

# Leadership from the bottom up: Reinventing dementia care in residential and nursing home settings

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**Abstract:** *A number of recent policy initiatives have sought to improve the quality of dementia care in residential and nursing homes. Drawing on current literature and themes identified from in-depth interviews with four managers working in these settings, this paper discusses the potential for different styles of leadership in developing a suitable organisational culture in which quality dementia care might develop and thrive. It argues that alongside valuable strategic imperatives coming from the UK National Dementia Strategy (DH, 2009), there is a corresponding need for more 'bottom-up' approaches within dementia care settings themselves through the empowerment of staff. It argues that this would enable more participatory approaches to organisational development. The paper specifically discusses the concepts of both 'climate' and 'culture' in institutional care for older people and how these features can be enhanced to support a more person-centered approach. Particular emphasis is given to the significance of leading a culture of learning, which we view as crucial to any transformation process.*

**Key words:** *dementia; National Dementia Strategy; leadership; organisational culture; organisational climate; nursing care; residential care; older people*

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## **Introduction**

The quality of dementia care in the UK has attracted a great deal of attention following allegations of poor levels of service in both people's own homes and care homes (Care Quality Commission, 2010; Manthorpe, 2009). This adds further to the bleak realities of inappropriate use of antipsychotic medication (Guthrie et al, 2010); the scarcity of funding for residential care (Laing & Buisson, 2009) and the disappointment felt by many over the National Dementia Strategy (National Audit Office, 2010; Banerjee, 2010). Rising predictions on the future prevalence of dementia both in the UK and globally have implications for the future trajectory of dementia care (Wimo et al, 2010) and indicate that a radical overhaul of the current system is required if these challenges are to be addressed. There is also a corresponding need for increased research and debate on any solutions (O'Connor et al, 2007) particularly with attention to the organisational development factors influencing current models of dementia care and which tend not to be stressed in the dementia care literature.

Notwithstanding any breakthrough in scientific research, there is now a substantial body of evidence to demonstrate that the most effective interventions lie in the purposeful development of services to support a person with dementia and their carers by addressing the diverse and individual nature of their experience (Kitwood & Benson, 1995; Kitwood 1997; Killick and Allan, 2001; Nolan et al, 2002). The transformation of dementia care envisaged in the UK national dementia strategy has also highlighted the necessity for strong leadership as essential to its success, particularly at a local level (DoH, 2009; DoH, 2010). Alongside a range of strategic activities cited to promote the social care needs of older people with dementia, we thought it timely to review how leadership in dementia care might be encouraged to evolve at a local level to complement strategic imperatives. The term 'leadership' tends to be endorsed uncritically in the policy literature (Lawler, 2007) so through a small research study, we explored with managers themselves what meanings they associated with this term in the day-to-day realities of their own practice and some of the findings from this study are discussed briefly here. A more detailed report of this wider study is provided by Chalfont (2007). This paper seeks to explore any associations made by these managers with styles of leadership and the subsequent creation of a suitable culture or climate in care settings seen to be effective in supporting and enabling those involved in delivering more person-centred care.

## **Background**

This paper discusses two key concerns emerging from the literature which the authors see as particularly challenging to leaders and managers within homes delivering dementia care. As mentioned earlier, the discussion is informed by the key themes which arose from data captured through in-depth individual interviews with four managers working in the field. These themes were originally drawn from a much larger research study which investigated the impact of nature and the importance of environmental design in dementia care (see Chalfont, 2007). During this study however, some interesting data was captured in relation to leadership and the organisational climate or the so called 'softer' aspects of the dementia care environment. The researcher then decided to explore some of these aspects in greater depth, by interviewing a further small sample of residential home managers. Using a broad topic guide, in-depth individual interviews of four managers sought to explore their perspectives of what constituted effective leadership within institutional residential care settings. Transcribed data from these interviews were subject to content analysis (Bryman, 2001) from which three key themes were identified. The first theme concerned the influence of different factors on organisational climate specific to a care home environment. The second theme concerned how managers identified the presence and potential of leadership roles at different levels in the organisation and their views about how this could be fostered and utilised including what also hindered leadership development. The third theme related to what managers said about the practical challenges they encountered in relation to staff learning and development. Drawing on these three main themes, some associations were observed about the importance of encouraging participation in developing better quality dementia care from the 'bottom up' as opposed to the more 'top-down' approach implied by national policy. Whilst our sample is small, we have utilised some of the managers' narrative from the interviews by interspersing quotes throughout this paper in order to promote a fuller discussion of the relevant issues. Working through challenges confidently at a local level, we suggest, might contribute to the evolution of more creative and positive dementia care practice. This might facilitate the evolution of the service in a way that reflects aspirations of improved dementia care coming 'from above', that is in policy declarations.

