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Published in:
Nordisk Velfärdsforskning

DOI:
[10.18261/nwr.8.1.4](https://doi.org/10.18261/nwr.8.1.4)

Publication date:
2023

Document Version
Publisher's PDF, also known as Version of record

Citation for published version (APA):
Liveng, A., Aamann, I. C., & Dybbroe, B. (2023). In-service training for dementia care staff: Knowledge lost in transfer between opposing logics . *Nordisk Velfärdsforskning*, 8(1), 34-51. <https://doi.org/10.18261/nwr.8.1.4>

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In-service training for dementia care staff: Knowledge lost in transfer between opposing logics

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Abstract

One health policy goal in Denmark is the improvement of the quality of dementia care. One Danish region launched a training programme for frontline staff based on a learning transfer principle. The article investigates potentials and barriers for transfer of learning in dementia care using a school-based learning programme, and examines the role of logics in care work for opportunities for knowledge transfer. The article draws on transfer theory and logics theory in health and care work. The methods used are interviews and observations. A hermeneutic analysis shows that the course participants experienced a gap between new ideals and knowledge, and opportunities to apply these in practice. The training programme was met with enthusiasm among the staff, but they became frustrated when they could not see any possibility to use the knowledge they had acquired. Lack of time was pointed out as a crucial barrier to working in a person-centred manner. The article concludes that quality improvement in dementia care is dependent on competence building, but that predominant efficiency logics in the workplace prevent the transfer of the care logics that were fundamental elements in the teaching.

Keywords

learning, transfer logics, care workers, dementia, care efficiency

Introduction

The number of people living with dementia in the European Union is estimated to be above seven million. By 2025 the number of people with dementia in Europe will almost double to 14 million (Alzheimer Europe Yearbook, 2019). As the illness progresses, the need for long-term professional care intensifies.

Approximately 3.3% of the Danish elderly population has been diagnosed with dementia according to national health registers. The Danish Dementia Research centre estimates that around 87,000 persons are living with dementia, meaning that a considerable number of dementia cases have not been diagnosed (Danish Dementia Research Centre, 2021). According to a new Norwegian sample survey, the number of people with dementia in Norway is around 100,000, whereas the number in Sweden is between 130,000 and 150,000 citizens (Gjøra et al. 2020; Svenskt Demenscentrum, 2020). In all the Nordic countries the percentage of the population suffering from dementia is expected to increase due to demographic changes and longer life expectancy (Danish National Board of Health, 2018).

The necessity to improve the quality of care for people with dementia has been internationally recognised (World Health Organization, 2017). Dementia is included in WHO's Mental Health Gap Action Programme, and successive training resources for care providers have been developed (World Health Organisation, 2018). National dementia plans and policies frequently include improved training of health professionals and care providers in dementia care. In Denmark, The National Dementia Action Plan 2025 was launched with the aim of supporting the long-term development of the dementia field (Danish Ministry of Health, 2017). Important objectives of the policy were to detect dementia earlier than before and to give people suffering from dementia a priority in the Danish Elderly Care institutions.

Following on from the Dementia Action Plan, a Danish region, a university college and a school of health and social care developed an in-service training programme for frontline staff in dementia care. Since the Action Plan calls for a focus on how knowledge and skills development can be applied to everyday care practice (Danish Ministry of Health, 2017), the authors of this article were recruited to conduct trailing research on the Interdisciplinary Dementia School programme (Aamann, Dybbroe & Liveng, 2020). As previous studies have shown challenges in the transfer of knowledge from in-service training to practice, more research in this field is needed.

Background

The responsibility for elderly care lies with Denmark's 98 local authorities, which run nursing homes and home care. The Danish National Knowledge Centre for Dementia estimates that between 64 and 80 percent of nursing home residents suffer from dementia, apart from other illnesses (Danish Dementia Research Centre, 2022). In protected units targeted at people with dementia, staffing standards are determined according to the extra care tasks that the disease entails. However, regular care centres' staffing standards are only to a minor degree adjusted according to the estimated number of residents with dementia. A survey carried out by The Danish Centre for Social Science Research (Hjelmar & Jensen, 2019) illustrates a great variation in staff standards in care centres primarily depending on the political and economic priorities of the given municipality and not on the number of residents suffering from dementia. The capacity in care homes has not grown in Denmark in correspondence with the growing number of older people with care needs. The capacity is relatively larger in Norway, while being much reduced in Sweden (Gunnarsson et al., 2021).

In 2014, key organisations relevant to elderly care (The Dane Age Association, the trade union For Public Employees FOA, the pension fund PenSam, The Danish Alzheimer's Association and The Danish Nurses Organisation) formed the Dementia Alliance. One of its focus areas was to improve the skills of care workers (Dementia Alliance, 2016, 2017). However, this was not a novel idea as negligent care had previously been partly attributed to a lack of staff competence (Danish Alzheimer's Association, 2013).

In the same period, the Danish universal welfare state model has increasingly been challenged by a neoliberal model of governance (Dybbroe, 2020; Stahl 2018; Kamp & Hvid, 2012). This model has imposed increased documentation requirements on care workers, leaving less time for social care (Hjelmar & Rostgaard, 2020; Rostgaard & Matthiessen, 2016). A scarcity discourse (Bruun et al., 2016) legitimises extensive cost-cutting, and funding for elderly care has been reduced following the local government reform of 2007.

