Evaluation of the Pilot Implementation of the Dementia Care and Support: Home Care Education Programme

Dr. Maria Pierce

**School of Social Policy, Social Work and Social Justice,
University College Dublin**

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Contents

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List of tables

List of figures

Abbreviations

CHO	Community Healthcare Organisation
CSO	Central Statistics Office
DCU	Dublin City University
HSE	Health Service Executive
HSM	Home Support Manager
HSRM	Home Support Resource Manager
IT	Information Technology
ITT	Irish Times Training
LHO	Local Health Office
LLTM	Leadership, Learning and Talent Management
NDS	National Dementia Service
QQI	Quality and Qualifications Ireland
REO	Regional Executive Officer
UCD	University College Dublin
WTE	Whole-Time Equivalent

Executive summary

The majority of people with dementia live in their own homes in the community. While much care and support is provided by family members, home care workers provide a significant level of care to people with dementia living at home. It is crucial that the home care workforce is skilled and educated in dementia care. Training and education is key to the move to a person-centred approach to home care that promotes the personhood of people with dementia, although there is currently no requirement for Healthcare Assistants (Home Support) in Ireland, formerly known as home helps, to have dementia-specific training.

The Health Service Executive's (HSE's) Dementia Care and Support: Home Care Education Programme has been developed specifically for Healthcare Assistants (Home Support). It aims to produce Healthcare Assistants (Home Support) who are skilled, reflective, and self-aware and provide care to people with dementia with humanity, empathy, and dignity. A collaborative team of people comprising staff from the National Dementia Service (NDS), the HSE and Dublin City University (DCU) developed the programme, informed by people with dementia, their family carers, and relevant community-based staff. The NDS in the HSE oversees the implementation of the Dementia Care and Support: Home Care Education Programme. The programme is delivered to Healthcare Assistants (Home Support) who are directly employed by the HSE and provide home support to people with dementia living in their own homes.

The Dementia Care and Support: Home Care Education programme is a QQI Level 5 accredited programme. It achieved accreditation in 2020, following partnership with Irish Times Training (ITT) and a robust accreditation process. The accredited programme is based on six modules or units, delivered in-person by trainers over a four-month period. Learners attend four day-long sessions. They complete two modules or units per session. The session on the final day comprises a revision unit and a skills demonstration, recorded for assessment purposes. The sessions are supplemented with weekly supervision facilitated by healthcare professionals. The programme, through which learners gain an understanding of dementia (including belief systems and attitudes), places a strong emphasis on self-development (stress, self-care, boundary setting, relationship building) and ethical and strengths-based approaches to care. The programme has almost all of the features that make for effective dementia education and training programmes. The NDS piloted the programme in three CHO areas: CHO 1, CHO 4, and CHO 5. These are areas where the HSE employs the highest numbers of Healthcare Assistants (Home and Support) and where these Healthcare Assistants (Home Support) deliver a high proportion of HSE Home Support services.

This report presents an evaluation of the implementation of the Dementia Care and Support: Home Care Education Programme. The evaluation was primarily a qualitative study conducted over a five-month period (October 2023 to February 2024). It used a combination of individual interviews to explore the experiences and views of a range of stakeholders (n=16) involved in the implementation of the dementia education programme in the three CHO areas and focus groups (n=3) with Healthcare Assistants (Home Support) (n=11) who participated as learners on the programme. The evaluation reviewed data on registration and completion of programme as well as reports from external reviewers, provided by the ITT,

the education provider contracted by the HSE to deliver the pilot programme. The UCD Research Ethics Committee granted ethical approval for the study in October 2023.

The evaluation found a high level of commitment to the programme and its implementation among staff at both national level and local level, but the process of implementing the pilot programme took a lot of time and effort on the part of the stakeholders involved, which is to be expected with new education programmes. Cooperation from Home Support Managers (HSMs) and Home Support Resource Managers (HSRMs) was vital to the success of programme implementation. At local level, dementia care had been identified as a priority training issue for Healthcare Assistants (Home Support) by HSMs who embraced the training programme, and put processes in place to identify, recruit and release staff to participate in the programme, with the expectation that it would bring about service improvements for people with dementia.

In focus groups, learners shared the reasons why they chose to take part in the programme. Firsthand experience of caring for a relative with dementia was a motivating factor. Work-related motivations included the gap in learners' knowledge about dementia care, the guilt they felt knowing that they were providing sub-optimal care, and the desire to have the knowledge and skills that they could bring to their everyday care practice and improve the lives of people with dementia and their family carers. While they were eager to participate in the programme, some learners were initially concerned about the level of commitment or their ability to complete the programme.

It has been planned to have 18 programme intakes per annum. However, the programme was delivered only eight times during the pilot phase. The low number of intakes was due to three main challenges. These were the Covid-19 pandemic, time taken to put new processes in place to identify and recruit Healthcare Assistants (Home Support) for participation in the programme, and the supervisory element of the programme. Supervision proved to be most challenging aspect of programme implementation and there were difficulties with recruiting healthcare professionals to provide supervision, retaining supervisors and finding replacements. Based on lessons learned from the pilot programme, three main changes to the supervisory element were introduced and trialled in a sister SOLAS-funded programme, also delivered by ITT. Changes included incorporating dedicated time for supervision on the timetable, allowing trainers who had completed the training programme to work as supervisors and vice versa, and paying supervisors at the same rate as trainers. The amended supervisory element is working very well in the SOLAS-funded programme and the NDS plans to incorporate the same changes into the HSE-funded programme when it is rolled out nationally.

Although the number of programme intakes was low, the target for the take-up of the programme by Healthcare Assistants (Home Support) were mostly achieved, although there were variations in take-up across areas. Participants perceived organisational support to be an important factor promoting uptake. They put forward a wide range of reasons for why Healthcare Assistants (Home Support) might not take part in the programme including early school leaving; low qualification levels; age; lack of confidence; and anxiety and apprehension about participating in a QQI level 5 programme. Other perceived learning motivation barriers identified by participants included the time pressures that Healthcare Assistants (Home Support) are under due to the nature of their work; the time commitment

required to complete the programme including travelling to the venue but particularly for completing assignments; family/life responsibilities; non-requirement for continuous professional development; low pay; the low value placed on home support; lack of opportunities for career progression and lack of other incentives such as increases in pay. Staff shortages, which were reported to be an issue in only one LHO area, did not seem to affect programme take-up.

Leaners were not always well prepared for the programme in the early stages of piloting the programme, but well supported whilst on the programme. Despite some stakeholders expressing concern that retention rates on the programme were low, data show that the overall retention rate on the programme was high at 83%. However, there were marked variations among areas, with retention rates varying from 67% to 100%, indicating an issue with retention in some areas. Attrition from the programme occurred at two critical points. The first was at the very start of the programme, the key reasons seeming to be that learners either decided after attending the first or second session that the programme was not for them or decided not to return after missing a session due to personal matters. Some participants expressed a concern that the programme might be pitched at too high a level for Healthcare Assistants (Home Support). Reasons for dropping out later in the programme included personal issues, difficulties with assignments, anxiety about doing the demonstration, or leaving the HSE for another job.

While this study did not set out to evaluate the programme itself, participants rated the programme content very highly. They also regarded the delivery of the programme by ITT and the trainers highly. According to participants, the programme filled a significant gap in dementia training and specifically training targeted at Healthcare Assistants (Home Support). They perceived the programme to be beneficial for Healthcare Assistants (Home Support) and their clients with dementia. The specific focus on the role of Healthcare Assistants (Home Support) in supporting people with dementia was particularly valued. Learners particularly valued the focus on promoting person-centred care and relationship building with the person with dementia. Learners explained how it had changed their perspective on dementia and approach to work, increased their confidence, and gave lots of examples of the difference being on the programme made to their day-to-day work and the benefits it brought for people with dementia.