Firstly, we provide an overview of current issues and challenges in dementia care in the context of recent policy developments. Secondly, we discuss the potential features of leadership within dementia care settings. The manager's narratives are used to illustrate further the discussion about the experiences, issues and theoretical challenges discussed and provide some points of reflection in relation to promoting a positive person-centred culture.

## **Contemporary issues in dementia care**

The number of people with dementia in England is expected to double within 30 years with an associated estimated cost of care rising from £15.9 billion in 2009 to £34.8 billion by 2026 (McCrone et al, 2008). Dementia covers a range of progressive, organic brain conditions which affect an estimated 750,000 people in England and is expected to increase. People living with dementia present a complexity of needs, requiring a holistic approach which engages with support across traditional organisational boundaries. There are also significant patterns of inequality amongst older people with high support needs including: discrimination in service delivery; the failure of services to take a holistic approach which addresses different social, cultural, religious, spiritual, emotional or sexual needs: and a lack of voice, choice and control for those with dementia, particularly for those who experience language barriers (Blood and Bamford, 2010). Effective outcomes of care depend on focused co-ordination and co-operation between health and social care and their contracted agencies (Sheard & Cox, 1998, NICE and SCIE, 2006) as well as creative approaches to person-centred care (Hayes & Povey, 2010). Dementia continues to be a much stigmatised condition within our society despite recent media campaigns aiming to make it more visible (Dementia Awareness News, 2010). The Department of Health's National Dementia Strategy, *Living Well with Dementia* (DH, 2009) and its implementation plan provide an ambitious and comprehensive vision for people with dementia and their carers to be enabled to live as well as possible. Cited as an 'evidenced-based strategy' (Ministers Foreword, DH, 2009) it focuses on achieving outcomes for people living with dementia: to improve the public and professionals' awareness; to provide earlier specialist diagnosis and intervention through the provision of memory clinics; and to provide higher quality health and social care. Chalfont (2007) for example, refers to the importance of providing information and support about what helps to improve the quality of life for people living and caring for someone with dementia, alongside awareness raising and early diagnosis. He advocates publicising examples of positive experiences as many carers may have low expectations and therefore may settle unquestioningly for an institutional regime.

Many people living with dementia will spend some time in a care home and/or end their life in one (Laing & Buisson, 2009). Therefore demand for specialist care and support is expected to grow. Care homes are a key partner in planning to meet challenges to develop capacity and quality personalised services. There are around 18,000 care home places for older people in the UK, mostly provided by the private sector where 30% of beds for people with dementia are supplied by the largest ten providers (Laing & Buisson, 2009). Even if early diagnosis delays entry to a care home, the quality of care itself in homes will need to rise correspondingly. The *National Dementia Strategy* (DH, 2009) specifically identifies the need for improved quality of care in care homes (see objective number eleven). Major trends for the design, delivery and evaluation of services will need to incorporate the development

of partnerships between service providers and users and their carers, to facilitate the movement away from the dominance of professional viewpoints (Gilleard et al, 2005). An historical overview of movements in nursing homes which have successfully facilitated culture-change interventions (Rahman, 2008) demonstrates the importance of strengthening the empirical base for achieving these changes, particularly those which are based on the active engagement of service users and carers. The UK *Dignity in Care* campaign (DH, 2006) similarly aimed to stimulate a national debate and create a national care system with zero tolerance of disrespect with adults with dementia. Outcomes from these studies and initiatives reveal the significance of developing leadership and management skills within the sector to take change forward particularly within smaller providers. A study by O'Driscoll (2006) into the impact of management on care homes for example, identified specific difficulties for staff and service users in getting support from their managers when managers are seen to be too involved in administration matters and as a result, become distanced from daily activities and contact.