Additionally, the Danish elder care sector – as its Swedish and Norwegian counterparts – has difficulty in recruiting sufficient staff. In many places, staff shortages are coupled with the regular use of untrained temporary staff, which puts pressure on trained staff (Sørensen & Kjeldsen, 2018).

Research in the field of dementia is generally clinically dominated by a focus on medicine. At the same time, dementia is an under-prioritised field because the care of sick and debilitated elderly people is ranked low; this is reflected in the fact that the work is primarily handled by Social and Health assistants and helpers, who are the least educated and thus lowest placed in the health professional hierarchy. Therefore, more knowledge is generally needed about the non-clinical aspects of caring for citizens with dementia (Macdonald, 2018).

Evaluations of competence development often take place after participants have completed the course (for instance Garrod et al., 2019). In these summative evaluations, participants assess their benefit through oral feedback or online surveys distributed by the educational institutions. Evaluations often centre on whether the participants have learned the curriculum listed in the course description. A competency framework and training curriculum for staff working in specialist services for people with dementia has been developed (Smythe et al., 2014). However, there is a need for research in dynamics between staff, teachers, and curriculum at courses and in the potential of courses to actual changes of work practice.

The article aims at investigating the significance of integrating the context of care work for establishing potentials for transfer of learning aiming at increased quality in dementia care through competence development, as well as discussing the role of logics in care work in enabling or restricting knowledge transfer from teaching to practice. The article is based on trailing research of the Interdisciplinary Dementia School that explored learning in teaching and later revisited students to explore what they have taken into practice.

Previous studies have shown challenges in the transfer of knowledge from in-service training to practice. A comprehensive study was conducted in the UK. Based on forum theatre as part of upskill training of frontline staff in dementia care, Argyle and Schneider (2016) analysed questionnaires from 863 participants. The participants felt that they had gained new insights but raised doubts about utilisation: “Discrepancy between knowledge transfer and utilisation appeared to be partly the result of the influence of contextual factors in impeding this utilisation within work settings” (p. 102). Argyle and Schneider argue that there is a gap between competence-building measures and practice in dementia care. The authors emphasise that the work context is key to understanding the learning needs of staff.

In-service training courses are often used as a means of enhancing the quality of nursing and care. A Norwegian study of the staffing crisis in elderly care (Rasmussen & Kjevik-Wycherley, 2019) focuses on how competence development is used to help raise the status of nursing. The study indicates that staff find courses instructive but that it is difficult to integrate new knowledge into everyday routines. A ward manager explains: “Take the dementia course for example, we met up locally several times during the year, well-attended sessions with people from other places. There was good advice on how to protect someone

and so on, what to do in different situations. It sounded great, but we haven't got the staff for it... We're just rushing around all day" (Rasmussen & Kjevik-Wyherley, 2019, p. 319).

Over the last ten years, Kassah and Tønnesen (2016), Vabø & Szebehely (2013), Vabø (2012) and Rostgaard (2011) have analysed how the organisation of care in Norway, Sweden and Denmark have developed in a marketised direction. They describe how the purchaser-provider model gives home care nurses little scope for influencing the type and extent of the care provided. The most recent quantitative as well as qualitative knowledge contribution on transformations in Nordic Elderly Care, *Den Nordiska Äldreomsorgen* (2021), shows how the high level of liberalisation alongside a dehospitalisation in healthcare create requirements for high competencies, but difficulties in opportunities for acquiring these inside the sector itself, and rising difficulties in recruiting highly qualified nursing staff (Myndigheten för Vård och Omsorgsanalys, 2021).

Research thus points at demands on development of competencies in elderly care, but difficulties in finding learning spaces. The overarching Nordic analyses reveal similar trends in the three countries of organisational neglect of the relation between knowledge stimulating working contexts, workloads, and contents of work – and the possibilities and the invitation to use skills and try out new knowledge.

Previous research suggests that context, time, and influence have implications for transfer. Therefore, there is a need for additional knowledge about whether and, if so, how these aspects are handled in the teaching and what the implications are in relation to increased quality in dementia care. Not trying to understand the potential dynamics means that important resources both in the form of staff time and staff engagement and in the form of educational interventions risk being wasted. Ultimately, this does not lead to improved quality of dementia care.

Aim

The aims of this article are:

1. To investigate the significance of integrating the context of care work for establishing potentials for transfer of learning aiming at increased quality in dementia care through competence development.
2. To discuss the role of logics in care work in enabling or restricting knowledge transfer from teaching to practice.

Methodology

“The Interdisciplinary Dementia School”

A Danish region, a university college and a school of health and social care developed an in-service training programme for frontline staff in dementia care (Aamann, Dybbroe & Liveng, 2020).

The programme aimed to 1) improve the theoretical and practical knowledge and skills of frontline staff working in dementia care, and to further interdisciplinary and cross-sectoral collaboration to the benefit of people with dementia and their relatives.