With respect to the future of the programme, there was strong support for the roll-out of the programme to other areas across the country. While stakeholders and learners would like to see the programme become mandatory for all Healthcare Assistants (Home Support), none of the study participants expected this to happen. There was strong support among many stakeholders and all learners for the in-person format of the training sessions to be retained and better communication between trainers and supervisors. There was also support for extending the programme to HSMs and HSRMs. A short, non-accredited version of the programme. Some participants suggested that, given the range of learning motivation difficulties for Healthcare Assistants (Home Support), it would be useful to have the option of a short, non-accredited version of the programme available alongside the accredited Dementia Care and Support: Home Care Education Programme. This option would be welcomed by HSMs in areas experiencing staff shortages.

In conclusion, the findings of this qualitative study provide a rich and nuanced perspective on the Dementia Care and Support: Home Care Education Programme for Healthcare Assistants (Home Support) and its implementation on the ground, the challenges encountered during programme implementation and the changes needed to optimise implementation. The findings can be used to support strategic and operational decision-making for enhancing programme implementation within the HSE, and can also be used to inform training, including dementia specific training, for home care workers more widely in Ireland.

Recommendations

- *Retain the programme's current in-person format for training sessions*
  Given the strong preference for a face-to-face format, this report recommends that delivery of the programme's training sessions continues to be in-person without any substantive changes to the format.

- *Develop an overarching implementation plan*
  The national implementation plan would include: a realistic target for the number of programme intakes per annum per CHO area and per LHO area; timelines for delivery of programmes clearly stated including agreed programme commencement dates that should remain fixed; more detailed information about the target population and clarity around targeting for recruitment; roles and responsibilities of organisations and actors involved in implementation clearly stated.

- *State and clearly define the roles and responsibilities of all organisations and actors involved in the implementation of the programme*
  The NDS should not have any responsibility for the day-to-day operations of implementing the programme and its role restricted to strategic planning, oversight, monitoring, review, and evaluation.

- *Develop local implementation plans*
  In accordance with a national implementation plan, the NDS could develop implementation plans for agreement at local level. Development of implementation plans should take place in consultation with HSMs and with input from HSRMs. Whether the implementation plan is to be agreed at CHO or LHO level is yet to be decided. While there should be consistency across the country, some flexibility could be built in, for example, allowing HSMs to choose between two alternative forms of implementation plan.

- *Develop best practice guidelines to support implementation at local level*
  The NDS in conjunction with the LLTM could develop best practices guidance to support HSMs and HSRMs with the implementation of the programme at local level. Areas to be covered include programme promotion; identification and recruitment of learners including more clarity around the target population for the programme; staff release; organizational attitudes towards training and culture; organizational support for learning.

- *Better prepare Healthcare Assistants (Home Support) for participation on the programme*
  It must be ensured all learners are fully informed and fully prepared before joining the programme. There needs to be more clarity on where the responsibility for this lies. If this is to be part of the responsibility of HSRMs, they need to be better equipped for this and aware of the expectations of them.

- *Monitor and evaluate how well the planned changes to the supervisory element of the programme, as trialled by ITT in the SOLAS-funded iteration of the programme, are working. Checks should be in place to ensure that no learner gets the same person acting as both trainer and supervisor. Time should be scheduled in to promote and enable tutors and supervisors to collaborate when they are supporting learners on a programme.*

- *Encourage and support the development of a strong organisational ethos supporting continued training and education, included dementia-specific education, for Healthcare Assistants (Home Support) within the HSE and among approved home support providers*

- *Monitor programme implementation on an ongoing basis, and review regularly*
  Monitoring of programme implementation should be ongoing and include the collection of data on planned and actual programme start dates; and the collection of data to learn when and why learners are dropping out of the programme. Programme implementation should be reviewed regularly, with the NDS taking a leadership role.

- *NDS to consider supporting the development of a short, non-accredited version of the Dementia Care and Support: Home Care Education Programme for Healthcare Assistants (Home Support)*
  Informed by the existing research evidence and in consultation with the programme developers in DCU, consideration could be given to the development and implementation of a shortened, non-accredited version of the programme to meet the training needs of Healthcare Assistants (Home Support) experiencing diverse learning motivational difficulties and to accommodate areas experiencing staff shortages.

- *Findings of present study could usefully inform research led by the Department of Health aimed at gaining a better understanding of the experiences of care* workers
  To more effectively implement QQI level 5 training including the Dementia Care and Support: Home Care Education Programme, greater understanding is needed of the educational experiences of Healthcare Assistants (Home Support), their levels of qualification, literacy and IT skills, attitudes and motivations towards education and training, levels of confidence, and others learning facilitators and barriers. The Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants has pointed out that little is known about Healthcare Assistants (Home Support) or other care workers. With a view to filling the evidence gaps, the Department of Health has engaged a research body to conduct a national survey of the experiences of home support workers and healthcare assistants. The Department of Health's survey is currently under development (Department of Health, 2024). The

findings from this present review could usefully inform the survey development and contribute to filling the evidence gap in relation to the experiences of home support workers and healthcare assistants in relation to dementia-specific training.

1. Introduction

This is a report of the evaluation of the Health Service Executive's (HSE's) Dementia Care and Support: Home Care Education Programme. The Dementia Care and Support: Home Care Education Programme is one of a number of programmes designed to support the implementation of the Irish National Dementia Strategy, a stated goal of which is to enable people with dementia to continue living in their homes and communities for as long as possible and to improve supports for carers (Department of Health, 2014). The National Dementia Service (NDS) in the HSE oversee the implementation of the Dementia Care and Support: Home Care Education Programme.

A collaborative team of people comprising staff from the NDS, the HSE and Dublin City University (DCU) designed the Dementia Care and Support: Home Care Education Programme. The team consulted with people with dementia, their family carers, and relevant community-based staff during programme development, who informed its design. The programme's target group are Healthcare Assistants (Home Support), formerly known as home helps, who are directly employed by the HSE and provide home support to older people including people with dementia living in their own homes. The programme aims to produce Healthcare Assistants (Home Support) who are skilled, reflective, and self-aware and provide care with humanity, empathy, and dignity. Chapter 4 describes the programme in more detail.

This research project is concerned with assessing the process of implementing the pilot Dementia Care and Support: Home Care Education programme in three pilot Community Healthcare Organisation (CHO) areas, from the perspective of relevant stakeholders. Relevant stakeholders include three key groups: (1) those involved in designing, developing and securing accreditation for the programme; (2) those involved in facilitating the delivery of the programme at local level including Home Support Managers (HSMs) and Home Support Resources Managers (HSRMs), trainers, and supervisors; and (3) learners. The primary focus is on identifying lessons from the implementation of the pilot programme. The evaluation provides recommendations relating to the process of implementation, with a view to supporting future roll-out to all areas in the health and social care system. With National Service Plan Funding, secured in 2023, the roll out and implementation of the Dementia Care and Support: Home Care Education programme will continue.

Structure of the Report

The next chapter of this report (Chapter 2) provides the background and context to the Dementia Care & Support: Home Care Education Programme and its evaluation. It outlines the policy context, provides an overview of home support in Ireland including how it operates, the number of people in receipt of home support and hours provided, the number of Healthcare Assistants (Home Support) employed by the HSE, and how it is organised geographically. It also summarises evidence from literature on training on dementia for home support workers.

Chapter 3 outlines the methodology for the study.

Chapter 4 provides a brief overview of the Dementia Care and Support; Home Care Education Programme for Healthcare Assistants (Home Support), including how it originated in the Dementia Champions programme.

For this study, the researcher conducted interviews with a range of stakeholders involved in the delivery and implementation of the Dementia Care and Support: Home Care Education Programme and focus groups with Healthcare Assistants (Home Support) who participated as learners on the programme. Chapters 5 and 6 present the key findings from these interviews and focus groups.

Chapter 6 presents a synthesis of the findings, draws conclusions, and presents a set of recommendations.

