An exploration of Self-Efficacy in Dementia Care Home Staff.

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Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed: Date:

Acknowledgments

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“When equipped with an unshakable belief in one’s ideas, goals, and capacity for achievement, there are few limits to what one can accomplish. As Bandura has stated, “People see the extraordinary feats of others but not the unwavering commitment and countless hours of perseverant effort that produced them”. They then overestimate the role of “talent” in these accomplishments, while underestimating the role of self-regulation. The timeless message of research on self-efficacy is the simple, powerful truth that confidence, effort, and persistence are more potent than innate ability. In this sense, self-efficacy is concerned with human potential and possibilities, not limitations, thus making it a truly ‘positive’ psychology”

-James Maddux (2000)

Thesis abstract

Self-efficacy refers to our belief in our ability to complete tasks successfully or overcome the obstacles we face. It is a topic of considerable research with regard to familial dementia caregivers and the challenges they encounter. The subsequent three papers aim to provide more clarity of the topic of self-efficacy in paid dementia caregivers.

Paper One presents a literature review that demonstrates that previously little research has been dedicated to self-efficacy in paid dementia carers compared to familial caregivers. Whilst the quantitative evidence base investigating paid carer self-efficacy is growing, there has to date been only one qualitative study exploring this topic. The strengths and limitations of the evidence base are also discussed. This indicates that further clarity is needed to better understand the factors and experiences that might influence or impact on dementia care worker self-efficacy.

Paper Two details a piece of empirical research completed in response to gaps identified in the research literature. Fourteen people working in care homes registered for people living with dementia were interviewed to better understand the factors, approaches and experiences that influence self-efficacy. Transcripts were analysed using thematic analysis. Four themes were identified, (1) Maintaining wellbeing and self-care, (2) Support from others, (3) Values and attributes and (4) Demands of the role including subthemes of unpredictability, the emotive nature of the work, negotiating family issues and complex decision making. Implications for clinical practice were discussed including the opportunity for Clinical Psychology to support care staff in their role through the development of reflective practice and self-compassion interventions.

Paper Three presents an executive summary of the research. The paper is written in an accessible style for individuals working in the care sector such as Care Home Mangers and dementia Care Assistants. Recommendations on how best to support care workers are also provided.

Paper 1: Literature Review

Self-efficacy in paid dementia caregivers:
A literature review

This paper has been written to the standard required for submission to publication in the journal *Dementia* (excluding word count). Author guidelines for manuscript submission can be found in Appendix A.

Word count including abstract: 7996

(excluding references)

Abstract

Self-efficacy has been highlighted as an important resource in family caregivers of people living with dementia. This review provides an overview of the empirical literature concerning self-efficacy in paid dementia caregivers. Understanding more about what it means to be self-efficacious in a dementia care setting and the impact this has on carers could provide evidence regarding how best to support dementia care staff in their role. Eight studies were identified through a systematic search of the Healthcare Databases Advanced Search (HDAS), Web of Science, the Cochrane Library and Ethos. An overview of the studies is presented, their methodological quality critically appraised and a narrative synthesis of the findings was described. Three themes were identified; (1) self-efficacy in relation to quality of life, (2) environmental resources associated with self-efficacy, and (3) internal resources associated with self-efficacy. This review demonstrated that self-efficacy in dementia care staff has important clinical implications such as the ability to enhance staff wellbeing and consequently the quality of patient care. More research on this topic is warranted, including replication of studies after controlling for methodological issues such as small sample sizes. In particular, more qualitative research is needed to understand the range of experiences and beliefs that contribute to self-efficacy.

The terms paid care worker, care staff, paid carer and paid caregiver are used interchangeably within relevant literature to refer to formal, non-familial caregivers and will be assumed to be equivalent terms for the purposes of this review.

Introduction

Social Care in the UK

There are currently 1.45 million people employed in adult social care roles in the UK (Skills for Care, 2017); providing practical assistance, personal care and emotional support to vulnerable individuals. This represents a 19% increase in such roles since 2009 (Skills for Care, 2017). The need for care workers will certainly continue to rise as the large 'baby boomer generation' reach older age (Office for National Statistics, 2017) with a projected 82% increase in care home beds needed between 2010 and 2030 (Jagger et al., 2011).

The critical role care workers play in society should not be overlooked, "Their work is both socially and economically important, reducing considerable costs on hospitals and other professional staff while enabling many to live with dignity, contribute to society and maintain their autonomy for as long as possible" (Hussein, 2014, p.1).

However, there is currently a staff turnover rate of 27% in social care; with 48% of paid carers leaving the role within a year of starting (House of Commons Communities and Local Government Committee, 2017). This consequently affects continuity of care for individuals, the establishment of relationships and rapport between staff and client, as well as the overall quality of care provided. Additionally, observers have reported adverse implications of being a paid care worker such as low pay and difficult working conditions (National Audit Office, 2018). The risk of suicide in paid care workers is almost twice that of the national average (Office for National Statistics, 2017).

The context of Dementia

Dementia is "a syndrome due to disease of the brain – usually of a chronic or progressive nature – in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement" (World Health Organisation (WHO), 2012, p.7). The worldwide incidence of dementia is set to more than double from 50 million people in 2015 to 132 million people by 2050 (WHO, 2017). In the UK, one million people will have dementia by 2020, projected to double to two million by 2050 (Dementia UK, 2014). Dementia is now the most common reason for individuals living in a residential care setting (Alzheimer's Society, 2013).

Researchers have attempted to understand the demands of being a dementia caregiver. Findings suggest that familial caregivers experience a range of difficulties such as burden (van der Lee et al., 2014) and burnout (Astrom, Nilsson, Norberg, Sandman, & Winblad, 1991). Burnout is common in human service workers and has been described as "physical, emotional, or mental exhaustion, especially in one's job or career, accompanied by decreased motivation, lowered performance, and negative attitudes towards oneself and others" (VandeBos, 2007, p.140). Three different dimensions of burnout have been identified; emotional exhaustion, depersonalisation and decreased personal accomplishment (Maslach & Jackson, 1981). Emotional exhaustion refers to the reduction of emotional resources leading to irritability and fatigue. Depersonalisation comprises of a carer attempting to emotionally distance themselves from the care recipient and personal accomplishment is how competent an individual feels in their work.

Previous research has highlighted the pivotal role that care workers play in maintaining the psychological wellbeing of people living with dementia (Kitwood, 1997). It is therefore unsurprising that care worker difficulties such as burnout can have an adverse impact on the person living with dementia. Burnout has been associated with dementia care workers being less willing to help, having reduced optimism, less empathy and negative emotional responses to client behaviour; resulting in poorer quality of care (Astrom et al., 1991; Todd & Watts, 2005). Burnout in carers can lead to people living with dementia exhibiting more aggressive behaviours (Brodagty, Draper, & Low, 2003).

More recently, there has been an empirical shift towards investigating positive aspects of caregiving. It has been advocated that developing and maintaining positive features of caregiving, such as feelings of accomplishment and sense of self-efficacy, could buffer against the impact of burden and stress in caregivers (Carbonneau, Caron, & Desrosiers, 2010).

Self-efficacy

Self-efficacy (SE) is a psychological construct first introduced by Albert Bandura as part of Social Cognitive Theory. Self-efficacy has been defined as “the belief in one’s capacities to organize and execute the courses of action required to produce given attainments” (Bandura, 1997, p.3). Individuals are more likely to perform a particular behaviour if they believe with greater certainty that they can successfully complete the behaviour (Bandura, 1977).

Self-efficacy can have a big impact on psychological functioning. It can influence how much effort is invested in an activity and for how long individuals persist in the face of obstacles and presence of subjectively threatening situations. Self-efficacy can influence whether coping behaviours are instigated as well as susceptibility to anxiety and depression (Bandura, 1997).

Bandura (1982) hypothesised that perceived self-efficacy varies according to three components: magnitude (i.e. task complexity), generality (i.e. how much the self-efficacy beliefs are transferable to other situations) and strength (i.e. level of confidence in capability for the particular task). Bandura postulated that self-efficacy can be learnt or enhanced and identified four mechanisms through which self-efficacy is determined; performance accomplishments, vicarious experience, verbal persuasion and emotional arousal (Bandura, 1977). Performance accomplishments, the most influential determinant of self-efficacy, are based on personal mastery experiences: repeated success at certain tasks. A less influential factor is vicarious experience where others are observed performing a task successfully or unsuccessfully. Watching successful performance can enable the individual to develop expectations that they too will improve or succeed at a task if they persist. Verbal persuasion involves suggesting or encouraging people that they can successfully perform a behaviour/activity. Finally, individuals may judge their own capabilities through the emotional arousal they feel in a given situation.

A distinction is made between self-efficacy and other related concepts such as self-esteem or self-confidence. Self-esteem is a global term for how an individual feels about themselves and is not domain specific. Self-efficacy in contrast can change according to specific task and circumstance (Maddux, 2000).

Self-efficacy in caregivers

As self-efficacy is domain specific, any endeavour to understand self-efficacy in the context of caregiving should include a definition of the term. For the purposes of this review, dementia care self-efficacy is defined as follows; “the beliefs or judgments of staff about those caring and nursing behaviours, skills and knowledge which are needed to provide safe, independent care for residents” (Evers, Tomic, & Brouwers, 2001, p.442).

An extensive body of literature has been collated regarding the impact of self-efficacy in familial dementia caregivers. Components of self-efficacy have been correlated with more physical and emotional fatigue (Roepke et al., 2009), increased physical health risks (Harmell et al., 2011) and poorer mental health (Crellin, Orrell, McDermott, & Charlesworth, 2014), and self-efficacy also appears to moderate the impact burden has on caregiver distress (Romero-Moreno et al., 2011).

Evers, Tomic and Brouwers’ (2001) seminal study was one of the first to research self-efficacy in paid caregivers. Although participants were older adults rather than people living with dementia, their findings have been used as a foundation, demonstrating the need to further develop the evidence base regarding self-efficacy in dementia caregivers. Investigating the relationship between burnout and self-efficacy, Evers, Tomic and Brouwers demonstrated that perceived self-efficacy was positively correlated with the personal accomplishment component of burnout but found no significant correlation between self-efficacy and depersonalisation or emotional exhaustion.

Rationale for the review

Recent surveys indicated that paid dementia caregivers expressed a need for further information and skill development in working with people living with dementia (Marx et al., 2014) with 75% of care staff feeling frustrated and overwhelmed by dementia care (Adler, Lawrence, Ounpraseuth, & Asghar-Ali, 2015). Government white papers and third sector initiatives have recognised that it may be beneficial to improve the lives of people living with dementia through directly improving care staff experience and skills. For example, the Alzheimer's Society (2015, p.3), declared "providing front line staff with the skills and confidence to deliver responsive dementia care must be a priority". The Prime Minister's Challenge on Dementia 2020 (Department of Health, 2015, p.3) set out its aim to make the UK the "best country to live in for dementia care", and also acknowledged that creating a clear evidence base regarding the support and training needs of dementia care staff is a priority.

Research has identified that self-efficacy is an important factor in family dementia caregivers (Crellin et al., 2014) and has been found to buffer the negative effects of caregiving (Romero-Moreno et al., 2011). In light of the expressed need for support and training by paid care staff as well as the predicted increase in demand for long term dementia care in the next few years, it is important to further society's understanding of self-efficacy in paid dementia caregivers. This could provide useful insights into how care staff could be better supported in their role to provide high quality care.

Aim

This review aims to provide an overview of existing literature regarding self-efficacy in paid dementia carers. The central research question is;

‘What is known about the impact of self-efficacy on paid dementia carers and the factors that help shape it?’

Relevant studies will be described, their methodological quality critically appraised and a synthesis of their findings will be offered.

Method

Search strategy

A literature search for the current review was completed in May 2018. To ensure that the search terms used were comprehensive the thesaurus tool and Medical Subheading vocabulary were employed to explode the terms ‘dementia’ and ‘self-efficacy’. Following this and subsequent discussions with a clinical research tutor; search terms were developed (see Figure 1).

Dementia OR “Alzheimer’s disease”

AND

caregiver* OR "care giver*" OR caregiving OR carer* OR care* OR "care home staff" OR "care staff" OR "staff"

AND

“self-efficacy” OR “self-confidence”

Limiter: English Language only

Figure 1: Overview of search strategy terms.

Relevant literature was obtained through a search of the Healthcare Databases Advanced Search (HDAS); comprising of CINAHL, Medline and Psychinfo (including Psycharticles). A further search was completed on Web of Science. A search of the Cochrane Library was completed to identify any published review articles concerning self-efficacy in dementia caregiving or clinical trials. Grey literature, such as unpublished doctoral theses were also searched using the British Library E-Theses Online Service (EThOS). Both titles and abstracts of papers were searched to ensure no relevant articles were missed. No start date for the literature was set. A limiter, that articles should be published in English or translated into English, was applied due to the researcher only speaking English. One article that appeared to meet the inclusion and exclusion criteria at title and abstract was not published as a full research paper (Lim & Hong, 2014). As only an abstract was available, the research is briefly summarised in the ‘overview of studies’ section but it was not included within the critical appraisal process. A hand search of citations and reference lists within eligible articles was also conducted for any additional material, although none was found. See Figure 2 for a flow chart detailing the complete screening process.

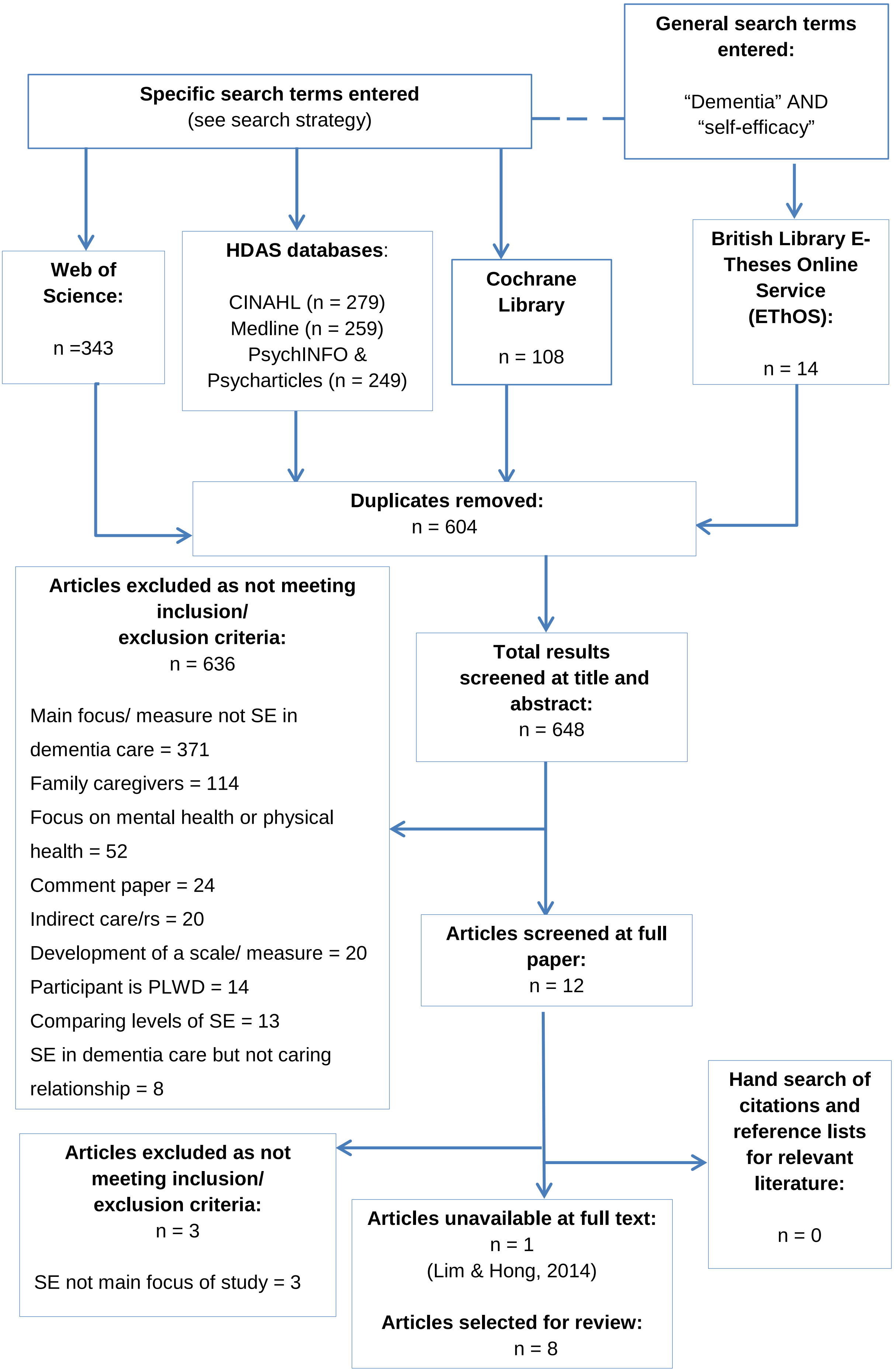

Figure 2: Flow Chart demonstrating the literature search screening process.

Inclusion/exclusion criteria

All articles were assessed against the following inclusion and exclusion criteria developed for the current review:

Inclusion criteria

- Self-efficacy or confidence was (one of) the main measures, outcomes, predictors or phenomena of interest within the study.
- The study investigated the impact of self-efficacy on the caregiving relationship or the factors that help shape self-efficacy.
- Care staff who had a direct caregiving relationship with a person living with dementia were the participants. This included all non-familial individuals who were paid to provide care, support and treatment to people living with dementia including care assistants, support workers, nurses and managers.

Exclusion criteria

- The main focus of the study was the comparison of levels of self-efficacy in different caregiving groups such as gender, age, or cultural differences.
- The main focus of the research was the effect of self-efficacy on mental health or physical health on direct caregivers of people living with dementia. A literature review had already been completed on this topic; however, all studies included in the review focused on familial caregivers (Crellin et al., 2014).
- Participants were individuals who had an indirect supportive (but non-caregiving) relationship with the people living with dementia, including GPs, Social Workers etc.
- Studies whose sole focus was on the development of a scale or questionnaire measuring self-efficacy.
- Comment papers or theoretical models that did not draw upon a sample of participants and where no new evidence was presented through research.

Limiters

- Published in English or translated into English.

Results

Overview of studies

The literature search identified eight studies of interest that met the inclusion. Only one study was of qualitative methodology (Coates & Fossey, 2016), whilst all of the others used quantitative methods (Duffy, Oyebode, & Allen, 2009; Hopkins, 2017; Karantzas et al., 2016; Kokkonen, Cheston, Dallos, & Smart, 2014; MacKenzie & Peragine, 2003; McCabe et al., 2015; Yan, Kwok, Tang, & Ho, 2007). For more information on all of the studies see Appendix B.

Several studies looked at the correlation between self-efficacy and burnout in dementia care workers (Duffy et al., 2009; Kokkonen et al., 2014; MacKenzie & Peragine, 2003). MacKenzie and Peragine (2003) developed an intervention focusing on improving care staff sense of self efficacy and measured the impact this had on levels of burnout in staff. In order to do this, they developed a self-efficacy questionnaire for paid caregivers. Duffy et al. (2009) used a cross sectional study to investigate the relationship between self-efficacy, reciprocity, organisational factors and burnout in a range of staff working within NHS Care Homes. The authors also aimed to identify the biggest predictor of burnout in care staff. Kokkonen et al. (2014) surveyed 77 members of dementia care staff on NHS older adult inpatient wards. They explored the relationship between staff attachment style, levels of self-efficacy and burnout.

Three studies investigated the organisational factors that impact on care workers' self-efficacy. Yan et al. (2007) used a cross sectional design to understand the factors that predict both life satisfaction and self-efficacy in 142 personal care dementia workers in China. Several factors were investigated including emotional support, satisfaction with training and staff to client ratio. McCabe et al. (2015) investigated whether organisational climate (e.g. autonomy or recognition) and workplace experience (e.g. job role) were correlated with residential care staffs' self-efficacy for managing behavioural and psychological symptoms of dementia and confidence in managing depression. Karantzas et al. (2016) asked 225 dementia care workers to complete several self-report measures. They aimed to explore how self-efficacy mediates the relationship between organisational factors (including autonomy, recognition of competence, support and work pressures) and staff strain.

A doctoral thesis by Hopkins (2017) surveyed 42 nurses on one long-term ward to understand levels of self-efficacy in providing different components of dementia care such as information on the management of dementia, observing the feelings of people living with dementia and patiently managing repetitive communication.

Coates and Fossey's (2016) study was the only qualitative study included in the review. They used Interpretative Phenomenological Analysis to analyse semi structured interviews of eight staff members within dementia care homes. They aimed to understand the experiences of dementia care workers who were highly self-efficacious.

One article, written by Lim and Hong (2014) was only available at abstract as it was not published as a full research paper. It will therefore not be included as part of the critical appraisal process. However, the results presented within the abstract are noteworthy and should be included within any review of relevant literature. In Lim and Hong's study of 595 care workers in Korea, care worker self-efficacy was found to mediate the relationship between attitude towards dementia and job satisfaction. These results are similar to some of the other studies included in the review (e.g. Yan et al., 2007) that are discussed in more detail within the synthesis of findings section.

Critical appraisal

To date, no 'gold standard' critical appraisal tool has been identified, despite many checklists being developed. The Down and Black Checklist (Down & Black,1998) and Critical Appraisal Skills Programme (CASP) Quantitative

Checklist (2013) are widely used, accessible appraisal tools. However, their focus on intervention led to them being disregarded for the current review as this was relevant to only one of the review's studies. The Crowe Critical Appraisal Tool (CCAT) (Crowe, 2013) was chosen due to its suitability for both quantitative and qualitative studies, allowing quality to be compared across studies.