The programme provided formal qualifications. Healthcare staff gained knowledge and skills in dementia detection, follow-up care, complications, and admissions to hospital. The understanding of dementia stemmed from Tom Kitwood's theory, and a key concept in the

courses was person-centredness¹ (Kitwood, 1997). According to Kitwood, the person-centred approach means to see the person with dementia as an equal person with feelings, rights, desires, and a life story that affected him/her even before he/she got dementia. The theorisations of Tom Kitwood (Kitwood and Bredin, 1992) represent a change from medical and behavioural conceptualisations of dementia and dementia care to a focus on relatedness and communication as central for stimulating well-being. A Danish book on the dehumanisation of care workers (Birkmose, 2013) was part of the curriculum and used in order to relate theory to the challenges of care work. Courses were held at three levels: “AMU” (short vocational courses), “academy”, and “diploma” (equivalent to a bachelor’s degree). Participants were invited to a common opening conference, midpoint seminars, and a closing conference.

A total of 163 social and health care helpers, social and health assistants and nurses completed the courses and were awarded a certificate. The empirical material used for this article consists of classroom observations of approximately 150 different participants and qualitative interviews with 11 students representing the three educational levels (Tanggaard & Brinkmann, 2015).

The aim of the trailing research was to explore why and how the participants learned on courses and seminars, and to reveal factors that could promote or prevent transfer from the classroom to practice. Authors 1 and 2 participated in organisational meetings, discussions of course planning and teacher meetings, besides doing ethnographic fieldwork at the courses. This dialogical approach (Fetterman, 2018) we believed would contribute to strengthen the information power of the research (Malterud et al., 2016) through discussions of preliminary findings.

To gain insight into students’ subjective experiences and assessments or dynamics taking place in classrooms, the empirical data were elicited through qualitative, reflexive ethnographic inspired research methods (Davies, 1999; Alvesson & Skjöldberg, 2009) in the form of observations in classrooms and on seminars and through individual and focus group interviews (See table 1). The observations concentrated on interactions between students and teachers, and in-between students with the curriculum as pivotal point. Authors 1 and 2 were present in the classrooms, joined group work, and talked with students during breaks. We met at the lectures at the same time as students and stayed for the full course day. Notes were taken during lectures, and later the same day extensive fieldnotes were written.

At a midpoint seminar, author 1 gave an open invitation to the students present to join a focus group interview immediately after the seminar ended. Seven students accepted, representing the three educational levels. The interview began with a brief presentation of the participants, name, workplace, and course level. There after the following questions were asked: 1) How were you enrolled in the course? Where did you hear about it/who took the initiative? 2) What expectations did you have for the course? (New knowledge, more collaboration across professional groups?) 3) What is your experience of the professional benefit so far? 4) What is your experience of the organisation of the course? 5) Can you tell about your benefit from the start-up seminar and the mid-term seminar that we just attended? 6) Do you have the impression that the knowledge you gain on the course is implemented in your workplace? Is it included in the procedures? How? 7) How do you perceive the intention that you should collaborate across educational levels on the course? 8) Other comments?

1. We refrain from entering into a discussion of the concept, and merely state that person-centeredness was referred to as the ideal for dementia care.

Seven months after the courses had ended, author 2 visited some of the students at their workplace and did observations of work practice and follow-up interviews. The intention with this final part of the fieldwork was to get insight in the students' actual use of the acquired competencies and in how they valued the potentials of the courses regarding an improved dementia care. Thereby we intended to improve information power too.

Focus group and individual follow-up interviews were fully transcribed by an experienced student assistant.

Table 1. Empirical data used

Activity	Number of transcribed pages	Date, observer, interviewer	Ref. number in text
Observations, AMU: 20 students, aged approx. 25–55. Educated social and health care helpers. Employed at nursing homes or in home-based care.	7	22.05.18 AL	1
Observations, AMU: 20 students, aged approx. 25–55. Educated social and health care helpers. Employed at nursing homes or in home-based care.	6	24.05.18 AL	2
Observations, academy: 18 students, aged approx. 28–55. Educated social and health assistant or nurse. One employed at somatic hospital, the others at nursing homes or home-based care.	8	12.06.18 AL	3
Observations, diploma: 18 students, aged approx. 28–50. Educated social and health assistant or nurse. Employed at nursing homes, in home-based care, one at an assistive technology centre.	7	27.08.18 AL	4
Observations, diploma: 18 students, aged approx. 28–50. Educated social and health assistant or nurse. Employed at nursing homes, in home-based care, one at an assistive technology centre.	6	03.09.18 AL	5
Observations, midpoint seminar 1: 35–40 students, aged 25–55. Educated as social and health care helper, social and health assistant, or nurse. Employed at nursing homes, in home-based care or in somatic hospitals.	14	30.05.18 AL	6
Observations midpoint seminar 2: 55–60 students, aged 25–55. Educated as social and health care helper, social and health assistant, or nurse. Employed at nursing homes, in home-based care, in somatic hospitals or in an assistive technology centre.	7	03.10.18 AL	7
Closing conference: approx. 150 students.	18	27.03.19 ICA	8
Focus group with 7 participants: 2 on AMU level, 2 on academy level, and 3 on diploma level. 28–50 years. Educated as social and health care helper, social and health assistant or nurse. Employed at nursing homes or in home-based care.	20	03.10.18 AL	9
Interview and observation: Home care nurse	20	01.10.19 ICA	10
Interview: Dementia coordinator in primary care	15	08.10.19 ICA	11
Interview: Regional mental health care worker, Social and health assistant	15	24.10.19 ICA	12
Interview: Primary care worker	14	01.11.19 ICA	13
Observation: Meeting of managers of elderly care at primary level	5	28.09.18 AL	14
Empirical material in total	160		

The analysis was inspired by the phases in thematic analysis suggested by Braun & Clarke (2006). The three authors of this article participated in all phases. First, all authors read the complete empirical material and established an initial thematisation of each interview and observation. Then, themes were collected and compared across the material and patterns were identified. (For an example of how themes were generated, see figure 1). In phase four, the focus was on data within the themes having a meaningful context and on creating a clear and identifiable distinction between the themes. Here we became aware of the pronounced contradictions in the material, which we decided could not be homogenised. We therefore ended up with two themes, which constitutes the overall theme, and which could not be understood solely by applying theory of transfer of learning. The final analysis therefore describes an abductive hermeneutic process (Alvesson & Skjöldberg, 2009).

