevailing perceptions as to what constitutes success ('what works') shaped the circumstances workers encountered within their learning and thus influenced learned practice in the following ways:

(1) setting the boundaries of acceptable results (whether these related primarily to resident well-being or fulfilling expectations);

(2) determining the nature of conflicting pressures that needed to be negotiated;

(3) shaping the milieu into which workers were 'thrown'.

It is easy for this type of decision to be considered mundane and inconsequential and thus be unexamined by those enacting it day-to-day, such as care home managers and providers. However, the LtCM warns against this inattention and identifies specific activities that need to be considered alongside efforts to improve practice, such as planning rotas, differentiating role responsibilities and the focus of daily reward and reprimand, to ensure that they do not work at cross purposes to PCC.

The influence of these practical aspects of organisational culture highlighted by the LtCM also helps to explain why multi-component quality improvement interventions within dementia care are more successful at translating learning into practice (and thus quality outcomes) than those focussed only on delivering training to care workers. The additional components influence these key decisions and reconfigure organisational structures ensuring that the training element is more likely to be reinforced, rather than contradicted, by the far more influential process of learning through "What Works". Therefore, this LtCM provides a way for future quality-improvement and learning interventions in dementia care homes to be built in awareness of the consequential aspects of organisational culture. It also

strengthens the argument that training of care workers is not by itself the primary route to improving delivery of PCC.

Communities of practice and learning to care

Interactions with colleagues formed a crucial part of the LtCM. It was the primary contributor to the cultural knowledge resource employed by workers within the "What Works" process. Whilst its influence was indirect, it was not insignificant because the outcomes of "What Works" fed-back into future interactions with colleagues. This created a self-reinforcing cycle in which past learning of practice influenced the cultural knowledge that could be drawn on in future learning of practice. This highlights two important issues related to the composition of this staff grouping.

Firstly, the LtCM demonstrated the following defining features of a COP within the care home setting (Lave and Wenger, 1991):

(1) meaning (as 'what works') was socially negotiated within the care home in the process of doing work;

(2) internalisation of knowledge by individuals was less significant to practice than the care home context within which a worker participates because of this social negotiation;

(3) opportunity and organisation of relationships in the care home were therefore significant to shaping the learning that occurred.

The relevance of COP theory has only been narrowly explored within care home settings thus far; either with reference to specific aspects of care (Gherardi and Rodeschini, 2016) or within efforts to create formalised multi-disciplinary COP between care homes and healthcare or other experts (Anvik *et al.*, 2020; Hullick *et al.*, 2022; Read *et al.*, 2023). The LtCM reinforces the relevance COP for those who wish to influence practice learning in the care home. It also advances the understanding of relevant care home COP by describing the informal, 'naturally' developing COP and the contingencies of its impact on learning dementia care practice. This provides detail as to the mechanisms through which initiatives such as COP actually affect outcomes, knowledge that has been called for to enhance COP

functionality in the sector (Read *et al.*, 2023). For example, the LtCM would suggest that a COP that prioritises nurses or managers rather than care workers will not reach the heart of learning dynamics in a care home.

The LtCM has also extended the evidence for COP beyond new entrants, addressing a common criticism of the original concept (Fuller *et al.*, 2005). More significantly, critics of COP theory argue that it does not explain the specific processes of learning that occur within the COP and fails to consider the effect of organisational factors (Illeris, 2003; Thomas, 2017). The LtCM demonstrates the ways in which the care home COP influenced the cultural knowledge that workers applied to their day-to-day learning and highlights how organisational decision-making circumscribed the composition of the COP, impacting on learning. Further to this, within the LtCM workers displayed choice within COP interactions. Subthemes 2.2 and 2.3 (asking for/giving advice and observing others) showed that workers chose who to consult with, listen to, observe or provide guidance for. This suggests that sometimes a worker constructs their own chosen-COP from whom they will learn, rather than being influenced by the COP as a whole. Illeris (2003) critiqued COP theory for subsuming workers' agency within the COP process, and the LtCM explains how individuals were active agents within such a process. Significantly, when aiming to achieve PCC, the basis of this chosen-COP was not necessarily rooted in PCC but in interpersonal relationships.

This leads to the second significant consideration for the care home COP prompted by the LtCM: the importance of interpersonal skills. The extent and quality of learning within the LtCM was highly influenced by the interpersonal skills of workers. This concurs with the importance PCC literature places on interpersonal skills (Kitwood, 1997; Kadri *et al.*, 2018; Sabat, 2019). However, these have not been linked explicitly to learning processes. This study suggests that how staff related to one another was a highly important component of facilitating the learning of PCC. Within the current dementia care and care home field, these aspects are often considered secondary to providing competence and knowledge-based content to "unqualified" care workers. The LtCM suggests that to improve PCC practice, attention must be given to developing skills that workplace learning literature has long-since recognised as significant such as: developing trust and rapport, positive relationships, team working and communication skills (Fejes and Nicholl, 2011; Newton *et al.*, 2015; Leicher and

Mulder, 2016; Mornata and Cassar, 2018; Jack, Jones and Hamshire, 2021; Hullick *et al.*, 2022). The LtCM also articulates the organisational challenges to creating such features such as pace of work, poor leadership and insufficient resources (Evans *et al.*, 2006; Bound and Lin, 2013; Noar *et al.*, 2023; Hockley *et al.*, 2024). These findings challenge the predominant conception of learning PCC as aimed towards training in expert practice, replacing it with one of learning to facilitate reflexivity, empower others and function effectively as a team (Newton *et al.*, 2015; Leicher and Mulder, 2016; Anvik *et al.*, 2020; Jack, Jones and Hamshire, 2021). Without such skills, any efforts to explain, promote and resource PCC could well be compromised at the first learning hurdle; when it has to be communicated from one person to the next.