Crowe Critical Appraisal Tool (CCAT)

The CCAT has been found to have good inter-rater reliability and construct validity (Crowe and Sheppard, 2011; Crowe, Sheppard, & Campbell, 2011). The tool consists of eight different domains with several questions for consideration. Each domain is scored out of five. Scoring is not solely based on how many of the criteria have been met within each domain. For example, if four out of five of the domain criteria were met but the one absent criteria is fundamental to the research design, the study may score very low on that domain (Crowe, 2013). The highest total score a paper can achieve is 40. A rating of either: good, average or poor was given to each of the studies once the appraisal was completed. For more information on the domains and criteria, a copy of the CCAT checklist can be found in Appendix C.

Quality Assessment

Using the CCAT checklist three studies achieved a quality rating of 'good' (Coates & Fossey, 2016; Duffy et al., 2009; Kokkonen et al., 2014). A further three studies (Karantzas et al., 2016; McCabe et al., 2015; Yan et al., 2007) attained a quality rating of 'average'. Mackenzie and Peragine (2003) and Hopkins' (2017) studies were rated as 'poor'. Further information on the critical appraisal scores for each of the studies is included in Appendix D.

Recruitment, Participants and Sampling

The studies sampled their participants from locations such as a hospitals, care homes or day care centres. It is unclear from any of the studies why the particular setting was chosen. Little detail was also given in some studies regarding the exact nature of the setting. For example, some settings were simply described as a 'long term care facility' (Mackenzie & Peragine, 2003) or ‘high/low care aged facility’ (McCabe et al., 2015). These omissions may leave international readers unclear about what type of service the sample was drawn from and the applicability to their own setting. Three studies recruited from multiple locations thus increasing generalisability of findings (Coates & Fossey, 2016; Duffy et al., 2009; Kokkonen et al., 2014).

The number of participants within the studies ranged from 8 to 255. Participants included care workers, support workers, nurses, diversional therapists, physiotherapists and managers. Hopkins’ (2017) participants included, among other roles, nurse administrators. It is unclear from Hopkins’ description what their role involved and if this included direct caregiving contact. It is also unclear whether the nurses surveyed were general nurses questioned about providing care to people living with dementia on general health wards or were working on in a specialist dementia ward. The issues identified might impact on the validity of findings.

Most of the studies’ participants were mainly female with a mean age within the 40-50 brackets. This suggests they are a representative sample of the larger paid caregiving population (Skills for Care, 2017), increasing generalisability of results. A minority of studies provided information on the ethnicity of care workers (Coates & Fossey, 2016; Kokkonen et al., 2014) despite this being identified as an important factor in caregiver self-efficacy (Depp et al., 2005).

All participants had some experience of working with people living with dementia. However, not all worked in a solely dementia setting. Three studies failed to provide details on the percentage of residents with a diagnosis of dementia within the care setting that was being researched (Coates & Fossey, 2016; Mackenzie & Peragine, 2003; McCabe et al., 2015). Yet, reported data from the other studies suggests this is a noteworthy detail. The percentage of people living with dementia in the other care settings varied from 17% (McCabe et al., 2015) to 100% (Duffy et al., 2009). This highlights the potential ramification that questionnaire data might not be a true reflection of the assessed phenomena. This is particularly pertinent as all of the quantitative studies utilised retrospective self-report questionnaires that reduce the likelihood that participants are solely remembering/using their experience of working with people living with dementia to answer the measures. As such, the internal validity of these studies is reduced.

Inclusion and exclusion criteria were provided in four studies, enhancing replicability of the research (Coates & Fossey, 2016; Duffy et al., 2009, Kokkonen et al., 2014; Yan et al., 2007). All of the studies' exclusion criteria included a stipulation that participants had been paid carers for a minimum period of at least three months. The validity of the studies is enhanced as this increases confidence that the studies are measuring self-efficacy rather than a lack of exposure to dementia care.

Limited information was given regarding the sampling process in many of the studies. It was reported in one study that staff were approached by their manager to take part (McCabe et al., 2015). This raises several ethical issues such as individuals possibly feeling pressurised to take part. It could represent a selection bias as it is unclear how participants were chosen by their manager. This may create specific confounding characteristics within the sample if, for example participants were those the manager felt likely to give socially desirable responses. This sampling strategy could therefore undermine the validity of the study. Hopkins (2017) reported a very high response rate of 90%. Although this is remarked upon, "the survey response rate was high because the nurse manager informed all of the dementia care nurses about the survey" (p.31), there is no further consideration of this. It is known that generally response rates lie around 50% for self-report surveys (Baruch, 1999). This raises questions about what was said to the participants to encourage them to take part or whether they were coerced. If their participation was voluntary, these individuals may represent a specific subset of a target population that is particularly motivated to participate in research and not representative of the wider care worker population.

The characteristics of those who did not take part (i.e. non-responder rate) was not analysed in any of the studies. Duffy et al. (2009) reported that although 251 participants were available to participate in their research, only 61 responded to the questionnaire. It is possible that non-responders may have differed in some way to those that took part; further information on these individuals would have offered the reader greater insight into the study. The authors acknowledge that during their visits to the care setting, some individuals felt unable to participate as they did not have the time due to feeling stressed and 'burnt out'. Also, individuals who were on sick leave were not approached to participate; they therefore concluded that the results may be indicative of a 'healthy worker effect'.

Methodological Quality

Design

All of the studies defined the outcomes they were investigating and used designs that were appropriate to the aims and hypotheses of the research. Nonetheless, several weaknesses have been identified. Mackenzie and Peragine (2003) assessed the impact of a self-efficacy intervention developed specifically for the study, on dementia caregivers. It was acknowledged by the authors that this was a quasi-experimental design which non-randomly allocates participants to intervention and control groups. A weakness of this type of design is that there may be significant differences between the groups prior to intervention, which was the case in this particular study. Nevertheless, there were details omitted by the authors that could have strengthened the overall design of the study. For example, the characteristics of the control group were not clearly described, therefore undermining replicability and reducing the generalisability of results. The control group also scored significantly higher on the job satisfaction scale which the authors felt reflected their achievement of a 'team recognition award' a few weeks prior to the intervention. Participant numbers were also very different between the two groups (control n=13, intervention n=28). As the authors state they chose the wards as either the intervention or control group out of a possible nine wards, it is unclear why they made their decision to pick these particular wards when they were aware of several potential sources of bias. These issues should have been addressed prior to the intervention commencing (Strasak, Zaman, Pfeiffer, Gobel, & Ulmer, 2007). The authors provided some details of the intervention within the study such as the general topics covered, teaching methods and frequency of training. Nevertheless, more information on the specific content and details of ‘trainer characteristics’ would be required to enhance reliability and ensure replicability of the intervention in future research.

The six other quantitative papers used cross-sectional designs which although appropriate to each of the studies’ aims and objectives, have their own strengths and limitations (Mann, 2003). Some of the main limitations are that causality of results cannot be established and as data collection occurs at a single point in time, findings could be due to variables extraneous to the phenomena of interest. The use of self-report measures within the quantitative studies also increases the possibility of response bias such as demand characteristics (i.e. under/over reporting of difficulties), ambiguity or social desirability bias which can limit the validity of the study (Rossenman, Tennekoon, & Hill., 2011).

As Coates and Fossey (2016) were attempting to understand care workers subjective experiences, the use of Interpretative Phenomenological Analysis (IPA) was considered a suitable method for obtaining this type of data. The authors gave examples of questions used within the interviews which increased the rigour of the study.

Measures

Four of the studies (Duffy et al., 2009; Karantzas et al., 2016; Kokkonen et al., 2014; McCabe et al., 2015) used standardised outcome measures with clearly reported Cronbach’s alpha levels and test-retest reliability, and were considered to be reliable and valid research instruments. One of the studies (Mackenzie & Peragine, 2003) developed a new measure; however, this was evaluated within the study and information provided on internal and temporal consistency as well as test-retest reliability increased the generalisability of results. Although several of the questionnaires utilised by Yan et al. (2007)

have good psychometric properties, one particular questionnaire (Minnesota Satisfaction Questionnaire) standardised with an English speaking population was used with a Chinese sample of participants. It is unclear whether the measure was administered in English or Mandarin, and whether the psychometric properties of any Chinese version are known. Hopkins (2017) created her own likert style measure with therefore unknown psychometric properties. It is unclear why Hopkins decided to use this rather than standardised measures, and no data were provided regarding the reliability or validity of the questionnaire.

Data collection

Reporting of the data collection process was generally good across the studies. Whilst most provided clear information on the setting, location and process, replicability of the research process could have been enhanced in some studies through providing further information on the setting and procedure (Hopkins, 2017; Mackenzie & Peragine, 2003).

Some thought had been given in a few studies to attempting to minimise socially desirable responding (Duffy et al., 2009, Karantzas et al., 2016; McCabe et al., 2015). Bias was reduced through providing either a stamped addressed envelope or a closed box for completed questionnaires in order to provide assurance of confidentiality to participants. Hopkins (2017) reports that questionnaires were left at the nurses' station. It is unclear what happened to them once completed or whether participants might have felt pressurised to answer in a certain way due to lack of anonymity/confidentiality.

Ethics

Ethical approval details were provided in the majority of studies (Coates & Fossey, 2016; Duffy et al., 2009; Kokkonen et al., 2014; McCabe et al., 2015; Karantzas et al., 2016). However, discussion of other ethical issues such as gaining informed consent and maintaining confidentiality and anonymity was variable throughout the reviewed studies. Mackenzie and Peragine (2003) made no reference to any ethical matters and as such it is difficult for the reader to assess the ethical robustness of the study.

Data analysis

The majority of the cross sectional studies used recognised methods such as correlation and multiple regression as part of their analysis (Duffy et al., 2009; Kokkonen et al., 2014; Yan et al., 2007). This was appropriate to their aims and objectives of investigating the relationship between self-efficacy and other caregiving factors. Hopkins (2017) reported analysing her data using basic analysis techniques such as frequencies and percentages. More robust conclusions could have been drawn from the data had standard deviations been reported that allow the reader to quickly ascertain which components/questions regarding self-efficacy nurses struggled with most.

Every study provided data on all of the outcome and predictor measures administered, allowing the reader to gain a comprehensive understanding of the results and the implications for the conclusions drawn. Non-parametric statistical methods were used appropriately for non-normally distributed data (Kokkonen et al., 2014). Karantzas et al. (2016) were the only study to enhance the validity of their findings through missing data analysis.

Whilst it is considered good research practice to provide a power calculation within quantitative data analysis (Nayak, 2010); very few studies within the current review did so (Duffy et al., 2009). Several of the quantitative studies reported small sample sizes ranging from 40 to 77 (Duffy et al., 2009; Hopkins 2017; Kokkonen et al., 2014). This limits the researcher’s ability to detect small to medium effects and increases the risk of making a Type II error, missing small but important effects and reducing validity of the studies. In acknowledgment of a small sample size, Kokkonen et al. (2014) attempted to mitigate against a Type II error by utilising a conservative alpha level (p=0.001).

Four out of six studies correctly reported statistical information for each hypothesis/outcome measures and exact p-values (Duffy et al., 2009;

Karantzas et al., 2016; Kokkonen et al., 2014; McCabe et al., 2015). In contrast, only one of the studies reported effect sizes, confidence intervals or standard deviation (Duffy et al., 2009); without which validity is reduced. Effect sizes would allow the reader to make inferences on the magnitude of the effect and its clinical significance as results can be statistically significant without being clinically meaningful (Sullivan & Feinn, 2012). Conclusions drawn within the studies were consistent with the strength of findings offered in most studies with the exception of Hopkins (2017) and Mackenzie and Peragine (2003).

Coates and Fossey (2016) followed an established IPA analysis protocol for their qualitative data analysis. They also attempted to improve the credibility of findings through using quotes to support their data extraction themes and having two researchers simultaneously code themes. Nevertheless, credibility of findings could have been increased through member checking. There were other essential components of qualitative rigour that were not encompassed within the study. For example, no reflexivity statement was included which would have allowed the reader to understand how the author may have influenced the research. (Newton, Rothlingova, Gutteridge, LeMarchand, & Raphael., 2011). This lack of transparency is particularly pertinent as IPA methodology emphasises how experiences are first interpreted by the individual and then their interpretation is decoded by the researcher through a double hermeneutic (Smith, 2004).

Synthesis of findings

All of the studies considered in this review regarded self-efficacy to be an important factor within the role of a paid dementia caregiver. An analysis was conducted on the findings to synthesis the results into themes. The papers were read through thoroughly and any results relating to the research question were noted down. These were reviewed and refined into themes in order to reveal commonalities across papers. Any results from the studies that were not relevant to the research question were not included in the analysis (e.g. self-efficacy in carers of people with depression or how attachment style is related to burnout in dementia carers).

Theme 1: Self-efficacy in relation to quality of life

This theme was evident in four of the papers included in the review (Duffy et al., 2009; Kokkonen et al., 2014; Mackenzie & Peragine, 2003; Yan et al., 2007). All of these studies concurred that self-efficacy was an important indicator of certain aspects of quality of life for paid dementia caregivers. Self-efficacy was significantly correlated with factors associated with either burnout or satisfaction with life. Mackenzie and Peragine (2003) found self-efficacy to be positively correlated with the personal accomplishment component of burnout, namely feeling more competent in their job role. However, Duffy et al. (2009) demonstrated a negative correlation between self-efficacy and emotional exhaustion and depersonalisation in addition to being positively correlated with personal accomplishment. Duffy et al's findings were replicated by Kokkonen et al. (2014). Self-efficacy was found to be a significant predictor of burnout in paid caregivers in two studies (Duffy et al., 2009; Kokkonen et al., 2014). Yan et al. (2007) investigated a similar topic, finding that self-efficacy was a significant predictor of life satisfaction in personal care workers. High self-efficacy was therefore speculated to have the potential to act as a buffer against work stressors that lead to burnout (Duffy et al., 2009). In response to this, several studies have advocated for the use of self-efficacy training in managing work related challenges in order to reduce burnout (Duffy et al., 2009; Kokkonen et al., 2014; Mackenzie & Peragine, 2003).

Theme 2: Environmental resources

Team Working

Team working, and in particular feeling supported within their caring role, was a strong theme across four of the studies (Coates & Fossey, 2016; Karantzas et al., 2016; McCabe et al., 2015; Yan et al., 2007). One dimension of this theme emphasised how dementia care self-efficacy was dependent on the staff team around the caregiver. The expertise and skill levels of other care workers 'on shift', the ability to 'offload', share the stresses of the role and 'not feel alone' was important for many participants (Coates & Fossey, 2016). Quantitative analysis bolstered these findings;

identifying that self-efficacy is positively associated with organisational/team support (McCabe et al., 2015), high levels of social support is predictive of higher levels of self-efficacy (Yan et al., 2007) and high self-efficacy appears to mediate the association between autonomy, trust, support and pressure with strain in their job role (Karantzas et al., 2016).

Organisational environment

This theme referred to aspects of the care environment determined by the employer that can impact on levels of self-efficacy. Organisational factors such as autonomy afforded to the care worker, as well as trust and support provided within the organisation have been found to be positively associated with self-efficacy. Job stress was negatively associated with self-efficacy (McCabe et al., 2015). Karantzas et al. (2016) developed this hypothesis further, demonstrating that whilst organisational factors (such as autonomy, trust, support) in themselves were not directly associated with staff reports of strain, levels of self-efficacy mediated this relationship. The significance of staff autonomy was also highlighted by Yan et al. (2007) who found that a low staff to client ratio was predictive of high levels of self-efficacy. The authors hypothesised that this occurrence could be due to creating a strong sense of accomplishment in the caregiver, thus increasing self-efficacy. Reference has been made to employers and organisations attempting to mitigate the effect of the workplace environment by implementing strategies that may improve self-efficacy (Karantzas et al., 2016); for example promoting staff autonomy through a trusting and supportive team and management whilst minimising organisational pressure.

Training

Much has been previously written about training for dementia caregivers. Many care workers expressed a lack of self-efficacy in providing care to people living with dementia (Hopkins, 2017) with several authors hypothesising that training is linked with an increase in self-efficacy (Hopkins, 2017; Mackenzie & Peragine, 2003). However, the exact mechanism of how this works appeared to be less about the content of the training but more about the satisfaction with the quality of training (Yan et al., 2007).

Participants have suggested that care work is ‘intuitive’ and emphasised the value of developing the notion of feeling ‘better equipped’ to provide care rather than gaining further ‘technical knowledge’. This may manifest in a feeling that training allows them to develop more expertise in the skills they already ‘intuitively’ possess rather than acquiring new skills (Coates & Fossey, 2016). Thus, the likelihood of putting the skills into practice was linked to the level of self-efficacy rather than learning new skills in itself, namely self-efficacy relies on care staff ‘doing rather than knowing’ (Mackenzie & Peragine 2003; Yan et al., 2007).

Theme 3: Internal resources

The majority of the concepts encapsulated within this theme were taken from Coates and Fossey (2016). Although there are not multiple studies from the review corroborating these viewpoints, the points raised by Coates and Fossey’s study nevertheless richly supplement an understanding of the research topic, which would be greatly reduced if these points were to be omitted. One weakness of quantitative research is that it only provides a limited range of responses for participants. In the first qualitative study on this topic, Coates and Fossey enabled vital new perspectives to be shared. This includes beliefs or attitudes personal to the individual’s experience which may not have been previously considered (NHS England, 2017).

Personal attributes

Coates and Fossey’s (2016) participants emphasised many personal resources that impacted on self-efficacy. Having a compassionate attitude, genuine interest in people living with dementia and viewing caring as part of their identity were all attributes described by caregivers who felt highly self-efficacious in their roles. Coates and Fossey reflect that together these qualities may create an ‘internal guide’ as to how to act in their role, thus facilitating self-efficacy and good quality care.

Outlook regarding the role

Several components regarding caregivers’ attitude towards the role were identified as important in individuals high in self-efficacy. Commitment and investment in the role was one such factor (Coates & Fossey, 2016; Mackenzie and Peragine, 2003). This was emphasised through being prepared to ‘go the extra mile for residents’ and attending training sessions to increase confidence in the role. The perceived ability to manage competing demands and expectations of both staff and residents was also a significant contributor to self-efficacy, with low self-efficacy often exacerbated by a perceived lack of experience (Coates & Fossey, 2016). It appears that it is the individuals’ appraisal regarding lack of experience that affects self-efficacy rather than actual years spent in the job role. No correlation was found between self-efficacy and job satisfaction or number of years working as a caregiver in one study (McCabe et al., 2015). Therefore, an individual with many years’ service as a care worker might have low self-efficacy in a particular situation if they felt they lack the necessary experience to deal with it.

Discussion

This review critically appraised and synthesised the findings of eight papers. Themes were identified on a number of key topics associated with self-efficacy in paid dementia care workers; (1) self-efficacy’s relationship with caregiver quality of life, (2) environmental resources and (3) internal resources associated with self-efficacy.

There is evidence to suggest that self-efficacy has a significant impact on burnout in paid dementia carers. As these findings were replicated across inpatient, residential and day care settings it suggests that the results are generalisable across settings. Nevertheless, low response rate and small samples within the studies means that further research is needed to demonstrate the robustness of the findings. The review did identify fixed attributes that impact on self-efficacy, such as personal resources like a compassionate and committed attitude and ability to manage competing demands. Alongside this were potential means of enhancing self-efficacy through organisational contexts such as employers increasing the autonomy, trust and support of the care worker.

The findings of the current review are consistent with previous caregiver research. It has previously been acknowledged that working within a dementia setting requires a robust collaborative team response (Grand, Casper, & McDonald., 2011) and that the working environment can affect self-confidence of direct caregivers of older adults (Josse-Eklund, Petzall, Sandin-Bojo, & Wilde-Larsson, 2013). It is thus unsurprising that participants highlighted the importance of team trust and support in maintaining self-efficacy. Research demonstrates how self-efficacy can mediate the impact of staff strain is also consistent with family caregiver studies that emphasise a similar ‘buffering’ mechanism of self-efficacy (Carbonneau et al., 2010; Romero-Moreno et al., 2011).

Many of the themes identified within the current review are consistent with Bandura’s (1997) theory of self-efficacy. It may be that a supportive and effective team/working environment allows the care worker to enhance their self-efficacy through mechanisms such as vicarious experience or verbal persuasion. The finding that self-efficacy was linked to putting training into practice rather than just having the ‘technical knowledge’ emphasises a core component of Bandura’s theory; self-efficacy requires the individuals to have the belief that they can complete a particular task as well as the skills and knowledge to do so.

Although the findings do not explicitly note the impact these factors have on the caregiving relationship or wellbeing of the people living with dementia; there are important conclusions to be drawn. A recent study identified how care recipient neglect is most common in care staff experiencing high levels of burnout (Cooper et al., 2018). It is known that compassionate and committed care staff enable patients to experience a better holistic experience of their care (Wood, 2016). It would therefore be reasonable to suggest that self-efficacy indirectly mediates the quality of the care/caregiving relationship an individual would receive.

One important factor to note within the current review is that all studies reported participants either having moderate or high levels of self-efficacy. As many of the studies had small sample sizes, it is difficult to ascertain whether this is representative of the paid carer population. Thus, very little is known about those individuals with low self-efficacy who are perhaps most at risk of leaving their job and having poor wellbeing. Although they may be a more difficult-to-reach cohort of participants, more needs to be done in the future to hear the voices of those that are most in need of support and assistance in this important role.

Strengths and limitations of the review

This is the first paper to explore and review the literature regarding paid dementia caregivers and self-efficacy in any depth. Although the researcher attempted to complete the review systemically, a second reviewer was not used for either the screening process or critical appraisal. Inclusion of papers is subjective and another researcher may have chosen different articles. The selection process was fully disclosed to make the process as transparent and replicable as possible.

