Implementation of a complex intervention to support leadership development in nursing homes

Dewar, Belinda

Published in:
Journal of Applied Gerontology

DOI:
10.1177/0733464817705957

E-pub ahead of print: 28/04/2017

Document Version
Peer reviewed version

Abstract

This article reports on the analysis of the transformational My Home Life Leadership Support programme for nursing home managers being implemented in Scotland. It analyses learning from a multi-method participatory descriptive study.

Contribution Analysis theory informed the evaluation. Evidence-based Practice, Relationship centred Care, Appreciative Inquiry, and Caring Conversations informed the intervention to develop transformational leadership. Data generation methods included baseline and post-intervention questionnaires to describe culture change within the study population, together with in-depth qualitative data generated from group discussions. Qualitative data analysis was an iterative collaborative process with participants to generate themes about the impact of the programme on themselves and their practice.

Data showed positive changes in managers' perceptions of their self-awareness, leadership communication and relationship skills, and development of positive cultures.

This model offers lessons for those interested in ways to approach the emotional, educational and cultural dynamics of change in other human service contexts.

Keywords: cultural change, leadership, care homes, nursing homes, relationship centred practice, transformation.

Introduction

Internationally, there is a recognised need to improve quality of life and care for residents and their relatives in nursing homes, plus a need to support the workforce to flourish and be more effective in increasingly complex and changing environments (Jeon, Simpson, Cunich, Thomas, Chenoweth, & Kendig, 2015; Tolson, et al., 2011). The links with effective leadership to improve service user outcomes and transform the culture of care is also recognised (Alimo-Metcalfe & Alban-Metcalfe, 2008; Buchanon, 2007; Cummings et al., 2010; Hardacre, Cragg, Shapiro, Spurgeon, & Flanagan, 2011; Jeon,et al., 2013; Jeon, Merlyn, Chenoweth, 2010, MacPhee, Chang, Lee, Spiri, 2013). However, to date there has been a paucity of research into leadership in nursing homes, despite the fact that they are caring for some the most vulnerable people in our society (Kennedy 2014).

The research based literature highlights the value of transformational leadership approaches in complex systems (Cummings et al., 2010; Newman & Hughes, 2007); in particular, relational (Brown Wilson 2009; Dewar and Cook, 2014; Nolan et al., 2008), appreciative (Dewar and Mackay 2010: Richer, Ritchie, & Marchionni, 2010; Whitney et al., 2011), collaborative (Raelin, 2003) and authentic leadership (George, 2014; Wong, Laschinger, & Cummings, 2010) models. Such models emphasise enduring relationships, a strong values base, drawing out and nurturing potential, creating conditions for success, and practicing self-discipline; all congruent factors with the values underpinning caregiving. A key consideration is how to bring these principles to life through innovative educational programmes. This issue has been addressed in the My Home Life Leadership Support programme for nursing home managers, which is the focus of this paper.

My Home Life (MHL) is a UK-wide initiative to promote quality of life for those living, dying, visiting and working in nursing homes for older people, through appreciative,

relationship-centred and evidence-based practice (www.myhomelife.org.uk). It comprises a number of research, enterprise and social action activities, which inform each other. This paper presents the findings from a large participatory study of the MHL Leadership Support programme in Scotland and includes data generated from 119 participating nursing home managers (11 cohorts). It examines the learning and perceived impact of the programme on leadership development and nursing home practice, from the perspectives of the participating managers.

Background

In the UK there are 17,678 nursing homes providing care and support for over 405,000 older people (Age UK, 2016). Nursing homes are complex organisations which are influenced not only by demographic and societal changes; but also by health, social care and broader government policy, legislation, regulation, and the prevailing economic climate (Royal College of Nursing, 2012).

Current UK and international government policy focuses on people being cared for in their own home for as long as possible; as a result residents are entering nursing homes later with complex and multiple conditions. They are increasingly older and frailer, with higher levels of physical and cognitive impairment (Bowman, Whistler & Ellerby, 2004; Froggatt, Davies & Meyer, 2009; Laing & Buisson, 2009; ISD Scotland, 2014). These changes present significant challenges for older people and their families, with the move to a nursing home often associated with feelings of failure and loss (Hurtley, 2004; Barnes, 2012). These changes have also placed additional demands on nursing home staff, whilst staffing levels, status and pay remain unchanged (Kennedy, 2014); resulting in problems with workforce recruitment, frustration, demoralisation and retention difficulties. Nursing homes are also

suffering from a poor public image, increased public expectations and restrictive funding arrangements (Kennedy 2014).

Leading on culture change during a sustained period of austerity and in a system that can be performance-driven, blame-oriented and that lacks a relational sensibility is a tall order. In Corazzini et al's (2015) study of facilitators and barriers to cultural change a key challenge was providing person centred care in the context of extant rules or policies. They argue that there needs to be less reliance on technical solutions and more emphasis on supporting staff to reframe norms and expectations and collaborate to develop novel solutions**.** The role of nursing home managers in nurturing positive relationships between residents, relatives and staff and helping everyone to feel valued is pivotal and yet they are not always properly supported themselves (Cavendish, 2013; Kennedy, 2014; Owen & Meyer, 2013). Indeed research evidence suggests that emphasis in workforce education is usually placed on legislative or organisational needs rather than emotional and relational issues. This situation is surprising given the current rhetoric of person-centred care and emphasis on dignity (Ross, Carswell, Dalziel & Aminzadeh, 2001; Ruckdeschel & Van Haitsma, 2004). Tyler and Parker (2011) suggest that culture change initiatives that address more deeply held attitudes and beliefs greatly improve experiences of care workers and those they care for in long term care settings. Other research has shown that consistent modelling of relational behaviours in practice, by managers, results in more positive culture change (Anderson et al 2003; Andre et al 2014; Corazzini et al 2014; Scalzi et al 2006). The nursing home workforce need support to develop visions and strategies that recognise the relational, complex and multidimensional nature of living, dying, and working in nursing homes (Tolson, Dewar & Jackson, 2014) and also to meet the particular needs of relatives, who often get overlooked. This is the focus of the MHL initiative and its theoretically grounded, evidence informed activities.

Theoretical underpinnings informing the intervention

The underpinning MHL vision was developed from an extensive literature review about 'what matters' to older people and 'what works' in nursing homes (NCHR&D, 2007). It comprises eight themes (Table 1) that integrate evidence from both health and social care and places Relationship-Centred Care (Tresolini & Pew-Fetzer Taskforce, 1994; Nolan, Brown, Davies, Nolan & Keady, 2006) and the Senses Framework (Nolan, Brown, Davies, Nolan & Keady, 2006) at its core. To translate the evidence base for best practice into local settings, MHL focuses on Appreciative Inquiry methods (Bushe & Kassam 2005; Cooperrider, Whitney & Stavros, 2003; Dewar & Mackay, 2010) and enhancing relationships through developing Caring Conversations (Dewar & Nolan 2013; Dewar, 2011).