The dominance of informal learning for learning to care

The LtCM demonstrates that learning to care took place primarily through processes that are not explicitly focussed on or designed for learning. This lends weight to the argument that the current narrow focus on training to improve PCC is unwarranted. The "What Works" process demonstrated routes of learning that occurred when workers engaged in the practice of 'doing work', rather than 'doing learning'. The way in which resources were drawn upon within the "What Works" process highlighted the subtle activities of relationship, which is best described as incidental learning; learning that occurs when a person is exclusively focussed on a task (Rogers, 2003; Marsick *et al.*, 2009). Several concepts elucidated within existing informal learning literature should therefore be operationalised in future efforts to improve dementia care practice.

Firstly, learning via socialisation was strongly implicated within the "What Works" process. Socialisation occurs whilst workers engage in the mundane activity and interactions of their day-to-day work and it determines the way workers understand their purpose and interpret situations (Rogers, 2003; Eraut, 2004; Marsick *et al.*, 2009; Gherardi and Rodeschini, 2016). By performing the job, workers master organisational processes as well as the technical actions required (Boud and Middleton, 2003; Eraut, 2007; Billett, 2014a). However, the LtCM highlighted that there is a care home-specific property of socialisation which had the potential to influence learning towards PCC. Residents were contributors to this cultural

climate in which workers were socialised. This is something that makes care homes distinct from many workplaces thus far empirically investigated. Therefore, the LtCM indicates that resident experience could be a significant factor in influencing learning if other aspects of that climate permitted it. This suggests, that considering how resident feedback is interpreted and integrated into daily work (for example through observational practices), is an important dimension to influencing care home learning.

The second example of informal learning present within the LtCM is problem-solving. Subtheme 1.3 (thrown in the deep end) arose from the unpredictability of dementia care, and subtheme 1.2 (negotiating conflicting pressures) concerned solving the dilemmas that were an everyday part of practice. Change, uncertainty or unpredictable work all present critical 'disjunctions' for workers, placing expectations and reality at odds and requiring problem-solving (Marsick *et al.*, 2009; Hetzner, Heid and Gruber, 2015; Takase *et al.*, 2015). The LtCM suggests that these disjunctions are actually the core of care work, rather than occasional, unusual events. Thus, accepting this ubiquity and nature of the disjunctions faced each day is central to influencing that learning. Indeed, some isolated work in care homes shows the promise of interventions that directly confront every-day problem solving such as: facilitating peer-assisted learning,(Jack, Jones and Hamshire, 2021) occupational adaptation of knowledge (McKay *et al.*, 2020) and expert facilitated reflection (Hockley *et al.*, 2024). The LtCM indicates a need to more fully resource and evaluate these more innovative approaches.

Reflection is the third significant component identified within the LtCM. This is unsurprising given its significance within curricula of other 'caring', people-focussed professions such as nursing and social work (Kyndt, Vermeire and Cabus, 2016; Ryding, Sorbring and Wernersson, 2018). However, what is noteworthy was the predominance of informal reflection-in-action as opposed to reflection-on-action; considering situations after the fact, addressing feelings, actions and outcomes in a potentially more systematic way (Schon, 1991; Moon, 2000; Gibbs, 2015). Learning through reflection within the LtCM was subsumed within other, more action-oriented events, with few explicit references. Again, understanding the circumstances under which reflection plays a role enables efforts to

influence that learning. This could be achieved by creating more opportunities within daily work to bring such reflection under explicit attention. Here, existing literature indicates environmental factors which maximise the benefits from reflective practice: creating temporal spaces for reflection (Liveng, 2010; Kubiak and Sandberg, 2011; Anvik *et al.*, 2020); providing opportunities for feedback (Kyndt, Vermeire and Cabus, 2016; Sparr, Knipfer and Willems, 2017b; Takase, Yamamoto and Sato, 2018); utilising regular opportunities such as handover (Reich, Rooney and Hopwood, 2017); and supporting more formalised activities such as critical incident groups or peer-assisted learning (Hetzner, Heid and Gruber, 2015; Jack, Jones and Hamshire, 2021).

Conclusion and limitations

This study has produced a model of "Learning to Care" derived from within the context of the dementia care home and the perspectives of those who live and work there. The LtCM demonstrated the primacy of informal modes of learning, with formalised attempts to influence learning only having indirect effect on practice. However, informality is not synonymous with uncontrollability. By providing insight into what occurs within day-to-day learning it becomes possible to influence the key events and decision-making towards the desired quality of care. The LtCM thus contributes to a more sophisticated understanding of the learning processes that result in PCC practices for people living with dementia in care homes and cautions against over-emphasising the role of traditional training in this. This has implications, not only for day-to-day efforts intending to foster quality dementia care, but also the design and implementation of any specific interventions intended to improve care practice; they must consider the dynamics of the LtCM to ensure their impact.

Inherent to an ethnographic approach is a recognition of the need for caution when extrapolating findings beyond initial settings. Therefore, it is important to note key study limitations. Only two care homes took part, limiting the range of care home and workforce characteristics that could be accounted for within data. For example, both care homes had a predominantly white, non-migrant staff group with low staff turnover. This is not comparable with the wider care home workforce. Moreover, as study data was collected in 2015/16 the discrepancy between participating homes' composition and that of the wider workforce has grown in the intervening years. This issue is important to consider because it is likely that

experiences of turnover, discrimination and migration will impact on workers' experiences of learning. Furthermore, organisational characteristics such as size of home, ownership and location will also impact on the organisational decision-making highlighted as important in the LtCM. Again, two care homes did not allow exploration of these factors. These limitations suggest that broader exploration of the LtCM to investigate such issues would be a valuable next step.

References

Anvik, C. *et al.* (2020) 'Practice-based learning and innovation in nursing homes', *Journal of Workplace Learning*, 32(2), pp. 122–134. Available at: https://doi.org/10.1108/JWL-09-2019-0112.

Avby, G. (2015) 'Professional practice as processes of muddling through: a study of learning and sense making in social work', *Vocations and Learning*, 8(1), pp. 95–113. Available at: https://doi.org/10.1007/s12186-014-9123-y.

Bambustic, J. (2011) 'Conducting critical ethnography in long term residential care: experiences of a novice researcher in the field', *Journal of Advanced Nursing*, 67(1), pp. 184–192.