The exclusion of non-English language papers was necessary due to resources. This may have led to potential articles being excluded as many of the published research articles for familial caregivers were completed in China and Taiwan. Eight papers were reviewed and, whilst reviewing a larger number may have given a broader understanding of the topic, this was beyond the scope of the paper. As such, generalisabiliy is reduced and the findings cannot currently be considered conclusive. It is unfortunate that one article found in the literature search (Lim & Hong, 2014) was only available at abstract as the study’s focus on care worker life satisfaction could have complimented the evidence base on self-efficacy and quality of life.

Clinical implications and future research

There is some evidence to suggest that being a paid dementia carer has negative consequences for an individual’s wellbeing and can lead to burnout.

As burnout has been linked to negative care experiences for people living with dementia (Astrom et al., 1991; Brodagty et al., 2009; Cooper et al., 2018) it is vital that care providers consider strategies to enhance carer self-efficacy to ensure high quality care for their residents.

In order to do this, it is important for researchers to further society's understanding of the nuances of self-efficacy in different settings. Therefore, replicating the studies included in the review (with larger sample sizes and adequate power) would be valuable in understanding any differences in self-efficacy experience of care workers in inpatient, residential or day care settings.

The majority of research has focused on quantitatively understanding the prevalence and factors associated with self-efficacy in paid care staff. It is still important to understand personal perspectives from caregivers about what they believe makes them self-efficacious. A number of limitations have been identified within the one qualitative study reviewed in the current paper (Coates & Fossey, 2016). These include participants having a higher than average level of qualification leading to the possibility of increased declarative knowledge as a source of bias and only interviewing individuals who were highly self-efficacious rather than understanding the concept of self-efficacy from a range of individuals. Thus, there is a need for further research using a qualitative methodology to understand the range of experiences and beliefs that contribute to self-efficacy in paid dementia caregivers.

Conclusion

This review critically appraised eight articles looking at self-efficacy in paid dementia caregivers and a synthesis of findings was presented. The eight reviewed studies demonstrate the significance of self-efficacy to paid caregiver wellbeing and levels of burnout and some of the factors that help shape self-efficacy, such as workplace environment and personal attributes. The clinical implications of providing paid dementia carers with the right skills, work environment and training to successfully negotiate the demands of their role were discussed. The review demonstrated that although research into paid caregivers is warranted, the evidence base is minimal and further research is therefore required. This could be done through replication of studies with larger sample sizes and controlling for confounding variables. In particular, it is important to understand the views and experiences of paid care workers with a range of self-efficacy levels.

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Appendix A: Submission guidelines for the journal ‘Dementia’

1. What do we publish?

1.1 Aims & Scope

Before submitting your manuscript to Dementia, please ensure you have read the Aims & Scope.

1.2 Article Types

Dementia welcomes original research or original contributions to the existing literature on social research and dementia.

Brief articles should be up to 3000 words and more substantial articles between 5000 and 6000 words (references are not included in this word limit). At their discretion, the Editors will also consider articles of greater length.

Dementia also welcomes papers on various aspects of innovative practice in dementia care. Submissions for this part of the journal should be between 2,500-3,000 words. Innovative practice papers should include the words 'Innovative Practice' after the title of their article when submitting to the journal. For further information about innovative practice papers, please refer to the guidelines.

The journal also publishes book reviews.

1.3 Writing your paper

The SAGE Author Gateway has some general advice and on how to get published, plus links to further resources.

1.3.1 Make your article discoverable

When writing up your paper, think about how you can make it discoverable. The title, keywords and abstract are key to ensuring readers find your article through search engines such as Google. For information and guidance on how best to title your article, write your abstract and select your keywords, have a look at this page on the Gateway: How to Help Readers Find Your Article Online.

2. Editorial policies

2.1 Peer review policy

Dementia operates a strictly anonymous peer review process in which the reviewer’s name is withheld from the author and, the author’s name from the reviewer. Each manuscript is reviewed by at least two referees. All manuscripts are reviewed as rapidly as possible.

As part of the submission process you will be asked to provide the names of peers who could be called upon to review your manuscript. Recommended reviewers should be experts in their fields and should be able to provide an objective assessment of the manuscript. Please be aware of any conflicts of interest when recommending reviewers. Examples of conflicts of interest include (but are not limited to) the below:

- The reviewer should have no prior knowledge of your submission,
- The reviewer should not have recently collaborated with any of the authors,
- Reviewer nominees from the same institution as any of the authors are not permitted.

Please note that the Editors are not obliged to invite any recommended/opposed reviewers to assess your manuscript.

2.2 Authorship

All parties who have made a substantive contribution to the article should be listed as authors. Principal authorship, authorship order, and other publication credits should be based on the relative scientific or professional contributions of the individuals involved, regardless of their status. A student is usually listed as principal author on any multiple-authored publication that substantially derives from the student's dissertation or thesis.

2.3 Acknowledgements

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

Any acknowledgements should appear first at the end of your article prior to your Declaration of Conflicting Interests (if applicable), any notes and your References.

2.4 Funding

Dementia requires all authors to acknowledge their funding in a consistent fashion under a separate heading. Please visit the Funding Acknowledgements page on the SAGE Journal Author Gateway to confirm the format of the acknowledgment text in the event of funding, or state that: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

2.5 Declaration of conflicting interests

It is the policy of Dementia to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles.

Please ensure that a 'Declaration of Conflicting Interests' statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that ‘The Author(s) declare(s) that there is no conflict of interest’. For guidance on conflict of interest statements, please see the ICMJE recommendations here.

2.6 Research ethics and patient consent

Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki.

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals, and all papers reporting animal and/or human studies must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval. Please ensure that you have provided the full name and institution of the review committee, in addition to the approval number.

For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.

Information on informed consent to report individual cases or case series should be included in the manuscript text. A statement is required regarding whether written informed consent for patient information and images to be published was provided by the patient(s) or a legally authorized representative.

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Appendix B: Data Extraction Table for papers selected for literature review

Data extraction table.

Author, Year, Location	Participant	Setting	Purpose/ Aims	Methodology	Key Findings	Strengths	Limitations
Coates and Fossey 2016. United Kingdom.	Care Assistants.	Care homes.	To explore the experiences of care assistants providing dementia care in care home settings who perceive themselves to be highly self-efficacious in providing care.	Qualitative. Semi structured interviews analysed using Interpretative Phenomenological Analysis.	Four major themes regarding care assistants experiences were identified: experiencing and resolving dilemmas, togetherness and connections, emotional attunement and caring being part of their life. Subthemes around peer support, closeness, personal perspective taking, reciprocity of emotion, a genuine interest in people and an accepting attitude towards challenging situations were also identified.	Recruited from multiple locations. Inclusion/ exclusion criteria provided. Steps taken to enhance rigour of the study, i.e. use of reflective diary, providing details of interview schedule.	No information provided on percentage of care home residents living with dementia. No reflexivity statement provided**.**
Duffy, Oyebode & Allen, 2009.	Care assistants, Nurses and Managers	NHS funded Continuing Care homes	To investigate the roles of reciprocity, self-efficacy and organisational factors on the	Observational Cross sectional design –	**Reciprocity**: No significant correlation was found between the reciprocity of relationships with staff or clients and any components of the measure of	Recruited from multiple locations. Bias considered	Small sample size. Large number of non-responders.

United Kingdom.	working with people living with dementia (PLWD).	for PLWD.	components of burnout in care staff of PLWD. To understand which of these variables is the greater statistical predictor of burnout.	administration of questionnaires.	burnout. There was a small negative correlation between levels of reciprocity with the organisation and personal accomplishment. **Self-efficacy**: was negatively correlated to both the emotional exhaustion and depersonalisation components of burnout. A positive correlation was found between self-efficacy and personal accomplishment. **Organisational factors**: A small negative correlation was found between occupational commitment (O.C) and emotional exhaustion. O.C positively correlated with personal accomplishment. Emotional exhaustion was negatively predicted by levels of reciprocity with colleagues. Occupational commitment did not predict any components of burnout Self-efficacy significantly predicted all three components	prior to data collection – steps taken to avert this. Inclusion/ exclusion criteria provided. Standardised and validated measures used. Effect sizes provided within data analysis.

					on a measure of burnout. Self-efficacy was the biggest predictor of burnout.		
Hopkins, 2017. USA.	Nurses, Nurses' aides, Nurse administrator and Licenced Nurse Practitioners.	Long term health facility.	To understand what is the self-efficacy of dementia care in nurses. .	Quantitative. Descriptive survey design.	40% of nurses lacked confidence in the awareness PLWD's individual needs.	Ethical issues discussed.	Used self-constructed unstandardized and non-validated measure. Data collection protocol unclear.
Karantzas et al. 2016. Australia.	255 Residential care staff. Including; Registered Nurses, Managers, Physiotherapists, and Personal Care Assistants.	Residential aged care facilities.	To investigate the extent to which aged care staff self-efficacy mediates the association between organizational climate variables and strain in providing care to PLWD.	Observational Cross sectional design – administration of questionnaires	Organisational climate variables and self-efficacy was found to account for 22% of variance in staff strain. Self-efficacy was found to mediate the relationship between pressure, autonomy, support, trust and staff strain. High organisational pressure was negatively associated with self-efficacy.	Standardised measured used Thought given to minimising social desirability bias. Missing data analysis.	Low percentage of care home residents living with dementia in care homes sampled. No power calculation given. Sampling method poorly described. No inclusion/ exclusion criteria given.

Kokkonen, Cheston, Dallos & Smart, 2014. United Kingdom.	Permanent members of care staff; bands 2a to 8a (support workers through to Managers)	NHS inpatient wards for older people.	To examine the relationships between staff attachment style, older adult nursing self-efficacy, approaches to dementia, and burnout in paid caregivers for people with dementia.	Observational Cross sectional design – administration of questionnaires.	**Attachment style**: Attachment related anxiety was significantly correlated with and all three components of the burnout measure. Attachment related avoidance was significantly correlated with emotional exhaustion and depersonalisation but not personal accomplishment. Attachment anxiety was significantly negatively correlated with self-efficacy and recognition of personhood. **Self-efficacy:** There was a significant negative correlation between self-efficacy and emotional exhaustion and depersonalisation components of a burnout measure. Personal accomplishment was significantly positively correlated with self-efficacy. **S**elf-efficacy and staff approaches to dementia accounted for 16.5% of the variance for emotional exhaustion. They accounted for	Recruited from multiple locations Inclusion/ exclusion criteria included. Reliable and valid self-report measures used. Lost data discussed Methods to manage non-participation discussed.	Small sample size Unadjusted data was not analysed.

					21.5% of variance on personal accomplishment component.		
MacKenzie and Peragine, 2003. Canada.	28 Full and part time nursing caregivers.	Long term care facility.	To describe the development and outcome of an intervention for long-term care nurses designed to decrease stress and burnout by enhancing their self-efficacy in managing challenging team, resident, and family situations. To present a self-efficacy inventory designed to measure the effectiveness of the intervention.	Quantitative. Quasi-experimental design. Self-efficacy training intervention provided. Differences between intervention and control group measured through self-report questionnaires.	Following the training intervention, intervention group participants demonstrated higher levels of self-efficacy than control participants. Although not significant at post-test, this was significantly different at three month follow up. Self-efficacy training did not have an effect on participants' emotional exhaustion and depersonalisation components of the burnout inventory. ANOVA revealed a significant interaction effect over time and between groups for the personal accomplishment component of burnout. Intervention participants had significantly higher levels of personal accomplishment than control participants at post-test but not three month follow up.	Comprehensive reliability and validity information provided on self-report measure used. Missing data discussed.	No discussion of ethical issues. Control and intervention group characteristics and number of participants significantly differed prior to intervention. Small sample size. Unclear data collection protocol.
McCabe, Mellor, Karantzas, Von	Senior staff, (i.e. Nurses, Managers,	Residential aged care facilities.	To examine the extent to which organizational climate factors,	Observational Cross sectional	Autonomy, trust and support were significantly positively associated with self-efficacy. Job stress was significantly negatively associated	Standardised measures used.	Sampling bias. Recruitment protocol

Treuer, Davison & O'Connor 2015. Australia.	Physiotherapists) and junior staff (Care assistants)		such as autonomy, trusting, and supportive workplace relations, and recognition of competence and ability, are related to the self-efficacy of aged care staff.	study design – administration of questionnaire.	with self-efficacy. These variables predicted 23% of the variance in self-efficacy in working with PLWD.	Attempt made to minimise reporting bias.	possibly biased. No inclusion/ exclusion criteria provided. No power calculation provided
Yan, Kwok, Tang & Ho, 2007. China.	142 Personal Care Workers.	Day care centres.	To understand the contribution of individual and interpersonal factors to the overall life satisfaction and self-efficacy among Personal Care Workers.	Observational Cross-sectional design – administration of questionnaires	Participants' life satisfaction was positively correlated with self-efficacy. High levels of self-efficacy were a strong predictor of overall life satisfaction. Female gender, satisfaction with training, low staff to client ratio and high levels of social support were predictive of high levels of self-efficacy.	Good sample size. Provided details of inclusion/ exclusion criteria. Good level of information provided on data collection protocol.	No rationale for the study provided. Some of the self-report measures used were self-constructed and not validated. No power calculation provided. Did not report exact p-values or provide information of effect sizes.

Appendix C: Example Crowe Critical Appraisal Tool (CCAT) scoring form.

Category Item	Description of item [☑ Present; ☒ Absent; ■ Not applicable]	Score [0–5]
Preamble		
Text	1. Sufficient detail others could reproduce ☐ 2. Clear/concise writing ☐, table(s) ☐, diagram(s) ☐, figure(s) ☐	**Preamble score**
Title	1. Includes study aims ☐ and design ☐	
Abstract	1. Key information ☐ 2. Balanced ☐ and informative ☐	
Introduction		
Background	1. Summary of current knowledge ☐ 2. Specific problem(s) addressed ☐ and reason(s) for addressing ☐	**Introduction score**
Objective	1. Primary objective(s), hypothesis(es), or aim(s) ☐ 2. Secondary question(s) ☐	
Design		
Research design	1. Research design(s) chosen ☐ and why ☐ 2. Suitability of research design(s) ☐	**Design score**
Intervention, Treatment, Exposure	1. Intervention(s)/treatment(s)/exposure(s) chosen ☐ and why ☐ 2. Precise details of the intervention(s)/treatment(s)/exposure(s) ☐ for each group ☐ 3. Intervention(s)/treatment(s)/exposure(s) valid ☐ and reliable ☐	
Outcome, Output, Predictor, Measure	1. Outcome(s)/output(s)/predictor(s)/measure(s) chosen ☐ and why ☐ 2. Clearly define outcome(s)/output(s)/predictor(s)/measure(s) ☐ 3. Outcome(s)/output(s)/predictor(s)/measure(s) valid ☐ and reliable ☐	
Bias, etc	1. Potential bias ☐, confounding variables ☐, effect modifiers ☐, interactions ☐ 2. Sequence generation ☐, group allocation ☐, group balance ☐, and by whom ☐ 3. Equivalent treatment of participants/cases/groups ☐	
Sampling		
Sampling method	1. Sampling method(s) chosen ☐ and why ☐ 2. Suitability of sampling method ☐	**Sampling score**
Sample size	1. Sample size ☐, how chosen ☐, and why ☐ 2. Suitability of sample size ☐	
Sampling protocol	1. Target/actual/sample population(s): description ☐ and suitability ☐ 2. Participants/cases/groups: inclusion ☐ and exclusion ☐ criteria 3. Recruitment of participants/cases/groups ☐	
Data collection		
Collection method	1. Collection method(s) chosen ☐ and why ☐ 2. Suitability of collection method(s) ☐	**Data collection score**
Collection protocol	1. Include date(s) ☐, location(s) ☐, setting(s) ☐, personnel ☐, materials ☐, processes ☐ 2. Method(s) to ensure/enhance quality of measurement/instrumentation ☐ 3. Manage non-participation ☐, withdrawal ☐, incomplete/lost data ☐	
Ethical matters		
Participant ethics	1. Informed consent ☐, equity ☐ 2. Privacy ☐, confidentiality/anonymity ☐	**Ethical matters score**
Researcher ethics	1. Ethical approval ☐, funding ☐, conflict(s) of interest ☐ 2. Subjectivities ☐, relationship(s) with participants/cases ☐	
Results		
Analysis, Integration, Interpretation method	1. A.I.I. method(s) for primary outcome(s)/output(s)/predictor(s) chosen ☐ and why ☐ 2. Additional A.I.I. methods (e.g. subgroup analysis) chosen ☐ and why ☐ 3. Suitability of analysis/integration/interpretation method(s) ☐	**Results score**
Essential analysis	1. Flow of participants/cases/groups through each stage of research ☐ 2. Demographic and other characteristics of participants/cases/groups ☐ 3. Analyse raw data ☐, response rate ☐, non-participation/withdrawal/incomplete/lost data ☐	
Outcome, Output, Predictor analysis	1. Summary of results ☐ and precision ☐ for each outcome/output/predictor/measure 2. Consideration of benefits/harms ☐, unexpected results ☐, problems/failures ☐ 3. Description of outlying data (e.g. diverse cases, adverse effects, minor themes) ☐	
Discussion		
Interpretation	1. Interpretation of results in the context of current evidence ☐ and objectives ☐ 2. Draw inferences consistent with the strength of the data ☐ 3. Consideration of alternative explanations for observed results ☐ 4. Account for bias ☐, confounding/effect modifiers/interactions/imprecision ☐	**Discussion score**
Generalisation	1. Consideration of overall practical usefulness of the study ☐ 2. Description of generalisability (external validity) of the study ☐	
Concluding remarks	1. Highlight study's particular strengths ☐ 2. Suggest steps that may improve future results (e.g. limitations) ☐ 3. Suggest further studies ☐	

Appendix D: CCAT checklist scores for each paper in the literature review.

	Coates & Fossey (20160	Duffy et al. (2009)	Hopkins (2017)	Karantzas et al. (2016)	Kokkonen et al. (2014)	Mackenzie & Peragine (2003)	McCabe et al. (2015)	Yan et al. (2007)
Preliminaries	5	4	4	3	4	4	3	3
Introduction	5	5	3	5	5	5	5	3
Design	4	4	2	4	4	3	3	2
Sampling	4	2	2	1	4	2	1	3
Data collection	3	4	2	4	5	1	4	4
Ethical matters	5	4	2	3	3	0	3	1
Results	4	4	1	4	4	3	4	3
Discussion	4	5	3	4	4	2	4	4
Total score	34	32	19	28	33	20	27	22
Rating	Good	Good	Poor	Average	Good	Poor	Average	Poor

Paper 2: Empirical Research paper

An exploration of self-efficacy in paid Dementia Care Home Staff.

This paper has been written to the standard required for submission to publication in the journal *Dementia* (excluding word count). Author guidelines for manuscript submission can be found in Appendix A.

Word count including abstract: 7995
(excluding references)

Abstract

There is a wealth of research on familial dementia caregiver self-efficacy, yet little research focusing on paid dementia caregiver self-efficacy. This study aimed to explore how self-efficacy is constructed by dementia care home staff and the factors or experiences described as helping to shape self-efficacy. Fourteen care workers from four care homes were interviewed. Transcripts were analysed using thematic analysis and four themes were identified; Wellbeing and self-care, Support from others, Values and Attributes and Demands of the role. The findings demonstrate the multi-faceted and dynamic nature of the dementia care worker's role. The clinical practice implications are discussed and suggestions are made regarding the best way in which Clinical Psychologists can support care staff self-efficacy. The possibility of using interventions such as developing self-compassion and facilitating reflective practice is explored.

The terms paid care worker, care staff, paid carer and paid caregiver are used interchangeably within relevant literature to refer to formal, non-familial caregivers and will be assumed to be equivalent terms for the purposes of this paper.

Introduction

Dementia Care

Dementia has been defined as a "clinical syndrome characterised by global cognitive impairment, which represents a decline from previous level of functioning, and is associated with impairment in functional abilities" (National Institute for Clinical Excellence, 2006, p.67). The UK is an ageing population, with life expectancy rising steadily during recent decades (Public Health England, 2018).The prevalence of dementia in care homes has risen by 14% in just over a decade (Matthews et al., 2013) and the need for care home beds has been predicted to increase by 82% between 2010 and 2030 (Jagger et al., 2011).

The essential role social care staff perform has been highlighted within Parliamentary reviews (Hussein, 2014). Nevertheless, there is a yearly social care workforce turnover rate of 27%; with 48% of individuals leaving within a year (House of Commons Communities and Local Government Committee, 2017). In response to identified issues, further support/training for the dementia care workforce has been pledged by the UK Government as part of the Prime Minister's Challenge on Dementia 2020 (Department of Health, 2015).

Burnout, commonly found in caregiving jobs (Wallang & Ellis, 2017) has been described as "physical, emotional, or mental exhaustion, especially in one's job or career, accompanied by decreased motivation, lowered performance, and negative attitudes towards oneself and others" (VandeBos, 2007, p.140). Maslach and Jackson (1981) identified three different components of burnout. Personal accomplishment refers to how competent an individual feels in their work, emotional exhaustion describes the reduction of an individual's emotional resources leading to fatigue and depersonalisation involves the caregiver emotionally distancing themselves from the care recipient. Burnout can impact on individual wellbeing as well as on the care recipient. Being less willing to help, having reduced optimism, less empathy and negative emotional responses to client behaviour have been associated with burnout in dementia carers resulting in poorer quality of care (Astrom, Nilsson, Norberg, Sandman, & Winblad, 1991; Todd & Watts, 2005). Carer strain/burnout has been linked to increased aggressive behaviours being demonstrated by people living with dementia (Brodagty, Draper, & Low, 2003). Additionally, a study of care home staff by Cooper et al. (2018) reported that 51% described carrying out or observing potentially abusive or neglectful behaviour at least once in last three months. Care homes with higher burnout or depersonalisation scores reported more abusive behaviour. It is therefore vital for care recipients that more is done to reduce burnout in care staff. One way of doing this, as explained in the following paragraphs could be to increase self-efficacy.