The MHL Leadership Support programme (referred to as 'the programme' from here on) is an intervention grounded in a firm appreciation of the crucial role nursing home managers' play in setting the culture of care. Throughout the programme, nursing home managers are supported to integrate the eight best practice themes (identified in Table 1) into the everyday life and work of their homes through a complex social process of cultural development that has Relationship Centred Care, Appreciative Inquiry and Caring Conversations as the underpinning principles. The programme supports nursing home managers to develop in their leadership role and take forward quality improvement**.** Participatory evaluation is interwoven throughout the programme, where nursing home managers generate data alongside their learning and development experience. Key elements of the programme are outlined in Table 2.

In essence, the programme creates a safe place where nursing home managers can learn from each other, understand and apply the evidence base for best practice to everyday

situations, reflect upon and address their own leadership styles and recognise their pivotal role as change agents. Using relational and experiential approaches to learning (Nolan, 2006; Nolan, Brown, Davies, Nolan & Keady, 2006; Nolan et al, 2008), the 12 month programme begins with four days of preparatory workshops (two days on two consecutive months), followed by monthly half day action learning sets (Dewar & Sharp, 2013; McGill & Brockbank, 2004) for the remainder of the year.

The programme rests on a social, dialogical, emancipatory and iterative 'theory of change', underpinned by trust and valuing emotionality; which locates innovation in the myriad of relational and conversational practices that take place in everyday nursing home life. It recognises that practice developments and the fostering of a relationship-centred culture happen through a series of steps, that can be likened to a 'ripple effect', that start with the individual nursing home manager.

Theoretical underpinnings informing the evaluation

Contribution Analysis Theory (Mayne 2001) informed our approach to evaluation. This is an example of a 'theory-based' approach to impact evaluation. The conceptual development of theory-based approaches lies primarily with the evaluation of complex community initiatives in the USA (Connell et al 1995) and realistic evaluation in the UK (Pawson and Tilley 1997). Realistic evaluation is used to evaluate programmes delivered in complex and dynamic settings where traditional experimental designs are not possible or indeed appropriate. It is particularly well suited to social programmes where outcomes are determined through stakeholder input and interaction, and where outcomes are likely to be influenced by social structures and pre-existing social processes. Unlike traditional positivist approaches which attempt to *prove* causality in situations of success, a theory-based approach uses a different process of logical argumentation, which first sets out how and why the

programme is believed to have the potential to generate change (this is the 'theory' of change). It then embarks on a learning journey to determine whether or not this potential has been released in practice. Critically, it is recognised that it is not 'programmes' per se that work, but the actions of stakeholders that make them work (or not). The generative potential of a social intervention takes the form of providing reasons and resources to break into existing patterns of interactions, behaviours and norms to enable programme participants to change. It requires disruption of established ways of thinking, feeling, doing, being and relating.

The metaphor of a ripple effect is helpful in conveying how development is expected to occur. Many traditional 'theory of change' models prove inadequate for describing developmental and transformational change programmes; often because they are too linear, too simplistic or mechanistic, or neglect key community behaviours and critical questions of influence and control (Regine & Lewin, 2000). Our 'theory of change' is that developments influenced by the MHL Leadership Support programme happen through a series of steps or ripples that start with the individual participant. This learning influences other individuals, teams and the wider context in which care homes operate through a series of 'circles of influence' (Montague 2002). These circles can encompass, most immediately, those living, dying, visiting and working in the home. However, it is recognised that outcomes are also influenced and mediated by organisational policies and procedures, the local community, the wider health and social care system, the regulatory system, public policy and societal expectations. In reality, change is not straightforward and linear; it is a messy process that occurs at different rates, amongst the different 'circles of influence', which are dynamic and interconnected.

Methods

Aim

To examine the learning and perceived impact that the MHL intervention has made to leadership development and nursing home practice, from the perspectives of the participating managers.

Participants

Data were generated from 119 nursing home managers (11 cohorts) who had completed the on-going MHL Leadership Support programme in Scotland. Each cohort comprised up to 15 managers, who had been invited to participate in the programme and its evaluation on a voluntary basis.

Data generation

The study spanned the period from January 2013-April 2015. The multi-method design involved the collection of both quantitative and qualitative data. Quantitative data were collected pre and post intervention via self- completion questionnaires, whilst more in-depth qualitative data in the form of group discussions were collected throughout the study period and recorded in facilitator feedback sheets. The participatory nature of the research primarily related to the analysis whereby participants were involved in the validation and interpretation of these data.

Participants gave informed consent to be part of the study on the basis that anonymity and confidentiality would be maintained. Throughout the study, findings were regularly fed back to participants to check for resonance, relevance, any gaps and permission to share with a wider audience. Establishing trust with each cohort was paramount, both for the experiential

methods used to help them reflect on their own leadership styles and change agent roles and also for their willingness to be involved in the research. Approval for the study was given by the Faculty of Health, Nursing and Midwifery Ethics Committee at the University of the West of Scotland. Data were collected at the start (Day One of the workshops), throughout the 12 month programme, and at the end (Validation Event) and comprised:

- Demographic data (time in post, qualifications, gender, nursing home type, number of staff supported, number of residents supported).
- Two sets of questionnaire data generated at baseline and on completion of the programme (Validation Event) to give an indication of the prevalence and distribution of specific perceptions of change: a) Assessment of Workplace Schedule -(AWES), 36 item and b) the Perceptions of Workplace Change Schedule (POWCS), 28 item (Nolan, Grant, Brown & Nolan, 1998). These questionnaires were informed by research on culture change in older people's care settings (Nolan, Grant, Brown & Nolan, 1998) and demonstrated high internal consistency and relevance with the conceptual underpinnings of this study. The two questionnaires are complementary and, whereas AWES offers a 'snapshot' assessment, POWCS asks for managers' perceptions of the nature and direction of change over the course of the previous year. Both comprise a series of statements that relate to the nursing home environment and broader organisational issues, as well as the managers' own workload, regard and feelings, skills and capabilities, staffing considerations, communication and relationships with and amongst staff, and perceived implications for relatives and residents.
- Workshop group discussions (n=132) for each of the 11 cohorts (Three group discussions per day, for each of the 4 day workshops). Photo elicitation was used to support group discussions. Photo elicitation uses a set of generic images to facilitate

enhanced articulation of meanings, generate more complex understandings and redress power differentials (Collier, 1967, 1987; Dewar, 2012; Harper, 1993). Topics explored, for instance include, perceptions of being a nursing home manager; the relationships managers have with others; staff wellbeing; promoting a positive care culture and perceptions of leadership. All participants (n=119) were present for and contributed to the four day workshop group discussions. Data were recorded on flip charts and in facilitator field notes and fed back to participants for validation.