In their review of progress made on the impact of the *National Dementia Strategy* (DH, 2009), the National Audit Office (2009) found that many local care home managers lacked an actual awareness of the strategy and that there was little participation in developing local services whereas this is expected to be a significant feature within care home managers' relationships with local commissioners. Similarly, those care homes consulted in the review reported that they had minimal communication about the *National Dementia Strategy* and revealed a lack of leadership in their own sector. Care home managers also identified lack of support from local specialist services which posed a particular challenge in their ability to provide good dementia care. The *National Service Framework for Older People* (2001) stipulated that specialist mental health services for older people should provide advice and outreach services for residential and nursing care providers and acknowledges that being an active part of the community care homes requires vital support from primary care services as well as from other mainstream services. Yet a review of implementation of the National Service Framework found that only 51% of teams provided training and several respondents from Community Mental Health Teams reported a lack of capacity to undertake such work (Tucker et al, 2007).

As well as contributing to improvements in nursing or residential care, there is also evidence that more effective liaison services can potentially save costs (Ballard et al, 2001) which is an important factor in the current trajectory for the business planning side of dementia care in the UK population. There are a number of limitations that confront nursing and residential home managers in developing effective local strategies. Current developments in social care tend to concentrate on making strategic arrangements with less reflection upon the politics of organisational and professional change and their ideological imperatives (Carnwell & Buchanan, 2005). This can result in inadequate co-ordination of joint working arrangements and a lack of resources to support these at the local level. Local leadership therefore

needs to be able to capitalise on potential for partnerships across local boundaries. There have been some good examples such as the formation of dementia partnership groups or local dementia 'summits' (see South West Dementia Partnership, 2010) illustrating the need for managers to find ways of developing their networking and political skills. To provide a meaningful strategy, one needs to focus not only on the outcomes specified in government legislation and policy but also on those outcomes which meet the needs of the local community and are determined by their actual involvement in defining these. Substantial support for the legitimate involvement of people using services within a model of participatory democracy must therefore acknowledge the potential of both managers and staff working in organisations to work in appropriately supportive ways (Postle & Beresford 2007). This is not an easy task where many care homes are often seen to be isolated without essential networks to their local community.

Finally, a more recent report which documents findings from thirty unannounced inspections to residential and nursing homes in Scotland (Care Commission and Mental Welfare Commission, 2009) makes uneasy reading about some of the progress for change being made in dementia care to date. Some care homes had fallen seriously short of best practice and people with dementia were not always getting the best possible care to meet their needs. Whilst 70% of people living in the homes visited had dementia, more than half had never gone outside of the home environment since their admission to it, for example for a visit or to engage in community activities. Further only 24% had any of their previous personal history documented by staff since their admission to the home and an even smaller number of these latter residents were involved in day-to-day decisions about their care. Most significantly only a third of care home managers had undergone a recognised training course on caring for people with dementia. The majority of care staff were generally unaware of best practice guidance and some felt that their knowledge was insufficient or that they did not have enough time to be able to give the care they wanted to (Care Commission and Mental Welfare Commission, 2009). Serious concerns have thus been raised over whether the workforce has the right training, support and leadership to enable it to provide the level of support needed to achieve the objectives of the Dementia Care Strategy, for example the All Parliamentary Group (HMSO, 2010) stated that 'the need for workforce development is profound' (p.2). Further, leaders within both service commission and provision are crucial to establishing the right tone and to providing guidance and support to care staff through the acquisition of good generic management skills in addition to good dementia care skills. One CSCI report (2008) highlighted that vacant managers posts provided a further reason for training not being implemented, resulting in an overall poor performance and a poorly developed climate. All partners therefore play an important role in creating working practices that enable positive outcomes for people with dementia.

One can only conclude from these limited studies that despite policy imperatives, and notwithstanding pockets of innovative practice in some areas, the care home

sector remains relatively underdeveloped to take advantage of what is known about quality dementia care. Despite a range of recent campaigns, the issue of dementia and its fundamental association with upholding human rights, one might conclude that there has been partial failure to ignite the passion, pace and drive or to align leadership with the necessary funding, incentives and information to help deliver the person centred care much cited in the research and policy literature. We now go on to discuss some of these issues in more detail and with reference to our own study findings.