Self-efficacy

Self-efficacy was first developed by Albert Bandura. Bandura stated that "perceived self-efficacy is not a measure of the skills one has but a belief about what one can do under different sets of conditions with whatever skills one possesses." (1997, p.37). Self-efficacy is not an indication of what an individual can or will do but what they believe they are capable of. This is why people with similar skills may perform very differently depending on levels of self-efficacy.

Self-efficacy not only determines how much effort is applied and how long an individual will persist with an activity in the face of obstacles, but also how much stress they experience in such situations (Bandura, 1977, 1989). Bandura also postulates that self-efficacy is context specific and refers to beliefs about capabilities in particular situations rather than a global static characteristic; thus self-efficacy can be learnt or enhanced (Bandura, 1982).

Self-efficacy in dementia caregivers

Familial caregivers

Most self-efficacy research in dementia has focused on familial carers. Studies have revealed the impact of self-efficacy on aspects of caregiver wellbeing including; physical and emotional fatigue (Roepke et al., 2009), physical health risks (Harmell et al., 2011) and the impact burden has on caregiver distress (Romero-Moreno et al., 2011). In a systematic review of the literature, Crellin, Orrell, McDermott, and Charlesworth (2014) hypothesised that self-efficacy influences both positive and negative aspects of caregiving. Results indicated that low self-efficacy appeared to be associated with negative affect and depression; whilst high self-efficacy promoted emotional robustness and positive appraisals.

Paid caregivers

There has been limited research exploring the issue of self-efficacy in paid dementia carers. Within the current study, self-efficacy in paid dementia caregiving is defined as “the beliefs or judgments of staff about those caring and nursing behaviours, skills and knowledge which are needed to provide safe, independent care for residents” (Evers, Tomic, & Brouwers, 2001, p.442).

In a study within dementia care homes, Duffy, Oyebode, & Allen (2009) found that self-efficacy was negatively correlated with the emotional exhaustion and depersonalisation and positively correlated with the personal accomplishment. Self-efficacy was the biggest predictor of burnout in care staff. They suggest that irrespective of the magnitude of stressors at work, self-efficacy appears to act as a buffer against burnout in paid carers. These findings have been replicated by another study (Kokkonon, Cheston, Dallos, & Smart, 2014). The authors of both studies advocate that further research is needed to understand how self-efficacy can be increased and levels of burnout reduced. Only one piece of research has investigated self-efficacy interventions in paid dementia carers (Mackenzie & Peragine 2003). The intervention was found to significantly impact on the personal accomplishment component of burnout. However, methodological flaws in the study may have impacted on the reliability and validity of findings (Poole, 2018).

Several researchers have explored interpersonal and organisational factors impacting on self-efficacy. In a study of Chinese dementia day centre workers, Yan et al. (2007) found that female gender, satisfaction with training, low staff to client ratio and high levels of social support were predictive of high levels of self-efficacy, whilst self-efficacy was a significant predictor of life satisfaction. A study by McCabe et al. (2015) revealed that higher perceived autonomy, more support and trust were positively associated with self-efficacy. Greater perceived job stress was negatively associated with self-efficacy. This research was extended by Karantzas et al. (2016) who demonstrated that self-efficacy mediated the relationship between four different organisational factors (autonomy, trust, support and pressure) and strain in dementia care workers. Karantzas et al. suggest that fostering a good organisational climate, where staff trust one another and feel supported by management, may help enhance self-efficacy and in turn, the level of 'strain' they experience.

In the only qualitative study on the topic, Coates and Fossey (2016) explored how self-efficacy was conceptualised by dementia care home staff. Using Interpretative Phenomenological Analysis (IPA) they identified several facets of self-efficacy. These included both internal and external resources such as feeling connected to the person living with dementia and staff team, staff perspective taking and emotional attunement. Coates and Fossey reflected that the 'ethical sensitivity' demonstrated by participants implies the need to employ individuals with the 'right skills' rather than simply increasing staffing levels.

Gaps in the research literature and research rationale

A small evidence base has developed regarding the link between self-efficacy in paid dementia caregivers and factors such as organisational climate and burnout. The current study aims to explore the self-efficacy experiences of dementia care home staff with lower levels of qualification (e.g. NVQ level) which is more representative of the care worker population in the UK (Hussein, 2014). This study will include individuals with lower levels of self-efficacy as these individuals have often been under-represented in previous research (see Poole, 2018).

A recent report has suggested that social care employers are struggling to recruit and retain suitable care staff (Skills for Care, 2018a). Previous research suggests it is those with lower levels of self-efficacy that are most at risk of burnout, poorer wellbeing and perhaps leaving their jobs. It is hoped that information gained from this study could help to further understand the nuances of dementia care self-efficacy and how care workers can be further supported in their roles.

Aim of the study

The following research questions were developed;

- How is self-efficacy constructed by care staff in dementia care home settings?
- What factors, approaches or experiences do care workers report helping shape self-efficacy or belief in their ability to work in their role?

Method

Ethical Approval

The study was reviewed and approved by Staffordshire University Ethics Committee (Appendix B).

Recruitment

Participants were recruited through the National Institute of Health Research Enrich Research Ready Care Home Network within the West Midlands. The network aims to bring together care home staff and residents with researchers in order to facilitate research (National Institute of Health Research, 2019). As part of their role, the Midlands Network Research Co-ordinator ensured the study was promoted to network care homes. Managers interested in their home taking part were provided with a brief description of the study (Appendix C) and their contact details were passed on to the researcher. Two care homes from the research ready network were approached and both were interested in taking part.

The researcher contacted other (non-research ready network) care homes within the Staffordshire and West Midlands area by telephone and email. The brief description of the study was forwarded to these homes if further information was requested. Out of nine care homes whose managers were contacted, two were interested in taking part. A meeting or telephone consultation was then arranged to discuss the study in further detail with interested Home Managers.

After discussing the study with the Care Home Manager, written agreement was gained for the researcher to recruit participants through the care home. Information sheets (Appendix C) were left for staff potentially interested in taking part, which contained the contact details of the researcher. Managers were given the option of distributing information sheets or having the researcher speak to care staff directly. All managers distributed information themselves. Potential participants were asked to either let their manager know or contact the researcher via email if they wished to participate.

Inclusion/exclusion criteria

The following criteria were used within the study:

Inclusion criteria

- Aged 18 or over.
- Fluent in English.
- Currently working as a paid Care Assistant in a care home registered to provide dementia care.
- Have been working as a paid caregiver for at least six months prior to participating in the study.

Exclusion criteria

- Nursing or other ‘Professional’ Qualification.

The criteria were developed in accordance with previous research in this area (Coates & Fossey, 2016) to ensure individuals had sufficient time to become accustomed to their role. Previous research that interviewed staff with higher levels of qualification suggested that declarative knowledge may have acted as a source of bias when conceptualising self-efficacy (Coates & Fossey, 2016). The exclusion criterion was set to exclude professional qualifications, as the majority of care assistants are educated to NVQ level (Hussein, 2014).

Participants

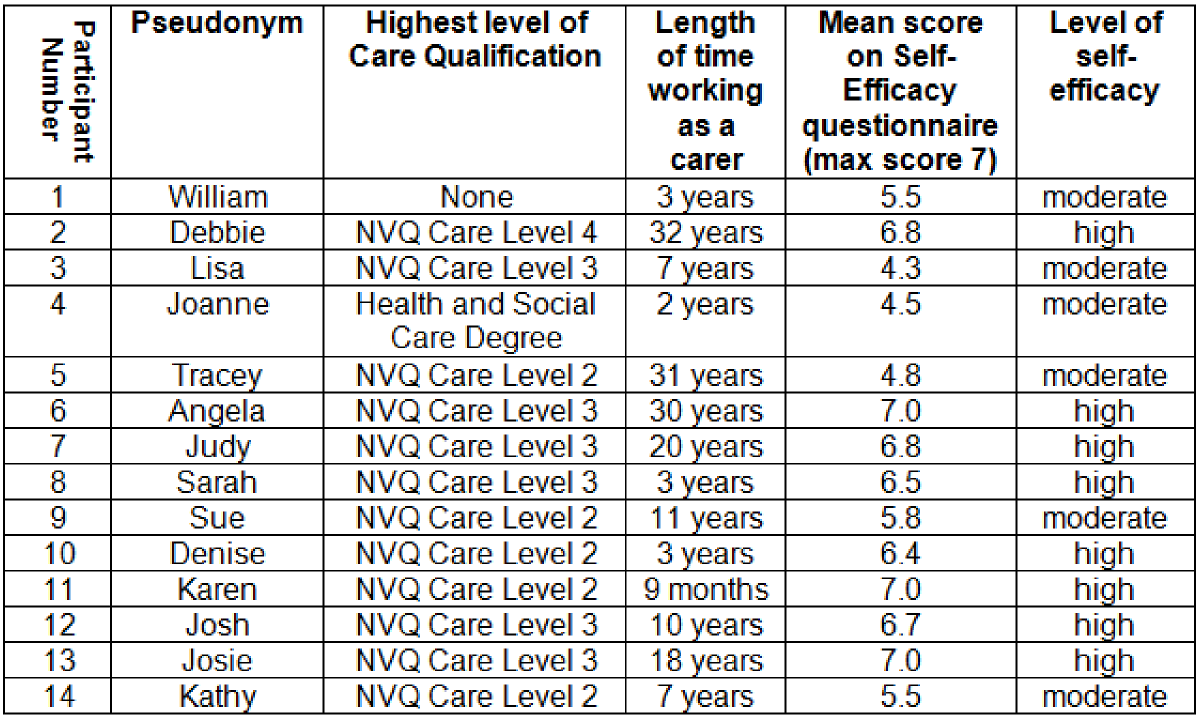
Fourteen participants were recruited from four care homes within the Staffordshire and West Midlands area between February and March 2019.

All participants were recruited from residential care homes. Ten of the fourteen participants worked in care homes (or ‘specialist units’) where all residents had a diagnosis of dementia. Four participants worked in a home registered for dementia care, although not all residents had a diagnosis of dementia. Residential homes were chosen as the current study was extending previous research conducted in a care home setting (Coates & Fossey, 2016). It was felt that recruiting from care homes would enhance the clinical applicability and ecological validity of the research regarding Clinical Psychology as most of this type of work is completed in care homes rather than with paid domiciliary carers.

Only a small proportion of staff from each care home participated in the study (14 out of an estimated 120 eligible staff). Care Home Managers at two of the homes notified the researcher that other staff not currently ‘on shift’ had indicated an interest in participating. Due to time constraints the researcher limited participation to individuals ‘on shift’ on the day each care home was visited.

Demographic information

Demographic information for each of the participants is shown in table 1.



Participant Number	Pseudonym	Highest level of Care Qualification	Length of time working as a carer	Mean score on Self-Efficacy questionnaire (max score 7)	Level of self-efficacy
1	William	None	3 years	5.5	moderate
2	Debbie	NVQ Care Level 4	32 years	6.8	high
3	Lisa	NVQ Care Level 3	7 years	4.3	moderate
4	Joanne	Health and Social Care Degree	2 years	4.5	moderate
5	Tracey	NVQ Care Level 2	31 years	4.8	moderate
6	Angela	NVQ Care Level 3	30 years	7.0	high
7	Judy	NVQ Care Level 3	20 years	6.8	high
8	Sarah	NVQ Care Level 3	3 years	6.5	high
9	Sue	NVQ Care Level 2	11 years	5.8	moderate
10	Denise	NVQ Care Level 2	3 years	6.4	high
11	Karen	NVQ Care Level 2	9 months	7.0	high
12	Josh	NVQ Care Level 3	10 years	6.7	high
13	Josie	NVQ Care Level 3	18 years	7.0	high
14	Kathy	NVQ Care Level 2	7 years	5.5	moderate

Table 1: Table demonstrating participant characteristics.

Participants included twelve women and two men, aged between 21 and 58 (mean age = 41 years). The demographics appear to be representative of the overall care worker population (Skills for Care, 2018b). The duration participants had been employed as care workers ranged from 9 months to 32 years (mean = 12 years), indicating they had time to adjust to the role. Twelve participants described their ethnicity as White British, one participant as both White British and Black African and one as Black.

Procedure

Interviews took place on days participants were ‘on shift’ and were completed in a quiet side room within each care home to maintain confidentiality. Informed written consent was obtained (Appendix E) and participants were notified of their right to withdraw from the study up to two weeks after the interview date. The researcher informed participants about boundaries of confidentiality prior to the interview. Participants were told that should they disclose information that suggested that an individual was at risk in some way, this would be shared with relevant services/ professionals.

Demographic information regarding the participants' gender, age, ethnicity, qualification level and number of years' service as a paid carer (Appendix F, also see table 1 for further information) was gathered prior to the participants interview.

Participants completed a self-report questionnaire (The Inventory of Geriatric Nursing Self-efficacy, Mackenzie & Peragine, 2003) to assess their levels of perceived self-efficacy (Appendix G). This was used solely for demographic information and to allow the reader to 'situate' the participants (see Table 1). The questionnaire was used for the same purpose in previous research (Coates & Fossey, 2016). This data was not quantitatively analysed within the study. As the vignettes used within the questionnaire were situation specific, ratings of self-efficacy should only be used as a guide.

Interviews were audio-recorded, then transcribed verbatim by the researcher. They lasted between 18 and 40 minutes in length. Participants were allocated a pseudonym following the interview to maintain anonymity.

Interview schedule

Although the interviews were semi-structured, an interview schedule was developed which helped to guide the discussion (Appendix H). Schedule topics were informed by questions used in a previous qualitative study (Coates & Fossey, 2016) as well as issues identified as pertinent following a literature review conducted by the author (Poole, 2018).

Analysis

Thematic analysis

Thematic analysis was used to analyse the interview data. This methodology involves gaining a rich detailed understanding of a phenomenon whilst allowing the researcher to identify themes and commonalities across a whole data set (Braun & Clarke, 2006). Thematic analysis was chosen over other qualitative methodologies as it enables a flexible approach that allows the researcher to make sense of collective/shared meanings or experiences (Braun & Clarke, 2012).

Due to the limited research on the topic, the researcher took an inductive approach to data analysis. This meant that the themes developed were strongly linked to the content of the data rather than fitting interpretations to certain theoretical topics or concepts that may be important to the researcher (Braun & Clarke, 2006). Guidelines regarding the completion of thematic analysis were followed during analysis (Braun & Clarke, 2013). Firstly, transcripts were read several times to familiarise the researcher with the data, and notes were made regarding anything the researcher felt might be relevant to the research questions. Subsequently, potential codes were generated and then sorted into themes and subthemes. Finally, these continued to be reviewed, refined or changed. Extracts from the data were selected to support the themes. Please see Appendices J and K for further information on the analysis process.

Rigour

To ensure rigour, initial themes were discussed and reflected on in research supervision with a Clinical Psychologist working within a dementia setting. The researcher attended a qualitative research peer supervision group to gain feedback regarding emerging themes. Feedback from this facilitated further reflexivity by the researcher and led to some rearrangement of themes. One example of this is that initially the ‘support from others’ theme was named ‘teamwork’. Following discussion it was decided that some of the quotes from the ‘wellbeing’ theme involved support from others more than self-care activities. However, this support was not necessarily from members of the work team. The theme was refined to include these quotes and was renamed ‘support from others’. Nevertheless, the close link between the two themes was acknowledged within the thematic map.

Epistemological position and Reflexivity

The researcher’s epistemological position is described as ‘social constructionist’.

Social Constructionism can be viewed as an umbrella term for a range of epistemological ideas as there is no single agreed definition of the term (Burr, 2015). Broadly speaking, the approach proposes that knowledge is the product of social processes rather than ‘a truth’ to be discovered by the mind. Consequently, socially defined meanings and understanding come to assume a ‘taken for granted’ reality (Andrews, 2012). Knowledge gained in qualitative research is therefore a complex interplay between the researcher, participant and the unique historical, social and cultural context within which the interviews took place (Losantos, Montoya, Exenim, Santa Cruz, & Loots, 2016).

Some criticisms of social constructionism are that it can be seen as denying any form of existence outside that created through language (Elder-Vass, 2012). It has been suggested that such criticisms misconstrue social constructionism’s epistemological perspective, i.e. that any attempt to describe the nature of the world involves language as the medium through which we do this (Edley, 2001). Thus, misunderstandings arise when social constructionism is viewed as taking an ontological perspective (Nightingale and Cromby, 2002). It has been argued that social constructionism makes no such ontological claims, instead proposing that the world may exist independent of our perception of it. However, there can be no direct access to that reality, only a construction from the perspective of an individual/group (Andrews, 2012).

Consistent with this approach, ontologically I believe that a form of self-efficacy as a referent may exist beyond language. Nonetheless, epistemologically I believe that the way in which dementia care self-efficacy is constructed, is embedded within societal context and may be subject to change depending on the cultural perspectives available at the time.

I noticed that as the researcher I co-constructed the interviews. Whilst transcribing, I noticed that I had clarified certain comments rather than others. For example, when a participant discussed the multiple demands of the role, I commented how hard this must be and asked to know more.

Whilst I was conscious to avoid interviewing participants as a ‘psychologist’, occasionally I struggled to avoid trying to ‘make sense’ of experiences, especially those that more closely resembled my own experiences as a care worker.

More information locating the researcher’s beliefs and interest in the chosen research topic is included in Appendix I.

Findings

The data reflected the complexities of working as a paid carer. Four themes were identified, (1) ‘*Demands of the role’* with subthemes of *unpredictability*, *emotive nature of the role*, *complex decision making* and *negotiating sensitive family issues*; (2) ‘*Maintaining wellbeing and self-care*’, (3) ‘*Support from others’* and (4) ‘*Values and attributes’*. Each theme will be separately discussed; however it is acknowledged that all themes appear to be inter-linked. The themes and relationships between them are detailed in a thematic map in Figure 2 on the next page.

The central organising concept or overarching theme demonstrating the link between all of the themes is that ‘*Dementia care is dynamic’*. Examples of transcript coding and details of the theme development process demonstrating which initial codes linked to participants and how these mapped onto themes can be found in Appendix K.

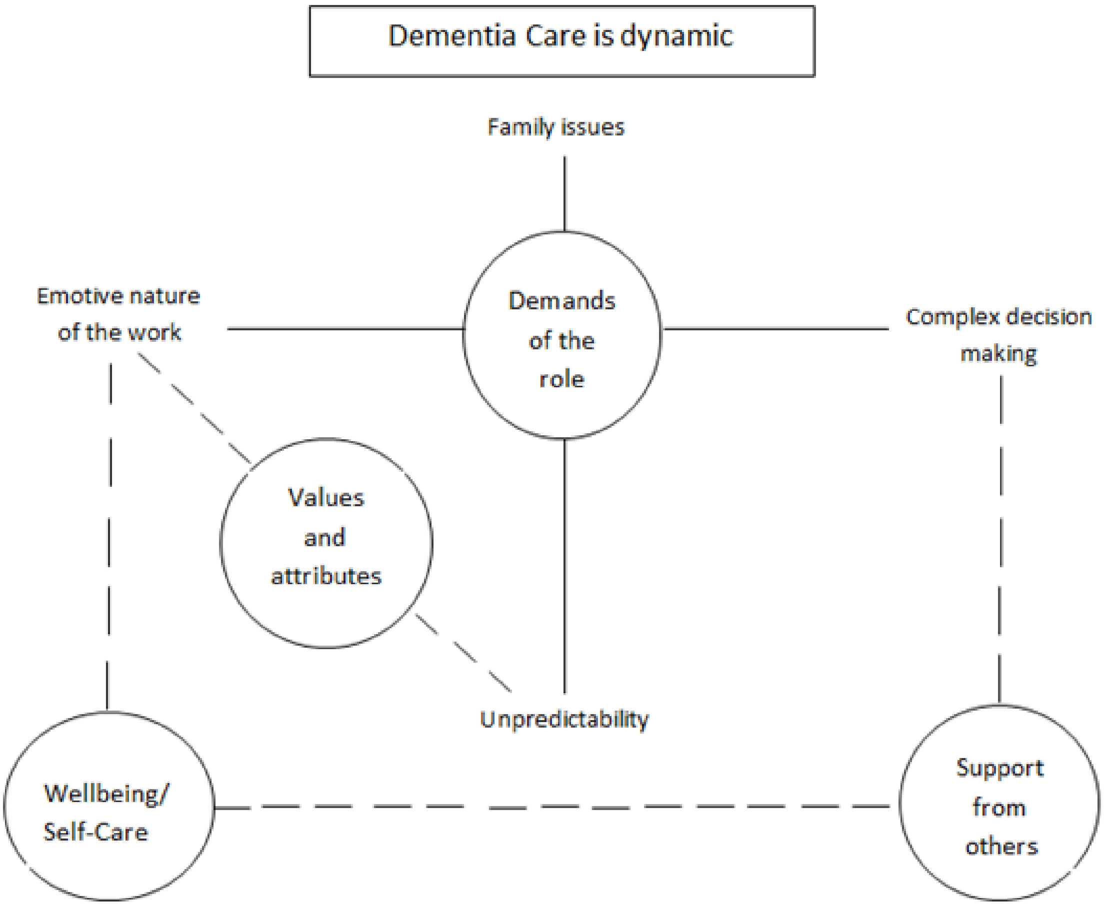


Figure 3: Thematic map representing themes and subthemes. Links between themes and subthemes are demonstrated by a dotted line.

Demands of the role

All participants reported that many demands were placed on them on a daily basis as part of their work as a paid carer. This included negotiating sensitive issues and making complex decisions in emotive or unpredictable situations or environments. Participants described that a crucial part of managing these demands was learning from experience.

Unpredictability

The majority of participants constructed dementia care as unpredictable; making it difficult for carers to predict what might happen or stick to a planned routine. Participants talked about having to quickly adapt to a given situation using a perceptive and flexible approach;

> "People with dementia can be unpredictable, there are certain patterns and you work around those, but you don't really know what's going to happen next" – William (Lines 12-14)

> "You can't plan what is going to happen, you just have to go with it" – Lisa (Lines 15-16).