Terminology

Healthcare Assistants (Home Support)
Many different terms are used to refer to workers who provide home care (D'Astous et al., 2019). The term 'homecare worker' tends to be adopted in the United Kingdom (D'Astous et al., 2019). Traditionally in Ireland, 'home help' was the term commonly used. The term home help was 'used to include home helps and home care assistants who deliver home based services (personal care and/or domestic tasks) to people who live at home.' Following the streamlining of the home help service and Home Care Packages in 2018, the HSE began to refer to home helps as Health Care Support Assistants. This is the term used in the HSE's Dementia Care and Support: Home Care Education Programme. However, the HSE has now officially adopted a new term, Healthcare Assistants (Home Support). This is the term primarily adopted for the purposes of this report. There is still widespread use of the term home help including in certain HSE reports. This report occasionally uses the term home help, in accordance with the use of the term in HSE reports, e.g. HSE Sector Employment Reports.

Community Healthcare Organisations
As part of Ireland's healthcare reform agenda, the HSE is undergoing internal reorganisation, as outlined in the HSE Health Regions Implementation Plan (HSE, 2023b). Following Cabinet approval of the plan, six new Health Regions (Areas A-F) became operational from March 2024. Each Health Region will have responsibility for the planning and coordinated delivery of health and social care services. The plan is that the nine Community Healthcare Organisation (CHO) areas through which the HSE has organised home support since 2016 will be stood down by September 2024. The report refers to CHOs and not Health Regions. This is because the pilot Dementia Care and Support: Home Care Education Programme took place prior to March 2024. Programme implementation took place in selected areas within named CHO areas. These CHO areas do not easily map onto six new Health Regions.

2. Background and context

2.1 Policy context

There were an estimated 55,266 people with dementia in 2016, as shown in Table 1 (Pierce and Pierse, 2017). Most people with dementia wish to remain living in their own homes for as long as possible (D'Astous et al., 2019) and the majority of people with dementia in Ireland are living at home in the community (Pierce and Pierse, 2017). Government policy supports this preference. A priority action area of the Irish National Dementia Strategy is 'Integrated Services, Supports and Care for People with Dementia and their Carers' (Department of Health, 2014). Under this priority action area, the stated goal of government policy is to enable people with dementia to continue living in their homes and communities for as long as possible and to improve supports for carers. A task allocated to the HSE has been to consider how best to configure resources to achieve this goal. Home Support services are the main type of formal service that underpins the National Dementia Strategy's policy aim of supporting people with dementia to remain at home (Keogh et al., 2018).

Table 1: Estimated number of people with dementia in Ireland (2016)

Age groups	**Population (Census 2016)**			**Persons with dementia (estimated using EuroCoDe age/gender-related dementia prevalence rates)**		
	Male	Female	Total	Male	Female	Total
30-59 years	986,600	1,018,403	2,005,003	1,973	1,018	2,992
60-64 years	118,698	120,158	238,856	237	1,081	1,319
65-69 years	104,961	106,275	211,236	1,889	1,488	3,377
70-74 years	79,501	82,771	162,272	2,544	3,145	5,689
75-79 years	54,117	61,350	115,467	3,788	4,663	8,451
80-84 years	35,196	45,841	81,037	5,103	7,518	12,621
85-89 years	16,676	28,186	44,862	3,485	8,033	11,518
90-94 years	5,234	12,740	17,974	1,528	5,657	7,185
95+ years	1,152	3,567	4,719	373	1,741	2,114
Total				20,922	34,344	55,266

Source: Pierce and Pierse (2017)

The National Dementia Strategy seeks to progress the overarching principles of personhood and citizenship by enabling people with dementia to maintain their identify, resilience and dignity and that they recognise that they remain valued, independent citizens who, along with their carers, have the right to be fully included as active citizens in society. While much of the care and support to people with dementia is provided by family carers, home care workers provide a significant level of non-clinical formal care for people with dementia. Accordingly, home care has the potential for improving care and support to people with dementia and achieving the ideals of the National Dementia Strategy. Citizens want home care that is person-centred and based on the principle of personhood (Walsh et al., 2020).

Given the significant role of home care workers for improving the lives of people with dementia, it is paramount that they are a skilled and experienced workforce (D'Astous et al., 2019). The HSE requires new Healthcare Assistants (Home Support) entrants to hold Quality

and Qualifications Ireland (QQI) Level 5 modules in ‘Care Skills’ and ‘Care of the Older Person’ if they have less than one-year’s prior experience in the field (Department of Health, 2022). However, there is no requirement for Healthcare Assistants (Home Support) to have dementia-specific training.

‘Training and Education’ is a priority action area of the National Dementia Strategy, which states that the HSE will engage with relevant professional and academic organisations to encourage and facilitate the provision of dementia-specific training (Department of Health, 2014). O'Shea et al. (2017) identified training and education as key to the evolution of a person-centred, personalised approach to dementia care in Ireland. The potential of training for home care workers to make personalised care a reality for all home care has been highlighted (Keogh et al., 2018). More recently, the provision of specialised training to care workers including in dementia care has been recommended by the cross-departmental Strategic Workforce Advisory Group on Home Carers, which was established in March 2022 in response to the shortage of care workers and the difficulties many providers are experiencing in sourcing home care workers (Department of Health, 2022). Moreover, people want good quality home care which includes developing and upskilling home care workers to ensure that they are equipped with the training, supervision and experience to do their care work effectively (Bennett et al., 2018).

The Strategic Workforce Advisory Group, from an analysis of submissions from key relevant stakeholders, identified a wide range of challenges relating to recruitment, retention, pay and conditions, career development, barriers to employment and training of care workers (Department of Health, 2022). Training issues identified in these submissions included the need for continuing professional development opportunities to support care workers’ career-progression and the inadequacy of ICT infrastructure for the provision of online training to care workers in some rural areas. Among the priority actions recommended during the Group’s structured programme of stakeholder engagement were the provision of funded training by employers for care workers, the provision of paid leave to engage in training, the provision of specialised training (e.g. in dementia care) for care workers, and the provision of online training courses and greater opportunities for flexible learning. In its report issued in September 2022, the Group made a series of recommendations on recruitment, pay and conditions, barriers to employment, training and professional development, sectoral reform and monitoring and implementation, acknowledging that there would be cost implications for the exchequer. Before making its recommendation relating to training and professional development, the Group acknowledged that:

> … there is strong capacity for the training of care-workers within the further education system and that many of these training opportunities are provided on a free-fee basis. However, a key finding emerging from the stakeholder-consultation undertaken was the need to provide care-workers with opportunities for career-progression and for the recognition and reward of training, qualifications, and experience. Accordingly, the Group recommends the development of a competency framework for care-workers which will be aligned with qualifications and grades of employment with commensurate remuneration (Department of Health, 2022).

Recommendation 10 followed this statement:

> A competency framework for home-support workers and healthcare assistants should be developed to enable the recognition of prior learning and qualifications, to support career-development, and to align grades of employment with qualifications in line with relevant regulations. For example, providing recognition of those with specialist qualifications in reablement, dementia, and end-of-life care (Department of Health, 2022).

The Group identified the HSE as the owner of this recommendation, and the Department of Health, the Department of Further and Higher Education, Research, Innovation and Science and SOLAS as supporters. Indicative costings were not presented but it has been acknowledged that further exploration into the scope and resource requirements of this recommendation is needed (Department of Health, 2024). Although indications are that the implementation of this recommendation will take place over the long-term, some progress has already been made. In its Resourcing Strategy *Resourcing our Future,* the HSE has committed to creating competency frameworks/eligibility criteria for roles within Healthcare Support Assistant and Healthcare Assistant job categories (HSE, 2023a). Initial scoping of this recommendation has commenced. Internal engagements have taken place within the HSE to examine the scope and resource requirements necessary to consider this recommendation (Department of Health, 2023).

The HSE has identified a number of other challenges relevant to the training of Healthcare Assistants (Home Support) and has agreed actions to address these. These include: standardising healthcare QQI level courses to HSE requirements through engagement with educational partners; standardising current educational requirements to become a Healthcare Assistant (Home Support); and developing and implementing a small specialised function to oversee the development and professionalisation of the Patient, Client Care and General Support Workforce, which includes Healthcare Assistants (Home Support) (HSE, 2023a).