Billett, S. (2006) 'Constituting the workplace curriculum', *Journal of Curriculum Studies*, 38(1), pp. 31–48. Available at: https://doi.org/10.1080/00220270500153781.

Billett, S. (2014a) 'Mimesis: learning through everyday activities and interactions at work', *Human Resource Development Review*, 13(4), pp. 462–482. Available at: https://doi.org/10.1177/1534484314548275.

Billett, S. (2014b) 'Securing intersubjectivity through interprofessional workplace learning experiences', *Journal of Interprofessional Care*, 28(3), pp. 206–211.

Bottery, S., Ward, D. and Fenney, D. (2019) *Social care 360*, *King's Fund*. London. Available at: https://www.kingsfund.org.uk/publications/social-care-360.

Boud, H. and Middleton, H. (2003) 'Learning from others at work: communities of practice and informal learning', *Journal of Workplace Learning*, 15(5), pp. 194–202.

Bound, H. and Lin, M. (2013) 'Developing competence at work', *Vocations and Learning*, 6(3), pp. 403–420. Available at: https://doi.org/10.1007/s12186-013-9102-8.

Bourbonnais, A. and Ducharme, F. (2010) 'The meanings of screams in older people living with dementia in a nursing home', *International Psychogeriatrics*, 22(7), pp. 1172–1184.

Bransford, C. (2006) 'The use of critical ethnography in mental health care settings', *Journal of Sociology and Social Welfare*, 33(4), pp. 173–190.

Braun, V. and Clarke, V. (2013) *Successful Qualitative Research*. London: Sage Publications, Ltd.

Bridges, J. and Fuller, A. (2015) 'Creating learning environments for compassionate care: A programme to promote compassionate care by health and social care teams', *International Journal of Older People Nursing*, 10(1), pp. 48–58. Available at: https://doi.org/10.1111/opn.12055.

Brooker, D. *et al.* (2013) 'The Development of PIECE-dem: Focussing on the Experience of Care for People Living with Advanced Dementia.', *The British Psychological Society Clinical Psychology Forum*, 250, pp. 38–46.

Brooker, D. and Latham, I. (2016) *Person-centred Dementia Care: making services better with the VIPS framework*. 2nd Ed. London: Jesscia Kingsley.

Brunkert, T. *et al.* (2019) 'Pain Management in Nursing Home Residents: Findings from a Pilot Effectiveness-Implementation Study', *Journal of the American Geriatrics Society*, 67(12), pp. 2574–2580. Available at: https://doi.org/10.1111/jgs.16148.

Care Quality Commission (2017) *The Adult Social Care Key Lines of Enquiry and Prompts: Sources of evidence*. London. Available at: https://www.cqc.org.uk/sites/default/files/20171220_ASC_assessment_framework_with_sources_of_evidence_v4_0_0.pdf.

Carspecken, P. (1996) *Critical Ethnography in Educational Research*. London: Routledge.

Caspar, S. *et al.* (2013) 'Influence of individual and contextual characteristics on the provision of individualised care in long term care facilities', *The Gerontologist*, 53(5), pp. 790–800.

Clardy, A. (2018) '70-20-10 and the dominance of informal learning: a fact in search of evidence', *Human Resource Development Review*, 17(2), pp. 153–178. Available at: https://doi.org/10.1177/1534484318759399.

Clarke, K. (2009) 'Uses of a research diary: learning reflectively, developing understanding and establishing transparency', *Nurse Researcher*, 17(1), pp. 68–76.

Collin, K. and Valleala, U. (2005) 'Interaction among employees: how does learning take place in the social communities of the workplace and how might such learning be supervised', *Journal of Education and Work*, 18(4), pp. 401–420.

Crang, M. and Cook, I. (2007) *Doing Ethnographies*. London: Sage Publications.

Cruz, E. and Higginbottom, G. (2013) 'The use of focused ethnography in nursing research', *Nurse Researcher*, 20(4), pp. 36–43.

Deforge, R. *et al.* (2011) 'Afraid to care, unable to care', *Journal of Aging Studies*, 25, pp. 415–426.

Department of Health (2009) *Living Well With Dementia; A National Dementia Strategy*. London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf.

Ellstrom, E. (2012) 'Managerial support for learning at work: a qualitative study of first line managers', *Leadership in Health Services*, 25(4), pp. 273–287.

Ellström, E. and Ellström, P.E. (2018) 'Two modes of learning-oriented leadership: a study of first-line managers', *Journal of Workplace Learning*, 30(7), pp. 545–561. Available at: https://doi.org/10.1108/JWL-03-2018-0056.

Engin, M. (2011) 'Research diary: A tool for scaffolding', *International Journal of Qualitative Methods*, 10(3), pp. 296–306.

Eraut, M. (2000) 'Non-formal learning and tacit knowledge in professional work', *British Journal of Educational Psychology*, 70, pp. 113–136. Available at: https://doi.org/10.1348/000709900158001.

Eraut, M. (2004) 'Informal learning in the workplace', *Studies in Continuing Education*, 26(2), pp. 247–273.

Eraut, M. (2007) 'Learning from other people in the workplace', *Oxford Review of Education*, 33(4), pp. 403–422. Available at: https://doi.org/10.1080/03054980701425706.

Evans, K. *et al.* (2006) *Improving Workplace Learning*. London: Routledge.

Fejes, A. and Nicholl, K. (2011) 'Activating the worker in elderly care: a technique and tactics of invitation', *Studies in Continuing Education*, 33(3), pp. 235–249.

Fereday, J. and Muir-Cochrane, E. (2006) 'Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development', *International Journal of Qualitative Methods*, 5(1), pp. 80–92.

Fetterman, D. (2010) *Ethnography*. 3rd edn. London: Sage Publications, Ltd.

Fossey, J. *et al.* (2019) 'What influences the sustainability of an effective psychosocial intervention for people with dementia living in care homes? A 9 to 12-month follow-up of the perceptions of staff in care homes involved in the WHELD randomised controlled trail', *International Journal of Geriatric Psychiatry*, 34(5), pp. 674–682. Available at: https://doi.org/10.1002/gps.5066.