> "You've got to think quickly on your feet and think about the best way to deal with certain situations and keep level-headed" – Angela (Lines 164-165).

Complex decision making

Participants reported having to make complex decisions about what is best for a client in challenging situations often feeling unsure about whether they were making the 'right decision' for the client;

> "I try and stop it escalating by taking the lady to her own room where it's quiet and you start to think, 'is that right? I'm not trying to punish anybody'" – Lisa (52-54)

> "Sometimes you just don't know how to answer the residents…like if someone says they want to go home or when is their husband coming to pick them up, sometimes it's hard to know what to say" – Sarah (37-39)

Some participants constructed the decision making process as involving ethical dilemmas as well as weighing up risk with autonomy, other people's viewpoints and the best interests of the individual, with the gravity of the decision. Participants described how this sometimes led them to internally question the suitability of their decisions;

> "You've got to make (decisions) for (the residents) sometimes and you feel a bit guilty doing it but sometimes you have to do it for their own best intentions…if you see they're going to hurt themselves doing it, that's when you stop it...even though it upsets them, you know in

> yourself you're doing the right thing. It will occasionally upset me and I think ‘oh dear I'm stopping them from doing this’ but I've got to do it in their best interests because they might hurt themselves and if they end up in hospital how would I feel then?” – Tracey (Lines 66-75)

> “One of our residents, her husband died a couple of years ago, now she does know that he’s passed away but she does forget, so you think, ‘well I don't want to tell her again because it's going to upset her all over again’…and you'll feel a bit bad lying but you think…it's going to cause a lot of heartache all over again, and you don't want to do that so you do find yourself fibbing, and it's like, ‘oh god that's terrible’…you feel bad for a couple of minutes and then you think at least they're all right now, they settled again’” – Tracey. (Lines 79-90)

> “I do have my doubts as a carer, you start to think, am I doing something right, am I doing it wrong?... sometimes other members of staff make you feel like that...things can be kind of conflicting sometimes with what other people would rather do... I’m trying to do what’s in the best interests of all the residents at the end of the day, not just one person” – Lisa (Lines 44-63)

Many of the decisions were constructed as being further complicated by competing demands and priorities felt by the care worker;

> “When (the residents) follow you around and they seem to attach to one person and you've got to deal with doing your job, like the medication, answering the phone, and helping other staff…you’ve got to think about all those things and sometimes you can feel that you're not giving your all to the resident. That's what I found the hardest, because when you've got a lot of jobs to do and you have to prioritise” – Angela (Lines 42-47)

> “You think, this resident needs more of your time than other people, but then you might have another resident that's saying they don't feel well because they're not getting as much attention but I think, I can't

> give you the attention at the minute I've got to help this other lady but I will come back to you" – Judy (Lines 84-87)

Some participants described how during the complex decision making process, no matter how hard you try, due to individual differences there may be no definitive right decision regarding how best to care for people living with dementia;

> "There's not always an answer…sometimes (different strategies) can help, sometimes it doesn't, because there's not a text book." – Josh (Lines 37-41).

> "However confident you feel you are, you can't reach out to every person because sometimes they just can't be calmed and sometimes you just have to let them ride that feeling" – Josie (Lines 44-46).

Emotive nature of the role

Participants often described caring for people living with dementia when they were at their most vulnerable, especially during end of life care. Many participants stated that it was very difficult to not form some sort of attachment to residents they cared for and saw this as an inevitable part of their caring role. However when a distressing event did occur, their attachment only amplified the emotional impact this had;

> "You treat and feed (the residents) like they were your own grandmother but then it can be difficult if you're in that emotional state and then they start hitting you" – William (Lines 14-16)

> "I feel the people I care for are like my family and I can't detach, I don't think it's possible…if you don't get attached to at least some residents you look after, you're not human" – Karen (Lines 70-73)

> "You care about (the residents) and they say you shouldn't get attached, but you do, you can't help it…like if somebody has passed

> away, you do get upset…It is a very difficult part of the job but sadly you don't get used to it" – Tracey (Lines 100-106)

> "The first time it happened (a resident passing away), I was really sobbing my heart out, I couldn't work, I couldn't carry on working" – Sue (Lines 29-30).

Negotiating sensitive family issues

Several participants constructed an important yet challenging part of their role as negotiating the discussion of sensitive topics such as individual choice or dementia progression with relatives. Participants described care decisions being scrutinised by family members making them feel undermined or misjudged. This left some carers feeling frustrated whilst trying to manage families' expectations;

> "With their families you have to try and explain to them that mum doesn't always mean what she says, and try and help them through it as well. That's a big part of it I always feel, the family is…you have to try and pave the way a little bit as it involves everybody in the family group doesn't it? I think that's important" – Angela (Lines 36-40)

> "I've had quite a few (relatives) thinking their mum's going to come back and it's not going to get worse…and then you try and explain. With some of (the relatives) it is difficult when you try and explain what's going to happen" – Sue (Lines 41-45)

Experience is better than knowledge

Several participants described training as helpful, yet reported it could never fully prepare someone for the demands of the role. The experience of encountering varied situations and getting to know residents well was positioned by participants as making them feel more confident in effectively managing a situation;

> "You just need to get hands on…I know you get all the training as well but I think you just need to do the job…at first I felt like I'd been dropped in the deep end, but I think it's what you need, you learn on the job" – Joanne (Lines 39-42)

> "I don't think there's ever enough training to prepare you for this job, the best way to prepare you is just to get stuck into your job" – Karen (Lines 185-186)

> "All the training obviously that helps, but I feel like you learn more doing it… I feel actually doing it, is more of a help" – Sarah (Lines 98-100)

Support from others

Participants described gaining support through a variety of mechanisms such as other carers on shift, managers and also the wider care-giver community. The ability to ask others for advice if they were unsure was constructed by some as helping them manage the challenges of care work as well as enhancing carer wellbeing.

> "We all keep an eye on each other, so if there's a situation going on, obviously the other girls will come in to see what's happening, then the other one that is getting more stressed, she can walk away and have five minutes because someone else has taken over the situation" – Debbie (Lines 29-32)

> "It can be really challenging, so sometimes you can't cope with it but that is why we work as a team and I'll ask for help from someone. If not, I can always speak to management who help us a lot, especially with the challenging behaviour; they come on to the floor and help us with what to do. That does make it less stressful." – Denise. (Lines 84-88)

Participants described how valuable it was to be able to ask other team members for support if they were unsure;

> “See if there’s a way, if there’s not, go and ask for help because there might be somebody else that can help. Never be scared to ask for help if needed” – Karen (Lines 131-133).

> “The senior team and the manager, they have all got a lot of experience … so you feel confident that way, that you’ve got someone there that's knowledgeable…
>
> …Never try to deal with it on your own, go and ask the team, there is always somebody that would know if you're unsure” – Josh (Lines 98-102, 136-138).

Many participants talked about team dynamics and differing ways of approaching care. ‘Pulling together’ as team and becoming more focused on care was positioned by some as enabling staff to feel more confident;

> “If you've got a good team then you know the job will be done ok, but if you got a team member that doesn't want to work with you or doesn't work well then it would make the job hard” – Judy (Lines 65-66)

> “I think like at any workplace you’re going to have people you disagree with, don’t get on as much with, you just put that to one side in order to look after the people that need looking after” – William (Lines 86-88)

> “Spending seven hours with another carer, you’ve got to work as a team, you have to learn to get on with people…there’s been challenges with different carers and different personalities… but you got to get on the best you can, you’ve got to communicate” – Joanne (Lines 55-61).

Maintaining Wellbeing/Self-Care

Throughout the interviews, participants used adjectives such as “challenging” “tiring” “demanding” “draining” “hard” “stressful” and “wearing”, positioning care work as having a negative impact on their wellbeing.

Not only did care staff report managing physically aggressive behaviour but they also expressed how verbally challenging behaviours could be mentally draining due to their recurring nature. Participants described how this was helped by the support of others whether that was co-workers or family and friends;

> "It's more mentally draining sometimes, not physically, we do get hit and kicked sometimes, mentally you're like, 'when does it stop?', yeah it can bring you down...but I get days where I think 'oh my gosh' because (a resident) is going on and on… and then you've got tomorrow to do it again, it can be really stressful…but you don't show it …we help each other, we have to pick each other up"" - Debbie (Lines 111-130)

> "Mentally you've got the residents always shouting all the time, there's always noise…I like doing it, but some people can find it quite exhausting" – Sarah (Lines 26-28)

> "My husband used to say 'switch off from it now' because I used to take it home with me and worry and in a job like this… I think if you care enough, you can't always shake it off… and I used to say 'now be sensible, you were with the residents, that was more important that day then whatever else you should have been doing" – Angela (Lines 208-213)

Participants described coping strategies including the use of humour, thinking positively, taking a break or unwinding with an alcoholic drink. The majority of participants expressed that taking themselves out of the situation allowed them to gain a fresh perspective in order to better cope with the situation.

> "It does help if you just pop out for fresh air for a couple of minutes... It just gives you time to think 'ok, what do I do now…you're going to be alright'…gives you a bit of time to think rather than panic" – Tracey (Lines 208-211)

> “You just take a step back, take a deep breath, look at it from the outside and come up with a way to get round it” – Karen (Lines 126-127).

> “We had a gentleman once who struck out while I was trying to help another lady and he hit me…but that felt like it shouldn't have happened, why did that happen? …I did end up getting a bit upset…I just had five minutes out…it helped me think about things and calm myself down” – Kathy (Lines 75-84).

Values and attributes

There were several personal attributes participants constructed as being critical to feeling confident in their role. These included having a gregarious and demonstrative approach to interacting with residents and demonstrating a calm and level headed approach when needed in unpredictable, demanding or emotive situations;

> “You can't be a shy person…you're going to make a fool of yourself at some point, you have to get up and dance, so you can't have a shyness about you” – Josh (Lines 86-88).

> “You do need to be the right kind of person, you need to be a little bit… quirky yourself... if you put on a happy approach and you can sing your head off and get residents to join in and you're not sort of embarrassed about dancing to some music, you've got to lose your own inhibitions in a way” – Angela (Lines 172-175)

> “My motto is ‘do not stress’, everything can be resolved, it might take a little longer than normal but everything is manageable, just step back, take a deep breath and then carry on” – Karen (Lines 117-119).

> “I’m pretty laid back, it’s my nature… you’ve got to not take offence… your attitude and keeping calm and be gentle, have a gentle manner” – Angela (Lines 130-138)

Many participants described care work as being more than a job, attuned with their life values regarding a passion for caring and treating others how they would wish to be treated. These values were positioned as particularly helpful in dealing with situations that had very emotive elements;

> “It’s about looking after (the residents’) needs, not as in a chore, but as in, as if it’s your Mum, your Grandparents, so how would you care for them?” – Debbie (Lines 48-49).

> “I’ve always wanted to work in some form of care, I see it as giving back…so I felt like I need to be doing my part and helping” – Karen (Lines 8-14).

> “When I finish my shift it’s nice to know…most importantly that (the residents’) feel safe...all of that makes it worthwhile ‘cause I’d like to think if I was in my 80’s in a care home, there would be somebody that would look after me like that” – Lisa (Lines 35-40).

Discussion

This study explored dementia care home workers’ constructs of self-efficacy in dementia care and the factors and experiences that help shape it. Four themes were identified; ‘Demands of the role’, ‘Support from others’, ‘Maintaining wellbeing and self-care’ and ‘Values and attributes’. This study highlights the multi-faceted, immensely complex and dynamic nature of a dementia care worker’s role.

Participants described self-efficacy as being affected by several factors, including the ability to effectively manage the demands of the role, making quick complex decisions in unpredictable, highly emotive or ethically ambiguous situations, and managing sensitive family issues. Underpinning this is the ability to ask for and utilise support from others, as well as maintaining good levels of self-care and wellbeing. Some participants felt that certain values and personal attributes could also help shape perceived self-efficacy in dealing with challenging situations.

A previous qualitative study with dementia care staff reflected similar themes to those within this study, namely ‘feeling torn (about decisions)’ ‘togetherness and connection’ ‘emotional attunement’ and ‘caring as part of life’ (Coates & Fossey, 2016). Nevertheless, the current study contributes to the evidence base with data from individuals with lower levels of perceived self-efficacy than in previous studies.

One significant difference between the current study and Coates and Fossey was the inclusion of ‘negotiating sensitive family issues’ within the current subthemes. This issue has been highlighted in other research and suggestions have been made regarding resolution of the issue using different ‘interaction styles’ (Uttley-Smith et al., 2009). Family involvement is an important factor in dementia care and can impact on quality of life (Roberts, 2017). It is vital that care staff feel efficacious when working closely with relatives. This can be challenging due to the lack of perceived resources available to establish effective working relationships (Hertzberg & Ekman, 2000). This perhaps represents a wider issue regarding how joint working between staff and relatives is facilitated in care homes. Any guidelines developed should be cascaded to care staff to help them feel supported in this role.

The current findings are consistent with previous research identifying feeling supported by others as a factor influencing dementia care self-efficacy (Karantzas et al., 2016; Yan et al. 2007). The prevalence of participants reporting asking for help is interesting as other studies have identified autonomy as an important factor in self-efficacy (McCabe et al., 2015). One potential reason for this discrepancy is that while the current research interviewed ‘unqualified’ care staff, McCabe et al’s participants included nurses and other ‘qualified professions’. These individuals already have a higher level of training/declarative knowledge and may have felt more empowered than care workers in making independent decisions.

One factor identified as impacting on how self-efficacy was constructed was the ability to effectively make complex decisions within the care environment. Common topics included managing aggression and repetitive questioning/

‘therapeutic lying’. It is significant that both these issues involve substantial ethical considerations and due to the complexities of dementia presentations, have no clear panaceas or definitive ‘right course of action’ (e.g. Alzheimer Europe, 2014; Cutcliffe & Milton, 1996; Division of Clinical Psychology, 2013). Instead, carers have to rely on ‘thinking on your feet’: basing a decision around the quick identification and synthesis of pertinent issues. This is perhaps why many participants reported that training cannot always prepare someone for the practicalities of care work as it cannot cover every eventuality.

The connection made within the current study between demands of the role, support from others and wellbeing is supported within previous care home research (Woodhead, Northrop, & Edelstein, 2016). Woodhead et al. found that job demands (occupational stress) were significantly associated with components of burnout, whilst job resources (support from others) were significantly associated with reduced levels of burnout. Therefore, without support from others, carers with multiple job demands are at increased risk of burnout.

Many of the themes identified from the data are consistent with Self-Efficacy Theory (Bandura, 1997). The two most influential determinants of self-efficacy as identified by Bandura (1977) were highlighted within the current study: performance accomplishments (experience) and vicarious experience (assistance/learning from others). Although several participants expressed that experience helps them develop self-efficacy in challenging situations, it appeared unlikely to be the main factor influencing its development. Inspection of the participant characteristics table demonstrates that a participant with nine months care experience rated perceived self-efficacy in dementia care in the ’high’ range. By contrast, another participant with 31 years’ experience was rated as having moderate levels of self-efficacy. One reason for this could be that Bandura (1982) theorised that self-efficacy varied according to perceived task complexity and generality of efficacy beliefs. Thus, if care staff believe that making complex decisions is very difficult and, the unpredictability of dementia care means what they learn may not be applicable to other situations, this could impede the development of self-efficacy.

Strengths and Limitations

The recruitment of ten of the fourteen participants from ‘units’ solely providing dementia care strengthens the credibility of findings. It is likely that themes raised in the interviews pertain to dementia care rather than older adult care more generally. This has been a limitation in previous studies (reported in Poole, 2018).

The current study included men and women from different ethnic backgrounds with average levels of care qualification (see Table 1). This represents a better cross section of the care worker population (Skills for Care, 2018b) than previous self-efficacy research (reported in Poole, 2018). Nevertheless, only a small percentage of eligible staff from each home took part. Additionally, all care home managers decided to distribute information about the study themselves. Although every effort was made to remind home managers and participants that participation was voluntary, it is possible that home managers could have encouraged socially desirable responding or certain care staff may have felt pressurised to take part. It is therefore unclear how representative the participating staff members were of each care home.

All of the interviews were conducted within care homes, which although logistically beneficial, may have created some limitations. Although all ethical guidelines and informed consent procedures were followed, it is unclear whether some participants’ decisions to take part were influenced by the time out of work whilst ‘on shift’. The majority of interviews conducted with those with moderate levels of self-efficacy were of a shorter duration and required more follow up probe questions to gain reflective data from participants. This could have been due to individuals being less willing or able to reflect on their lower levels of self-efficacy. It is unclear whether participants would have provided different answers if they were interviewed away from the work environment and more removed from managers/colleagues. This study did not recruit participants with perceived ‘low’ levels of self-efficacy. These individuals could have been discouraged from participating for fear of being judged. Any further research conducted with carers with lower levels of self-efficacy would need to carefully consider how best to encourage participants to be more open about their experiences.

Out of eleven homes approached, only four participated which might have resulted in some systematic bias in responses. There could be characteristics of the participating care homes that made them more willing to take part in research. Support from others and wellbeing and self-care were identified as important aspects of how staff constructed self-efficacy, yet potentially, staff in other homes may position themselves as less likely to receive support or be able to maintain good self-care. More needs to be done to engage care homes that are less likely to take part in research in order to maximise representativeness of participants/care homes in future research.

Another consideration is the analysis method used. Whilst thematic analysis does not analyse data to the same depth as other approaches such as IPA, it does allow for a greater range of experiences to ‘be heard’ and commonalities to be drawn. In qualitative research, the researchers’ own beliefs will always influence their interpretation of interview data. Nonetheless, every effort was made to ensure transparency and rigour; a reflexive statement was included and the researcher attended a qualitative research peer supervision group.

Implications for Clinical Practice

Presently, the majority of care home input from Clinical Psychologists is provided in the form of training or ‘support guidelines’. These findings which describe care staff as relying on experience and ‘thinking in the moment’ rather than utilising knowledge and training, suggests that Clinical Psychology needs to reconsider how best to help paid carers enhance their self-efficacy.

During transcription the researcher noted that despite the complexities and demands of the role, many participants were less than compassionate towards themselves in their caregiving role. Self-compassion refers to self-kindness rather than criticism and not over identifying with negative or difficult thoughts (Gilbert, 2010; Neff, 2003). Participants described critically analysing/judging (‘you feel a little bit guilty’ or ‘I’m not giving my all’) or ruminating on (‘am I doing it wrong?’) the care decisions they made. Research suggests that self-criticism is associated with lower levels of compassion (Gilbert, Clark, Hempel, Miles and Irons, 2004). Conversely, practicing compassion towards oneself has been associated with decreased self-criticism (Levis and Uttley, 2015).

One potential avenue for intervention may be to help paid carers develop and enhance self-compassion within their role. Self-compassion has been linked to increased empathic concern and greater perspective taking in the general population (Neff & Pommier, 2013) and enhanced self-care and emotional resilience in healthcare workers (Beaumont, Irons, Rayner, & Dagnall, 2016). Self-compassion may help reduce emotional arousal in stressful situations, one component through which self-efficacy can be developed (Bandura, 1982). Future research regarding such interventions in the dementia care worker population is therefore warranted.

The finding that ‘support from others’ impacted on self-efficacy highlights the need for care providers to ensure robust support mechanisms within the work place, such as regular supervision and reflective practice opportunities. A recent study suggested lack of support and respect for care staff needs, in the face of the burden of caring, can leave care staff being viewed as ‘depersonalised instruments of care’ (Kadri et al., 2018). In other healthcare professions, reflective practice has been found to have a supportive function (Dawber, 2013). It can enhance critical thinking abilities, help develop greater autonomy in decision making and increase professionalism (Platzer, Blake, & Ashford, 2000). This could be especially important for ‘new’ care workers who lack the experience that might otherwise promote self-efficacy in demanding situations and therefore rely on support from others and good self-care to enhance their self-efficacy.

Clinical Psychologists taking a largely proactive stance to care home work rather than piecemeal provision, as and when challenges arise, presents a new way of working. It brings logistical challenges regarding time and money. However, this culture of change regarding the need for reflective practice is starting to be recognised by some dementia learning initiatives and care homes (Dementia Services Development Centre, 2017). Nevertheless, changes are needed within dementia services if the government is to truly achieve its aim of making the UK the best country to live in for dementia care (Department of Health, 2015).

Conclusion

This study provides an insight into how paid dementia carers construct self-efficacy in their role. The findings suggest that self-efficacy is related to their belief in their ability to effectively negotiate very complex, sensitive, emotive and unpredictable situations on a daily basis. Participants described experience rather than knowledge as helping to promote self-efficacy. Other factors such as self-care, support from others and values and attributes that influence self-efficacy in effectively managing the challenges associated with contemporary dementia care. The study provides a direction for future research and clinical initiatives such as more robust self-care and support mechanisms, as well as Clinical Psychologists supporting paid carer self-efficacy through the promotion of self-compassion techniques. There are still gaps in the evidence base and an increased understanding of paid carers with low levels of perceived self-efficacy would be beneficial.

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Appendix A: Submission guidelines for the journal ‘Dementia’

1. What do we publish?

1.1 Aims & Scope

Before submitting your manuscript to Dementia, please ensure you have read the Aims & Scope.

1.2 Article Types

Dementia welcomes original research or original contributions to the existing literature on social research and dementia.

Brief articles should be up to 3000 words and more substantial articles between 5000 and 6000 words (references are not included in this word limit). At their discretion, the Editors will also consider articles of greater length.

Dementia also welcomes papers on various aspects of innovative practice in dementia care. Submissions for this part of the journal should be between 2,500-3,000 words. Innovative practice papers should include the words 'Innovative Practice' after the title of their article when submitting to the journal. For further information about innovative practice papers, please refer to the guidelines.

The journal also publishes book reviews.

