**Introduction**

In the United Kingdom (UK), there are 450,000 people living in care homes (Demos 2014). Whilst current policy, ‘Our health, our care, our say’ Department of Health (DH) in England (2006) and ‘Transforming Your Care’ in Northern Ireland (DHSSPS, 2011), focus on supporting people at home. An increase in the number of people with chronic illness and dementia along with the costs associated with caring for these people at home, means that nursing homes will continue to play an important role in the care and support system (DHSSPS, 2011). Orellana *et al* (2016) identified that care home managers tend be ‘overlooked in research, despite their pivotal role.’

**Literature Review**

*Leadership support in care homes*

A literature review by Masso & McCarthy (2009) examined how change management, quality improvement and evidence-based practice influenced the uptake and continued use of evidence in residential aged care settings in the USA. The authors concluded that staff need support to develop the necessary skills and that stakeholder engagement, participation and commitment were essential prerequisites. These findings were supported by other studies into specific practice developments initiatives (Armitage & Evans, 2005, Fossey *et al*, 2006, Elliott & Adams 2012) which reported a positive change in practice and an improved culture as a result of practice development programmes. The Department of Health recognised that registered managers had ‘not been sufficiently supported to achieve high quality leadership required for quality care’ (HM Government 2012). In the UK, The My Home Life (MHL) programme is aimed at improving quality of life for people living, dying, visiting and working in care homes. This is achieved by supporting managers to develop their leadership skills through a programme of action learning drawing on the work of leading researchers in the field (Meyer, 2010, McCormack *et al* 2012, Cooper *et al* 2013, Dewar, 2013; Dewar and Nolan, 2013). The MHL programme has been widely implemented across England and Scotland with the overall aim of creating real and sustainable improvements for their residents, relatives and staff (MHL, 2015). While there is a general consensus in the literature that managers play a key role in influencing practice development and quality of life in nursing and residential homes, there is a dearth of research exploring this issue. This study aimed to address this imbalance by evaluating the implementation of MHL in Northern Ireland.

**Aim**

To explore the impact of a leadership support (LS) programme for managers of care homes.

**Objectives**

1. To explore the views of care home managers on the impact of a LS programme on their leadership skills and professional development.
2. To explore the views of managers on relationships within care homes as a result of their participation in this programme.

**Methodology**

The aim of this study was to explore the views of care home managers on the impact of the Leadership Support Programme. As the study was focused on participants’ views and perspectives, a qualitative approach was deemed most suitable. As all of the managers were participating in the same programme and therefore sharing a similar experience, focus groups interviews were used to explore participants ‘experiences and opinions with each other in a group discussion’ (Kreuger &Casey, 2000). Focus groups were selected as their synergistic nature often produces data that are seldom produced through individual interviews and this can ‘result in powerful interpretive insights and provide access to the social interactional dynamics amongst specific groups of people’ (Kamberelis & Dimitriadis, 2005, p. 901). In order to explore changes in the views and experiences of managers over time, the focus group interviews were conducted at two time points, the beginning and end of the 12 month Leadership Support Programme.

***The MHL LS Programme*** consists of a 4 day workshop followed by a cycle of 8 monthly action learning & PD sessions. The aim of the programme is to support leadership development and improve practice in participants’ respective care homes. Each cohort comprises of sixteen participants who meet as a group for the 4-day workshops and who subsequently work in two smaller groups (n=8) for the action learning component of the programme (MHL 2015)

The Leadership Support programme is grounded in a developmental and transformational approach and informed by the My Home Life evidence base (NCHR&D Forum, 2007). Care home managers are supported on a personal and professional journey to a change of culture in care home settings. The process of action learning provides the opportunity for participants to review their action plans, highlighting the challenges and successes and possibly reflecting on what further action could be taken to achieve their desired goal.

**Sample**

The study sample consisted of sixteen care home managers drawn from a mix of large and small, nursing and residential homes of different ownership arrangements (corporate, family owned, not for profit) across urban and rural areas in the study site.

**Inclusion and exclusion criteria**

Due to financial and time constraints, the study was limited to managers of care homes within the catchment area of a large health and social care trust in a region of the United Kingdom. Only managers of homes caring for older people were included. Homes caring for other age groups (e.g. residents with learning disabilities) were excluded. Because of the demands of the programme and the need to release managers to attend monthly action learning sessions, managers who did not have the support of their care home owner were unable to participate. Similarly, managers who were not able to make an initial commitment to attend all the session were excluded.