### **What types of leadership contribute to person-centred care?**

A limited number of studies and theoretical debates have revealed the potential contribution of leadership and leadership style to social care organisations (Seden, 2003; Lawler, 2007; Hafford-Letchfield et al, 2008; Lawler & Bilson, 2010, Boehm & Yoels, 2010) highlighting a preference for more inclusive, distributed and participatory styles. The Department of Health (2008) refers to local clinical leadership as fundamental to its devolved management model - a prerequisite for improved provision of dementia care. In a review of the progress of the Dementia Care Strategy by the National Audit Office (2009), few frontline staff could identify leaders who were championing dementia, and few could give examples where the profile and priority of dementia at local level had been raised.

Within our own very small sample, we were able to explore different types of leadership which the four managers identified in the interviews. Leadership theories are very much associated with change and organisational development and as an essential agreement in being able to achieve transformation. As stated earlier, one of the themes to emerge from the interviews related to the type of leadership styles perceived as important or even desirable within the dementia care environment. We were particularly looking for any indications of transformational leadership which Senge (1996) describes as being present in individuals who learn to lead through critical thinking and who are equipped to achieving action and results in a wider context as well as a personal one. For example, all four managers interviewed made some reference to the type of leadership that is commonly referred to as 'transactional' in the leadership literature (Storey & Mangham, 2004). Our managers referred to a form of leadership likely to dominate in residential care by being based on an exchange approach in which the aims of the service and rewards are presented but tend not to provide staff with any expectation beyond the existing demands of the service. Whilst useful for some aspects of institutional care, these types of relations were explained by our interviewees as being related to expectations of the overarching owner of the residential service or expectations from 'head office'. One of the managers described this as follows:

*I struggle with it, in what I've read and what I continue to read, the leadership at the top lacks real inclination to change. The system is still very much geared around the mental health model of service .... Are we really open to thinking differently and innovatively about the way that we do things, or are we kind of straight-jacketed into a way of thinking that's traditional, that's based on a very controlled medical model? (Manager 4)*

Leadership theory places great emphasis on the interaction between leaders and followers (Bass, 1990; Avolio et al, 1999) where an authentic approach to leading is cited as desirable and effective in achieving positive and enduring outcomes in organizations (George & Sims, 2007). Authentic leaders are thought to be those who know and act upon their true values, beliefs, and strengths, while helping others to do the same. Paying attention to employees' well-being at different levels is thought to show positive impact on follower performance (Ryan & Deci, 2001). The role that leaders play in follower engagement at work suggests that engagement is best enhanced when employees feel they are supported, recognized, and developed by their managers (Harter et al., 2002). Again this was something articulated by our management interviewees in relation to participatory approaches to leadership as illustrated below:

*I think managers have to be open to listen ... to their staff who might not always be seen to be doing the right thing, but they see so much about us as managers that they can learn a lot from. I'm driven by the people for whom I work. Most staff have much more potential than we give them credit. (Manager 3)*

This manager was clearly open to a consensus style approach in which mistakes were allowed and from which staff could learn. Donoghue and Castle (2009) used the Slevin leadership inventory (Slevin, 1989) to assess leadership styles within nursing homes. This is a survey instrument with a 50-item questionnaire consisting of statements answered using five-point Likert scales. Responses are based on how characteristic each item is of the leadership behaviour of the individual for example from 'to a very great extent' to 'to little or no extent.' The instrument aims to measure different leadership dimensions such as transactional or transformational leadership (Slevin, 1989). For example our capacity to make transformations or develop ways of knowing have affective, interpersonal and moral dimensions and the instrument attempts to measure these. Donoghue and Castles research demonstrated that those deploying a consensus management style were more likely to enhance employee satisfaction and that a consensus management style was associated with lower turnover amongst caregivers than where there was a more autocratic style for instance. Only 30% of their sample however exercised a consensus style and/or were moving towards a more transformational style. A transformational style was considered to be present and effective where staff was engaged in local governance and where managers were



also given purposeful leadership training. Donoghue and Castle (2009) also noted that consensus management preserved the authority of the manager considered crucial to the organisation's best interest. Further to their study, an empirical study of leadership in welfare organisations in Israel conducted by Boehm & Yoels (2008) found that the contribution of leadership style to the effectiveness of social workers in welfare organisations was relatively weak compared with the contribution made through the empowerment of staff and team cohesion. The most influential component of staff empowerment in their study was the enhancement of staff knowledge and competence. Their study adds something to what we know about the personal and team aspects of organisational effectiveness and the importance of promoting a participatory and distributed style of leadership to foster these developments and which might be more suited to dementia care settings.