1.3 Writing your paper

The SAGE Author Gateway has some general advice and on how to get published, plus links to further resources.

1.3.1 Make your article discoverable

When writing up your paper, think about how you can make it discoverable. The title, keywords and abstract are key to ensuring readers find your article through search engines such as Google. For information and guidance on how best to title your article, write your abstract and select your keywords, have a look at this page on the Gateway: How to Help Readers Find Your Article Online.

2. Editorial policies

2.1 Peer review policy

Dementia operates a strictly anonymous peer review process in which the reviewer’s name is withheld from the author and, the author’s name from the reviewer. Each manuscript is reviewed by at least two referees. All manuscripts are reviewed as rapidly as possible.

As part of the submission process you will be asked to provide the names of peers who could be called upon to review your manuscript. Recommended reviewers should be experts in their fields and should be able to provide an objective assessment of the manuscript. Please be aware of any conflicts of interest when recommending reviewers. Examples of conflicts of interest include (but are not limited to) the below:

- The reviewer should have no prior knowledge of your submission,
- The reviewer should not have recently collaborated with any of the authors,
- Reviewer nominees from the same institution as any of the authors are not permitted.

Please note that the Editors are not obliged to invite any recommended/opposed reviewers to assess your manuscript.

2.2 Authorship

All parties who have made a substantive contribution to the article should be listed as authors. Principal authorship, authorship order, and other publication credits should be based on the relative scientific or professional contributions of the individuals involved, regardless of their status. A student is usually listed as principal author on any multiple-authored publication that substantially derives from the student's dissertation or thesis.

2.3 Acknowledgements

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

Any acknowledgements should appear first at the end of your article prior to your Declaration of Conflicting Interests (if applicable), any notes and your References.

2.4 Funding

Dementia requires all authors to acknowledge their funding in a consistent fashion under a separate heading. Please visit the Funding Acknowledgements page on the SAGE Journal Author Gateway to confirm the format of the acknowledgment text in the event of funding, or state that: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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It is the policy of Dementia to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles.

Please ensure that a 'Declaration of Conflicting Interests' statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that 'The Author(s) declare(s) that there is no conflict of interest'. For guidance on conflict of interest statements, please see the ICMJE recommendations here.

2.6 Research ethics and patient consent

Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki.

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals, and all papers reporting animal and/or human studies must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval. Please ensure that you have provided the full name and institution of the review committee, in addition to the approval number.

For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.

Information on informed consent to report individual cases or case series should be included in the manuscript text. A statement is required regarding whether written informed consent for patient information and images to be published was provided by the patient(s) or a legally authorized representative.

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3. Publishing Policies

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4.1 Formatting

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Language and terminology. Jargon or unnecessary technical language should be avoided, as should the use of abbreviations (such as coded names for conditions). Please avoid the use of nouns as verbs (e.g. to access), and the use of adjectives as nouns (e.g. dements). Language that might be deemed sexist or racist should not be used. All submissions should avoid the use of insensitive or demeaning language. In particular, authors should use ‘dementia-friendly’ language in positioning people living with dementia in their article and avoid using pejorative terms such as ‘demented’ or ‘suffering from dementia’. We recommend that authors refer to the Dementia Engagement and Empowerment Project (DEEP) guidance which was developed by people living with dementia and offers a range of advice and support, including writing dementia-friendly information. Alternatively, Alzheimer’s Australia sets out guidelines for dementia-friendly language. Please also consider how you are using abbreviations in your submission. Whilst QoL (for quality of life) and MMSE (for Mini-mental State Examination) may have common usage, please try to avoid unnecessary abbreviations in the submission of your manuscript, such as PWD (for people with dementia) and abbreviations that detract from the overall flow of the manuscript.

Abbreviations. As far as possible, please avoid the use of initials, except for terms in common use. Please provide a list, in alphabetical order, of abbreviations used, and spell them out (with the abbreviations in brackets) the first time they are mentioned in the text.

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This journal is able to host additional materials online (e.g. datasets, podcasts, videos, images etc) alongside the full-text of the article. For more information please refer to our guidelines on submitting supplementary files.

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Innovative Practice papers must be submitted via the online system. If you would like to discuss your paper prior to submission, please email Jo Moriarty jo.moriarty@kcl.ac.uk.

Books for review should be sent to: Book Review Editor, Dementia, Caroline Swarbrick University of Manchester,
UK caroline.swarbrick@manchester.ac.uk

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As part of our commitment to ensuring an ethical, transparent and fair peer review process SAGE is a supporting member of ORCID, the Open Researcher and Contributor ID. ORCID provides a persistent digital identifier that distinguishes researchers from every other researcher and, through integration in key research workflows such as manuscript and grant submission, supports automated linkages between researchers and their professional activities ensuring that their work is recognised.

We encourage all authors to add their ORCIDs to their SAGE Track accounts and include their ORCIDs as part of the submission process. If you don't already have one you can create one here.

5.2 Information required for completing your submission

You will be asked to provide contact details and academic affiliations for all co-authors via the submission system and identify who is to be the corresponding author. These details must match what appears on your manuscript. At this stage please ensure you have included all the required statements and declarations and uploaded any additional supplementary files (including reporting guidelines where relevant).

Dementia requires authors to submit a short author biography. You will be asked to upload this as a seperate file.

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Please also ensure that you have obtained any necessary permission from copyright holders for reproducing any illustrations, tables, figures or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please see the Copyright and Permissions page on the SAGE Author Gateway.

6. On acceptance and publication

6.1 SAGE Production

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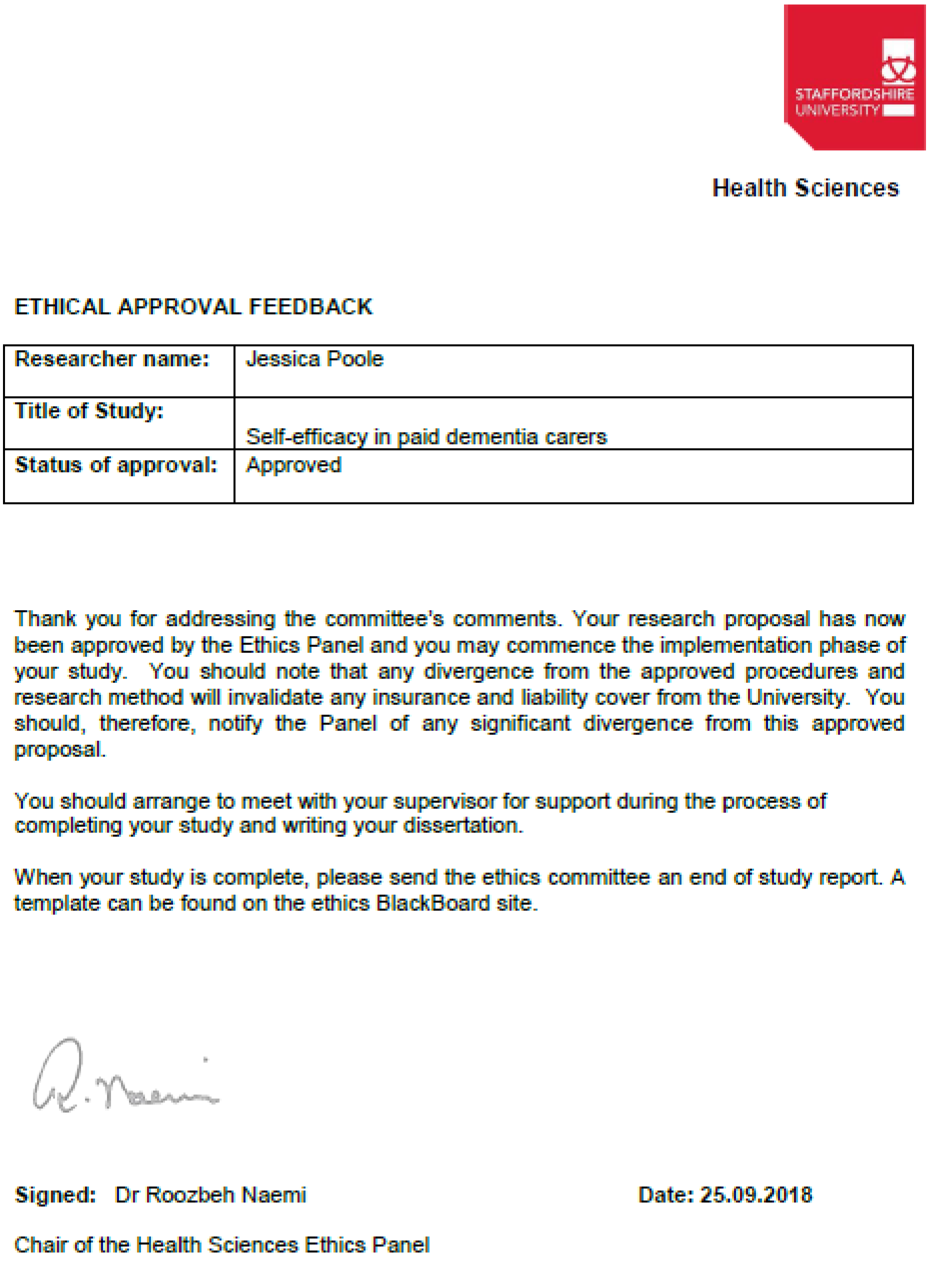
7. Further information

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the Dementia editorial office as follows:

dem.pra@sagepub.com

Appendix E: Ethical approval form and amendment approval form.



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Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	Jessica Poole
Title of Study:	Self-efficacy in paid dementia carers
Status of approval:	Approved

Thank you for addressing the committee's comments. Your research proposal has now been approved by the Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

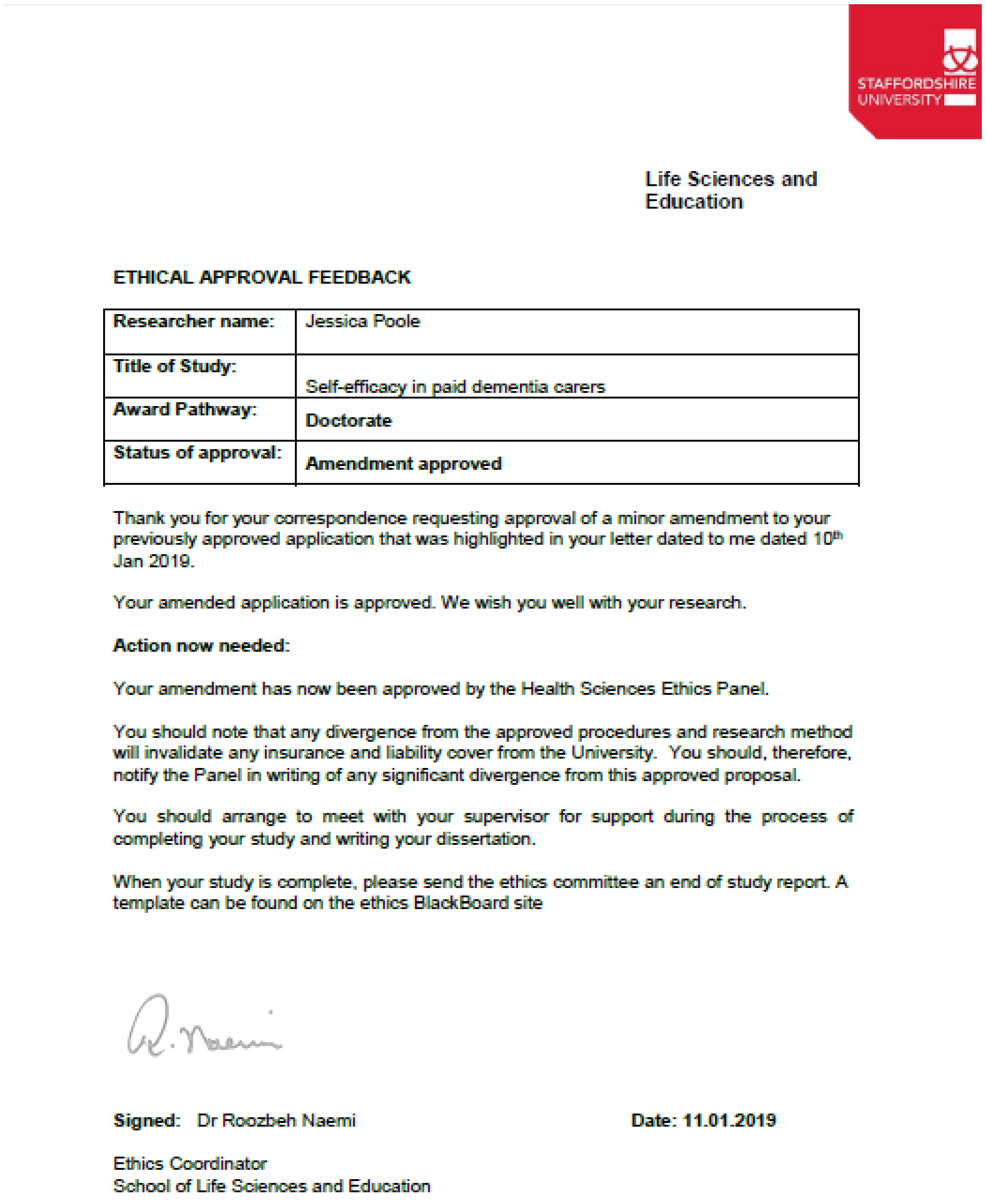
You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

R. Naemi

Signed: Dr Roozbeh Naemi **Date: 25.09.2018**

Chair of the Health Sciences Ethics Panel



Life Sciences and
Education

ETHICAL APPROVAL FEEDBACK

Researcher name:	Jessica Poole
Title of Study:	Self-efficacy in paid dementia carers
Award Pathway:	**Doctorate**
Status of approval:	**Amendment approved**

Thank you for your correspondence requesting approval of a minor amendment to your previously approved application that was highlighted in your letter dated to me dated 10th Jan 2019.

Your amended application is approved. We wish you well with your research.

Action now needed:

Your amendment has now been approved by the Health Sciences Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

R. Naemi

Signed: Dr Roozbeh Naemi **Date: 11.01.2019**

Ethics Coordinator
School of Life Sciences and Education

Appendix F: Information sheet for Care Home Managers

Research opportunity: Self efficacy in paid dementia care home staff

Dear Care Home Manager,

I am a Trainee Clinical Psychologist completing my Professional Doctorate in Clinical Psychology at Staffordshire University. I am carrying out research looking at the factors that help paid carers feel more confident in carrying out their role in caring for people living with dementia.

The Government has acknowledged that creating a clear evidence base regarding the support and training needs of dementia care staff is a priority over the next few years (Department of Health, 2016). However, currently very little research has been completed on care worker confidence in carrying out their role. It is therefore hoped that the results of this study could help us better understand the multiple demands of caring, how confidence in the caring role is developed and identify possible interventions that might help promote care workers' confidence in carrying out their role. This, in turn could positively impact the quality of care received and overall wellbeing of the person living with dementia.

The research would involve me coming to your care home and meeting with care staff individually and confidentially to complete interviews about their experiences as care workers and qualities or approaches they think help them in this role. Each interview is expected to last around 40 minutes. I am looking to interview individuals who have been in a direct caring role (rather than registered nurses etc.) for at least 6 months. All responses are confidential and no individual or care home will be individually identified in any written report.

If you are interested in your care home taking part in this research, please let me know and I can come and discuss it further either with yourself and/or care staff. You can find my contact details at the bottom of this letter.

I would be very grateful for your help with this research. Please do not hesitate to contact me if you have any further questions.

I look forward to hearing from you.

Yours Sincerely

Jessica Poole

Trainee Clinical Psychologist

Professional Doctorate in Clinical Psychology, Staffordshire University.

Email: p025087g@student.staffs.ac.uk

Appendix G: Participant Information Sheet

An exploration of self-efficacy in paid dementia carers within care homes.

Participant information sheet

Researcher: Jessica Poole

Invitation
You are being invited to take part in a research study looking at how the experiences of paid care staff impact on their confidence and ability to work with people living with dementia. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything you do not understand, or if you would like more information, please ask.

What is the purpose of the study?
We know that working as a paid carer for people with dementia can be stressful. To help ensure that care staff get the best support they can in their job, we would like to better understand the qualities, experiences and approaches that care home staff feel impact on their confidence and belief in their ability to care for people living with dementia.

Who is eligible to take part?
Men and women aged 18 years or over are eligible to take part provided they are working (for at least the last six months) in a care home with people living with dementia. Participants should be fluent in English. We are not looking to recruit those with a professional nursing qualification.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you decide to take part you would be given this Information Sheet to keep and be asked to sign a Consent Form.

What will happen to me if I take part?
If you decide to take part in the study you will then be invited to participate in an interview session asking you about your experience of caring for people living with dementia, how you feel about being a carer and qualities you think you need to do your job effectively. The researcher may also ask some other follow up questions regarding your experiences. This session will last approximately 40-60 minutes and will be audio recorded. Although a face to face interview will be offered initially, should you be unable to attend this for whatever reason, a skype interview could be offered as an alternative. The skype interview would also be recorded.

The study will also ask for some descriptive information such as gender, age, ethnicity, work qualifications gained, and length of time you have worked as a paid caregiver. Just before your interview you will also be asked to complete a short 5 minute questionnaire looking at how confident you feel in managing stressful situations associated with being a dementia carer.

Please note that:

- You can decide to stop the session at any time without giving a reason.
- You need not answer questions that you do not wish to.
- Your name will be removed from the information gathered in the study and it will not be possible to identify anyone from our reports on the study.

What are the benefits of taking part?

There is no direct benefit for you, however, it is hoped that the information we gather will help us develop our understanding of the qualities, experiences and approaches that impact on how paid dementia carers work with people living with dementia. This could help us understand if staff training needs to be adjusted and to help support care staff to better deal with challenging situations at work.

What are the possible disadvantages and risks of taking part?

We believe this is a very low risk study. However as the interview topics may include discussion of stressful work situations, this could potentially become distressing for participants. We therefore aim to maximize your wellbeing at the end of the interview by discussing any concerns you may have and signposting you to relevant support if required.

What if I do not wish to continue with the study?

You are free to withdraw from the study up to two weeks after your interview date without giving a reason. If you do withdraw the data, already collected from you will not be used.

What if there is a problem?

We believe that this is a very low-risk study and the researcher will check how you are feeling immediately following the interview.

Should you feel distressed at any time following the interview you can contact Samaritans and talk to trained helpline volunteer regarding emotional support.

Tel: 116 123 (Freephone 24hr confidential helpline) Website: www.samaritans.org

Would my taking part in this study be kept confidential?

All the information about your participation in this study will be kept confidential. All interview audio recordings will be stored on a computer in a password protected file. The audio files will be destroyed once your interview has been transcribed. The interview transcription will be coded with a participant number and no personal information will be attached to the data. Interview transcriptions will be stored on a computer while personal details will be stored separately in a locked filing cabinet. Other paperwork such as consent forms, demographic information or questionnaires will be electronically scanned (and stored in a password protected file on a computer) at the first available opportunity and then original paperwork will be shredded. Personal data on your paperwork will be replaced with a 'case identifier' i.e. numbers or letters so that you cannot be distinguished from your recordings or information on your paperwork.

We are obliged to keep all research data for a period of 10 years. After this time it will be destroyed.

Only the named researchers will have access to this data. [If this study is audited by the University Research Ethics Committee, then members of the audit team will also have access to the data but this will be specifically for the purpose of checking that the research has been carried out appropriately].

The overall results of the study may be published in scientific journals. However, all personal data will remain confidential. The only circumstances in which confidentiality would be breached would be in the rare situation in which it was judged that you or someone else was at risk of serious harm or if a court applied for the information. In these circumstances we would endeavour to discuss the matter with you and would disclose only information of immediate relevance.

What will happen to the results of the research?

This study is being carried out as part of the course requirements for a postgraduate qualification. It is also hoped that the results will eventually be published in an academic journal. Any research publication would not identify you individually.

Who is organising and funding the research?

The research is being carried out by Jessica Poole as part of a postgraduate qualification, under the supervision of Dr Helena Priest (Staffordshire University). The study is sponsored by Staffordshire University.

Who has reviewed this study?