**Ethical consideration**

As this research was conducted within independent care homes, ethical approval was granted from the Ulster University Filter Committee. All information about participants and all data emerging form the study were kept strictly confidential and stored in a password protected computer. As the potential existed for participants to disclose issues of a sensitive or distressing nature, a de-brief was held at the end of each focus group and if required, additional support was available from a counselling service.

**Data Collection**

The 15 participating managers were divided into two focus groups of seven and eight as the full group would be too large to facilitate an in-depth exploration of the key issues under investigation. Krueger & Casey (2008) suggest the ideal size of a focus group is 8-10 subjects. A topic guide was used to guide the focus group discussions which explored the impact of the programme of the mangers’ leadership skills and its impact on practice development and relationships within the home. All questions were open-ended to encourage participants to provide in-depth information about their experience of the programme. The initial interviews were held after the 4 workshops which preceded the action learning sets. In hindsight, it would have been ideal to hold the focus groups prior to these workshops but this was not possible as some managers did not confirm their commitment to the programme until they had attended these initial workshops.

**Analysis**

The focus groups were digitally recorded and then fully transcribed. They were then analysed using Colaizzi’s (1978) approach which consist of the following seven stages: 1) reading and rereading the participants’ descriptions of the phenomenon to acquire a feeling for their experience and make sense of their account; 2) extracting significant statements that pertain directly to the phenomenon; 3) formulating meanings for these significant statements; 4) categorizing the formulated meanings into clusters of themes common to all participants by referring these clusters to the original transcriptions for validation and confirming consistency between the investigator’s emerging conclusions and the participants’ original stories; 5) integrating the findings into exhaustive description of the phenomenon being studied by employing a self-imposed discipline and structure to bridge the gaps between data collection, intuition and description of concepts; 6) validating the findings by returning to some participants to ask how it compares with their experiences and 7) incorporating any changes offered by the participants into the final description of the essence of the phenomenon (Colaizzi, 1978, pp. 48-71). Using this approach ensured that the true nature and meaning of participants’ experiences were accurately captured within the data analysis procedure.

**Rigour**

The rigor and dependability of the study was also enhanced by a process of peer verification whereby a second experienced researcher independently analysed a sample of the transcripts. However it must be acknowledged that whilst there is evidence to support this approach (Burnard 2002; Casey 2007) and refute (McBrien 2008) it is generally accepted that no two researchers will analyse data in the exact same way, (McBrien 2008, Ryan-Nicholls & Will 2009).

**Findings**

Analysis of respondent data from the initial interviews revealed three themes; time to think, recognition of relatives and potential for change. In the following quotations participants will be referred to using pseudo names.

***Time to think***

The managers appreciated the time out to reflect and develop that the programme offered ‘*we need time to look outside the box’, ‘away from the distractions demands and challenges”.* They identified that until now they were trying to juggle a very busy workload; *we’re constantly against the paperwork’* (JAN), and that *‘we don’t have time for anything else’* (KIM). They started to look at how their leadership affected all aspects of their work. ‘if *the manager is having a bad day and is stressed out, that impacts on the staff’ (*EMMA)*,* and they began to recognise how their behaviour trickled through to the resident *‘how we are [behave] really can affect the care’.* They alsobegan to reflect on what needed to change, ‘*previously I would just tell the nurses to do something’*  *‘it’s learning to step back’* (MARY) and realised that they were central to that change ‘*what sort of a leader you are sets the tone’ (*JOHN). They identified that this project was offering them insight into how to change these things.

*I’ve had a light bulb moment….* *‘This [new approach] is a more collaborative approach that I would never have done before’* (ETHEL).

***Recognition of relatives***

Managers began to recognise that until now they had not given much thought to relatives’ feelings or perceptions.

*I am so much more conscious now of relatives feelings, before I wouldn’t even have considered that’* (JOHN)

They began to appreciate the impact of admission to a care home for older people and their relatives. They also began to acknowledge that there was very little information or support available to families going through this transition. . They felt *‘relatives’ expectations can be so different…..in the relative’s eyes the resident can be receiving so much less’* (PAULA)

*‘For them it’s such a different thing [moving a relative into a care home] and it’s important we help them through this’.* (KERI)

‘*I need to speak to these people [relatives] you know, with them not at them.”*(ESTHER)

Participants were all new to the concept of relationship-centred care as this was not a term they were familiar with but it appeared to resonate with them.