- Action learning group discussions (n=99) were held at the start of each of the nine action learning sets for each of the 11 cohorts. Key focus was on recording lessons learned and outcomes of actions taken forward and their perceived impact on the well- being for residents, staff and families. Attendance at the action learning set group discussions varied throughout the year due to sickness, holidays, and absence for other pressing matters; but on average included at least 75% of the participants (n=89). Data were recorded in facilitator field notes and fed back to participants for validation.

Data analysis

Drawing on our theory of change (Contribution Analysis) the focus of the analysis was on the 'inner circle' of influence, that is, the nursing home manager and how they perceived the programme had influenced them. A descriptive statistical analysis of baseline and post-programme questionnaire data was conducted to explore how they felt they had changed and/or impacted the culture of the nursing home over time. During the group discussions (workshops and action learning sets) additional data were generated about what factors influenced how they were able to enhance (or not) quality of life in nursing homes.

Congruent with the collaborative ethos of the programme, participants took an active part in the on-going analysis of these data. Group discussions (workshop and action learning) focused on articulating learning, and identifying the enabling factors and barriers arising from attempts to implement learning in practice. Data were recorded and initially analysed by the facilitator and then fed back to participants after each meeting for validation and further analysis. In this way, emerging learning was subjected to iterative testing in the contexts in which it was expected to be applied; while supporting participants to build inquiry into the fabric of their everyday practice.

At the end of the programme, participants and facilitators worked together in a process of co-analysis to map data generated across the lifespan of the MHL Leadership Support programme to the MHL conceptual framework (Validation Event). This involved an Immersion/Crystallization (Borkan,1999) process to thematically analyse the data with the facilitator and participants progressing through a number of stages: initial description of the data; crystallizing the core messages in data extracts; considering these in relation to all other data; reflecting these back to each other; and creative synthesis and corroboration of the themes. This resulted in a draft report of the learning from the programme being written up by the facilitator, which was then validated by participants who checked for resonance, relevance, any gaps and permission to share with a wider audience as a final report.

Six facilitators were involved in generation of the initial data from the cohorts. The facilitators were all experienced educators and researchers. Each cohort had one dedicated facilitator. This paper reflects on the learning from a second level analysis of these final reports which was carried out collaboratively by three researchers who were part of the MHL Scotland facilitation team.

Trustworthiness and transferability of the data

Data quality was enhanced through peer debriefing and the use of multiple sources of evidence. As stated above peer debriefing (Lincoln and Guba 1985) involved the researchers independently theming the data and then meeting with participants to discuss similarities and differences. Participants were also involved in member checking and validating the findings. In addition, a detailed audit trail was created. The analysis of the final reports (11 cohorts) provided insight into the factors that have influenced local implementation and allowed common themes across the programme to be identified. The cross case analysis of the 11 cohort reports helped to strengthen the reliability of the findings and their possible transferability to other contexts, which is consistent with a co-inquiry approach to evaluation.

Results

Quantitative findings

The nursing home demographics are summarised in Table 3. Participating homes were inclusive of the diversity of nursing home provision encountered across Scotland, with differences in characteristics including size (large, medium, small), and organisational structure (corporate group, owner provider).

Upon completing the baseline questionnaires (AWES and POWCS) at the beginning of the programme, each manager placed their response in a sealed self-named envelope, which was handed to the facilitator for safekeeping until the end of the programme. At the end of the programme (Validation Event), the participants were asked to complete the AWES and POWCs again (post-intervention). The sealed envelopes were returned to the managers in attendance immediately after completion of the post-intervention questionnaires and the managers were invited to open the envelope, providing the opportunity for them to reflect privately on any reported changes. The managers then placed both questionnaires in an

unnamed envelope (ensuring anonymity) and handed this back to the facilitator for analysis. 98 sets of pre-and-post questionnaires were collected and analysed (response rate 82%), as not all the managers (n=119) were present at the Validation Event (sickness, holidays, absence for other pressing matters, left the programme).

Table 4 compares the AWES results pre and post programme, showing the total percentage of responses that either agreed or strongly agreed with those statements pertaining to the participants perceptions that relate directly to leadership development.

The Perceptions of Workplace Change schedule (POWCS) asks managers to rate the changes related to perceptions of self and the place in which they work over the previous 12 months. Table 5 reports the results for those statements that relate most directly to perception of self and leadership capabilities, and offers a breakdown of responses post-programme

Overall, comparison of the pre- and the post-programme questionnaire data provides a picture of consistent positive change across many aspects of the workplace environment, including those aspects that were rated highly in the beginning. For instance, reported shifts in the AWES data pre and post-programme relating directly to the managers' assessment of their leadership and communication skills were particularly striking in view of the high baseline scores. Post-intervention, all managers agreed that they actively listen compared to baseline measures (100% vs. 80%, respectively). Post intervention almost all agreed that they had the management and leadership skills to undertake an effective role (96% vs. 80%, respectively). There were also marked improvements in areas where aspects were rated less highly pre-intervention, for instance, actively providing the space and time to listen to staff (96% vs. 63%, respectively) and the development of effective influencing skills (91% vs. 57% respectively). These shifts were consistent with the corresponding perceptions of change reported through the post-programme POWCS questionnaire. Encouragingly, one area of notable development in the managers' perceptions of change over the course of the programme was that post intervention almost all indicated that their understanding of how to improve the culture of care had increased (96%). Consistent with these findings, post intervention, almost all managers also reported that their confidence had increased over the past 12 months. Given that there was almost one year between completing the pre- and post-intervention questionnaires, these consistent positive changes in both those items rated highly and less highly at the beginning are encouraging and show that the nursing home managers were able to discern nuanced differences in themselves as a result of the programme.

Alongside these personal developments, managers perceived many broader positive changes within the home, notably staff prioritising residents' quality of life over tasks, improved interaction with residents and relatives, and improved staff morale. Broader aspects shaping the culture of care where less change was identified include the managers' perceived

workload, overall working conditions, job security, plus staffing levels and retention issues. Despite the lack of change in these respects, the managers nevertheless reported perceived reductions in their levels of stress, together with increased job satisfaction, enthusiasm for working in nursing homes, feeling valued and improvements in their own quality of life.

Perhaps most encouragingly, whereas the baseline POWCS data indicated that the overall climate was characterised by stability or 'staying about the same', almost all (more than 90%) managers reported that things had moved in a positive direction for many of the questionnaire statements.