Under the heading of evaluation and monitoring, the Strategic Workforce Advisory Group recommended (Recommendation 16) that 'a national survey of the experience of home support workers and healthcare assistants should be established to enhance the evidence base for monitoring the implementation of the recommendations of the Strategic Workforce Advisory Group and their impact' (Department of Health, 2022). The Department of Health is leading this work. The survey is to be conducted in 2024. According to the more recent progress report, a research body has been engaged to carry out this work, and early discussions around survey design, purpose and methodologies have taken place, and the survey development will be progressed further in Quarter 2 2024 (Department of Health, 2024).

2.2 Home support in Ireland

Home care is one of the main State-funded services to support people with dementia to remain living at home. It can be defined as follows:

> "Home care in Ireland is typically understood as home help services, which include cleaning, cooking and other light household tasks that a person is unable to do

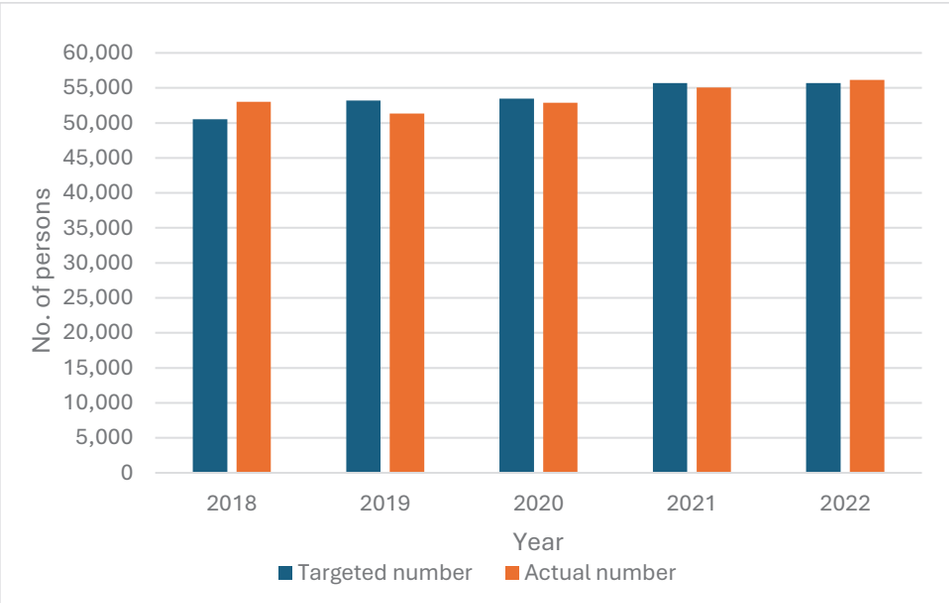
themselves due to old age or disability. The scope of home help has subsequently developed to include more personal care assistance such as support with personal hygiene, washing, and dressing also" (Kiersey and Coleman, 2017).

The HSE is the largest funder of formal home care in Ireland. The term Home Support services has been used since 2018, when the HSE combined resources for home help services and Home Care Packages, moving home care to a single home support service. This change was introduced to improve accessibility and experience of these services for older people and their families, make the home support service easier to understand, and reduce complexity of the application process (HSE, 2019). The provision of home support services however remains complex. While the HSE arranges publicly funded home support services, these services can be provided by HSE staff or by staff employed by approved private providers. The latter can be not-for-profit (voluntary) organisations such as the Alzheimer Society of Ireland and Family Carers Ireland or for-profit organisations. This study focuses on HSE home support services provided by HSE-employed staff.

Home support services in Ireland have no statutory basis, which means among others, that there is no statutory entitlement to the existing provision and no statutory regulation of such matters as quality-assurance, accountability, training, and skills. Currently, HSE home support services are not means-tested or 'limited' in any other way, e.g. services are not restricted to medical card holders and there are no charges for these services.

Home support is provided mainly to older people, although it can also be provided, in a limited way, to some people with disabilities and others with identified care needs. In 2022, 56,162 older people were in receipt of HSE Home Support, greater than the targeted number of 55,675 in that year, and up from 53,013 persons in 2018. While the number of people in receipt of home support is growing, only a small proportion of older adults in Ireland use formal home care services (O'Brien et al., 2019).

Figure 1: Number of older persons in receipt of HSE Home Support, 2018 to 2022

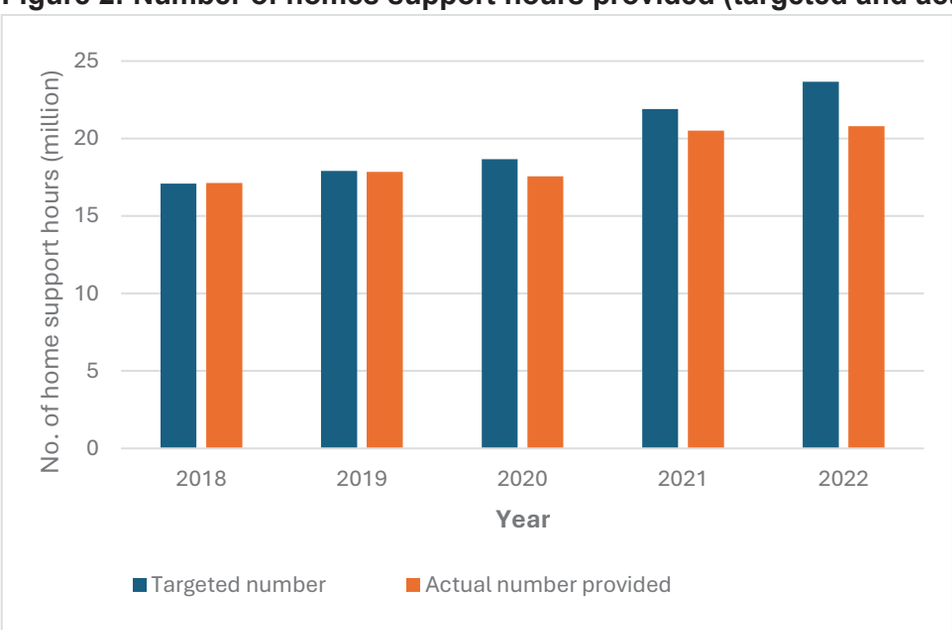


Source: HSE Annual Reports and Financial Statement 2018-2022.

It is not known exactly how many of those in receipt of home support are people with dementia, but it is known that they make up a sizeable proportion. A study in North Dublin which involved an audit of all clients aged 65 years and over receiving HCPs found that out of a sample of 935 community-dwelling older people, 347 people (37.1%) had a documented diagnosis of dementia and received, on average, 13 hours of home care per week. A further 81 (8.7%) were categorised as suspected cognitive impairment using a validated cognitive screening tool (O'Brien et al., 2019).

The actual number of home support hours provided to older people has increased each year since 2018, from 17.13 million hours in 2018 to 20.79 million hours in 2022. But this increase is taking place in the context of population ageing. Census data show that there were almost 139,000 more people aged 65 years and older in Ireland in 2022 than in 2016, and that the number of people aged 85 year and over increased by 25% (CSO, 2023).Despite more older people receiving home support and an increase in the number of hours provided, the reality is that the increased level is not enough to meet demand (Social Justice Ireland, 2023). The number of additional home support hours delivered did not reach the target of 23.7 m hours in 2022. The gap between targeted and actual number of hours provided has increased in recent years (Figure 2). Evidence on waiting lists (for 2019) indicates that some 5,400 people were waiting for homecare in that year (Walsh and Lyons, 2021). This is due mainly to capacity issues. Both the supply and ageing of the health care workforce have been identified as significant challenges for Ireland's health system, with the long-term care sector particularly affected (Government of Ireland, 2023).

Figure 2: Number of homes support hours provided (targeted and actual), 2018-2022



Source: HSE Annual Reports and Financial Statement 2018-2022.