Within our own small study, the terms that managers used to describe themselves at work included 'change agents' and 'motivators', all common aspects of transformational styles. These descriptions were however tempered by a critical, realistic view mostly in relation to resource constraints but also by restraints perceived to be imposed from within the hierarchical management structures they worked within. The managers interviewed felt that their own preferred personal styles were not however modelled at the strategic level. Surprisingly to us, one of the themes that emerged in the discussion about the differences between management and leadership was the association made between leadership style and the traditions or background of the professional working in residential dementia care. One manager for example stated:

*On the health side ... there's a much more management-traineeship type of approach... less grounded in on-the-ground delivery of services than say the social care services, where there are more people who have come through the ranks having worked with people, and are steeped in the values of what those kind of people's services are. I think that's a tremendous strength of the social care side in terms of management. (Manager 1)*

As our sample was very small, generalizations from these comments are invidious but the illustrative comments quoted here do call for consideration as to whether the social model of disability might provide a helpful framework for transforming dementia care (Gilleard et al, 2005). Likewise, Gilleard et al (2005) have considered whether application of the social model can help to reconsider the value of hearing and responding to personal experiences of those living with dementia and as a means of considering abilities instead of losses seen associated with dementia and to better understand the impact of public policy.

## **Towards a person centred culture in dementia care**

Some of the factors discussed so far illustrate the complexity of issues behind concerns raised about the inconsistencies and lack of person-centred focus in the provision of care to people with dementia (National Audit Office 2007; Alzheimer's Society 2008; Ballard et al 2001). The concept of empowerment is widely embraced in the social work and social care literature as a process in which the older person with dementia acquires personal, organisational and community resources to enable them to gain more control of their lives and environment (Kitwood, 2007). For care staff, empowerment is seen to be an essential ingredient to achieve appropriate support for service users including the potential for autonomy and self-awareness at work; being aware of and recognising the demands for person-centred approaches, and the staff members own contribution and influence on the care environment. Empowerment of care workers involves a process in which they are given the opportunities to gain knowledge, skills and competence which increases their own sense of authority and responsibility to achieve the goals of the dementia care strategy and its underpinning evidence as well as to cope with the day to day challenges in the workplace. Managers interviewed in our sample for example made frequent references to the significance of interactions between managers which might promote empowerment. As one manager put it:

*It can't be down to the manager to drive it .... I do think they are really stretched to the limits sometimes and carers face a high risk of burnout, and I think a lot of it is about support, supervision, training and involvement – feeling that you have a part to play in the service.*  
(Manager 2)

James et al (2007) suggest the term 'organisational climate' to refer to the estimations that people have of their jobs, co-workers, leaders, pay, performance expectations, opportunities and equity which impact on the individuals wellbeing. They argue that climate and culture are two different constructs although within the last decade have been discussed simultaneously in the organisational literature (Schneider, 1990; Holt and Lawler, 2005). The way in which people describe environmental objects in relation to themselves are seen as important aspects of culture. These are not only physical objects but include variables with a subjective, judgemental component that can be operationally defined. For example, the managers interviewed in our study made frequent inferences about the relationships between the environment and the atmosphere of the homes they worked in and inferred that the layout of the dementia care environment itself can determine spaces for more dynamic interaction, for example:

*I think what makes x unique is its layout and location of its building because it's situated on a main road, there's lots of windows, there's lots for people to see, and there's lots of small rooms where people can interact better.* (Manager 1)

Holt and Lawler (2005) develop the idea of organisational 'climate' in social care which they suggest provides a means of identifying and indicating specific organisational initiatives which might impact positively on service delivery over time (p.32) and which has the advantage of making service improvements amenable to management. They see the culture of an organisation as being rooted in its values system and thus provide an aggregate view of what goes on there. They suggest that focussing on the climate however increased amenability to change even where this does not explicitly engage or reflect the organisations value system. Visible features of organisational climate may be described as peer support, relationships with supervisors such as those referred to above by the manager in this study as well as rewards and incentives (Holt & Lawler, 2005). Likewise, a different manager in our study highlighted this supposed link between the atmosphere and person-centred care:

*By being person-centred with the service users we got round to being like that with staff. And there aren't many organisations like that so we found it really challenging when staff have been in one organisation for many years and come to us. (Manager 3)*

Locke (1976) proposed four latent factors that underpin personal and work-related values. These included; the desire for clarity, harmony and justice; a desire for challenge, independence and responsibility; desires for work facilitation such as leadership, support and recognition and desires for warm and friendly social relations. These correspond with empirically derived factors of organisational climate and culture illustrated in a number of studies of person-centred approaches in dementia care (for example, Kitwood, 1997) and their direct impact on service users. Kitwood argued against the depersonalisation that he observed to occur through a dialectical interplay between neurological alterations in brain function within people with dementia and their exposure to a negative social environment. He noted that these contribute to an unintended spiral away from well-being. More recently however, a three year study reported by Kelly (2009) in which she observed interactions between staff and service users on continuing care wards noted that this 'old style' culture is still very much alive. She documented the abusive, regimented and punitive task centred nature of experiences between nursing staff and older people and concluded that delivering a person-centred approach is extremely difficult without extensive support, mentoring and explicit organisational commitment to change. Further there is some evidence that the values and ethos of an organisation can provide major barriers to workforce development. Those management staff without good leadership skills or specialist dementia care knowledge may themselves present a barrier to recognising and promoting staff development. Current commissioning practices may also create barriers because of the working practices they tend to develop. For example, what appears to be a systemic failure within care homes on the surface might actually be

related to low fee levels and which are also related to inadequate resources of time and skills or poor quality supervision for staff in the homes. All of these combine to undermine the personal development of care staff and the development of effective strategies to raise the quality of care,

As organisation culture often reflects the normative beliefs (that is, systems and values which furnish the ideologies) and shared behavioural expectations (that is, system norms) in an organisation, it may be that promoting positive group dynamics or interactions amongst people in a care setting will contribute towards collectively making sense of the environment at a systems level. Interviews with the four managers in our study all demonstrated a strong belief in the role of leadership in fostering work attitudes, and perceptions of staff and users about each other. For example, managers acknowledged the importance of giving attention to staff behaviour as being crucial to promoting job satisfaction and commitment to person-centred care. It was also seen to enhance the perceptions in individuals and teams of service quality and had an impact ultimately on turnover of staff:

*I do not think I have any 'special' skills that cannot be used in any area of care. I think my management style is based around passion, respect, empathy, knowledge and understanding. You need this in all areas of care but you also need to be able to use these aspects of your management as a 'team player' with your staff to ensure the staff team work to the same vision, the same culture, if you like. (Manager 2)*

## **Leading a climate for learning in dementia care**

As indicated above, building workforce capacity and capability for example through recruitment, retention and support for care staff working on the ground was the third key theme in the interviews reported here and highlights the importance of empowered local leadership for delivering transformational change. The creation of an informed and effective workforce for people with dementia is a key objective of the National Dementia Care Strategy (DH, 2009) in a context where there is a paucity of coherent, relevant training, high staff turnover and vacancies (Donoghue and Castle, 2009). Likewise, the stigma attached to dementia is reflected in the low status society gives to this work, which reduces morale and motivation. Staff turnover rates (23.2% in nursing homes, 20.5% in residential homes and 22% in domiciliary care) are around twice the 2004-05 NHS rate of 11.8 per cent, and the 2006 private sector rate of 12 per cent (National Audit Office, 2010). Staff turnover in care homes is frequently attributed to local economic factors as well as individual and organisational factors. Little is said however, in relation to the specific role of the care home manager. The creation of a new qualifications and credit framework may provide opportunities to develop a career path within dementia care (SfC, 2010) attributing higher status. All

of these factors are important features of a positive organisational climate.

However, staff learning is not just about achieving competence at the instrumental level. Effective learning requires reflection and thought in relation to organisational development where people to interact in a collective learning experience for the development of knowledge about what constitutes effective care (Hafford-Letchfield et al, 2008). Collective learning is also achieved at both the explicit and tacit levels (Wenger et al, 1998). Emphasis on individual experiences of learning must somehow be integrated into the interpersonal experiences of organisational learning with an organisation as it starts to build a learning community or as referred to earlier, in building an appropriate culture for learning. Reed (2009) asserts that any attempt to change the 'norm' of organisational relationships brings about some degree of chaos at physiological levels as well as those at the personal, interpersonal and the organisational. Community building occurs through addressing integration of these elements (2009, p36). Such a culture promotes awareness, trust and accountability leading to benefits such as increased efficiency, job satisfaction and decreased absenteeism and attracts more motivated employees.