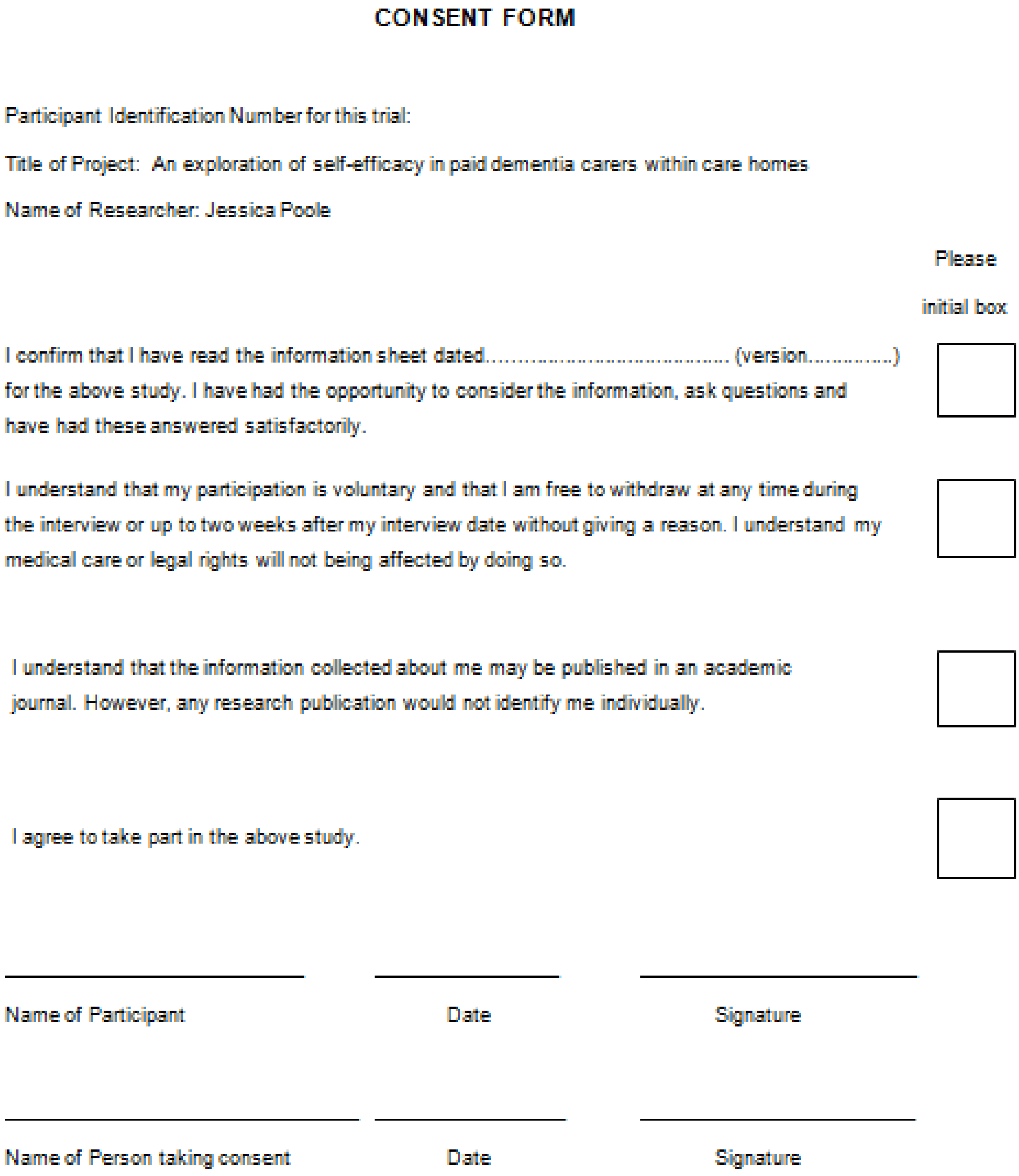
This research has been reviewed by the Staffordshire University Research Ethics Committee in order to protect your safety, rights, wellbeing and dignity and has been given favourable opinion.

Contact for further information

If you would like more information or have any further questions about any aspect of this study please do contact Jessica Poole (email: p025087g@student.staffs.ac.uk).

Thank you for taking the time to read this information sheet and considering whether to take part in this research.
You will be given a copy of this Information Sheet and a signed Consent Form to keep if you do take part.

Appendix H: Participant consent form



CONSENT FORM

Participant Identification Number for this trial:

Title of Project: An exploration of self-efficacy in paid dementia carers within care homes

Name of Researcher: Jessica Poole

Please initial box

I confirm that I have read the information sheet dated…………………………….. (version…………..) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time during the interview or up to two weeks after my interview date without giving a reason. I understand my medical care or legal rights will not being affected by doing so. ☐

I understand that the information collected about me may be published in an academic journal. However, any research publication would not identify me individually. ☐

I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix I: Participant Demographic form

PARTICIPANT DEMOGRAPHIC FORM

Participant Identification Number for this trial:

Title of Project: An exploration of self-efficacy in paid dementia carers within care homes.

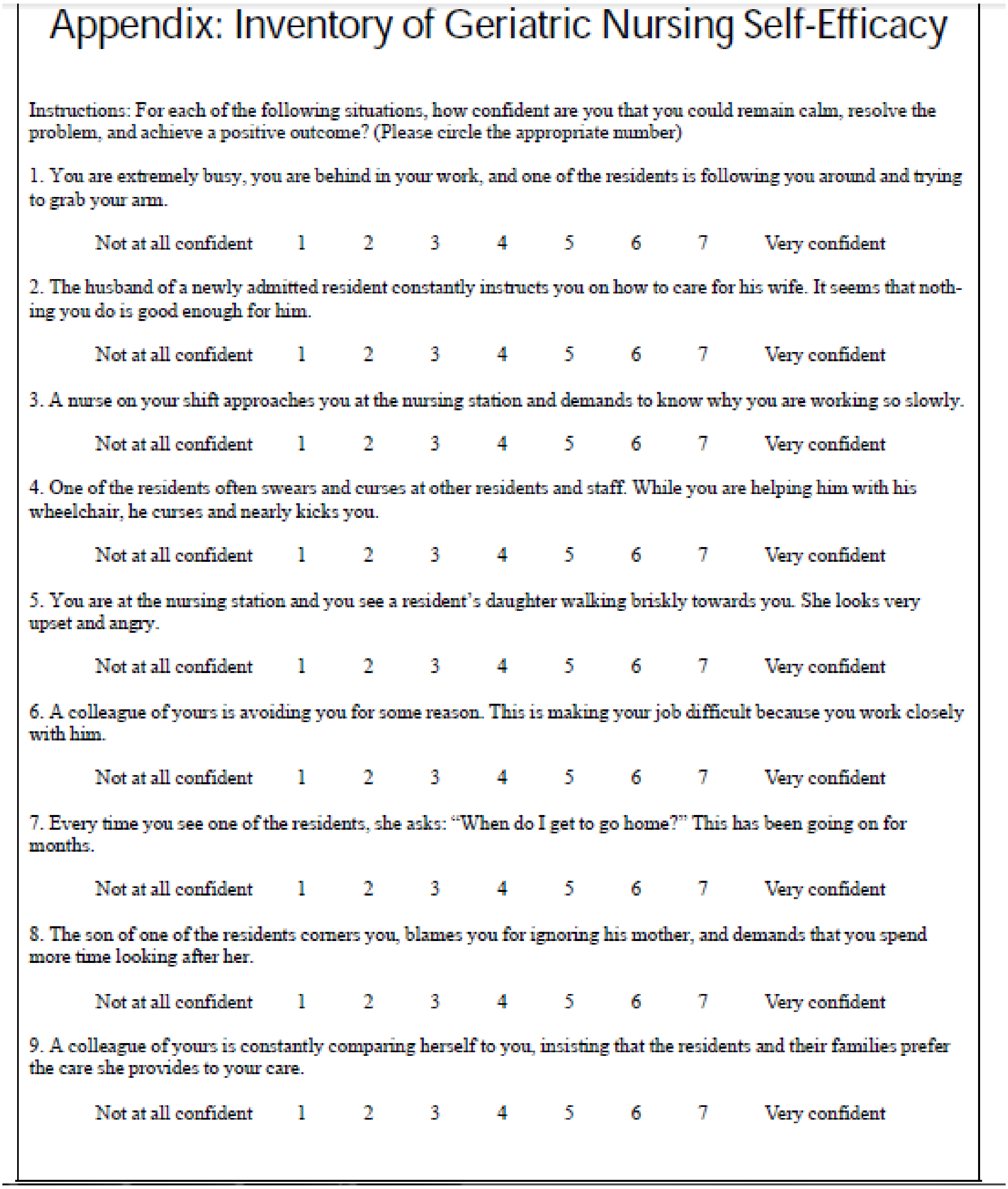
Name of Researcher: Jessica Poole

How old are you?				
I am: (please circle)	**Female**	**Male**	**Other**	**Prefer not to say**
Please describe your ethnicity: (e.g. White, Black, Asian British etc or tick the box 'prefer not to say')				☐ **Prefer not to say**
Highest level of work qualification obtained?				
Length of time you have worked as paid carer?				

Appendix J: Inventory of Geriatric Nursing Self-Efficacy Questionnaire (Mackenzie & Peragine, 2003).

This questionnaire was developed to specifically measure self-efficacy in paid older adult care givers. The inventory asks the reader to rate on a likert scale ranging from 1 (not at all confident) to 7 (very confident) how confident they would feel in dealing with each of the nine described scenarios. Individual scores on each scenario are collated and an average score worked out for the whole questionnaire.

The inventory was deemed to have good internal consistency with a Cronbach's alpha level of .96. Due to a lack of normative data, previous studies have used a cut off of 6 on the likert scale to indicate that a participant had high levels of self-efficacy in dealing with that particular situation (Coates and Fossey, 2016). For the purposes of the current study moderate levels of self-efficacy will be considered to be between 4 and 6.



Appendix: Inventory of Geriatric Nursing Self-Efficacy

Instructions: For each of the following situations, how confident are you that you could remain calm, resolve the problem, and achieve a positive outcome? (Please circle the appropriate number)

1. You are extremely busy, you are behind in your work, and one of the residents is following you around and trying to grab your arm.

Not at all confident 1 2 3 4 5 6 7 Very confident

2. The husband of a newly admitted resident constantly instructs you on how to care for his wife. It seems that nothing you do is good enough for him.

Not at all confident 1 2 3 4 5 6 7 Very confident

3. A nurse on your shift approaches you at the nursing station and demands to know why you are working so slowly.

Not at all confident 1 2 3 4 5 6 7 Very confident

4. One of the residents often swears and curses at other residents and staff. While you are helping him with his wheelchair, he curses and nearly kicks you.

Not at all confident 1 2 3 4 5 6 7 Very confident

5. You are at the nursing station and you see a resident's daughter walking briskly towards you. She looks very upset and angry.

Not at all confident 1 2 3 4 5 6 7 Very confident

6. A colleague of yours is avoiding you for some reason. This is making your job difficult because you work closely with him.

Not at all confident 1 2 3 4 5 6 7 Very confident

7. Every time you see one of the residents, she asks: "When do I get to go home?" This has been going on for months.

Not at all confident 1 2 3 4 5 6 7 Very confident

8. The son of one of the residents corners you, blames you for ignoring his mother, and demands that you spend more time looking after her.

Not at all confident 1 2 3 4 5 6 7 Very confident

9. A colleague of yours is constantly comparing herself to you, insisting that the residents and their families prefer the care she provides to your care.

Not at all confident 1 2 3 4 5 6 7 Very confident

Appendix K: Semi-structured interview schedule

1. **What brought you into this job?**

2. **Can you tell me about your experience of caring for people living with dementia (PLWD)?**

   Prompt question if needed;

   a) Tell me about the rewarding or challenging aspects?

3. **How do you feel about yourself as a carer?**

   Prompt questions if needed;

   a) What makes you more confident in your ability to care for PLWD?

   b) What makes you less confident in your ability to care for PLWD?

4. **What qualities do you think you have that help you to do your job?**

   Prompt question if needed;

   a) Can you give me examples of how it is helpful?

5. **How do you deal with unexpected events in your job?**

   Prompt questions if needed;

   a) What have you found helpful in these situations?

   b) How do you cope with or manage (the difficult situation)?

6. **In what way does work environment impact on your ability to do your job?**

   Prompt question if needed;

   a) How does the team, training, level of support affect it?

Appendix L: Locating the researcher

Reflexivity regarding one's own position and beliefs about a topic, and how this may influence engagement in the research process is essential in helping the reader to establish the credibility of findings.

I am a 33 year old, White British female working within an NHS setting. I have previously worked as a paid dementia care worker in the private sector. At times during the role, I felt out of my depth and unsure of what to do, with little guidance on how to manage the challenges of care work (i.e. the more non-practical aspects of the role) such as 'behaviour that challenges'. Thus I am aware that in certain situations, I might have constructed myself as having lower levels of self-efficacy in my care worker role.

I have also worked as an Assistant Psychologist and Trainee Clinical Psychologist in Dementia Services. Within these 'professional roles' I have received further training on types of dementia and bio-psycho-social models of dementia care. In particular, I believe training in Kitwood's person centred care model of dementia has influenced my views on the importance of the care workers role in promoting a person living with dementia's (PWLD) sense of identity and meaningful participation in the social world. I am aware that my own more optimistic views on the process of ageing and dementia care are still often very different to the attitudes I observe within 'mainstream' society and the media.

The idea for the current study was developed during my placement in a community dementia setting in which supervision often featured discussion and exploration of paid care workers perceived self-efficacy in implementing suggested interventions.

Appendix M: Thematic analysis process (Braun & Clarke, 2013)

Phase 1 & 2: Transcription, familiarisation with the data, and initial coding.

Example of transcript coding:

	Initial Codes
Q: Anything else you want to add?	
Erm…Yeah when I first started I used to go home and find it hard to switch off, I can do it now ‘cause it's easier because you think well the somebody else taking over my shift now and they're taking over the care of the person but… yeah sometimes if you've got a resident in hospital or they're just not very well, you still find yourself going home and worrying about them and think you think ‘oh dear I hope they're ok’ for a couple days you might think ‘oh dear and you think, they’ll be alright, they're in a safe place, but in the back of your mind when you care about them and they say you shouldn't get attached, but you do, you can't help it and you do get upset if something happens, like recently if somebody has passed away you do get upset about them passing on because you've looked after them and you do get upset. It is a very difficult part of the job but sadly you don't you'll get used to it I've been working this job for 30 years and you still don't get used to that, really that's the hard bit of it, yeah.	Emotional/ mental impact Connection with clients
Q: How do you feel about yourself as a carer?	
Erm…Sometimes I do feel less confident a little bit at times, because you do, especially if you've got a really upset person or resident, and you just can't calm them down for some reason and you'll have to get some help. You feel like a little bit of a failure but you're not, it's just the way they're feeling at the time. I did have an experience once…actually with the same person I was talking about before, the husband with the wife, she did have a history of getting upset and getting a bit, she didn't want to be touched, but I managed to get around to her bedroom and I sat on the toilet and then she started to get a bit agitated and aggravated and I was going to get her in a pyjamas for bed and bring her back round for a drink and take her to bed after… but she obviously thought ‘oh no, I'm going to get into bed now, it's too early, I don't want to go’ so she started to get	Asking others for help Acknowledging limitations

aggressive so I had to buzz for help and I got a little bit upset about that, because she just didn't want me anywhere near her. It wasn't me, one of the carers I was working with said 'it's not you, don't worry about it, why don't you go out for your break and I'll help her' and that made me feel a little bit better 'it's not you, it's just the way she is she is'. She was a little bit aggressive with her as well but it still made me feel a little bit…at the time, but I've learnt to deal with that now…So, she got it in her mind that I wasn't helping and she just wanted me to leave her alone and that's that affected my belief in my ability, 'am I doing the right thing?' yeah	I should be able to manage myself? Best isn't good enough?
Q: In those situations where you're feeling less confident, what was it that helped?	
I think it was the help of my colleague and the fact that she asked me to go for my break as well, just to take 10 minutes out, you know, gather my thoughts back, have a quick cigarette, have a drink, just like get yourself back again, and that helps. **So taking yourself out of the situation?..** Yeah that's what I'd call it, getting out of the way, and letting somebody else deal with it, yeah. It's not that they dealt with it better, it might have just been a change of face to the person or… maybe she just suddenly understood that I wasn't trying to do anything to hurt her but it's just one of those things that you can't help even now, even after all the experience that got you're still learning things along the way you still do have a tiny bit of doubt sometimes, you think 'oh dear, I hope I've done the right thing'.	Support from team Gain new perspective Self-care important Doubt decisions
Q: So how do you cope with that when you have those little doubts?	
I just have to put them a back of a mind at the end of the day and think 'yeah I am a good carer, otherwise I wouldn't still be in a job' you just have to kind of give yourself your confidence back but rather than thinking of a negative thing, think of a positive instead, put the negative away and bring the positive forward and that makes you feel better about yourself then, yeah.	Supress negative thoughts Positive thinking

Phase 3 and 4: Collating codes and identifying themes

Once initial codes had been generated the researcher looked for commonalities amongst them, grouping them into initial themes (see key below).

THEMES KEY

Demands of the role	Support from others	Wellbeing and Self-Care	Values and attributes	Not grouped into theme

CODES FROM ALL TRANSCRIPTS

Dementia care is unpredictable	Individual differences	Just keep going
Closeness/connection to clients	Managing conflict	Multiple Demands of the job/priorities
Emotional impact	Sense of achievement	Self-care is important
Mental impact	Treat others how you want to be treated	Need to be adaptable/think on feet/problem solving
Will this happen to me?	Compare self to others	Feeling heard
Coping strategies	Complex decision making	Conflicting emotions
Caring attitude/part of being human	Rewarding/positive aspects of caring	Balancing risk with autonomy
Ignore emotions/shrug it off	Am I doing the wrong thing?	Frequent difficult decisions/ethical dilemmas
Carers have support needs	Doubt/ Justifying decision	Communication is important
Learn from experience	What's best for the client?	Complexities/pressure of role
I should be able to manage myself	Hoping for dis/confirmation from others	Team relationships/ dynamics
Never ending cycle	Dementia Care has changed	Close knit
Individual differences/understanding clients well	Best isn't good enough/can't always make it better	Working systemically – not just PLWD
Wish to help others	Learn from experience	Caring part of identity
Talk to/learn from colleagues	Calm attitude/ level headed/ unflappable	Lack of recognition of effect of caring
Managing competing demands	Going the extra mile	Easy going
Physical aggression/consequences of caring	Love the role/enthusiasm or passion makes job easier	Link between client and carer emotions
Limited opportunity to manage feelings/ no chance to reflect	Ask others if unsure/acknowledge own limitations	Relatives questioning ability
Client and carer wellbeing linked	Feeling unprepared/nothing can prepare you	Make do with limited resources
Put client needs before own	Manage family expectations/ care is scrutinised	Unpredictability of behaviour
Looking out for each other	Un/ afraid to ask questions	Carers have bad reputation
Clients depends/rely on me	Importance of good relationships	Try to stay positive
Empathy for client	Overcome differences	Colleagues intervening
More than a job	Gain focus and perspective	Emotive nature of work
Treat clients like family	Respect for experience/established way of doing it	Feeling undermined by family
Don't stop to think	Not afraid to look silly	Need to work together
Worry/how much can I take?	Praise/encouragement/appreciation	Making a difference
Employers care about us/supportive employers	Suitability for care work/innate ability	Emotive issues with family/ explain sensitive nifo
Develop new skills	Humour helps	

Phase 5: Reviewing themes

Theme names were later refined and themes subdivided to best suit the data following discussions with a clinical supervisor and in a qualitative research supervision group (see below).

<table>
<tr><td colspan="4">SUBTHEMES KEY</td></tr>
<tr><td>🟥 Unpredictability</td><td>🟩 Complex decision making</td><td>🟪 Emotive nature of the role</td><td>🟧 Negotiating sensitive family issues</td></tr>
<tr><td colspan="4">CODES FOR ‘DEMANDS OF THE ROLE’ THEME</td></tr>
<tr><td colspan="2">🟥 Dementia care is unpredictable</td><td colspan="2">🟩 Doubt/Justifying decision</td></tr>
<tr><td colspan="2">🟪 Closeness/connection to clients</td><td colspan="2">🟩 What’s best for the client?</td></tr>
<tr><td colspan="2">🟪 Will this happen to me?</td><td colspan="2">🟥 Individual differences/ understanding clients well</td></tr>
<tr><td colspan="2">🟧 Feeling undermined by family</td><td colspan="2">🟥 Unpredictability of behaviour</td></tr>
<tr><td colspan="2">🟧 Never ending cycle</td><td colspan="2">🟥 Learn from experience</td></tr>
<tr><td colspan="2">🟩 Managing competing demands</td><td colspan="2">🟩 Make do with limited resources</td></tr>
<tr><td colspan="2">🟥 Physical aggression/ consequences of caring</td><td colspan="2">🟥 Feeling unprepared/nothing can prepare you</td></tr>
<tr><td colspan="2">🟩 Clients depend/rely on me</td><td colspan="2">🟩 Multiple Demands of the job/priorities</td></tr>
<tr><td colspan="2">🟪 Treat clients like family</td><td colspan="2">🟥 Need to be adaptable/think on feet</td></tr>
<tr><td colspan="2">🟥 Managing conflict</td><td colspan="2">🟩 Balancing risk with autonomy</td></tr>
<tr><td colspan="2">🟩 Compare self to others</td><td colspan="2">🟩 Frequent difficult decisions</td></tr>
<tr><td colspan="2">🟩 Complex decision making</td><td colspan="2">🟧 Working systemically – not just plwd</td></tr>
<tr><td colspan="2">🟩 Managing dilemmas</td><td colspan="2">🟪 Link between client and carer emotions</td></tr>
<tr><td colspan="2">🟩 Am I doing the wrong thing?</td><td colspan="2">🟧 Managing family expectations/ care scrutinised</td></tr>
<tr><td colspan="2">🟧 Best isn’t good enough</td><td colspan="2"></td></tr>
</table>

Appendix N: Table demonstrating participants whose interview data was used within each theme and subtheme.

Theme	Subtheme	Initial Codes	Participants
Demands of the role	Unpredictability	Need to be adaptable/ Think on your feet. Individual differences/ Understanding clients well. Nothing can prepare you. Dementia care is unpredictable. Verbal and physical aggression/ Physical consequences of caring. Gaining focus and perspective. Learn from experience.	1, 2, 3, 4, 6, 9, 10, 11, 12 13
	Complex decision making	Complex decision making. Managing dilemmas. Managing conflict. Am I doing the wrong thing? Doubt/ Justifying decision. What's best for the client? Clients rely on me. Compare self to others. Balancing risk with autonomy. Frequent difficult decisions. Make do with limited resources. Managing competing demands. Demands of the role/priorities.	2,3, 4, 5, 6, 8, 10, 11, 12, 13

	Negotiation of sensitive issues	Managing relative’s expectations. Care scrutinised. Best isn’t good enough. Feeling undermined by family. Working systemically – not just PLWD.	2, 5, 6, 9, 12, 13
	Emotive nature of caring	Emotive impact. Connection/closeness with clients. Link between client and carer emotions. Will this happen to me? Never ending cycle. Treat clients like family.	1,2, 3, 4, 5, 8, 9, 10, 11, 12
Support from others		Need to Work together. Team relationships/dynamics. Need to overcome differences. Support needs. Look out for each other. Colleagues intervening. Ask others for help if unsure/acknowledge limitations. Close knit. Hoping for dis/confirmation. Praise/encouragement/ appreciation. Talk to/learn from colleagues. Un/afraid to ask questions. Managers care/support us. I should be able to manage this. Importance of good relationships.	1,2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14

		Respect for experience/established way of doing it. Feeling heard. Communication is important.	
Wellbeing/ self-care	----	Humour helps. Limited opportunity to manage own feelings/ no chance to reflect. Coping strategies. Don't stop to think. Self-care is important. Lack of recognition of impact of caring. Worry/how much can I take? Shrug it off/ignore the negatives. Stay positive. Just keep going. Emotional/mental impact.	1,2, 4, 5, 6, 8, 9, 11, 14
Values and Attributes	------	More than a job. Wish to help others. Sense of achievement/satisfaction. Treat others how you want to be treated. Putting client needs before own. Caring attitude/part of being human. Caring instinct/innate/suitability for care. Caring is part of identity. Love the role/enthusiasm or passion makes job easier. Unflappable/calm attitude/level headed. Empathy. Going the extra mile/ Making a difference.	1, 2, 3, 4, 5, 6, 8, 9, 10, 11 12, 13

Paper 3: Executive Summary

Word Count: 2806

This paper is not intended for publication. The report has been written in an accessible style aimed at external care providers, managers and care staff**.**

This summary uses the words 'care worker', 'care staff', 'paid carer' and 'paid caregiver' interchangeably to refer to formal, non-family caregivers.