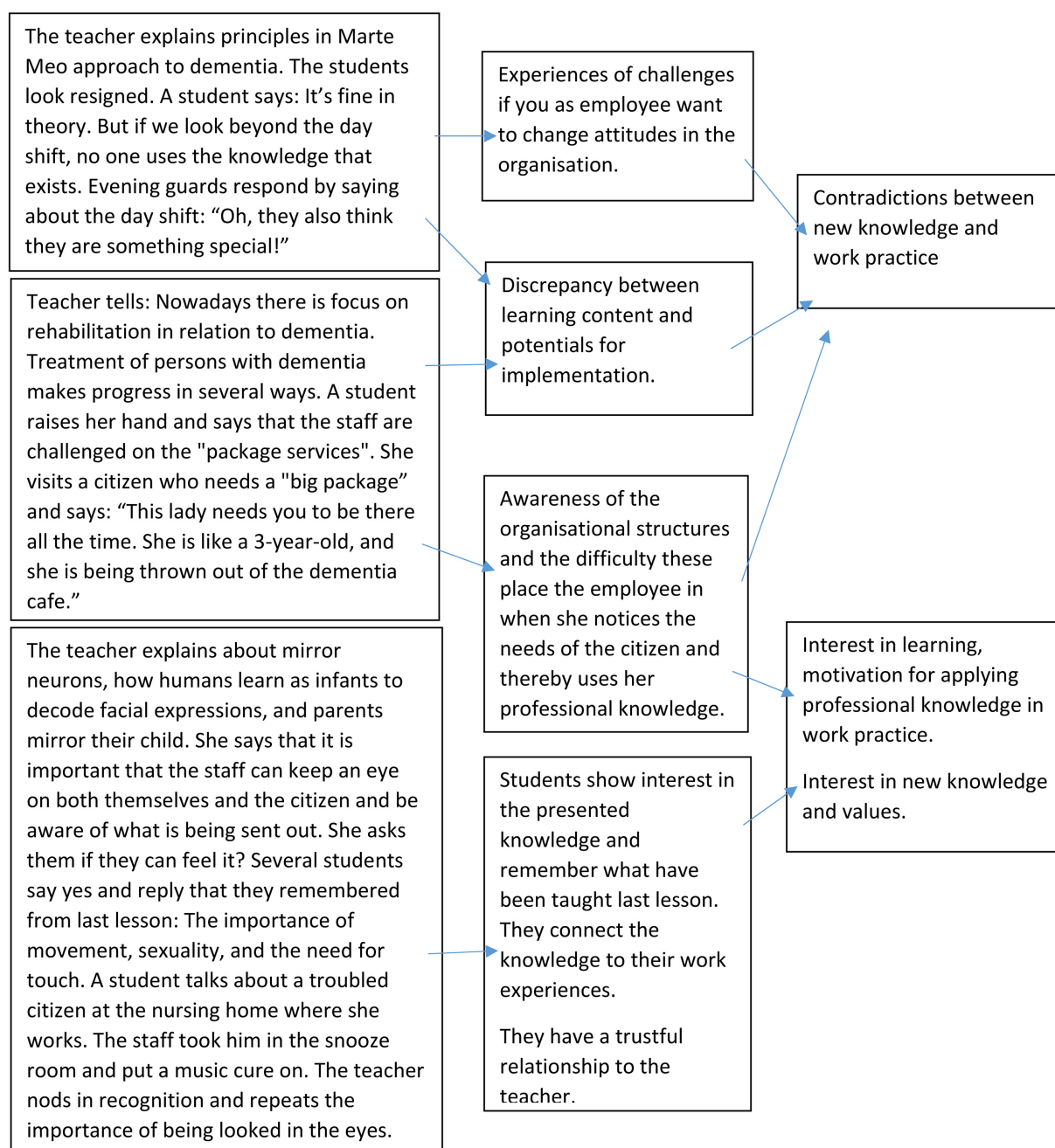


Figure 1. Example of generating of themes: Excerpts from observation 12.06.18.

The teaching methodology of the Interdisciplinary Dementia School was based on a transfer principle, i.e. an understanding that knowledge can be transferred via the participant in the classroom to the work context. In order to be true to this approach and thereby understand what happened at the course and after, within the course's own theoretical framework, we initially chose to analyse the empirical material from the perspective of theory of learning transfer. This theoretical analysis revealed a pattern of contradictions between the knowledge communicated on the courses and the practical working conditions as perceived by the participants. These contradictions led to the inclusion of the theoretical concept of logics in health and care work.