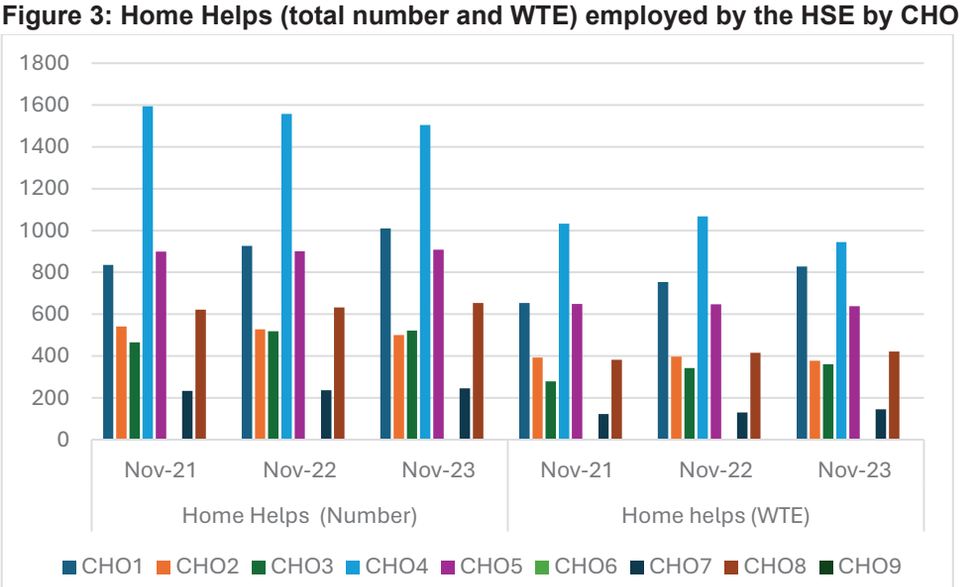
The level of homecare provision varies by need but it is important to note that the average HSE home care service provides one hour of care per day - 6 hours a week (Care Alliance Ireland 2018).

Staff employed by the HSE, not-for-profit (voluntary and community) organisations, and for-profit organisations deliver home support in Ireland. Estimates are that in 2019 HSE staff in 2019 directly delivered around 44% of HSE Home Support services. As of July 2022, 38% of home support services were delivered through direct provision (Department of Health, 2022). The total number of Healthcare Assistants (Home Support) employed by the HSE in November 2021 was 3,329 and increased marginally over the period in which the pilot programme was implemented to 3,523 in November 2023 ((HSE, 2024, HSE, 2022)). As indicated by the number of WTEs, which also increased over the same time period from 2,335 to 2,412 (HSE, 2024, HSE, 2022), many Healthcare Assistants (Home Support) are employed on a part-time basis. Home care workers including Healthcare Assistants (Home Support) are the backbone of the home support service. Their work is often complex, and tends to be demanding, both physically and mentally, but their rate of pay is low relative to other health care workers (Llena-Nozal et al., 2022) and regarded as too low given the complexity of work (Department of Health, 2022). Most Healthcare Assistants (Home Support) are women.

2.3 Geographical and organisational context

There is evidence of variations in the provision of home support service geographically. In an examination of the distribution of the annual average number of home care hours per person for those aged 65 years and over in Ireland in 2014, Smith et al. (2019) found significant geographical variation. The rural counties have consistently higher per capita home care hours across all years. The geographical variations across Local Healthcare Office (LHO) areas are wide. More than 80% of HSE Home Support services are delivered by HSE staff in LHO areas in CHO1, CHO4 and CHO5, whereas in stark comparison none of these services are provided by HSE staff in LHOs in CHO6 and CHO9 (Walsh and Lyons, 2021). This is consistent with data from the HSE showing the total number of home helps and WTEs employed by the HSE in November 2021, 2022, and 2023 by CHO areas (Figure 3). It shows that the highest number of home helps were employed in CHO4 followed by CHO5 and CHO1. Smaller numbers of home helps were employed by the HSE in CHO2, CHO3 and CHO8. There are no home helps employed by the HSE in CHO6 or CHO9.

Figure 3: Home Helps (total number and WTE) employed by the HSE by CHO areas, 2021-2023



Source: HSE Health Sector Employment Reports, November 2021, 2022, and 2023.

Given the high proportion of HSE Home Support services provided by HSE staff in CHO1, CHO4 and CHO5 and the higher number of HSE home helps employed in these CHOs, the NDS chose these areas to pilot the Dementia Care and Support: Home Care Education Programme. Interviews with Home Support Managers in these areas for this study revealed that there are also widespread variations within CHO areas. For example, the majority of Healthcare Assistants (Home Support) employed by the HSE in CHO 1 are in Donegal.

Figure 5 shows that between 2021 and 2023 the number of home helps decreased in some CHO areas and increased in others. In CHO 4, the number of WTE home helps decreased by almost 10% between 2021 and 2023, although it remained the area with the highest number of home helps in 2023. There were smaller decreases in the number of WTE home helps in CHO 2 and CHO 5. In contrast, there were substantial increases in the number of WTE home helps in CHO 1 between 2021 and 2023 as well as in CHO 3 and CHO 7, although in these areas the number rose from low levels.

Responsibility for the operation and management of home support in each CHO area lies with Home Support Managers (HSMs). The number of HSMs in each CHO area varies. For example, in CHO 1, there are three HSMs who share the responsibility for home support, with each managing one or more LHO areas. HSMs report to the General Manager in their LHO area, who in turn reports to the Manager for Older Person's Services in their CHO. LHO areas are further divided in a number of network areas. The HSMs is the direct line manager for Home Support Resource Managers (HSRMs), based in local health centres, who have responsibility for the day-to-day management of home support and coordinate HSE-employed Healthcare Assistants (Home Support) in their network area. For example, Donegal, where there are approximately 650 Healthcare Assistants (Home Support) employed by the HSE, is divided into 12 network areas. The 12 HSRMs each coordinate approximately 55 Healthcare Assistants (Home Support).

In a few LHO areas, HSMs have introduced a rota system to organise Healthcare Assistants (Home Support).

2.4 Reforms affecting home care

The Department of Health is developing a new statutory scheme for home support services in line with the Programme for Government and Sláintecare commitments. The new scheme when developed may lead to changes to the delivery of home support and may affect the training requirements of Healthcare Assistants (Home Support). The new scheme may lead to increased demand for home care (Walsh and Lyons, 2021). In any case, demand for home care by people with dementia is likely to grow due to the growing number of people with dementia commensurate with population ageing.

A central element of Ireland's healthcare reform agenda is the restructuring of the HSE into a leaner centre that supports six HSE health regions ((HSE, 2023b), in line with recommendations made in the Sláintecare Report (Oireachtas Committee on the Future of Healthcare, 2017) that regional bodies should be responsible for the planning and delivery of integrated health and social care services. Health regions will continue to be part of the HSE, but authority will be delegated to regional executive officers (REOs) appointed to each health

region, which will function as the primary service coordination and delivery units for the vast majority of health and social care services. Health regions will provide governance and organisational arrangements to plan, manage and deliver care for the people and communities across their respective region. They will have the authority to manage an operational budget with flexibility. While it will take several years to fully reorganise the HSE into health regions, certain arrangements have already begun to be put in place. These include realigned geographical and operational boundaries of existing CHOs and hospital groups; appointment of REOs to six health regions; and revised staffing requirements/allocations, governance structures and processes for the HSE Centre (HSE, 2023b)). It remains to be seen if the restructuring of the HSE will affect implementation of any future roll-out of the Dementia Care and Support: Home Care Education Programme.

3. Methodology

This study is primarily a qualitative study conducted over a five-month period (October 2023 to February 2024). The research used a combination of individual interviews and focus groups to explore the experiences and views of a range of stakeholders involved in the implementation of the dementia education programme in the three CHO areas. ITT provided data on registration and completion of programme as well as reports from external reviewers, which were reviewed as part of this evaluation. An analysis of a small sample of evaluation forms completed by Healthcare Assistants (Home Support) who completed the Dementia Care & Support: Home Care Education Programme was also undertaken.