“*The biggest thing for me so far is relationship centred care’ ‘it was like a light bulb moment for me, I thought yes, this is what we are doing and need to be doing’*. (JOAN)

They discussed how staff interact with residents, *‘like a family really’* and this helped participant’s to identify that perhaps ‘*staff already have relationship-centred care’.* They also considered how *‘staff are building those relationships with each other and can reply on each other’* (MIA)

***Potential for change***

Participant’s appeared to appreciate the potential impact of the programme on their relationship with staff and on practice development within their home. They reflected on their interactions previously ‘*I didn’t give those (staff) any recognition’* and began to recognisethe importance of their relationships with their staff and how they could empower them;

‘*I am now giving them the power to lead things and change things’* to develop better relationships with residents. ‘*I find myself becoming more aware of how staff are relating to residents’* (KIM)

The managers felt they had completed little or no practice development initiatives prior to this programme and they began to appreciate the way in which PD *‘changes attitudes’* (KERI) and is a way to *share new ideas with staff’.* (PAULA). Participants also identified that within the care home setting there can be a culture of depersonalisation towards residents and they became very aware of the inappropriate language that was sometimes used in care homes such as *‘feeders’* or *‘doubles’.* (MIA). These terms are often used to describe how much assistance a resident requires with nutritional assistance or mobility. They began to realise that this ‘*lack of understanding [among their staff] that needs to change’* (KIM)

A minority of participants found it difficult to see a need for a change in their relationship with residents as they felt these relationships were already working well.

*I’ve always had a good relationship with residents’* (ANN)

*We’ve always cared so our actual care will not change’* (MIA)

***Post Leadership Support Programme themes***

At the end of programme the focus groups were repeated and the following three themes were identified: leaders not managers, we, not them and us, and individuality of residents in practice development.

***Leaders not managers***

The managers ultimately felt they had developed individually as leaders, *‘a good manager is a good leader’* (KIM) and also believed they were now “*using the skills we have in a different way’.* They identifiedleadership as the most important thing; *‘if a home is not managed properly then everything falls apart’* (RACHEL) and in turn appeared to feel much more comfortable in finding ways to implement their skills as a leader. They recognised that they were now doing things differently:

*‘We are so time driven but now I can hold back….allow them to have that lightbulb moment’* (ESTHER)

*‘I allowed myself to develop relationships more with the staff’* (PAULA)

*‘It’s nice to feel a bit more secure in yourself’* (HANNAH)

The managers recognised that before ‘*staff were doing things because they were told to but now they have an explanation’* (EMMA) and as managers they had obviously changed their approach,

*My carers question me now because they know they can’* (MAEVE)

They felt staff were now *‘taking ownership’* and that their staff have noticed a difference,

‘*my staff would say I involve them more’ I am more open to suggestions’ I allow them more time to have that lightbulb moment’* (BARBARA)

***We, not them and us***

After the programme, managers reported an overwhelming change in their attitude towards staff. They became more focused on helping staff connect with residents and understand the importance of establishing relationships with residents and their families. They displayed a new appreciation of the importance of developing relationships with relatives and believed that they transferred this knowledge and understanding to their staff. This, they believed, resulted in changes in relationships with relatives who had been previously considered quite ‘difficult’. Participants stated that they had new ways of working within their homes‘ *we now have relationship centred care’* (JOAN) and the focus groups provided many examples of how interactions with relatives have changed. One example included how a daughter of a resident with dementia became more involved in her mother’s care as a result of a new approach to assessment which recognised the centrality of the resident-relative relationship.

*‘It really is the little things that are making a difference, we’ve found a way to make those things happen, and count’* (JAN)

In turn, there was a pride in how they observed their staff interactions with residents.

*‘they are advocating for our residents now’, ‘they question me now because they know they can’, they are taking ownership’ and the ‘outcomes are changing’* (ESTHER)

There was substantial enthusiasm about the positive impact of understanding relationship centred care,

‘*If we want person centred care we need to have relationship centred practice’*

(EMMA)

Reference to the experience of Action learning Sets (ALS) was made several times in this part of the discussion. Managers shared that they entered the ALS process with trepidation but at the end felt it was an invaluable process.

*‘Hearing others perspective really helps’, ‘I loved the connection at ALS, we were all so supportive’.* (BARBARA)

Managers realised that even when they weren’t sharing an issue themselves, they were learning as they were picking up on issue their own staff or colleagues could be experiencing and were able to bring this knowledge back to their own practice.