Therefore, we at first analyse the empirical material from the course's own premises, then we apply theories of logics in care work as a lens, throwing light on the generated themes from a perspective 'outside' the self-understanding of the course.

Transfer theory

The theory of transfer of learning between school and practice describes three overarching factors which function as potentials or barriers for transfer respectively (Wahlgren & Aarkrog, 2013). According to Wahlgren and Aarkrog (p. 18), transfer means "using what one knows, can do or has experienced in one situation in another situation". The authors describe 1) person-related transfer factors, 2) teaching-related transfer factors and 3) factors related to the situation where the knowledge is applied (p. 117).

Person-related factors include motivation (including the desire to improve one's actions), the ability to set goals (transform one's needs into realistic goals), confidence in one's own abilities (to apply the new knowledge despite any resistance at the workplace) and metacognition (reflecting on how to apply the new knowledge) (Wahlgren, 2010).

Teacher-related transfer factors refer to how the teacher organises the learning situation. The learner must have the opportunity to master the subject matter, e.g., through work that includes examples from practice and by studying possible applications. There must be exercises and training, and the learning should preferably be translated into an action plan for implementation in practice (Wahlgren & Aarkrog, 2013).

Wahlgren and Aarkrog emphasise the importance of factors related to the context of where the knowledge is applied (p. 132), i.e. the situation-related transfer factors. Wahlgren (2010) lists a number of factors here, most of which concern the systematic reception and inclusion of the employee's new knowledge and skills in the workplace. This involves comprehensive integration of the new competencies, which calls for involvement at management level and requires openness to change and the willingness of the employer to use the necessary resources.

Rationality of Care and Logics of Care

Care researchers in analysing care provision and care work have since the seminal work of Kari Martinsen and Kari Wærness (Martinsen, 2005; Tronto, 1993; Wærness, 1989) investigated care as a rationality in both nursing practices and other human work practices. A care rationality is seen as a specific rationality in which taking care of the needs of another human being is given highest priority – in a work context, for instance, priority over one's meeting time and written job descriptions. To Wærness, values such as empathy, dialogue and awareness of individual needs are core values of care. She argues that standardisation and reduced possibilities for care workers to adjust care to individual needs threaten this core value (Wærness, 2005). The process of care and caring is understood as situational; the potentials for caring are linked to care workers' knowledge and education, but as well to the

possibilities for care, that is offered by the specific contexts in which care is to take place. That is to say, organisation of work, standardisation and restricted time will influence the potentials for caring. Care is seen as based on mutual responsibility for existential conditions and recognition of other people's vulnerability. Along this line, in their research elderly care researchers such as Julia Twigg have focused on the basic conditions for health and care work, stressing among other conditions the need for time for care to take place (Twigg et al. 2021). More recently, in reflecting the changes in the way care services are managed and the values by which they are managed, several care researchers have adapted the notion of logics of care, implying that several logics may be present, i.e. the logic of care and the logic of choice (Mol, 2008). Using the concept of logics, Mol (2008) explores the complex practices of adjusting, experimenting, and tinkering in order to accomplish "good care". Where Mol's ambition is to distil several logics, Dahl (2017) uses the concept of logics to identify the dominant ways of thinking, the aims, and values in elderly care. "Logics are forms of thinking and governing (...) Logics, however, can also be more specific and concern the aim of care, or as I would say, the ideal of care" (Dahl, 2017, p. 45).

For Dahl, (2017) logics include subjective, professional, political, economic, and organisational rationales framing and involved in care practices. Logics appear as dynamic ways of seeing and arguing and thus act as rationales for the appropriateness of certain actions in a particular place and situation. In this way, logics of care offer understandings of practices of care, just as "the rationality of Care" described by Wærness and Martinsen. But where the concept of care rationality is studied as subjective and intersubjective dynamics in work (Dybbroe, 2012), Dahl (2017) studies logics of care in relation to specific levels of and forms of control. She relates the notion of logics to several different but interrelated changes in elderly care in the Nordic countries, such as bureaucratisation and neoliberalisation (p. 29). These processes can be said to simultaneously express *and* reinforce certain logics: "...neoliberalism in Denmark was translated into bureaucratization and standardizing care to ensure the rule of law – and to gain control over the content of care and the use of state funds." (p. 121).

Findings

One overarching theme emerged from the analysis of the empirical material: Students experienced a gap between the knowledge and values acquired at the courses, and the practice to which this knowledge was to be transferred. The overall theme contained two themes: 1) Interest in new knowledge and values related to practice and 2) Contradictions between new knowledge and work practice.

The overall theme underscores that transfer of knowledge in dementia care depends not only on the capability of the individual student, but that the organisational work context is of crucial importance. Theme one was generated on the basis of the many expressions of interest and engagement in improving the quality of care that are present in the material. Theme two contains the repeated statements about the difficulties in applying the new competencies in practice, which often collided with the intentions of the teachers. As obstacles, the students pointed out lack of time, quick staff turnover, efficiency as a primary value in work, and lack of opportunities to establish relationships with the elderly suffering from dementia.

Interest in new knowledge and values

Observations demonstrated that the participants acquired knowledge, challenges in practical work were discussed, and participants were given tools that could potentially be useful in specific work situations.

Knowledge about dementia care was communicated on the courses through presentations, discussions, and practical exercises. New ideas appeared to be eye-openers for the participants, such as realising that dementia is not a single disease but a term that covers several related neurological diseases (1).