In order to move from descriptive summary patterns to a richer and more textured understanding of change and the inherent complexities of fostering and sustaining a positive, relationship-centred culture in nursing homes, an in-depth consideration of the qualitative data gathered throughout the lifetime of the programme is provided.

Qualitative findings

Qualitative data analysis both drew upon and added further detail to our 'theory of change' for the MHL programme by focusing on the nursing home managers perspectives of impact.

The various elements implicated in developing a more relational way of thinking about leadership are closely intertwined and, sit within the myriad of relational and conversational practices at the heart of innovation. They are separated below for ease of discussion only. Key elements developed from the analysis are: knowing more about me, being curious about others, valuing emotionality, new ways of initiating conversations, opening up and creating genuine ownership of new ideas, taking ideas forward in a collaborative and appreciative way and security and belonging.

Knowing more about me

Developing a more relational way of thinking begins with the managers' relationship with self, taking the time to critically reflect upon their own attitudes, behaviours and assumptions before thinking about their impact on others:

"I am much more aware about how I come across, that I talk too much to cover up the fact I am feeling nervous – I have learned to press the pause button."

"I now know I don't have all the answers and that others can often come up with better solutions then me."

Managers were much more aware of the way in which they led teams. For example having greater awareness of their own hesitancy in trusting others to lead developments, again questioning themselves and the concepts they had about their own practice.

They expressed that they now think differently about their purpose, role, and how they influence others. In particular, managers acknowledged that creating a positive culture starts with themselves. They now believe their role is to empower others to lead developments, rather than being seen as the 'fixers':

"It's maybe much quicker to just do it all myself and make decisions but I realise now that involving others has a longer lasting effect and it makes people feel part of things and valued".

This new knowledge about themselves helped managers feel more confident about taking things on, to be less frightened about 'confrontation', to connect emotionally and really explore issues beneath the surface, and also to consider other perspectives. In essence, they have developed a stronger 'attitude of inquiry':

"I would go into a tailspin in the past if a relative approached me with a concern – I now see this as part of what we do."

Being curious about others

Developing a stronger attitude of inquiry led to being curious about others. Managers talked about feeling more confident, less defensive, and better at taking the time to explore things with people, rather than trying to solve problems instantly:

> *"I feel able to ask and hear what others have to say – it may be different from what I think but I now don't go on the defensive".*

The programme gave managers the impetus, tools, confidence and support to explore the perspectives of others much more fully in order to provide deeper insight. Many suggested that they had not always proactively done this in the past. Previously barriers to this kind of exploration included the flawed or untested assumptions about others, pressures of time and competing priorities, and the fears and anxiety of what might be asked of them in response. Being more curious generated many surprises for managers to which they were able to respond without defensiveness.

Throughout the programme, managers were encouraged to draw upon the Caring Conversations framework (Dewar & Nolan 2013). Through this, they became accustomed to challenging in a curious and positive way from a place of support and in a way that helped them to consider other people's perspectives more:

> *"I decided to ask some different appreciative questions at the end of a formal inspection with the Care Inspectorate (Regulatory Body in Scotland). I asked them what had worked well for them during the process and what could have made the experience better. We ended up doing this together and came up with some shared understanding about how we might encourage staff within the home to be more*

confident during inspections. We both thought that it was valuable to spend time with each other like this."

Valuing emotionality

Sharing emotions was a significant shift in thinking for participants as they had previously thought that this was 'unprofessional'. The extract below shows data from a manager about how they had explored emotions more deliberately in their work and the positive outcomes this had for others in the workplace.

'We do regular supervision with staff. It had become a bit stale. People come in and they don't know what to say. In the past we might discuss for example cleaning rotas etc. Now we use the emotion words and find out how they feel about practice. We learn so much. I get so many surprises. For example I did not realise that a member of our catering staff who was not engaging with residents about meals felt scared and apprehensive about going out and asking them for fear he would be criticised. Knowing this gave us something to really work on.'

Several managers talked about how they had used the different way of having conversations to help to avoid misunderstanding and the potential for escalation of disputes. For instance, one manager reported using the Caring Conversations framework to help transform a relationship with a relative. This involved the manager connecting emotionally with the relative by sharing how staff were feeling and asking for the relative's feelings in response. Together they were able to be more open and to use this new knowledge they had about each other to move forward. The manager asked the relative if it would be possible to share what had happened with the staff and the relative helpfully responded by suggesting that they should do this together.

New ways of initiating conversations

As their own ways of thinking altered, they found new ways into different kinds of conversations that stopped previous unhelpful patterns of behaviour, including their own:

"I used to think I had an open door policy – but when I asked staff if this was the case they had a different view – just having the door open and saying I had an open door policy did not mean I had one."

Other participants emphasised the enhanced dialogue with residents and relatives:

"In the past I did not always include residents and relatives in development. Evidence from residents and relatives is really powerful – because they are telling you about their experience".

In facilitating different conversations, the managers drew on some of the techniques they had learned on the programme. This included a range of simple, experiential approaches, for instance, using icebreakers and developing agreed ways of working during meetings. This created opportunities for others to contribute more and produced a stronger sense of belonging and inclusivity, a 'sense of justice in the room' and of greater value being given to the diversity of views:

"*...it set a very different tone for the meeting - people seemed able to contribute more and that continued well beyond the meeting"*

By talking in a more open and honest way together it led to '*opening up and creating genuine ownership of new ideas'* and *'taking forward ideas together'.*

Opening up and creating genuine ownership of new ideas

Managers reported having a strong sense of renewed purpose for themselves and their homes. A new shared purpose had grown in many of the homes as they engaged staff in thinking about change and in how to make the work they more meaningful for themselves and for residents and relatives:

> *"We are moving forward to a place where we are all singing from the same hymn sheet now and it's not just us as staff its relatives and residents"*

This sense of *shared* purpose helped to develop a culture of genuine 'ownership' of ideas and of trust, where managers could be confident that agreed innovations and practices continued even when they were not there:

> *"I don't call in when I am off duty anymore – the team get on with it and I don't come back in on a Monday to find things have slipped"*

There was also an element of 'letting go' of assumed managerial control and a greater sense of mutuality:

> "*I know I am confident to probe more and try to discover more. It's nice to feedback to staff what is working well because there are lots of things that are good that we didn't notice before".*

Managers reported a deeper understanding of how to develop a transformational culture that could support positive change.