Fukuda, K. *et al.* (2018) 'Effectiveness of educational program using printed educational material on care burden distress among staff of residential aged care facilities without medical specialists and/or registered nurses: Cluster quasi-randomization study', *Geriatrics and Gerontology International*, 18(3), pp. 487–494. Available at: https://doi.org/10.1111/ggi.13207.

Fuller, A. *et al.* (2005) 'Learning as peripheral participation in communities of practice: a reassessment of key concepts in workplace learning', *British Educational Research Journal*, 31(1), pp. 49–68. Available at: https://doi.org/10.1080/0141192052000310029.

Gartmeier, M. *et al.* (2017) 'Learning from errors: critical incident reporting in nursing', *Journal of Workplace Learning*, 29(5), pp. 339–352. Available at: https://doi.org/10.1108/JWL-01-2017-0011.

Gherardi, S. and Rodeschini, G. (2016) 'Caring as a collective knowledgeable doing: About concern and being concerned', *Management Learning*, 47(3), pp. 266–284. Available at: https://doi.org/10.1177/1350507615610030.

Gibbs, G. (2015) 'Maximising Student Learning Gain', in H. Fry, S. Ketteridge, and S. Marshall (eds) *Handbook for teaching and learning in Higher Education*. 4th edition. Routledge.

Di Giulio, P. *et al.* (2019) 'The Impact of Nursing Homes Staff Education on End-of-Life Care in Residents with Advanced Dementia: A Quality Improvement Study', *Journal of Pain and*

Symptom Management, 57(1), pp. 93–99. Available at: https://doi.org/10.1016/j.jpainsymman.2018.10.268.

Griffiths, A.W. *et al.* (2019) 'Barriers and facilitators to implementing dementia care mapping in care homes: Results from the DCM^{TM} EPIC trial process evaluation', *BMC Geriatrics*, 19(1), pp. 1–16. Available at: https://doi.org/10.1186/s12877-019-1045-y.

Hammersley, M. and Atkinson, P. (2007) *Ethnography: Principles in Practice*. 3rd edn. Abingdon: Routledge.

Hauer, E. (2012) 'Developmental intervention, learning climate and use of knowledge in elderly care', *Journal of Workplace Learning*, 24(1), pp. 19–33.

Hetzner, S., Heid, H. and Gruber, H. (2015) 'Using workplace changes as learning opportunities antecedents to reflection in professional work', *Journal of Workplace Learning*, 27(1), pp. 34–50. Available at: https://doi.org/10.1108/JWL-12-2013-0108.

Higginbottom, G. (2011) 'The transitioning experiences of internationally-educated nurses into the Canadian healthcare system: a focused ethnography', *BMC Nursing*, 10(14).

Hockley, J. *et al.* (2024) 'Practicalities of promoting practice-based learning in end of life care for care home staff: Lessons from "online" supportive conversations and reflection sessions', *International Journal of Older People Nursing*, 19(1). Available at: https://doi.org/10.1111/opn.12598.

Hullick, C. *et al.* (2022) 'Supporting residential aged care through a Community of Practice', *Nursing and Health Sciences*. John Wiley and Sons Inc, pp. 330–340. Available at: https://doi.org/10.1111/nhs.12917.

Hunter, C.L. *et al.* (2008) 'Learning how we learn: an ethnographic study in a neonatal intensive care unit', *Journal of Advanced Nursing*, 62(6), pp. 657–664. Available at: https://doi.org/10.1111/j.1365-2648.2008.04632.x.

Illeris, K. (2003) 'Workplace learning and learning theory', *Journal of Workplace Learning*, 15(4), pp. 167–178.

Illeris, K. (2011) *The Fundamentals of Workplace Learning*. Abingdon: Routledge.

Inker, J. *et al.* (2020) 'Implementing Microlearning in Nursing Homes: Implications for Policy and Practice in Person-Centered Dementia Care', *Journal of Applied Gerontology* [Preprint]. Available at: https://doi.org/10.1177/0733464820929832.

Jack, K., Jones, L. and Hamshire, C. (2021) 'An educational initiative to support the development of communities of practice in older people's care home settings', *International Practice Development Journal*, 11(1), pp. 1–12. Available at: https://doi.org/10.19043/ipdj.111.007.

Jarvis, P. (2010) *Adult Education and Lifelong Learning: Theory and Practice*. London: Routledge.

Jessop, T. *et al.* (2017) 'Halting Antipsychotic Use in Long-Term care (HALT): A single-arm longitudinal study aiming to reduce inappropriate antipsychotic use in long-term care residents with behavioral and psychological symptoms of dementia', *International Psychogeriatrics*, 29(8), pp. 1391–1403. Available at: https://doi.org/10.1017/S1041610217000084.

Killett, A. *et al.* (2016) 'Digging deep: how organisational culture affects care home residents' experiences', *Ageing and Society*, 36(1), pp. 160–188. Available at: https://doi.org/10.1017/S0144686X14001111.

Kincheloe, J. and Mclaren, P. (2005) 'Rethinking Critical Theory', in N. Denzin and Y. Lincoln (eds) *Sage Handbook of Qualitative Research*. 3rd ed. London: Sage Publications, Ltd, pp. 303–342.

Kitwood, T. (1997) *Dementia Reconsidered: The Person Comes First*. Maidenhead: Open University Press.

Knoblauch, H. (2005) 'Focused Ethnography', *Forum: Qualitative Social Research*, 6(2001), p. Art. 44. Available at: http://www.qualitative-research.net/index.php/fqs/article/view/20/44.

Kubiak, C. and Sandberg, F. (2011) 'Paraprofessionals and caring practice: negotiating the use of self', *Scandinavian Journal of Caring Sciences*, 25(4), pp. 653–660. Available at: https://doi.org/10.1111/j.1471-6712.2011.00875.x.