3.1 Interviews with stakeholders

The researcher recruited stakeholders to the study with assistance from staff in the NDS, who helped to compile a list of 19 stakeholders involved in the implementation of the Dementia Care & Support: Home Care Education Programme. Staff in the NDS contacted each stakeholder to obtain permission to include their names on the list and share their names and contact details with the researcher. The researcher sent an email inviting stakeholders to participate in a one-to-one interview. Of the 19 stakeholders invited to participate in an interview, two stakeholders did not respond, and one stakeholder nominated a colleague to participate in an interview in their place, but it transpired that this person had not been involved in the implementation of the programme. In total, 16 stakeholders participated in interviews, yielding a response rate of 84%. The researcher mostly conducted interviews online using Zoom. The researcher conducted two interviews by telephone at the interviewees' request.

At the interviews, stakeholders were invited to explain their role with respect to the implementation of the dementia education programme, their experiences and views of it, what they found helpful in implementing the programme and any challenges encountered as well as what they perceived the impacts of the programme to be and their views on the future roll out of the programme and any changes they would like to see.

3.2 Focus groups with learners

The researcher held three focus groups with a convenience sample of learners, i.e. Healthcare Assistants (Home Support) who were directly employed by the HSE and had completed the HSE's Dementia Care & Support: Home Care Education Programme during its pilot phase. Home Support Managers, from three areas where the education programme had been delivered, supported the researcher to arrange these focus group. The researcher held the focus groups online. Focus group participants included learners from two of the three CHO areas participating in the pilot phase of programme implementation.

The interviews explored the learners' experiences and perspectives of the programme.

With permission of participants, the researcher recorded interviews and focus groups, transcribed them, and analysed the data using thematic analysis.

3.3 Profile of study participants

Table 2 presents an overview of the sample achieved in the study. Stakeholders included staff from HSE National Offices including the National Dementia Service (n=5), the Programme Coordinator (n=1), Home Support Managers from two CHO areas (n=4), Programme trainers (n=4) and Programme supervisors (n=2). Eleven learners participated in focus groups. In total, 27 individuals participated in either a one-to-one interview or focus group.

Table 2: No. of study participants

Study participants	**Number**
Staff in HSE National Offices	5
Programme Coordinator	1
Home Support Managers for Older People	4
Programme Trainers/Facilitators	4
Programme Supervisors	2
Learners	11
Total	**27**

3.4 Synthesis of findings

Data collected from the various sources were analysed separately and the findings were synthesised.

3.5 Ethical approval

The UCD Research Ethics Committee granted ethical approval for the study in October 2023.

3.6 Strengths and limitations

This study has a number of strengths. It examined a dementia-specific training programme for Healthcare Assistants (Home Support) from multiple perspectives – implementers involved in designing, developing, and securing accreditation for the programme; (2) those responsible for programme delivery or facilitating programme delivery including home support managers and coordinators, trainers, and supervisors; and (3) learners. The researcher used several techniques to enhance the quality of the research. Concordance across perspectives increases confidence that the findings are robust, and a 'constant comparison' approach helped ensure that the researcher could treat data from all sources as a whole and identify emerging themes and themes not anticipated. The researcher also sought out, examined, and accounted for contradictory evidence in the analysis.

A limitation of the study is that not all areas where the programme was piloted are represented at all or fully in the study, due to a combination of non-response and short timeframe available to complete field work. The study does not include the perspectives of certain groups such as health care professionals who withdrew from their supervisory roles, HSRMs, Healthcare Assistants (Home Support) who chose not to participate in the programme or who dropped out of the programme. Inevitably, elements of the approach to

participant selection and recruitment introduced a certain degree of risk of selection bias in participant composition.

4. The Dementia Care and Support Home Care Education Programme: A brief overview

A collaborative team of people comprising staff from the NDS, the HSE and DCU developed the Dementia Care and Support: Home Care Education programme. During programme development, the collaborative team consulted with people with dementia, their family carers, and relevant community-based staff, and used their feedback to inform the programme's design. The programme originated in a non-accredited two-day training programme, which was successfully delivered over a two-year period between 2019 and 2020 to over 900 Health care Assistants (Home Support).

Table 3 summarises the key dimensions of the Dementia Care and Support: Home Care Education programme. The programme targets Healthcare Assistants (Home Support) who are employed by the HSE to directly provide home support to older people including people with dementia living in their own homes. The education programme refers to those participating as learners. The programme aims to produce Healthcare Assistants (Home Support) who are skilled, reflective, and self-aware and provide care with humanity, empathy, and dignity.

The Dementia Care and Support: Home Care Education programme is a QQI Level 5 accredited programme. It achieved accreditation in 2020, following partnership with Irish Times Training and a robust accreditation process. To meet QQI Level 5 accreditation standards, a programme must have 50 hours of learning, which meant that significant changes were made to the original two-day programme. To meet the specified number of hours of learning, the programme was extended from two to four days, and supplemented with weekly supervision. The programme accredited is a Level 5 Special Purpose Certificate in Dementia Care and Support. The accredited programme is based on six modules or units, designed for delivery in-person by trainers over a four-month period, although the programme is also accredited to be delivered online. Ideally, a learner will have completed at least two modules on a healthcare major before starting the programme or have five or more years of experience as a Healthcare Assistant (Home Support) providing care to a person with dementia. Learners attend four day-long-sessions. They complete two modules or units per session. The session on the final day comprises a revision unit and a skills demonstration, recorded for assessment purposes.

All trainers complete a training course delivered by ITT before delivering the programme and provide regular feedback to ITT and the programme developers. The modules are supplemented with a weekly supervisory component facilitated by healthcare professionals qualified and experienced in dementia care. This element of the programme was introduced as part of QQI accreditation. For the pilot programme, the NDS recruited supervisors.

As part of the programme there are self-learning exercises. While learners gain an understanding of dementia (including belief systems and attitudes), there is a strong emphasis on self-development (stress, self-care, boundary setting, relationship building) and ethical and strengths-based approaches to care.

Table 3: Key dimensions of HSE's Dementia Care and Support Home Care Education Programme

Dimensions	Details
Programme provider	Irish Times Training
Programme intakes per annum	18
Professionals targeted	HSE-employed Healthcare Assistants (Home Support) working with people with dementia
Mode of delivery	Face-to face sessions, supported by practical and reflexive exercises completed in the workplace and reflected on in journal assignment that learners are required to keep over the duration of the programme.
Programme length	Six units delivered over four months.
Facilitators	Facilitated by trainers selected from a panel of qualified trainers who have completed a train the trainer programme delivered by ITT
Supervision	Supervision is facilitated by supervisors who have an hourly online meeting with a group of learners on a weekly basis between the in-person sessions.
Sites delivered	Piloted in: CHO1 (Donegal, Cavan/Monaghan, Sligo) CHO4 (Cork and Kerry) CHO5 (Kilkenny)
Venue	Local venues including hotels, HSE facilities, Education and Training (ETB) Board facilities
Group size (Minimum and maximum per intake)	17-20 per intake; 18 intakes per annum
Accreditation / Incentive	QQI FETAC Level 5 Accreditation / Level 5 Specific Purpose Certificate in Dementia Care and Support
Assessment	Written assignment (3,500-word assignment) Skills demonstration (recorded for assessment purposes)

The National Dementia Services team oversee the programme and its implementation. The HSE awarded the contract to deliver the accredited programme to ITT. The HSE's Leadership, Learning and Talent Management unit, led by the general manager, manage the contract with ITT. HSE Leadership, Learning and Talent Management (LLTM) also hold responsibility for the application process. Ensuring that Healthcare Assistants (Home Support) are prepared for going on the programme lies with LLTM. Administrators in the four LLTM regional teams around the country support administration of the application and preparation process. At local level (i.e. within Local Health Office areas), Home Support Managers are responsible for the day-to-day operation of identifying, recruiting, and releasing Healthcare Assistants (Home Support) to participate in the programme and for administering the application process at local level. NDS staff spoke to Home Support Managers to inform them of the requirements needed to complete the course.