Taking ideas forward in a collaborative and appreciative way

New insights led to substantive developments, enhanced individual and team morale and produced positive forward momentum, whereby a range of developments were taken forward by a range of people in the care setting. People showed evidence of being connected more to their work and each other. For example, in one home, staff noticed that food was being wasted. Rather than simply implement a change, the manager decided to use this as an opportunity to explore residents' ideas about food and the mealtime experience. This led to a trial of changing breakfasts and having lighter meals at lunchtime and a larger meal in the evening. The staff worked out new shift patterns for themselves to accommodate this new approach. As well as saving money on food, this new approach had several tangible outcomes for residents:

> *"Residents aren't asleep because they'd had a large lunch. So there's better quality time. Residents feel better going to bed at night having had a main meal at night. They're going to bed with a full stomach, so they feel better and are not waking up ravenous.....and nobody has lost weight."*

The principles of collaboration and appreciation were also evident in the way people gave and received feedback both within and outside the organisation. Feedback was more specific and therefore more useful:

> *"I try to make sure I notice what people are doing well however small and feedback in the moment rather than waiting to the end of the shift and saying generally well done. I think people really value this"*

There was evidence that feedback was thus much more integrated, often informal and based on everyday encounters and relationships:

"We are using GWAS (Greet, Walk, Ask and Share) which we developed together. When relatives visit the home, staff are encouraged to greet them warmly, then walk with them some of the way to the resident's room. While they are doing that, they take time to ask them how they are doing and then share a bit about how their loved one has been in the home. ……"

Security and belonging: trust and peer connections amongst managers.

Finally, across the whole programme, there was a strong sense that this new approach to leadership development and cultural change was qualitatively different from any previous change programmes. The sense of security and belonging created amongst each cohort seemed critical to helping them to feel more confident in their role, better connected to each other, and part of something that had a collective vision and purpose:

"*Meeting the other managers has made me realise that we all face similar problems and concerns, which has made me feel less isolated, but also more capable than previously*."

This strong peer support was one of the surprises of the programme for the participants; previously whilst they may have been known to each other, they did not necessarily talk much to each other beyond courtesies and certainly did not share information about their own successes, challenges or resources as they were seen to be 'in competition'.

Discussion

While the aim of the study was to generate understanding and share learning from the programme, rather than to compare cohorts, the similarity of the results reported across all cohorts was striking. For instance, a comparison of the POWCS questionnaire items associated with the greatest positive change between pre and post-programme responses

found that the same eight statements featured across all 11 cohorts. '*My understanding of how to improve the culture of care'* was the item associated with the most positive change for six cohorts and was amongst the 'top five' items associated with positive change for all 11 cohorts. Little change was reported across all cohorts for more systemic items, such as those relating to the managers' workload, working conditions, job security and the perceived adequacy of staffing levels.

The nature of the positive change patterns together with the finding that these patterns were very similar across all cohorts offers an extremely encouraging starting point for the evaluation. Our theory of change seeks to understand contribution. The results suggest that the MHL Leadership Support programme contributes to managers' self-regard and leadership capabilities, most notably those related to the development of a more relational way of thinking about leadership. This is also associated with positive developments in other localised aspects of nursing home culture despite the persistence of more systemic challenges.

Managers provided evidence that they felt they had learned more about themselves and that this in turn helped them to develop as leaders. This seems consistent with the ethos of 'being true to themselves' that underpins authentic leadership where the leaders' behaviour is grounded in positive psychological capacity and sound ethical standards (Wong et al 2010).

The focus in the programme on Caring Conversations (Dewar and Nolan 2013) seemed to help managers to develop an attitude of inquiry which provided managers with better coping mechanisms; it did not eradicate the stressful situations but enabled them to act with more confidence, including in their encounters with their own managers and with the external environment including regulators.

Confidence to engage with a positive attitude in moments of conflict is recognised as a complex relational skill that is difficult to achieve (Anderson et al 2003). The new insights managers had into their role showed this shifting mind set. The realisation of the importance of their own behaviours in influencing others and the scope for greater involvement and collaboration with residents, relatives and staff in deciding what should change within the home were strong common themes. These findings corroborate with the quantitative data where almost all of the participants felt that the quality of engagement with staff had increased.

In addition, the participants developed a greater understanding of the perspective of others which enabled them to share knowledge from a range of perspectives more deliberately and to support informal learning in the workplace. Informal learning in the workplace recognises the social significance of learning from other people (McNeill 2011). Informal learning is often invisible and few management development programmes make this aspect explicit (Eraut et al 1998). This programme, with its underpinning philosophy, supported a relational approach to informal learning in the workplace that fostered an active process of inquiry and co-constructing knowledge with those who give and receive care.

The evidence from this study illustrates how managers tested out and experimented with new conversations with relatives and residents aimed at sharing perspectives. The outcome of these small shifts in dialogue had impact beyond the immediate conversation and challenged traditional notions of who is the 'keeper' and 'provider' of information and learning. Burns (2007) highlights that complexity thinking shows that very small actions can have major effects by shifting the focus of attention and intention, triggering different choice paths. These might occur as a result of bringing into visibility options that did not appear available before; what he calls 'seeding small interventions into opportunity spaces' (Burns, 2007). By initiating a ripple effect where very small actions can have a major effect,

managers helped to create a 'milieu' in which all participants were meaningfully involved (Pryor, 2000).

Learning that giving and receiving feedback can be part of the day to day conversations in the homes provided a significant challenge to previous ideas about participation and change. Residents, relatives and staff were encouraged to think about their own participation in the life of the home and their role in supporting change. Managers had begun to think more explicitly about how they can *facilitate* conversations and meetings, rather than *manage* them. They recognised the importance of consistent modelling of positive attitudes and conversations that have been identified as significant in bringing about cultural change (Tyler and Parker 2011; Corazinni et al 2014).

The increasing age, frailty and levels of cognitive impairment amongst nursing home residents poses a number of challenges to their participation and involvement in dialogue as narrowly understood and this is an area where there is still much to learn. Nevertheless, the programme involved everyone in thinking about the participation of residents more broadly, and in more every day and embodied ways, rather than forcing their participation through narrow, contrived and consumerist mechanisms, that see the staff as providers and residents as consumers of care (Mordey and Crutchfield 2004).

Many of the specific tools introduced through the programme were invaluable in providing insight into the values of residents, and the ways of thinking and behaviours of staff and relatives. Staff had begun to realise that often the acknowledgement of people's feelings and being heard is as important as a creating a solution. This is consistent with the move away from quick fix solutions that focus on doing rather than being with the person (Wheatley 2007). Indeed the very act of inquiry in the development of managers as leaders

was consistent with the concept of inquiry as intervention advocated by Cooperider et al (2003). These authors of an appreciative inquiry approach to cultural change and development advocate that inquiry is intervention and that the co-production of knowledge constitutes culture change.

The support network of My Home Life emerged as a strong theme from participants. This support network enabled a high degree of sharing of experience and discussion of the issues managers face in a place of safety. Support networks have been enhanced by the use of appreciative inquiry where meaning is created through new connections and bringing existing relationships to life.