Kuipers, P., Ehrlich, C. and Brownie, S. (2014) 'Responding to health care complexity: suggestions for integrated and interprofessional workplace learning', *Journal of Interprofessional Care*, 28(3), pp. 246–248. Available at: https://doi.org/10.3109/13561820.2013.821601.

Kuske, B. *et al.* (2007) 'Nursing home staff training in dementia care: a systematic review of evaluated programs', *International Psychogeriatrics*, 19(5), pp. 818–841.

Kutschar, P. *et al.* (2020) 'Nursing education intervention effects on pain intensity of nursing home residents with different levels of cognitive impairment: A cluster-randomized controlled trial', *Journal of Pain Research*, 13, pp. 633–648. Available at: https://doi.org/10.2147/JPR.S237056.

Kyndt, E., Vermeire, E. and Cabus, S. (2016) 'Informal workplace learning among nurses: Organisational learning conditions and personal characteristics that predict learning outcomes', *Journal of Workplace Learning*, 28(7), pp. 435–450. Available at: https://doi.org/10.1108/JWL-06-2015-0052.

Lave, J. (2009) 'The Practice of Learning', in K. Illeris (ed.) *Contemporary Theories of Learning*. Abingdon: Routledge, pp. 200–208.

Lave, J. and Wenger, E. (1991) *Situated Learning*. Cambridge: Cambridge University Press.

Leicher, V. and Mulder, R.H. (2016) 'Team learning, team performance and safe team climate in elder care nursing', *Team Performance Management*, 22(7–8), pp. 399–414. Available at: https://doi.org/10.1108/TPM-04-2016-0017.

Lewis, S. and Russell, A. (2011) 'Being embedded: a way forward for ethnographic research', *Ethnography*, 12(3), pp. 398–416.

Lichtwarck, B. *et al.* (2019) 'TIME to reduce agitation in persons with dementia in nursing homes. A process evaluation of a complex intervention', *BMC Health Services Research*, 19(1), pp. 1–17. Available at: https://doi.org/10.1186/s12913-019-4168-0.

Liou, C. (2014) 'Exploring staff-client interactions in adult day services centres: an ethnographic study in taiwan', *Journal of Ethnographic & Qualitative Research*, 8, pp. 85–98.

Liveng, A. (2010) 'Learning and recognition in health and care work: an inter-subjective perspective', *Journal of Workplace Learning*, 22(1), pp. 41–52. Available at: http://dx.doi.org/10.1108/13665621011012843.

Madison, D. (2005) *Critical Ethnography*. Thousand Oaks: Sage Publications.

Manuti, A. *et al.* (2015) 'Formal and informal learning in the workplace: A research review', *International Journal of Training and Development*, 19(1), pp. 1–17. Available at: https://doi.org/10.1111/ijtd.12044.

Marsick, V. *et al.* (2009) 'Informal and incidental learning in the workplace', in M. Smith and N. DeFrates-Densch (eds) *Handbook of Research on Adult Learning and Development*. Oxon: Taylor and Francis, pp. 570–600.

McKay, M.H. *et al.* (2020) 'Comparing Occupational Adaptation-Based and Traditional Training Programs for Dementia Care Teams: An Embedded Mixed-Methods Study', *The Gerontologist*, pp. 1–13. Available at: https://doi.org/10.1093/geront/gnaa160.

Miles, M., Huberman, A. and Saldana, J. (2014) *Qualitative Data Analysis*. 3rd Ed. London: Sage Publications, Ltd.

Moon, J. (2000) *Reflection in Learning and Professional Development*. London: Kogan Page Ltd.

Mornata, C. and Cassar, I. (2018) 'The role of insiders and organizational support in the learning process of newcomers during organizational socialization', *Journal of Workplace Learning*, 30(7), pp. 562–575. Available at: https://doi.org/10.1108/JWL-06-2017-0045.

Newton, J.M. *et al.* (2015) 'A contemporary examination of workplace learning culture: an ethnomethodology study', *Nurse Education Today*, 35(1), pp. 91–96. Available at: https://doi.org/10.1016/j.nedt.2014.07.001.

NICE (2018) 'NICE guideline 97 - Dementia: assessment, management and support for people living with dementia and their carers', (June 2018), p. 131. Available at: https://doi.org/10.1523/JNEUROSCI.3473-08.2008.Composition.

Nicolini, D. *et al.* (2008) 'Managing knowledge in the healthcare sector. A review', *International Journal of Management Reviews*, pp. 245–263. Available at: https://doi.org/10.1111/j.1468-2370.2007.00219.x.

Noar, A.P. *et al.* (2023) 'The aims and effectiveness of communities of practice in healthcare: A systematic review', *PLoS ONE*, 18(10 October). Available at: https://doi.org/10.1371/journal.pone.0292343.

Nolan, M. *et al.* (2006) *The Senses Framework: improving care for older people through a relationship-centred approach*. Sheffield.

Oliveira, M.P. and Sousa, L.X. (2020) 'VALIDA: A Validation Therapy-Training Program for Staff of a Residential Care Facility', *International Journal of Aging and Human Development* [Preprint]. Available at: https://doi.org/10.1177/0091415020920003.

Petyaeva, A. *et al.* (2018) 'Feasibility of a staff training and support programme to improve pain assessment and management in people with dementia living in care homes', *International Journal of Geriatric Psychiatry*, 33(1), pp. 221–231. Available at: https://doi.org/10.1002/gps.4727.

Prince, M. *et al.* (2014) *Dementia UK: Update*. London.

Rashid, M., Caine, V. and Goez, H. (2015) 'The encounters and challenges of ethnography as a methodology in health research', *International Journal of Qualitative Methods*, 14(5), pp. 1–16.

Read, M. *et al.* (2023) 'Communities of practice in residential aged care: A rapid review', *International Journal of Older People Nursing*. John Wiley and Sons Inc. Available at: https://doi.org/10.1111/opn.12563.

Reece, I. and Walker, S. (2007) *Teaching, Training and Learning: a practical guide*. Tyne & Wear: Business Education Publishers Ltd.