The teaching concentrated on abstract knowledge and theory, but participants became particularly engaged when this knowledge was related to their everyday experiences (5). One example was when two participants told a story about a nursing home resident who had physically and verbally attacked the staff. The staff now took turns to go into his room in the mornings to distribute the “burdens” involved in his care. The teacher asked whether it was necessary to wash the person every day and the participants talked about what they had done. However, these situations have resulted in several reports. A long discussion in the class about “problem behaviour” followed. The teacher went into detail about how she herself had helped to establish a “parallel dialogue” to divert attention from the care situation of an elderly woman who also reacted by pulling and hitting the staff. The concrete examples of talking about subjects that had previously interested the woman, such as pickling beetroot, led to laughter and surprise: “Just think that it’s possible – you need good imagination” (3).

By drawing on experience from her own work, the teacher managed to turn a difficult episode into a learning situation in which the resident’s whole life was involved as a basis for care, while her dignity was also maintained. The participants’ positive reaction to the teacher’s story can be interpreted as relief that there are alternatives to use with a difficult patient.

During one course, a so-called dementia simulator was presented to the participants. In the simulator, all the person’s senses were limited or disturbed while she was given different tasks. The goal was for the participants to feel with their own body how dementia patients may experience the world around them. The participant wore gloves to prevent her from touching and grabbing objects, and headphones that made noise flow into her ears. Two other participants had to report what was happening:

“There were big sighs, someone was saying ‘be quiet!’ There was an atmosphere of deep concentration in the room. The others in the group were upset to see how the person in the simulator was struggling with the tasks. She exclaimed: ‘I’m getting stressed’ – suddenly she dropped the beads she had to arrange – she cried ‘No!’ Frustrated, she added, ‘Now I’m starting to sweat’. The other participants looked on in astonishment.” (4)

Later, they discussed what happened during the experiment. The participants found it an extreme learning experience to realise what it may feel like to suffer from dementia. This insight shook them and confirmed how important it was to protect people with dementia. Later, one participant on the diploma course emphasised how the teacher was able to create “an experience scenario”. The teachers were “fantastic”, she said (12).

The importance of the work context for the participants’ motivation was illustrated by the joy and pride they showed when talking about using working methods based on the values taught on the course. Here they received acknowledgement that they were doing the “right thing”. A speaker at a seminar, for example, was discussing the issue of care cultures that place more emphasis on cleaning than on patients’ well-being. One participant then said that there was an extra person on night shift at her workplace, which enabled residents

to e.g. watch boxing at night or eat at 3 a.m. Another participant smiled and said proudly: “That’s where I work!” (7).

The focus group interview contains examples of how, in certain nursing homes, care was being changed towards a person-centred approach, while the staff supported this development:

“We decided to form some groups, we have a sense group, we have a men’s group, and we have a knitting group. We then said we must set aside time for this, and we must prioritize it. So, for example, we may well not have finished morning care for five residents, but we know that this colleague is leaving and going to the knitting club. Because it’s about some people being the hosts and some guests coming and we must make sure that someone’s made coffee and we must walk around and make it cosy, and say, now your guests are coming (...) You can really see how they come to life.” (9)

This participant adopted the understanding that previous priorities needed to be nuanced to allow people with dementia to live with dignity. The statements reveal the reciprocity of care work; the employee sees that the residents are happy, which adds joy and meaning to her work.

Contradictions between new knowledge and work practice

It was evident in the material that the participants did not find the conditions and contexts of dementia care sufficiently visible in the courses. Several students described an outdated “care culture” and criticised the organisation of care work.

The participants talked about how their new competencies could be stifled by the way the work was organised and expressed uncertainty about whether they could change the workplace culture. In practice there are specific barriers, such as staff turnover and a clear division between shifts: “It’s difficult to do person-centred care and nursing if it’s always changing who visits the patient and who you cooperate with” (10).

One midpoint seminar centred on avoiding dehumanisation of staff. Inhuman actions are the opposite of the logic of care that the course sought to promote. However, the observation below illustrates that the participants were frustrated when their options for changed behaviour were not brought into focus:

“During the seminar, there was an exchange of words between teacher and participants. The teacher talked about dehumanisation and about the pace of care, where patients must fit into the boxes of the purchaser unit. (...) She explained that natural defence mechanisms are triggered when one is powerless and said, ‘What we can do something about is to become more professional’. A participant said: ‘Politicians don’t relate to us, or to how our patients feel’. She mumbled something about ‘bypassing the subject again’. The teacher replied: ‘It’s a matter of professionalism and leadership’. She added that there would soon be a new handbook from the National Board of Health on person-centred care and leadership. Another participant joked: ‘Why shouldn’t we address the framework, even though we can’t immediately do anything about it?’ The question was left hanging in the air.” (6)

The teacher’s focus on professionalism and leadership as a solution was not connected to the ethical and value dilemmas that several participants experienced. They sought an inclusion of the organisation and societal status of the work, which influences their possibilities.