Conclusion

This article reports on the initial evaluation of the transformational My Home Life Leadership Support programme for nursing home managers being implemented in Scotland. The focus of the evaluation is on the 'inner circle' of influence (nursing home managers and their practice). While the programme does not necessarily claim that any identified changes would be directly attributable to the leadership support programme, determining changes in, for example, staff morale and ability to prioritise resident quality of life over tasks, and the extent to which these changes in turn have a positive influence on relative and resident experience and quality of life represent the next logical steps.

Our 'theory of change' offers a credible mechanism for the enactment of these positive changes, supported by the evidence gathered over the lifetime of the programme. In particular, the Caring Conversations framework and principles of participation and appreciation helped this group of managers to encourage and sustain genuine curiosity for themselves and others, deepen inquiry, explore values and acknowledge and express emotion

without dispute or judgement. It helped them to acknowledge achievements, encourage better listening and so make room for more contributions. It supported a different attitude to risk-taking and devising new approaches to problems and ultimately to feel more confident in translating the MHL evidence base (Table 1) into their local contexts in an authentic way that resonates with and gives voice to overlooked perspectives. It also provided a 'sense of learned hopefulness' in the face of complex and competing demands, which is consistent with other evidence from the literature (Dewar, 2011).

Supporting nursing home managers to develop leadership capability in the current context of health and social care is crucial if the vision of MHL to enhance the lives of those living, dying, working and visiting nursing homes, is to be achieved. The programme has strong theoretical foundations grounded in Evidence-based practice and Relationship-centred Care, delivered through Appreciative Inquiry and Caring Conversations. The findings presented in this paper help bring this conceptual model to life. They indicate that the programme has made an important contribution to significant markers of achievement and a very positive direction of travel.

The collection of systemic outcomes will be part of ongoing inquiry into the effectiveness of the programme and our understanding of how it 'works'. In particular, our inquiry will focus on co-creating data with staff, relatives and residents to complement and expand upon the managers' perspectives, consistent with the participatory and appreciative ethos of the programme.

The markers of achievement secured in the complex and often undervalued nursing home setting may therefore offer wider lessons for those interested in ways to tackle the emotional, educational and cultural dynamics of change in other human service contexts which value partnership working, relational practice and strengths or assets-based approaches

Acknowledgements

We would like to thank the nursing home managers and facilitators who contributed to this analysis.

Source of Funding

Each cohort was funded by the local Reshaping Care for Older People programme's Scottish Government 'Change Fund'.

[Words- 7228 including tables and excluding references]

References

Alimo-Metcalfe B., & Alban-Metcalfe, J. (2008). *Engaging Leadership: Creating organisations that maximise the potential of their people.* London: Chartered Institute of Personnel and Development.

Age UK, (2016). *Later Life in the United Kingdom.* London: Age UK (Downloadable at: http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true) [accessed 25/10/14].

Anderson, R. A., Issel, L.M. and McDaniel, R. (2003) Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. *Nursing research, 52,12-21*

Andre, B., Sjovold, E. Rannestad, T. and Ringdal, G (2014) The impact of work culture on quality of care in nursing homes – a review study. *Scandinavian Journal of Caring Sciences, 28, 449-457.*

Barnes, M. (2012). *Care in Everyday Life: An ethic of care in practice*. Bristol: The Policy Press.

Borkan, J. (1999). Immersion/crystallization. **In**: Crabtree, B.F. & Miller, W.L., (eds). (1999) *Doing qualitative research* (pp. 179-194) 2nd ed. Thousand Oaks, CA: Sage.

Bowman, C., Whistler, J. & Ellerby, M. (2004) A national census of care home residents. *Age and Ageing, 33, 6,* 561–6.

Brown Wilson, C. (2009). Developing community in care homes through relationship centred approach. *Health and Social Care in the Community, 17, 2,* 177–186.

Buchanon, D. (2007). Leadership transmission: muddled metaphor, or key concept?, *Journal of Health Organization and Management, 21,3,*246 – 258.

Burns, D. (2007). *Systemic Action Research*. London: Policy Press.

Bushe, G. R. & Kassam, A. F. (2005). When is appreciative inquiry transformational? A Meta Case Analysis. *The Journal of Applied Behavioural Science, 41,* 2 , 161-181.

Cavendish, C. (2013). *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings* [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf [accessed 24th February, 2015].

Collier, J. (1987). Visual anthropology's contributions to the field of anthropology, *Visual Anthropology, 1,1,*37–46.

Collier, J. (1967). *Visual Anthropology: Photography as a Research Method.* New York: Holt, Rinehart and Winston.

Cooperrider, D.L., Whitney, D., Stavros, J.M., (2003). *The Appreciative Inquiry Handbook*. Bedford Heights, OH: Lakeshore Communications.

Corazzini K; Twersky J; White H K; Buhr G T; McConnell E S; Weiner M; Colón-Emeric C S (2015) Implementing Culture Change in Nursing homes: An Adaptive Leadership Framework. The Gerontologist (2015) 55 (4): 616-627.

Cummings, G., MacGregor, T., Davey M.,, Lee, H., Wong, C., Lo, E., Muise, M., Stafford, E. (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review**.** *International Journal of Nursing Studies, 47, 3,* 363-385.

Dewar, B. & Cook, F. (2014). Developing compassion through a relationship centred leadership support programme. *Nurse Education Today.34,9*,1958-64.

Dewar, B. & Nolan, M. (2013). Caring about caring: Developing a model to implement compassionate relationship centred care in an older people care setting. *International Journal of Nursing Studies, 50,9*,1247-1258. DOI: 10:1016\j.ijnurstu2013.01.008.

Dewar, B. & Sharp, C.(2013). Appreciative dialogue for co-facilitation in action research and practice development. *International Practice Development Journal, 3*,2, 1-10.

Dewar, B. (2012). Using creative methods in practice development to understand and develop compassionate care. *International Practice Development Journal, 2, 1*,1-9.

Dewar, B. (2011). *Caring about Caring; an Appreciative Inquiry about Compassionate Relationship Centred Care*. *PhD thesis*. Edinburgh Napier University.

Dewar, B. & Mackay, R. (2010). Appreciating compassionate care in acute care setting caring for older people *International Journal of Older People Nursing,* 5, 299-308.

Eraut, M., Alderton, J., Cole, G. & Senker, P. (1998) Learning from other people at work, in: F.CofÆeld (Ed.) Learning at work (Bristol, Policy Press), 37±48.

Froggatt, K., Davies, D. and Meyer, J. (2009). Research and Development in nursing homes: setting the scene. In: Froggatt K, Davies S, Meyer J, eds. *Understanding Nursing homes: a research and development perspective.* London: Jessica Kingsley Press.