Reich, A., Rooney, D. and Hopwood, N. (2017) 'Socio-material perspectives on work and learning: sites of emergent learning', *Journal of Workplace Learning*, 29(7–8), pp. 566–576. Available at: https://doi.org/10.1108/JWL-05-2016-0034.

Reinhardt, J.P. *et al.* (2020) 'Dementia-focused person-directed care training with direct care workers in nursing homes: Effect on symptom reduction', *Journal of Gerontological Nursing*, 46(8), pp. 7–11. Available at: https://doi.org/10.3928/00989134-20200707-01.

Rogers, A. (2003) *What is the Difference? A new critique of learning and teaching*. Leicester: NIACE.

Rokstad, A. *et al.* (2017) 'The impact of the Dementia ABC educational programme on competence in person-centred dementia care and job satisfaction of care staff', *International Journal of Older People Nursing*, 12(2), pp. 1–10. Available at: https://doi.org/10.1111/opn.12139.

Rubin, H. and Rubin, I. (2005) *Qualitative Interviewing*. 2nd Ed. London: Sage Publications, Ltd.

Ryding, J., Sorbring, E. and Wernersson, I. (2018) 'The understanding and use of reflection in family support social work', *Journal of Social Service Research*, 44(4), pp. 494–508. Available at: https://doi.org/10.1080/01488376.2018.1476300.

Sævareid, T.J.L. *et al.* (2018) 'Implementing advance care planning in nursing homes - Study protocol of a cluster-randomized clinical trial', *BMC Geriatrics*, 18(1), pp. 1–12. Available at: https://doi.org/10.1186/s12877-018-0869-1.

Scerri, A. and Scerri, C. (2019) 'Outcomes in knowledge, attitudes and confidence of nursing staff working in nursing and residential care homes following a dementia training programme', *Aging and Mental Health*, 23(8), pp. 919–928. Available at: https://doi.org/10.1080/13607863.2017.1399342.

Schein, E. (2017) *Organizational Culture and Leadership* . 5th ed. New Jersey : Wiley & Sons Ltd.

Schon, D. (1991) *The Reflective Practitioner*. London: Routledge.

Silverman, D. (2011) *Interpreting Qualitiative Data*. 4th edn. London: Sage Publications, Ltd.

Skaalvik, M.W., Normann, K. and Henriksen, N. (2012) 'Nursing homes as learning environments: the impact of professional dialogue', *Nurse Education Today*, 32(4), pp. 412–416. Available at: https://doi.org/10.1016/j.nedt.2011.03.001.

Skills for Care (2016) *The Care Certificate Standards*. Available at: http://www.skillsforcare.org.uk/Documents/Learning-and-development/Care-Certificate/The-Care-Certificate-Standards.pdf.

Skills for Health, Health Education England and Skills for Care (2018) 'Dementia Training Standards Framework'. Available at: http://www.skillsforhealth.org.uk/images/projects/dementia/Dementia Core Skills Education and Training Framework.pdf.

Sparr, J., Knipfer, K. and Willems, F. (2017a) 'How Leaders Can Get the Most Out of Formal Training: The Significance of Feedback-Seeking and Reflection as Informal Learning Behaviors', *Human Resource Development Quarterly*, 28(1), pp. 29–54. Available at: https://doi.org/10.1002/hrdq.21263.

Sparr, J., Knipfer, K. and Willems, F. (2017b) 'How leaders can get the most out of formal training: the significance of feedback-seeking and reflection as informal learning behaviours', *Human Resource Development Quarterly*, 28(1), pp. 29–54.

Spiers, J. *et al.* (2014) 'Graduate nurses' learning trajectories and experiences of problem based learning: a focussed ethnography study', *International Journal of Nursing Studies*, 51, pp. 1462–1471.

Stephens, A., Cheston, R. and Gleeson, K. (2012) 'An exploration into the relationships people with dementia have with physical objects: an ethnographic study', *Dementia*, 12(6), pp. 697–712.

Stolee, P. *et al.* (2005) 'Factors Associated With the Effectiveness of Continuing Education in Long-Term Care', *Gerontologist*, 45(3), pp. 399–405.

Surr, C. *et al.* (2017) 'Effective dementia education and training for the health and social care workforce: a systematic review of the literature.', *Review of Educational Research* [Preprint].

Surr, C., Smith, S. and Latham, I. (2023) *Education and Training in Dementia Care: a person-centred approach*. 1st edn. Open University Press.

Surr, C.A. *et al.* (2019) 'A collective case study of the features of impactful dementia training for care home staff', pp. 1–16.

Surr, C.A. and Gates, C. (2017) 'What works in delivering dementia education or training to hospital staff? A critical synthesis of the evidence', *International Journal of Nursing Studies*, 75(July), pp. 172–188. Available at: https://doi.org/10.1016/j.ijnurstu.2017.08.002.

Takase, M. *et al.* (2015) 'The relationship between workplace learning and midwives' and nurses' self-reported competence: a cross-sectional survey', *International Journal of Nursing Studies*, 52(12), pp. 1804–1815. Available at: https://doi.org/10.1016/j.ijnurstu.2015.06.016.

Takase, M., Yamamoto, M. and Sato, Y. (2018) 'Effects of nurses' personality traits and their environmental characteristics on their workplace learning and nursing competence', *Japan Journal of Nursing Science*, 15(2), pp. 167–180. Available at: https://doi.org/10.1111/jjns.12180.

Taylor, J., Sims, J. and Haines, T. (2014) 'The emergent relevance of care staff decision-making and situation awareness to mobility care in nursing homes: an ethnographic study', *Journal of Advanced Nursing*, 70(12), pp. 2767–2778.

Teunissen, P.W. (2015) 'Experience, trajectories, and reifications: an emerging framework of practice-based learning in healthcare workplaces', *Advances in Health Sciences Education*, 20(4), pp. 843–856. Available at: https://doi.org/10.1007/s10459-014-9556-y.

Thomas, J. (1993) *Doing Critical Ethnography*. California: Sage Publications.

Thomas, N. (2017) 'Control and autonomy irony in communities of practice from a power-based perspective', *Journal of Management Development*, 36(4), pp. 466–477. Available at: https://doi.org/10.1108/JMD-04-2015-0049.