***Individuality of residents in practice development***

In the initial focus groups participants did not focus on their relationship with residents. However, in the second round of focus groups, they began to see residents as individuals with life histories and stories rather than a homogenous group of people. The practice development (PD) initiatives that were introduced by participants over the course of the programme aimed to provide a better quality of care for the men and women in the home. When discussing the PD initiatives, managers stated that; ‘*it helps build a better relationship with residents’* (KIM) and that their staff *‘are advocating for the residents’* and always working ‘*in the best interest of the resident’.* (HANNAH)

The group developed PD initiatives introduced as a result of the programme which recognised the individuality of residents. These included a new approach to the preadmission assessment process a ‘This is Me Now’ approach to maintaining the dignity and identity of residents with end–stage dementia or severe communication difficulties and initiatives to share decision making within their homes and to promote community engagement and intergenerational relationships.

They identified that sharing the resources was a positive benefit, *‘it’s great that these tools fit so well together’* and that *‘it’s great we now have a tool we can use’* ( JOAN). The managers all felt they had made significant changes through the PD work and the tools they produced

*‘Working collaboratively to produce these tools was such a supportive way to change things’* (HANNAH)

**Discussion**

Consistent with other studies (Owen & Myer, 2012; Dewar & Cook, 2014), the findings indicated that this particular approach to leadership support had a positive impact on managers’ leadership skills and on relationships and staff development within their care homes.

***Reflection on Leadership***

This programme provided managers with an opportunity to reflect on various aspects of their job and the care delivered within their care home. This ongoing reflection enabled them to develop not only their own leadership skills but also their relationships with relatives, residents and staff. This in turn, motivated them to dedicate time and resources to develop specific practice development initiatives. Participating managers were much more content in their jobs and felt better able to cope with the numerous demands and stressors associated with their managerial responsibilities within their respective homes. Several authors have concluded that quality of care can only be achieved when there is strong and effective leadership (Albinsson & Strang, 2002; Dewar & Nolan, 2013; Dewar & Cook, 2014). Hockley *et al* (2015) identified the need for further research into the use of ALS in the health care setting and this study appears to suggest that the inclusion of ALS was a positive approach. It enabled managers to reflect on difficulties or concerns they had and to do so in a safe and supportive environment.

At the end of the project managers were able to clearly demonstrate changes that occurred not only within themselves as leaders but in their relationship with staff, relatives and residents. Participants believed that they had a better insight into these relatives’ perspectives and as a result, were better able to respond to questions or concerns in a more positive manner.

Managers also prioritised the importance of facilitating staff to connect with residents on a more personal level and to help them move away from the traditional task orientated approach.

They identified the potential for focusing on the transition for relatives as well as residents when moving into a care home. Bauer (2005) identified that care homes often struggled to fully integrate families into the care home. This is supported by Ryan & McKenna (2014) who found that the difficult move to a care home was compounded by negative press coverage (Centre for Policy on Aging, 2012) and that initiatives like this can play a role in changing public perception which in turn can aid in the recruitment and retention of care home staff.

**Limitations for the study**

The study was relatively small with only 15 care home participating, however, due to the nature of the programme and resource constraints it was not possible to increase the numbers. All of the data collected was drawn from interviews with care home managers. It could be argued that the findings may have been enhanced by eliciting the views of other staff, residents and relatives.

**Implications for Practice**

Care home managers and their employers can use this study to support investment in the manager’s leadership skills. This type of programme appears to support managers to develop their leaderships skills in a safe and supportive manner, impacting positively on the managers themselves and on the staff and residents in their homes. Programme such as this can enable participant’s to make real practice development improvement’s with meaningful impact for residents. On a broader note managers can see the importance of developing their leadership skills as a direct route to improving quality of relationship with their staff and residents thus increasing the quality of care.

**Conclusion**

Care homes have historically received poor recognition and little support to develop services outside of the mandatory requirements. This study has achieved the aim by quantifying manager’s views on completion of the leadership programme. It has identified the positive impact on their professional development and the relationships with the residents, staff and relatives in their care home. With an ageing population and a rise in the incidence of chronic illnesses and dementia, it is essential that care home managers and staff have opportunities to reflect on and change their practice as this would appear to be a key factor in making care homes good places to live, die, work and visit.

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