George, W. (2014). *Authentic Leadership: Rediscovering the Secrets to Creating Lasting Value*. San Francisco: Jossey-Bass.

Hardacre, J., Cragg, R., Shapiro, J., Spurgeon, P., Flanagan. (2011). What's leadership got to do with it?: exploring links between quality improvement and leadership in the NHS. Health

Foundation, London. *Web publication* http://www.health.org.uk/public/cms/75/76/313/2119/What's%20leadership%20got%20to%20do%20with%20it.pdf?realName=JTGpo2.pdf. [accessed 20/01/16].

Harper, D. (1993). *On the authority of the image: visual sociology at the crossroads*, in Norman K. Denzin & Yvonna Lincoln, eds, Handbook of Qualitative Research. (pp.403-412) Newbury Park, CA: Sage Publications.

Hurtley, R. (2004).The developing culture in its political context. In Perrin T (ed.) *The New Culture of Therapeutic Activity with Older People*. Oxon: Speechmark Publishing Ltd.

ISD Scotland. (2014). *Care home Census 2014: Statistics on Adult Residents in Care homes in Scotland*. National Statistics for Scotland.

Jeon, Y., Simpson, J., Li, Z., Cunich, M., Thomas, T., Chenoweth, L., Kendig, H. (2015). Cluster Randomized Controlled Trial of An Aged Care Specific Leadership and Management Program to Improve Work Environment, Staff Turnover, and Care Quality. *Journal of the American Medical Directors Association (JAMDA), 16, 7*, 629.e19-629.e28.

Jeon, Y., Govett, J., Low, L., Chenoweth, L., McNeill, G., Hoolahan, A., Brodaty, H., O'Connor, D. (2013). Care planning practices for behavioural and psychological symptoms of dementia in residential aged care: A pilot of an education toolkit informed by the Aged Care Funding Instrument. *Contemporary Nurse, 44,2,* 156-169.

Jeon, Y-H., Merlyn, T., Chenoweth, L., (2010). Leadership and management in the aged care sector: A narrative synthesis. *Australasian Journal on Ageing, 29,2,* 54–60.

Kennedy, J. (2014). *John Kennedy's Nursing home Inquiry*, York: Joseph Rowntree Foundation.

Laing Buisson (2010). *Care of Elderly People*. London: UK Market Survey.

Lincoln, YS. & Guba, EG. (1985). Naturalistic Inquiry. Newbury Park, CA: Sage Publications.

MacPhee, M., Chang, L., Lee, D., Spiri, W. (2013). Global health care leadership development: trends to consider *Journal of Healthcare Leadership, 5*, 21 – 29.

Mayne, J. (2008) *Contribution Analysis: an Approach to Exploring Cause and Effect*. ILAC Brief No. 16, http://www.cgiar-ilac.org

Mayne, J. (2010) Contribution Analysis: Addressing Cause and Effect. In: R. Schwartz, K. Forss, and M. Marra (Eds.), *Evaluating the complex*. New Brunswick: Transaction Publishers.

McGill, I. & Brockbank, A. (2004). *The action learning handbook*. London: Routledge Falmer.

McNeill C (2011) The supervisor as a facilitator of informal learning in work teams, *Journal of Workplace Learning 13, 246-253*

Montague, S. (2002). Circles of influence: An approach to structured, succinct strategy http://pmn.net/library/Circles_of_Influence_An_Approach.htm

Mordey, M. & Crutchfield, J. (2004). User involvement in supported housing. *Housing, Care and Support,* 7 , 7-10

NCHR&D Forum (2007). *My Home Life: Quality of life in care homes – Literature review,* London: Help the Aged (available at: www.myhomelife.org.uk).

Newman, J, Hughes, M. (2007). *Modernising Adult Social Care: What's Working?* London: Department of Health.

Nolan, M., Davies, S., Brown, J., Wilkinson, A., Warnes, T., McKee, K. , Flannery, J., Stasi, K. (2008). The role of education and training in achieving change in care homes: a literature review. *Journal of Research in Nursing 13,* 411-433.

Nolan, M, Grant, G, Brown, J., Nolan, J. (1998). Assessing *nurses*' work environment: old dilemmas, new solutions. *Clinical Effectiveness in Nursing, 2,* 145-156.

Nolan, M., Brown, J., Davies, S., Nolan, J. and J. Keady. (2006). *The Senses Framework: Improving care for older people through a relationship-centred approach.* University of Sheffield. ISBN 1-902411-44-7.

Nolan, M., Brown, J., Davies, S., Nolan, J. and Keady, J. (2006). *The Senses Framework: Improving care for older people through a relationship-centred approach.* University of Sheffield.

Owen, T. and Meyer, J. (2013) *My Home Life: Promoting quality of life in care homes.* York: Joseph Rowntree Foundation (available at: www.jrf.org.uk).

Pawson, R. and N. Tilley (1997) *Realistic Evaluation*. London: SAGE.

Pryor, J., (2000). Creating a rehabilitative Millieu, *Rehabilitation Nursing*, *25*,141-144.

Raelin, J. A. (2003). *Creating leaderful organizations: How to bring out leadership in everyone.* San Francisco: Berrett-Kohle.

Regine, B. & Lewin, R., (2000). Leading at the edge: how leaders influence complex systems. *Emergence: A Journal of Complexity Issues in Organizations and Management 2, 2,* 5–23.

Richer, M. C Ritchie, J. & Marchionni, C. (2010). Appreciative inquiry in health care. *British Journal of Healthcare Management, 16, 4,* 164-172.

Ross, MM, Carswell, A, Dalziel, WB, Aminzadeh, F (2001) Continuing education for staff in long-term care facilities: corporate philosophies and approaches. J Continuing Education in Nursing, 32: 68–76.

Ruckdeschel, K, & Van Haitsma, K. (2004). A workshop for care home staff: recognizing and responding to their own and residents' emotions. *Gerontology and Geriatrics Education,24,* 39–51.

Royal College of Nursing. (2012). *Persistent challenges to providing quality care: an RCN report on the views and experiences of frontline nurses working in care homes in England*. London: Royal College of Nursing.

Scalzi, C.C., Evans, L.K. Barstow, A. and Hostvedt, K. (2006) Barriers and enablers to changing organisational culture in nursing homes . *Nursing Administration Quarterly*, 30,4,368-372.

Tolson, D., Dewar , B and Jackson, G. (2014). Quality of Life and Care in the care home, *Journal of the American Directors Association,15,3,* 154-7.