Vaismoradi, M., Turunen, H. and Bondas, T. (2013) 'Content analysis and thematic analysis: implications for conducting a qualitative descriptive study', *Nursing and Health Sciences*, 15, pp. 398–405.

Verreault, R. *et al.* (2018) 'Quasi-experimental evaluation of a multifaceted intervention to improve quality of end-of-life care and quality of dying for patients with advanced dementia in long-term care institutions', *Palliative Medicine*, 32(3), pp. 613–621. Available at: https://doi.org/10.1177/0269216317719588.

Wareing, M. (2010a) 'Using vignettes to explore work-based learning: part 1.', *British Journal of Nursing*, 19(17), pp. 1112–1117.

Wareing, M. (2010b) 'Using vignettes to explore work-based learning: part 2', *British Journal of Nursing*, 19(18), pp. 1185–1188.

Wenger, E. (2009) 'A social theory of learning', in K. Illeris (ed.) *Contemporary Theories of Learning*. Abingdon: Routledge, pp. 209–218.

Williams, K. *et al.* (2020) 'Moving Online: A pilot clinical trial of the changing talk online (CHATO) communication education for nursing home staff', *The Gerontologist*, (1), pp. 1–10. Available at: doi/10.1093/geront/gnaa210/6042577.

Williams, K.N. *et al.* (2017) 'A Communication Intervention to Reduce Resistiveness in Dementia Care: A Cluster Randomized Controlled Trial', *Gerontologist*, 57(4), pp. 707–718. Available at: https://doi.org/10.1093/geront/gnw047.

Wittenberg, R. *et al.* (2020) 'Projections of care for older people with dementia in England: 2015 to 2040', *Age and Ageing*, 49(2), pp. 264–269. Available at: https://doi.org/10.1093/ageing/afz154.

Yasuda, M. and Sakakibara, H. (2017) 'Care staff training based on person-centered care and dementia care mapping, and its effects on the quality of life of nursing home residents with dementia', *Aging and Mental Health*, 21(9), pp. 991–996. Available at: https://doi.org/10.1080/13607863.2016.1191056.

Figures and tables:

Table I: type and volume of data collected

Data type	CH1	CH2
Hours of ethnographic observation	20	25
Hours of PIECE-dem observation	13	5
Number of interviews	10	5
Number of in-situ interviews	52	39