Background

This report presents the findings of a study exploring self-efficacy in dementia care home staff.

Self-efficacy = a person's belief in their ability to succeed in specific situations or activities. Self-efficacy can affect how we approach goals, tasks and challenges.

Although self-efficacy is similar to other concepts such as self-esteem or self-confidence, there are some differences.

- Self-esteem refers to general feelings of an individual's own worth.
- Self-confidence refers to self-worth and a more general belief in success. In contrast, self-efficacy refers to a specific topic or activity.

Social Care and Dementia

- In the UK, the number of people living with dementia is predicted to rise from 1 million people in 2020, to 2 million people in 2050 (Dementia UK, 2014).
- The number of people employed in adult social care jobs has increased in recent years, with 1.45 million people currently employed in the sector (Skills for Care, 2018). This is

expected to rise further due to the predicted 82% increase in care home beds needed between 2010 and 2030 (Jagger et al, 2011).

- A recent survey suggests that social care employers are struggling to recruit and retain staff (Skills for Care, 2018) with 48% of paid carers leaving their jobs within the first year.

- The government has published a report aiming to make the UK the ‘best country to live in for dementia care’ (Department of Health, 2015,). To do this the government wants to get a clear understanding of the support and training needs of dementia care staff.

However, more needs to be known about what make dementia care workers confident in meeting the challenges of their role.

Self-efficacy Research

There is a lack of research into self-efficacy in paid dementia caregivers. What quantitative (questionnaire) research has already shown is that;

- ➢ **Self-efficacy is a significant predictor of life satisfaction (Yan, Ho, Kwok, & Tang, 2007).**
- ➢ **Female gender, satisfaction with training, low staff to client ratio and high levels of social support predict higher self-efficacy in carers (Yan et al., 2007).**
- ➢ **Levels of self-efficacy predict burnout in dementia care workers. (Duffy, Oyebode, & Allen, 2009; Kokkonon, Cheston, Dallos & Smart, 2014). Burnout refers to**

physical, emotional, or mental exhaustion alongside decreased motivation and poorer performance in a person's job or role.

- **Training in self-efficacy can improve a part of burnout called personal accomplishment. This refers to how competent a person feels in their work or role (Mackenzie & Peragine, 2003).**
- **Higher levels of care worker independence in their job as well as the support and trust placed on them were associated with higher self-efficacy. Higher levels of job stress was associated with lower self-efficacy (McCabe, Mellor, Karantzas, von Treuer, Davison, & O'Connor, 2015).**
- **Self-efficacy determined how much job strain and autonomy, trust, support and pressure in care staff. (Karantzas et al., 2016).**

There has been only one study (using qualitative research) that interviewed care workers to understand their view of self-efficacy in their role (Coates & Fossey, 2016). This identified different aspects of what it means to have self-efficacy as a paid dementia carer including;

- Having internal and external resources that made them feel connected to the person living with dementia (PLWD) and staff team.
- The ability to view the situation from different perspectives.

Aims of the research

The current study was developed as there is a lack of qualitative research (research such as interviews that helps describe or observe concepts) trying to understand how paid dementia carers effectively and confidently deal with the demands of caregiving.

The aims of the study were;

- To consider how self-efficacy is understood by dementia care home staff.
- To identify what factors were reported to affect paid dementia carers' self-efficacy.

Method

To take part in the study participants had to meet the following criteria;

- Be aged 18 or over.
- Be fluent in English so they could describe their experiences well to the researcher who only spoke English.
- Working as a paid care assistant in a care home registered for people living with dementia.
- Have been working as a paid carer for at least six months before participating in the research. This would mean that the care worker have time to adjust to the role.

The research excluded;

- People with a Nursing or other 'Professional' Qualification.

Recruitment

Participants were recruited through one of two ways; either through the ENRICH Research Ready Care Home Network in the West Midlands or through the lead researcher contacting the care home directly. The recruitment process is shown on the next page in Figure 4.

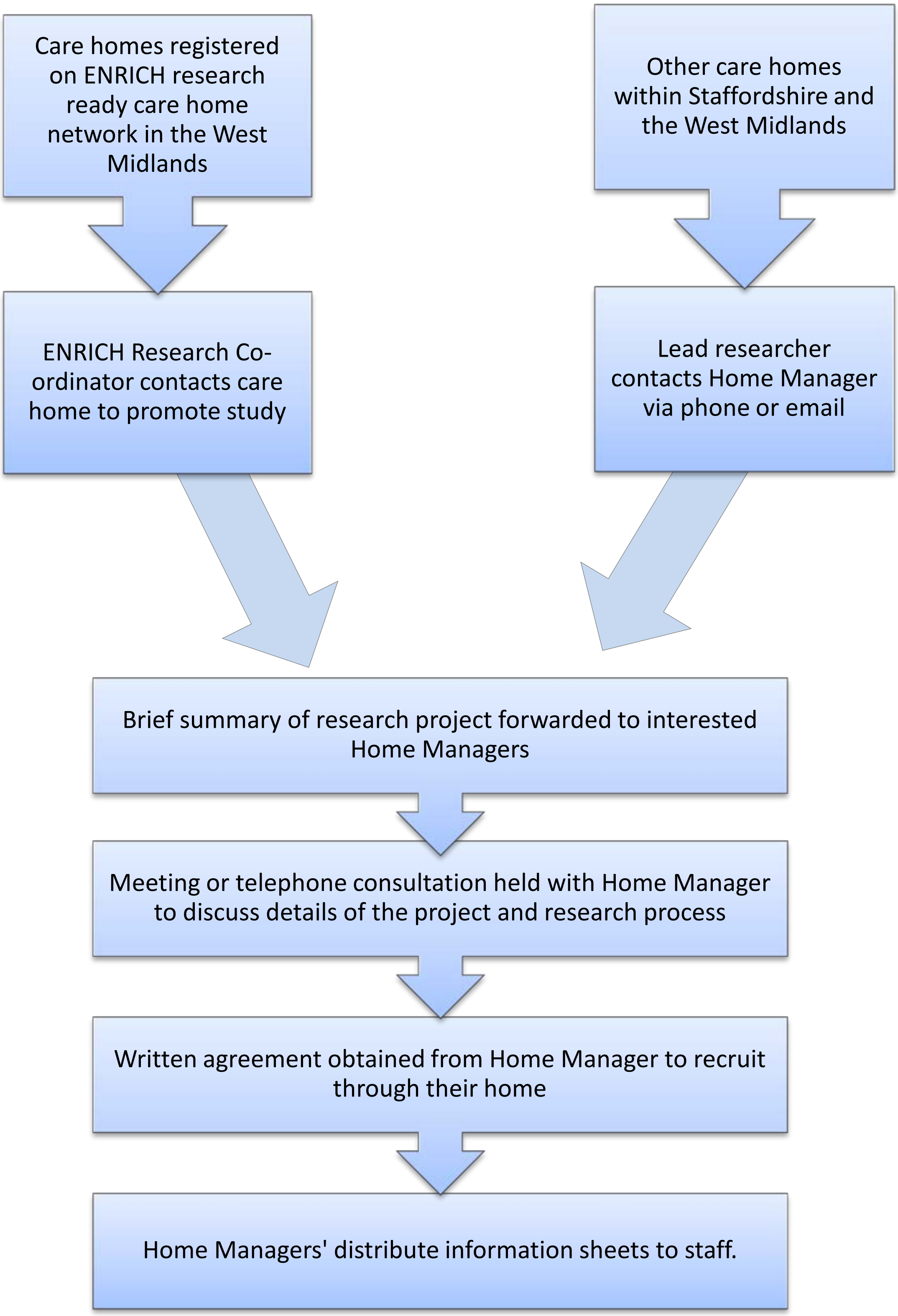


Figure 4: Flow chart demonstrating the participant recruitment process.

Fourteen care workers from four different care homes registered for people living with dementia within Staffordshire and the West Midlands took part in the research. This was considered to be a suitable number based on current research recommendations (Braun and Clarke, 2013). Ethical approval for the study was granted by Staffordshire University Ethics Committee.

Data collection

Interviews were scheduled for when participants were ‘on shift’ and took place in a quiet side room of each care home to maintain confidentiality The participants had read an information leaflet explaining the research and their right to withdraw up from the research to two weeks following the interview. The all volunteered to take part and signed a consent form to take part in the research.

Participants were asked to complete;

- A demographic form about their age, gender, level of care qualification and length of time working as a carer.

- A short questionnaire which presented common dementia care situations and were asked to rate how confident they would feel in successfully managing the situation on a scale of 1-7.

- Individual audio-recorded interviews looking at care staff experiences of caring for people living with dementia. Questions asked by the researcher included;
  ‘Tell me about your experience of caring for people with dementia?’, ‘How do you feel about yourself as a carer?’
  ‘How do you deal with unexpected events in your job?’

The demographic form and questionnaires were completed to understand the characteristics of the care staff included in the research. Only the interview data was analysed further.

Participants

- Twelve women and two men.
- Ages ranged from 21 to 58 years old (mean age = 41 years).
- Average length of time working as a carer was 12 years.
- Most had either Level 2 or 3 NVQ qualifications in Care.
- Eight participants were rated as high in self-efficacy, six were rated as having moderate self-efficacy.

Analysis

The interviews were analysed using thematic analysis. This technique identifies and analyses patterns in participant responses. This involved several steps. Firstly, the interviews were read several times and notes were made about anything the researcher felt might be relevant to the research questions. Next ‘codes’ were generated and then were then structured into themes that aimed to reflect the participants’ combined understanding of self-efficacy in their role.

Key findings

Four themes were identified from the data, (1) Wellbeing and self-care, (2) Support from others (3) Values and attributes, and (4) Demands of the role which had subthemes of unpredictability, complex decision making, emotive nature of the work and negotiating sensitive family issues. A thematic map of how the themes and subthemes are linked is represented on the next page.

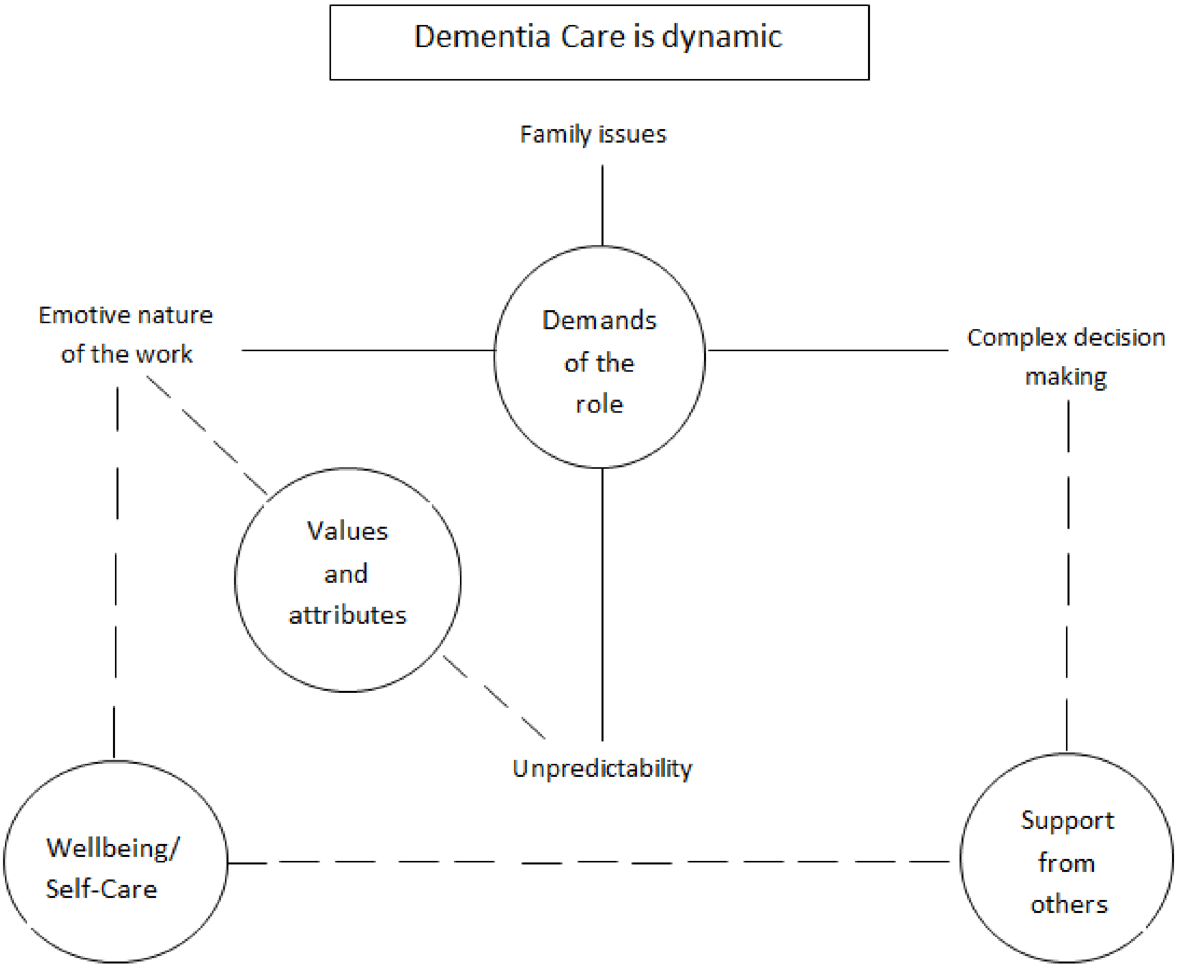


Figure 5: Thematic map of the relationship between themes and subthemes.

The overarching theme of the interview data, demonstrating the link between all of the themes is that ‘*Dementia care is dynamic’*. Each of the themes are shown in the circles. Links between themes and subthemes are demonstrated by a dotted line.

Theme 1: Demands of the role

All participants acknowledged that demands of the care worker role impacted on their self-efficacy. The theme was divided into four subthemes.

Unpredictability

Participants described the unpredictability of their role, reporting that "you can't plan what is going to happen" or "you've got to think quickly on your feet". This meant that it was difficult to stick to a planned routine and often required carers to quickly adapt and demonstrate flexibility to changing environments and situations.

Complex decision making

Many participants acknowledged the difficulties of having to make complex decisions about what is best for a client in challenging situations.

Carers discussed factors involved in their decision making process such as; weighing up risk with autonomy and thinking about the best interests of the individuals. Several care workers reported 'having doubts' about whether they were making the 'right decision' for the client as there was no clear cut, definitive answer in the moment. Many of the decisions were further complicated by trying to manage different priorities within the role. Participants reported sometimes feeling like they weren't 'giving their all' to the residents.

Some participants concluded that no matter how hard they tried there may be no definitive right answer when making complex decisions as "there's not a textbook".

Emotive nature of the role

Participants reported that while caring for PLWD it was difficult not to form an attachment with residents; "they say you shouldn't get attached, but you do, you can't help it".

This was seen as an inevitable part of their role as several carers stated "I feel like the people I care for are like my family". Nevertheless, this seemed to only increase the emotional impact of distressing events such as a resident passing away.

Negotiating sensitive family issues

Apart from caring for PLWD, participants also described that an equally important yet challenging part of their role was discussing sensitive topics with family members. This included attempting to explain to relatives about the impact of dementia on behaviour.

Participants reported feeling that their care decisions were often scrutinised by relatives leaving them feeling undermined or misjudged. Some participants stated they turned to managers at these times to gain support.

Experience is better than knowledge

Whilst training was reported to be an important part of feeling more confident, participants reported that this could never fully prepare someone for the demands of the role. Instead it was experience that many participants felt helped more; "the best way to prepare you is just to get stuck into your job".

Theme 2: Support from others

Several participants emphasised the value of asking other team members or managers for advice stating "never be scared to ask for help if needed". This also appeared to help enhance staff wellbeing; "I can always speak to management who help us a lot…they come on to the floor and help us with what to do. That does make it less stressful".

Some participants described how 'the team' looked out for each other and encouraged other staff members to have a break from a challenging situation. The ability to 'pull together' as a team, successfully managing dynamics and differing ways of approaching care was also discussed as a significant aspect of helping carers to feel more confident in their role.

Theme 3: Maintaining Wellbeing/Self-Care

Participants described dementia care work as "challenging" "tiring" "demanding" "draining" "hard" "stressful" and "wearing".

Several staff expressed that although physically aggressive behaviour was sometimes difficult to manage; verbally challenging behaviours were also mentally draining. Participants described how these aspects of their role were often difficult to 'shake off' at the end of a busy shift. Nevertheless, talking to their colleagues or their family members helped them to feel more supported.

Participants described using many coping strategies to cope with the demands of the role such as the use of humour, thinking positively, taking a break from the situation to help gain a fresh perspective on what to do or unwinding with an alcoholic drink after a shift.

Theme 4: Values and attributes

There were a number of attributes or personality traits that participants felt helped them do their job well. These included being the 'right kind of person' for care work, having a gregarious and demonstrative approach with residents but able to switch to a calm, level headed and gentle approach in order to think clearly in unpredictable, demanding or emotive situations.

Many participants described care work as being more than a job, in line with their life values such as being compassionate, and treating others how they would wish to be treated, for example "It's about looking after (the residents') needs, not as in a chore, but as in, as if it's your mum, your grandparents, so how would you care for them?". These values seemed particularly helpful in dealing with situations that often had very emotive elements.

Conclusion

The findings highlight that on a daily basis dementia care workers deal with many immensely complex issues in an ever changing environment.

Self-efficacy was described by participants as being impacted by several different factors. These included the ability to effectively manage the demands of the role, making quick complex decisions in often unpredictable highly emotive or ethically unclear situations, alongside managing sensitive family issues. The ability to manage these challenges was strengthened by the ability to ask for and utilise support from others as well as maintaining good levels of self-care and wellbeing. Some participants felt that certain values and personal attributes could also help shape self-efficacy in dealing with such difficult situations.

Key Recommendations

- **Care workers should be supported to feel confident in managing sensitive family issues.**

  Family involvement is essential in a care home environment as this can impact on PLWD's wellbeing. Clarification of the exact roles of both family and care workers within the care home environment may help to reduce the potential for misunderstanding or conflict between family and care staff. It is also important that care staff are able to provide the emotional support that families often seek during this time. It may be useful for care homes to develop guidelines for care staff on how joint working between relatives and staff is best addressed.

- **Managers should ensure robust support mechanisms are in place for care staff.**

  This might be especially important for new staff members within their first year of care work. The current study suggests that experience, as well as being able to ask and learn from others, may help promote self-efficacy. It is essential that new staff are able to shadow more experienced colleagues for an adequate amount of time. This may help them feel more confident. Frequent supervision or 'check in' sessions with senior team members can also help enhance junior carers' sense of support, encouragement and appreciation from the management team.

- **Clinical Psychologists could help support the development of ‘reflective practice’ and self-compassion for staff within care homes.**

  Care Homes could work more closely with mental health professionals such as Clinical Psychologists, to provide opportunities for care workers to come together to talk about the challenges of their role. Techniques such as ‘reflective practice’ allow individuals to learn from their own and other staff members’ experiences. Research in other health professions suggests it allows staff to feel more confident in their role (Dawber, 2013; Platzer, Blake and Ashford, 2000)

  The research highlighted that many care workers admitted critically analysing, judging and worrying about the care decisions they made. Self-compassion involves being kind to oneself, rather than judging or criticising oneself and over-identifying with negative thoughts. The practice of self-compassion has been linked to better wellbeing and resilience in other healthcare workers (Beaumont, Irons, Rayner and Dagnall, 2016).

Research recommendations

- The carers in this study were rated as having either high or moderate levels of self-efficacy. It is important that more research is completed with care workers with lower levels of self-efficacy to see if the current findings accurately represent the whole care worker population.

- Although reflective practice groups and self-compassion practice is common in healthcare professions, little is known about its use with dementia care workers. Further research should consider the impact these interventions have both on carer wellbeing but also on their levels of self-efficacy.

Limitations

- The majority of interviews completed with care workers with moderate levels of self-efficacy were of a shorter duration and required more follow up questions. This could have been due to individuals being less willing or able to reflect on their lower levels of self-efficacy. The current study did not interview any participants with ‘low’ levels of self-efficacy. These individuals could have been put off from taking part for fear of being judged. Any further research conducted with carers with lower levels of self-efficacy would need to carefully consider how best to encourage participant to be more open about their experiences.

- Interviews were completed within the care home for ease of interviews. However, it is unclear whether participants would have provided different answers if they were interviewed away from the work environment as they might have felt more able to talk about the parts of the job they felt less confident about and reasons for this.

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