Students expressed that on the one hand they were left with huge responsibility in the everyday interactions with the older persons suffering from dementia, and on the other had very limited possibilities for essentially improving their conditions in terms of the help offered. The empirical material reveals several examples of how the potential for change of

everyday practice was experienced as radically different from the ideals contained in the course content:

“One participant asked about resources for person-centred work. Deep sighs were heard in the classroom. The teacher replied: ‘You have to change your own attitude. The example can show the way.’ Two participants complained about their working environment, saying that things are difficult with the old staff. A third exclaimed angrily: ‘Some things come from us, but we also get some things from outside. Once again, the responsibility comes back to us!’” (2)

This comment can be understood as frustration that the organisational framework that determines employees’ scope for action was not included more actively in the teaching. The atmosphere in the classroom suggested that the call for a change of attitude did not lead to any constructive learning.

The interviews confirm the theme from the observations: the interviewees felt that their knowledge and skills would hardly lead to changes in practice. The disparity between the theory of the teaching and the realities of practice seemed too great:

“So of course, Kitwood’s there... What can I say? It’s all based on his theories, isn’t it? Well, I think the teaching was really good, so it was more a matter of how to use it in practice. How we can move on from there, I think. (...) But the word ‘usually’, that’s important when you’re busy, you see? Doing what you usually do.” (13)

This participant pointed out that improved dementia care not only requires the individual employee to be more professional, but also implies the development of a culture that accommodates person-centredness. Such a development is difficult because it must take place in a hectic work environment. As a participant said about the person-centred approach: “I’d like to focus on this more, but it’s just so hard to find room for it. (...) It’s like you’re standing there shouting all alone.” (13).

Participants seemed to be aware of the key role of care workers in relation to patients and the responsibility that this role entails:

“... We’re sometimes the closest relationship they get in a period of their lives. That’s the situation for some of the dementia patients I visit. If we don’t meet their basic needs, who else will?” (9).

The documentation and efficiency are prevailing logics in elderly care. As one participant explained, this affects how care can be performed:

“If all you think about is that they need medicine – that’s the quickest and the easiest way and it might work. But if we found out that if you went over to that person and stayed with him for 15 minutes every day when he was upset, that might also be medicine, you see? It’s about knowing those little things that are difficult to document, while you can say that medicine, that’s somehow much easier to write down and hand over.” (11)

Time is an indispensable factor in care provision. Care workers must provide care for a certain period, when there is a need, and must have enough time to meet the need. A participant exemplified how the efficiency logic makes time a scarce commodity in dementia care. She could not base her actions on the care logic she found important:

“We’ve no time to have a proper relationship with patients. We have one resident who is on the level of a two-year-old, and another one who is like a five-year-old... here we are with 17 dementia patients, with three evening shifts. On my way home yesterday, I thought hey, there are two residents who need help with eating, and I spend lots of time on them, give them food and talk to them..., and then there’s one who can eat herself. She just sits and watches television. So, when I got home, I thought, well, I didn’t talk to her very much.” (12).

The care worker's actual actions stood in contrast to her care ideals, and she went home with a bad consciousness.

A home care nurse addressed a similar paradox:

“Well, now I'm not going to mince words, there's a real focus on efficiency in our services. We speak a completely different language than that care language when we work with patients. The people in charge of the cases, that's what they focus on. You can always have some high ideals. But you might also think: 'This is what we can do here and now.' And not constantly let yourself be put down by your expectations. I normally say: 'Well, it's at this level. That's what we get paid for.' We provide care as best we can, so we mustn't have a guilty conscience about what we can't do.' There's no reason to get stressed because the whole of Denmark works like this.” (11)

This defeatist summary was the participant's conclusion after she had taken the diploma course and was back in practice. The gap between ideals and practice had deepened and her expectations of providing improved, person-centred care were disappointed. Her words suggest that for her the course led to resignation rather than encouraging changes in practice.

The difficulty in practice of establishing an organisational space to ensure the implementation of acquired knowledge was also noticeable at the information meeting for care managers halfway through the project (14). Here it appeared that several of the participating local authorities had not planned any implementation strategy in relation to their employees' new competencies.

Discussion

When analysing the themes through the lens of transfer theory, it becomes clear that some, but not all three crucial transfer factors (Wahlgren & Aarkrog, 2013) could be traced in the Interdisciplinary Dementia School programme.

Person-related transfer factors in the form of interest were present among the participants and were strengthened by elements in the subject matter and the teaching methodology. The teachers' knowledge of specific challenges enhanced the credibility of her knowledge and advice, which thus constituted a teacher-related transfer factor.

Teacher-related transfer factors lead to trust when they resonate with a person-related transfer factor in the form of participants' curiosity. In the experiment involving the dementia simulator, the employee must gain insight into what the world looks like *from the inside* of a person with dementia. Due to trust in the teacher, the students engage willingly in the experiment.

The analysis of theme one thus indicates that both person-related and teacher-related transfer factors were present in the course.

However, as theme two illustrates, situation-related transfer factors were challenged repeatedly during the programme. If a student experiences that she has the knowledge but cannot use it, the person-related transfer factors become also challenged. When, for instance, a teacher at the midterm seminar ignored responses raised by the students, a significant situation-related transfer factor was overlooked which negatively affected the participants' engagement.

The application context was thus not only difficult to relate to on the courses, but the management, which was to ensure that the new competencies were used and shared in different groups of employees, also appeared to be difficult to engage in the Interdisciplinary Dementia School programme. The lack of conscious involvement of the context as a framework for the transfer of new knowledge and values challenged learning and changes in

practice. There is therefore a risk that the course will benefit neither the workplace as a whole nor the elderly with dementia.