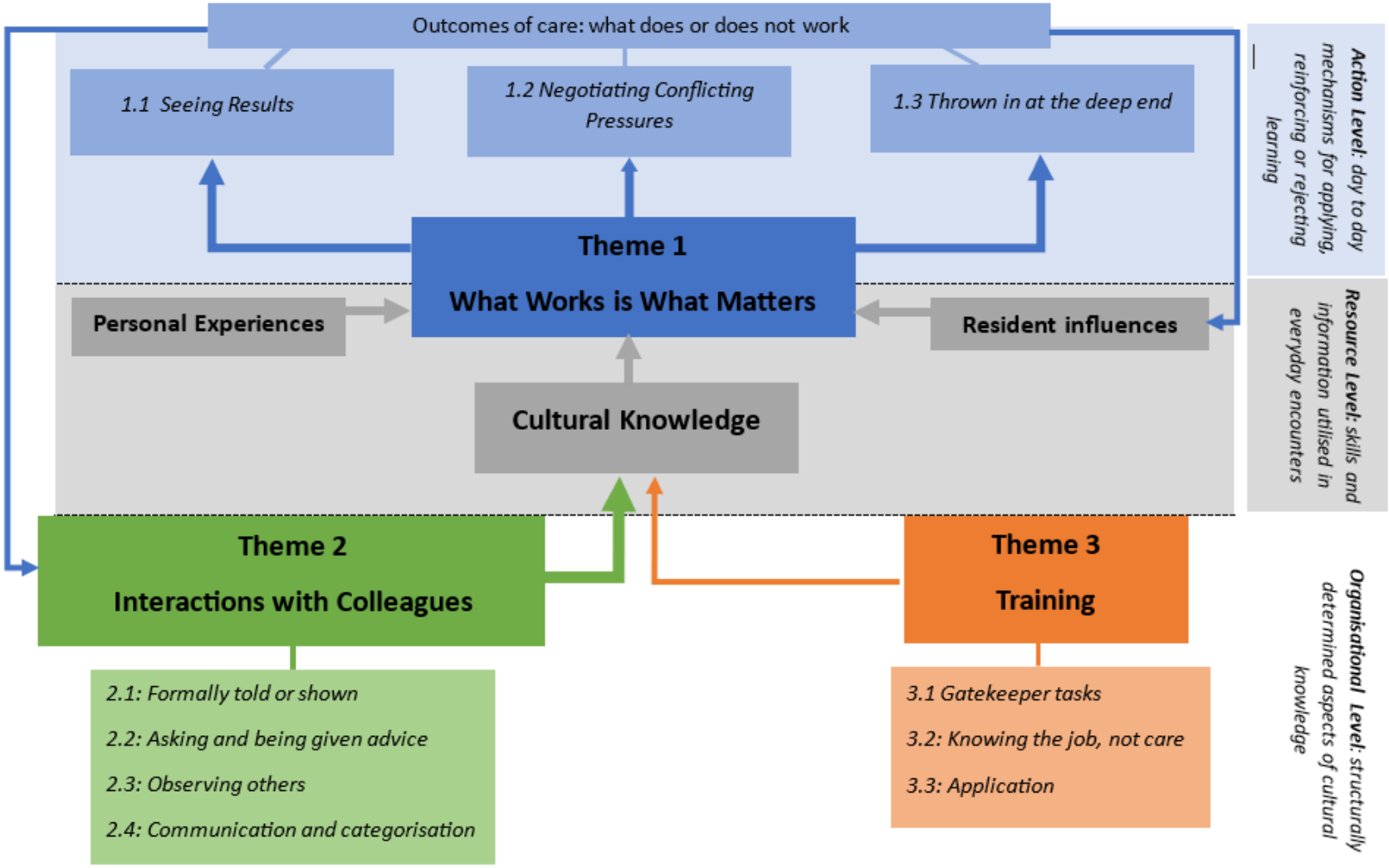

Fig 1: The Learning to Care Model

Fig 2: Action Level: theme one and subthemes

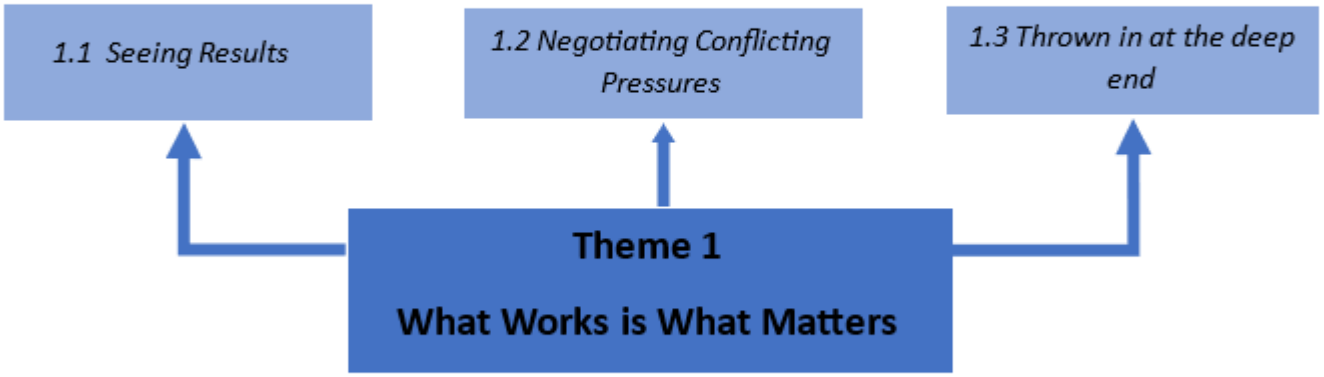

Fig 3: Resource Level: knowledge used in the What Works is What Matters process

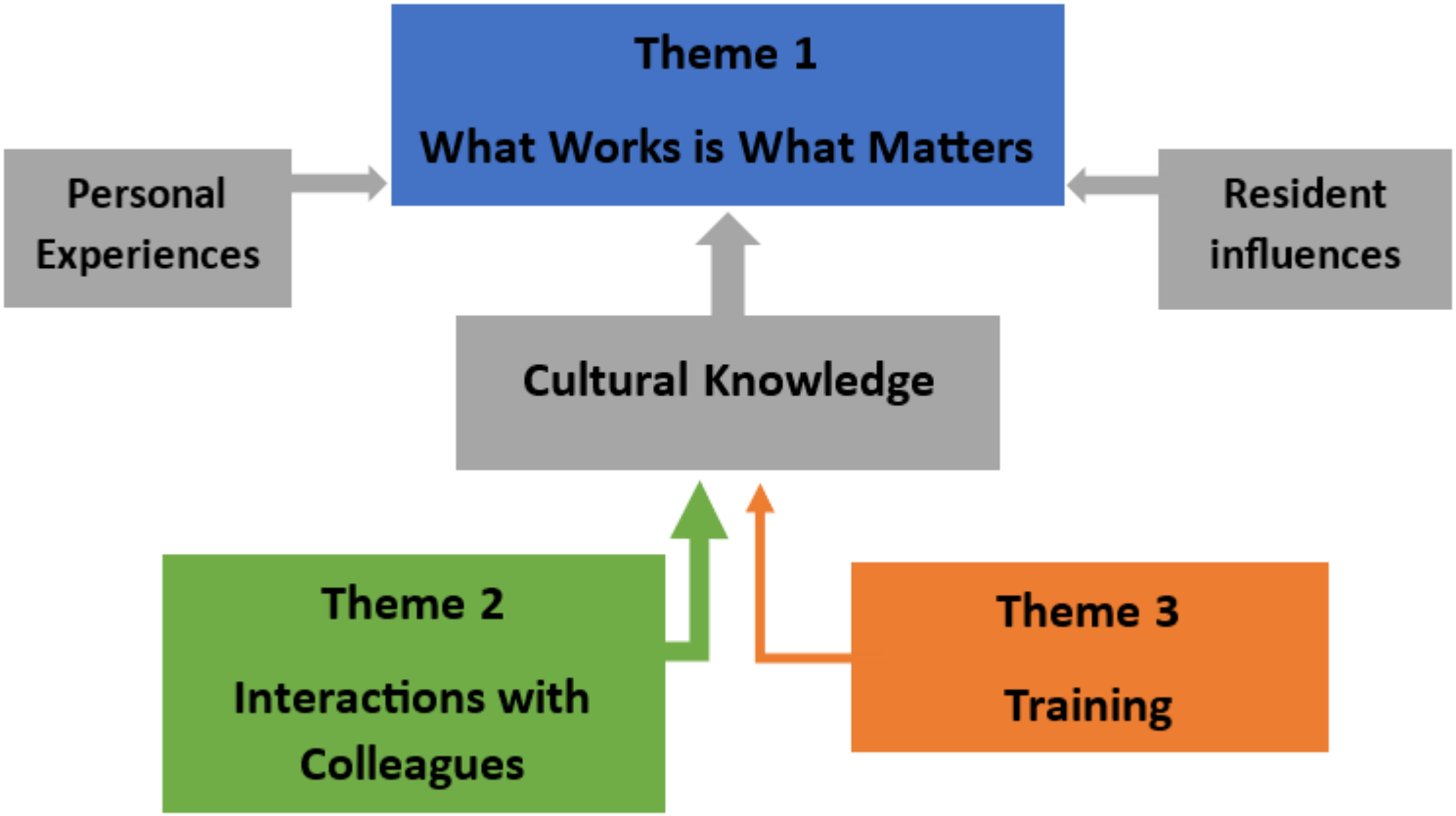

Fig 4: Organisational Level: themes two and three