The Department of Health supported the pilot of the Dementia Care and Support: Home Care Education Programme, through Dormant Account funding, used for the development of the programme. Following accreditation, further funding was allocated to engage ITT to deliver the programme, pay trainers, and hire venues. Supervisors did not receive payment during the pilot programme. Funding was allocated to pay Healthcare Assistants (Home

Support) participating in the programme for the hours that they attended the programme and travel expenses incurred. To facilitate the release of Healthcare Assistants (Home Support), the HSE made funding (referred to as backfill funding) available to Home Support Managers, for use as a contribution towards the cost of a locum person to provide home support while a Healthcare Assistant (Home Support) was attending the programme. This was set at a rate of €150 per person per programme. For example, this would amount to €3,000, where there were 20 learners on a programme and the HSM availed of backfill funding for each learner. The purpose of backfill funding was to make it easier for HSMs to release a Healthcare Assistant (Home Support) to participate in the education programme. None of the pilot sites availed of backfill funding.

The HSE piloted the education programme in three areas, i.e., CHO1, CHO4 and CHO5, selected by the NDS for the delivery of the pilot programme. Following the pilot phase, the intention is that the NDS will roll out the programme throughout the country with recurring funding from the Department of Health.

Table 4 shows the assessment of the Dementia Care and Support: Home Care Education programme against the key features of more effective dementia education and training programmes, as identified by Surr et al. (2017). It shows that, apart from being a one-size fits all programme for Healthcare Assistants (Home Support), the programme has all of the other key features of effective programmes.

Table 4: Presence of features for effective dementia education and training in the Dementia Home Care Education Programme

Features	Present
Relevant to role (as reported by participants)	Yes
Relevant to experience and practice of learners / Not one-size fits all	Yes - developed specifically for Healthcare Assistants (Home Support) and relevant to their experience / **No, it is a one-size fits all**
Includes active participation	Yes
Underpins practice-based learning with theoretical or knowledge-based content	Yes
Experiential learning includes adequate time for debriefing and discussion	Yes
Experienced trainer / facilitator who can adapt to the needs of the groups	Yes
Does not involve reading written materials (paper or web-based) or in-service learning as the sole method of learning	Yes
At least 3 hours with individual sessions of at least 90 minutes	Yes
Active, small, or large group face-to-face learning either alone or in addition to another learning approach	Yes
Includes learning activities that support the application of learning into practice	Yes

Funding through SOLAS (www.solas.ie) has allowed for the programme to be delivered by ITT in partnership with the Laois & Offaly Education Training Board in parallel to the HSE Dementia Care and Support: Home Care Education Programme. While both programmes are based on the accredited QQI Level 5 programme and both lead to the same award, the SOLAS-funded programme is distinct in the following ways. The SOLAS-funded programme started later. The funding available from SOLAS is greater than the funding for the HSE-funded programme. The target group of learners is much broader. The ITT is delivering the programme through the Laois & Offaly Education Training Board on a closed basis. Delivery of the programme is over a longer duration, using a blended approach. The supervisory element works differently. Evaluation of the SOLAS-funded programme was outside of the scope of this review. However, where participants referred to it in interviews, raised issues of relevance to the HSE Dementia Care and Support: Home Care Education Programme, these issues are covered in this report.

5. Perspectives on programme implementation

This chapter reports on the experiences and perspectives of study participants on the implementation of Dementia Care and Support: Home Care Education programme. It draws on interviews with staff involved in the implementation and delivery of the programme and on focus groups with learners. A core focus is on factors that contributed to and enabled successful implementation of the programme and on the challenges encountered in implementing the programme.

5.1 Commitment to the programme is high but implementation required time and effort

A strength of the implementation process was that commitment to programme implementation was remarkably high among staff working at a national level on implementing the programme, helped by good working relationships between all those involved.

> "In terms of benefits, I think it was working together on it, I suppose, and having everyone very committed to the end goal, which was to really make a difference to service users and their families, you know." [SH001]

There was also good buy-in and commitment from many of the staff involved at regional and local levels. Good relationships developed over a longer period between the NDS, and local managers helped with progressing implementation.

> "We'd ongoing contact from the NDO [NDS] about different things that are going on so they would have engaged with us around their pilot of the course at that time. 'Would we be interested in doing this?' We said, 'we would' and they said, 'happy days' and we said 'Okay, let's drive on and let's pilot it anyway, and be one of the sites." [SH009].

Even where there is a well-developed education programme, accompanied by high commitment and good working relationships, the amount of time and effort to implement a new intervention for the first time is considerable and often underestimated (Pierce et al., 2019). This is especially the case when programme implementation occurs in a number of different settings and contexts with many different stakeholders involved, as was the case with the Dementia Care and Support: Home Care Education Programme. Implementation involved a multitude of tasks and activities including selecting CHO areas for inclusion in the pilot programme; promoting the programme to HSE staff in different CHO areas and at different managerial levels from Chief Officers to local Home Support Managers; informing stakeholders about the programme; seeking commitment and buy-in; engaging and building relationships with local managers within the HSE; devising strategies and establishing processes for identifying, recruiting and releasing Healthcare Assistants (Home Support) to participate in the programme; providing Healthcare Assistants (Home Support) with information about the programme and preparing them for participation; finding suitable venues in each local area; recruiting, training and supporting trainers and supervisors; and supporting learners whilst on the programme.

5.3 HSMs and HSRMs play a key role in facilitating programme implementation

Implementing the programme would not have been possible without cooperation from HSMs and HSRMs. Before deciding to participate in the pilot programme, HSMs reviewed the education programme and considered the feasibility of delivering it within available resources. HSMs also considered whether the programme would bring added benefits to home support services when deciding to participate in the pilot programme. Some HSMs consulted with HSRMs to ensure they had their buy-in and commitment. HSMs identified consultation and joint decision-making with HSRMs as an important enabler for successful delivery of the programme. All HSMs identified an ongoing need for dementia-specific training for Healthcare Assistants (Home Support) in their areas, which fuelled their interest in the dementia education programme. In some areas dementia-specific training had been earlier identified as a priority training issue for Healthcare Assistants (Home Support). HSMs argued that the need for dementia-specific training had become even more pronounced because of the increase in the number of clients that their home support services were supporting, and consequently the greater number of clients with dementia supported.

> "… what keeps coming back from our managers is the kind of, yes, there is an ongoing need for specific dementia training and support for our staff particularly for those there, because the numbers are increasing year on year in terms of our client cohort, and those presenting with Alzheimer's and dementia, it's becoming a challenge for us in that context, in the level of care that's required, the interventions that are required and again, it's supporting staff to … that's why we're trying to … concentrate on prioritising it." [SH009]

Healthcare Assistants (Home Support) who participated as learners on the programme reported that they were supporting a high number of people with dementia but apart from one module in the QQI Level 5 Care Skills course which 'touches on dementia', they had received no prior training in dementia care.

> "We have a lot of clients that have dementia and I think it's on the increase as well." [L2, Focus group 1]

In some LHO areas, HSMs reported that the average number of home support hours allocated to clients with dementia had also increased, changing the nature of care and support, which had training implications.

Some HSMs placed a high value on training for Healthcare Assistants (Home Support) generally. As one HSM put it: "… I value every bit of training that our care staff are getting" [SH010]. This HSM believed that facilitating access to dementia-specific training was positive as it signalled a willingness on the part of the HSE to invest in the development of Healthcare Assistants (Home Support) and communicated a message that HSMs take an interest in and value the work of Healthcare Assistants (Home Support).

Some HSMs pointed out that their history of working with the NDS and innovative community-based dementia initiatives and projects (such as the K-Cord project in Cork), had led to the identification of dementia as a priority area for service improvement in their CHO /

LHO area. When dementia was a priority issue, it meant that HSMs were continually looking for and open to ways of integrating dementia into home support services to improve the lives of people with dementia, such as when approached by the NDS about participating in the pilot Dementia Care and Support: Home Care Education Programme. However, HSMs pointed out that implementing new initiatives and bringing about change was not always easy due to resource and time constraints and the demands of other competing priorities.