The lack of situational transfer factors is not just a pedagogical problem. It's a question of whether it is possible on the one hand to integrate the participants' experiences from work in the classroom and on the other transfer the knowledge acquired in the classroom to the work practice. Based on the hesitance of the participants regarding the prospects of providing person-centred care, the question arises as to whether it is possible to create transfer between such divergent logics as represented by the academic content of the Dementia School and the practice of dementia care.

The participants' comments suggest that a care rationality as promoted in the Dementia School programme in practice competes with logics of efficiency that are predominant in Danish elder care. Market reforms have taken different forms and been introduced at different rates in the Nordic countries, but have had a profound influence on the organisation of care (Kamp & Hvid, 2012; Rostgaard & Matthiessen, 2016). Since new public management involves an efficiency and optimisation logic that focuses on managing and limiting the financial costs of care, a holistic and person-centred approach is forced into the background (Vabø & Szhebehely, 2013).

According to Dahl, bureaucratization of care implies codification and standardisation of care practices. Through codification, certain care actions are expressed in language, while tasks that are not standardised are no longer recognised as care. She writes: "In order to be intelligible in a political-administrative logic, care becomes reduced to identity, that is, as something that has to fit into our governing rationales of reason and control" (Dahl, 2017, p. 45).

In this logic, care is seen as predictable, controllable, and transparent, and thus governable (p. 97). Elements that still play a role in practice are suppressed, as they are no longer part of the accepted language. In view of these changes, the participants' complaints about being unable to implement socio-pedagogical knowledge become an expression of a basic contradiction between the care logic of the course and the efficiency logic that determines work performance.

The generated themes are not unique to the Interdisciplinary Dementia School. Previous research has shown that staff are interested in enhancing their competencies, but that challenges exist in the transfer to dementia care practice.

As in Argyle and Schneider (2016), our trailing research found several contextual barriers to learning transfer, including bureaucracy, limited time, lack of staff and resources, and a task-centred work practice. In the present study, limited time appears to be crucial for the lack of transfer of knowledge into changes in practice. Employees' and managers' limited opportunities to influence the work context also constitute an obstacle to the practical application of knowledge.

In Kassah and Tønnesen's study (2016) the purchaser unit determines the services to be provided, despite having less contextual knowledge about patients than nurses: "Home nurses can thus find themselves in a dilemma because they cannot adequately meet patients' needs beyond their formal responsibility, which means limited opportunity to act on their professional moral responsibility. This can make it more difficult to provide individualized and comprehensive care to patients (...)" (Kassah & Tønnesen, 2016, p. 350).

As shown in the interview with the home care nurse, one "solution" to this dilemma can be to relate only to one's formal responsibility. This reinforces an efficiency logic, and the employee paradoxically moves closer to the dehumanisation that the courses sought to prevent.

The themes generated in the analysis of the Interdisciplinary Dementia School support other research that indicates challenges in applying new competencies to dementia care in

a way that clearly improves the quality of practical care work. The challenge in providing person-centred care lies not only with the staff in the form of lack of knowledge, but at least as much in the organisation of care.

Limitations of the study

The empirical material stemming from observations and focus group interview during the courses is comprehensive and provides rich descriptions. However, a limitation of the study lay in the fact that it proved difficult to recruit interviewees after the courses ended. It also turned out that it was only possible to get a limited access to observations with course participants in work practice. Explanations we met when contacting students were that they were too busy or that it was too complicated to get the organisational acceptance of researchers visiting during work. Other students simply did not answer our inquiries. The obstacles can be understood in line with the gap we point to in our analysis: the everyday operation of dementia care seem to suppress the attention towards the courses – the space for reflecting on learning and competencies is restricted.

Nevertheless, the study has informative power based on the variety of generated empirical material and on the consistency of its conclusions with other similar and more comprehensive studies (Malterud et al., 2016; Davies, 1999).

The chosen theoretical framework sheds light on some aspects of the empirical material. Other theories could have elaborated the analytical points; for instance, an organisational focus on the embeddedness of the course in the workplaces might have been fruitful.

Conclusion

In-service training is an important method of increasing the knowledge of care workers, which is one of several factors necessary to implement person-centred dementia care in practice.

The analysis in this article has shown how the logics involved in health and care work with people with dementia both facilitate and constrain the transfer of knowledge and skills in dementia care and the possibilities to change practice.

Potentials for learning are seen in the care workers' engagement in the knowledge they are presented for. This engagement is particularly strong when teachers manage to relate the theory to participants' experiences from practice, and the theories of person-centred care are an extension of a care rationality already present. In these cases, there is fruitful interplay between person-related and teacher-related transfer factors.

Barriers appear when teachers reject participants' complaints that their work context is an obstacle to person-centred care. In such cases, participants might decide against adopting new values.

A further barrier to changes in practice is the lack of inclusion of situation-related transfer factors in in-service training, which questions if new competencies can benefit the workplace and thus people with dementia.

The care logic inherent in the theories taught at the Interdisciplinary Dementia School clashes with the efficiency logic that currently dominates elder care. This constitutes a dilemma where care workers must constantly find a balance. To equip them to do so in ways that do not lead to resignation is an important and urgent task for future initiatives to improve staff competencies. These will only be successful if they involve real changes in work organisation and practices.

The authors declare no potential conflicts of interest.

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