The Alzheimer Society (2008) echo these sentiments, recommending that the training needs of care staff in residential care should not only commend knowledge and skills but also capture the 'hearts and minds' of staff thereby enabling them to work 'with the person first, dementia second' (no page given). This illustrates further some of these differences between climate and culture that one needs to be conscious of. It recommends training that not only develops specific care competencies but is also geared to drive forward the quality of life of the residents who live in the care homes where they work. However, work based training as one solution is not without its challenges. Where staff turnover is very high problems may arise for the development and sustainability of skills which might then detract from genuine culture change. This is not the only challenge to address when it comes to introducing and maintaining gains observed on a training course. Carmeli and Vinarski-Peretz (2009) highlight the role of reciprocity and self-efficacy to avoid burnout among care staff for older adults with dementia alongside the organisational barriers. When moving towards a person-centred culture of care, one needs to be aware of the resistance that can occur for people returning from a training course. Having a critical mass of staff who can act as agents of change can make a difference to the impact of training:

*Real meaningful change is often down to a small group of individual or an individual really driving something different ... whether they've got vision, they really understand where they want to get to and how they might get there. (Manager 4)*

A number of studies have already demonstrated the challenges in sustaining change, indicating the need for ongoing and sometimes external support to maintain benefits from training and to prevent slippage as staff resume their daily routines (Ballard et al, 2001; Hughes et al, 2008). Incentives in the form of rewards for

staff, who work better and financial support to release staff to attend training, are more likely to support any change effort (Hughes et al, 2008). Solutions to some of these challenges require a more creative approach to addressing staff learning and development needs, particularly those which involve users and carers. Added value can be supported by work based coaching and mentoring led by skilled experienced dementia care practitioners in order to support the emergence of staff leadership skills (Whitby, 2008). We already know from some studies, as noted above, that without a fresh approach, the effects of training may readily dissipate and all that remains are the fine rhetoric of policy. The task of leadership is often expressed as being able to motivate people to achieve outcomes that benefit the individual, the team and the organisation and a balance between all of these are needed (Hafford-Letchfield et al, 2008). It can also make a significant contribution towards collaboration and collectivist approaches by promoting the leadership roles taken by users and other professionals during the learning and development process.

## **Conclusion**

This paper has given a short overview to issues in important in transforming dementia care by paying attention to the implied notion of leadership within residential and nursing home provision. We have tried to reflect these through the illustrative narratives and themes from the interviews with care home managers. Whilst a very small and partial sample, these do provide case examples from which the issues can be illuminated further. Change skills have been identified as key skills for managers and leaders and an understanding of providing opportunities for both managers and staff to develop a range of skills through which change can be recognised, implemented and sustained. It is well documented that the general lack of training and poor level of qualifications within the residential and nursing home sector, coupled with the absence of registration with the General Social Care Council, all combine to affect the quality of care and safety of the people living with dementia (Parliamentary Group on Dementia, 2009). There is a relatively sound theoretical framework and guidelines for 'person-centred care' – a perspective that espouses the value of all people with dementia irrespective of age, level of impairment, or those who care for them (Kitwood, 1997). It is also an approach that values the perspective of the person with dementia as well as recognizing the importance of all the relationships and interactions with others that support the person with dementia. The key priorities of high standard dementia care are well espoused within the Dementia Care Strategy in which there are significant guidelines for managers and staff to use and develop, not least those that require the active involvement of users and carers themselves. From a macro perspective however, given the regular publicised scandals in care, and the broader economic and social challenges that face public and private organizations,

more positive and active forms of leadership in institutions and organizations need to be consciously and explicitly developed to restore public confidence. Developments should support the development of consistency of quality care rather than pockets of good practice as demonstrated in those managers we interviewed for this paper. Simply expecting leaders to be more value-driven and to demonstrate integrity will be ineffective if concrete tools for implementing and measuring important aspects of leadership are lacking. In lieu of what we know about the contribution of leadership and the importance of a positive learning culture, such developments are very difficult to argue against!

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