Tolson, D., Rolland, Y., Andrieu, S, Aquino, J-P, Beard, J., Benetos, A., Berrut, G., (2011). The IAGG WHO/SFGG (World Health Organization/Society Française de Gérontologie et de Gériatrie), International Association of Gerontology and Geriatrics: a global agenda for clinical research and quality of care in care homes. *Journal of the American Medical Directors Association*, *12*,*3*, 185-189.

Tresolini, C.P., & Pew-Fetzer, Task Force. (1994). *Health Professions Education and Relationship-Centered Care: Report of the Pew-Fetzer Task Force on Advancing Psychosocial Education*. San Francisco: Pew Health Professions Commission.

Tyler D. A. and Parker, V., A., (2011) Nursing home culture, teamwork and cultural change. *Journal of Research in Nursing*, 16, 1, 37-49

Wheatley, M.J. (2007) *Finding Our Way: Leadership for Uncertain Times*. San Francisco: Berrett-Koehler.

Whitney, D., Williams A, May N, Becker D, Frankel R, Harmon R, Schorling J, Haizlip J, Plews-Ogan, P. (2011). *Appreciative Inquiry in Healthcare: Positive Questions to Bring Out the Best*, Brunswick USA: Crown Custom Publishing, Inc.

Wong, C. A, Laschinger, H. K., S. & Cummings, G. G. (2010). Authentic leadership and nurses' voice behaviour and perceptions of care quality. *Journal of Nursing Management*, *18 8*, 889–900.

Table 1: The My Home Life best practice themes for enhancing quality in nursing homes for older people

Personalisation themes *(linked to quality of life)*	***Navigation themes*** *(linked to quality of care)*
1. Maintaining Identity	4. Managing transitions
2. Sharing decision-making	5. Improving health and healthcare
3. Creating community	6. Supporting good end-of-life
Transformation themes *(linked to quality of management*	
7. Promoting positive culture	
8. Keeping workforce fit for purpose	

Table 2

Key components of the Intervention
• Acknowledging and appreciating the unique context of care homes and the importance of their work as nursing home managers • Reflecting on their own quality of life as managers, as well as the quality of life of all other stakeholders • Introducing the evidence base for the My Home Life vision • Exploring the meaning of *relationship-centred practice* and the associated *Senses Framework* • Developing positive relationships in the workplace • Developing self-awareness as the key to successful practice development • Facilitating reflective practice in self and others • Engaging in *Caring Conversations* • Exploring emotions • Sharing perspectives and learning to be more open to challenge • Exploring different leadership styles and the importance of relationships in transformational leadership • Developing the workplace culture through positive engagement with others • Discussing some the challenges that can block quality in care homes • Using *Appreciative Inquiry* to influence quality improvement • Developing practice through *Action Learning*

Table 3

Participant Demographics

Nursing home Sector [a]		
Private	Local Authority	Not For Profit
91	15	13
Professional Background [a]		
Nursing	Social Work	Unspecified
93	17	9
Gender [a]		
Female	Male	
101	18	
Years in Post		
Minimum	Maximum	Mean
<1	25	6

[a] N=119

Table 4

AWES (Assessment of Work Environment) Baseline and Post Intervention Comparison

Prompt Question: Thinking about the place in which I work, I feel that:

Questionnaire Item	Baseline % Agree	Post % Agree
I actively listen to the opinions of my staff	80.0%	100.0%
My staff are congratulated when they do things well	83.3%	97.8%
Staff can try new ideas without criticism	56.7%	97.8%
The environment of care for residents is good	73.3%	97.8%
The overall quality of care provided is high	93.3%	95.5%
Staff play an active role in decision-making about resident care	60.0%	95.5%
I feel that I have the management and leadership skills required to undertake an effective role	80.0%	95.5%
I actively provide space and time to listen to the views of staff	63.3%	95.5%
Staff are actively encouraged to develop their skills	83.3%	94.4%
The quality of life of my residents is positive	76.7%	91.0%
I have a positive quality of life	70.0%	91.0%
There is a good spirit of cooperation between managers and staff	63.3%	91.0%
I feel that I have developed effective influencing skills	56.7%	91.0%
I am very satisfied with the level of care home practice that staff offer to residents	53.3%	89.9%
I currently get a positive sense of personal achievement from my work	70.0%	88.8%
There is a good spirit of cooperation between staff	56.7%	88.8%

Table 4

AWES (Assessment of Work Environment) Baseline and Post Intervention Comparison

Prompt Question: Thinking about the place in which I work, I feel that:

Questionnaire Item	Baseline % Agree	Post % Agree
I feel that the care home feels like a positive community where residents, staff and relatives enjoy spending time with one another	60.0%	86.5%
I am given respect by my superiors	63.3%	85.4%
I have a positive relationship with my line manager/ owner	66.7%	82.0%
Staff are provided with sufficient time to provide the type of care they need	46.7%	74.2%
There is a positive feeling of morale among my staff	43.3%	73.0%
I feel valued for the work I do	46.7%	71.9%
Staffing levels are adequate for the workload	66.7%	69.7%
I am content with the quality of interaction that staff have with residents	40.0%	69.7%
The amount of time I have to talk to relatives and residents is acceptable	36.7%	69.7%
I am congratulated when I do things well	50.0%	68.5%
I am content with the quality of interaction that staff have with relatives	50.0%	68.2%
I am able to make sufficient time to support staff to deliver care to residents	40.0%	64.0%
I feel that staff prioritise the residents quality of life before the tasks of the day	13.3%	62.9%

Table 4

AWES (Assessment of Work Environment) Baseline and Post Intervention Comparison

Prompt Question: Thinking about the place in which I work, I feel that:

Questionnaire Item	Baseline % Agree	Post % Agree
The amount of work I am given to do is realistic	33.3%	48.3%
Staff sickness levels are an on-going problem	43.3%	38.9%
I typically experience high levels of stress	60.0%	36.0%
My responsibilities as care home manager are too great	38.7%	31.5%
Staff retention levels are an on-going problem	20.0%	12.4%
My understanding of how to change the culture of care is limited	20.0%	9.0%
I lack confidence in my role as a care home manager	12.9%	9.0%

Table 5

POWCS (Perception of Workplace Change Schedule) Baseline and Post Intervention Comparison of Responses indicating a Perceived Increase

Prompt Question: Thinking about the place in which I work, I feel that:

Questionnaire Item	Baseline % Increase	Post % Increase
The sense of personal achievement I get from work has	37.5	84.9
My own quality of life has	32.1	65.6
The quality of management and leadership I am able to offer has	42.9	91.4
My management and leadership skills have	46.4	95.7
My confidence as a professional has	42.9	90.3
My satisfaction with my relationship with my line manager has	32.1	64.1
My enthusiasm for working in nursing homes has	28.6	63.0
My understanding of how to improve the culture of care has	51.8	95.7
My feeling of being valued has	35.7	65.6