HSMs expected that training Healthcare Assistants (Home Support) in dementia care would bring about service improvements, especially for clients with dementia who have behaviours that challenge. According to HSMs, some Healthcare Assistants (Home Support) are well able to meet the needs of clients with dementia, including those with behaviours that challenge, but others struggle and find it difficult. HSMs expected the training programme would benefit the former group of Healthcare Assistants (Home Support) by further enhancing their skills. They expected that with a greater understanding of dementia and behaviours that challenge, the programme would equip the latter group of Healthcare Assistants (Home Support) with the knowledge and understanding they needed to be able to support these clients. HSMs and HSRMs try to match clients with challenging behaviours to the more skilled Healthcare Assistants (Home Support), but this is not always possible. Having a greater pool of skilled Healthcare Assistants (Home Support) would they believed make it easier to match Healthcare Assistants (Home Support) with clients.

5.4 HSMs used different approaches to identify and recruit learners

Implementation of the pilot programme required HSMs putting processes in place to identify, recruit and release Healthcare Assistants (Home Support) to participate in the programme. HSMs used one of two main approaches to identify and recruit Healthcare Assistants (Home Support). In the first approach, HSMs reached out to all HSRMs in the LHO area and asked them to identify two to three Healthcare Assistants (Home Support) each. HSMs adopting this approach argued that selecting staff from different geographical areas made it easier to release Healthcare Assistants (Home Support) to participate in the programme.

> “What we did was we divided ... here into networks. So, there's eight Home Support Resource Managers. So, we gave an equal amount to each area so we could say that we had some somebody with the skill if we had a client [with challenging behaviours], and we do actually have … a challenging client … at the minute.” [SH010]

> “Like you couldn't have everyone going from one geographical area on the course. Otherwise, the service wouldn't be delivered. So, you’re looking at geographical areas, you know, small towns, and you probably have one carer from each area. So, you're looking at your Home Support Resource Managers and asking them to nominate two or three carers.” [SH012]

In the second approach adopted in areas such as Donegal and Cork, HSMs selected two network areas to participate in the programme and asked HSRMs in these two areas to identify 20 Healthcare Assistants (Home Support) each.

The provision of information from HSMs and through HSRMs to Healthcare Assistants (Home Support) also differed. In some areas, information was sent out to all Healthcare Assistants (Home Support) in the selected areas asking them to submit an expression of interest to HSRMs. HSRMs then met with Healthcare Assistants (Home Support) to tell them more about the programme and what taking part would involve, discuss release from work, and offer their support and reassurance.

Other areas adopted a more selective approach. In these areas, the HSM left it to HSRMs to promote the programme and identify or nominate Healthcare Assistants (Home Support). In areas adopting this approach, Healthcare Assistants (Home Support) identified for participation in the programme tended to be those currently supporting clients with dementia or who were known to have an interest in and be skilled at supporting people with dementia. This latter approach seems to be at odds with the intention of the programme which was to target all Healthcare Assistants (Home Support).

> “We made this clear to the homecare manager that we don't want you to send us somebody that's currently all the time caring for a person with dementia because the next client could be a person with dementia. So, everyone needs to be trying to change a bit.” [SH017]

HSRMs had the task of explaining the programme to Healthcare Assistants (Home Support) including that it was QQI Level 5 accredited and what that would mean in practice in terms of coursework.

> “They [HSRMs] would have known one or two people who would be up for it, and also in the context of who would be very good with providing support to people with dementia and had an interest in it themselves, because not everybody does or did, so they would have been given that task to go look, identify you know the people in your area that you call on and this would be an additional support for them.” [SH009]

> “I suppose we asked them to bear in mind too I suppose that it was a QQI and that there would be certain level of coursework and stuff with that, and to explain that to the carers in this sense, coming on as well you know …” [SH009]

While the ITT/NDS developed information materials, such as FAQs, and made these available to Healthcare Assistants (Home Support) through HSMs, there wad also a reliance on HSRMs to communicate information about the programme to Healthcare Assistants (Home Support). While the NDS explained requirements in full to HSMs through correspondence and conversations, it is not clear how much information about the programme was communicated to all HSRMs.

> “The line managers [HSRMs] have to put time in, and my experience has been depending on the CHO area very much depended on the … quality of information that the learner was provided when they came to classroom. So that is a challenge.” [SH003]

The initial plan had been for ITT to interview all prospective learners before coming on the programme, and while this happened at the start of the pilot programme, it did not continue.

Instead, it was decided that HSRMs would have a conversation with Healthcare Assistants (Home Support) and assess their suitability for the course. It is not clear how well-equipped Healthcare Assistants (Home Support) were to carry out this role. The ITT developed an application form to support the recruitment of Healthcare Assistants (Home Support). The application process involved HSRMs, HSMs, LLTM regional administration staff, staff in the LLTM national office, and ITT. Participants described the application process as overly complicated and cumbersome.

5.5 Learners' motivations to participate in dementia care training

In focus groups, learners shared the reasons why they chose to take part in the programme as well as their initial reactions to the invitation. Firsthand experience of caring for a relative with dementia motivated learners to take part in the programme as well as work-related reasons. Many learners spoke about the gap in their knowledge about dementia care, the guilt they felt knowing that they were providing sub-optimal care, and the desire to have the knowledge and skills that they could bring to their everyday care practice and improve the lives of people with dementia and their family carers. Below is a selection of quotes from the interviews and focus groups illustrating these points.

> "Partially personal, because I had a mother who was diagnosed with dementia … and I was at a loss as to how to deal with that and obviously wanted answers and I mean she was dead by the time I'd done this programme but I'm so sorry she is because I think I could have, you know, done a lot more to make her relaxed and less agitated and happy. So, there's the personal thing, but also the fact that we just … every second client we go to literally now has dementia. We're dealing with it so much, and the clients' families too that when I come to see the levels of stress that they're under … and they'd look to me as an expert and asked me questions and I felt I haven't been able to answer the questions, but now, you know, I feel I can do. And so, these were the things that drew me to doing the course and I'm really happy I did." [L9, Focus group 2]

> "You have people saying 'I really want to learn more because I am going to have more [clients] with dementia. And I am going to be looking after them and I really want to learn more.' Some might have had a particular interest in it." [SH018]

> "The whole field [of dementia] I find very, very interesting and really feel like that we all need to be educated a little bit more and of course, from a work point of view, anything that I can do to help me in my day-today practice is always welcome, you know." [L10, Focus group 2].

> "There are so many clients out there now with dementia and like I'm pretty new to the HSE as well. I just felt in my [Care Skills] course I didn't receive enough training [in dementia care] and then you walk into a house and you're just …" [L4, Focus group 1]

> "… if you're asked to go to a person with dementia, the first thing you think 'Oh God, am I going to be able to cope with this?' because I always found them to be the hardest jobs, not the physical side, but actually just trying to get them to go along

with what you need to do. I'm a carer and what I do really is usually have the person get washed and dressed and a lot of dementia clients that I have worked with want to do the exact opposite, you know what I mean, and I have had a lot of experience of people where I felt that I had kind of let them down in some ways or, you know, sort of pushed them into doing something that they didn't want to do and I didn't like that you know and I kind of thought there must be some key to understanding, you know, how to work with somebody …" [L8, Focus group 2]

"It's a very important issue and all over the years I've worked with the HSE, I was shown how to do everything, all the practical skills, washing, cleaning, you know, manual handling, all these things, use equipment. I could do all that, but nobody ever told me how to cope with a dementia person and I felt very untrained and inadequate. So, I just wondered about this course, to see what they could tell me about it without carrying my inadequacies with me. So, the more people I worked with the better I became at managing them, but it's more than about managing them, isn't it? It's about knowing them and understanding them and that's why I decided I wanted to do the course and see how I got on." [L8, Focus group 2]

Healthcare Assistants (Home Support) who participated in the programme were eager to be selected for inclusion in it.

"Well, I jumped at the chance." [L1, Focus group 1]

Some, however, were concerned about the level of commitment or had fears about their ability to complete the course, highlighting the importance of good information and support at programme recruitment stage.

"First of all, when I seen it, it was kind of like over … was it six months that you were doing the course … and I says 'Oh no', but I just says you know 'Will I or won't I?' so then I just rang up the people that were doing it, the Irish Times [Training], and just asked them a few questions and that and they said that you'd have, you know, the support there and they'd go through all the topics, and what you have to write and that … and so I decided to go for it." [L11, Focus group 3]

"Your biggest fear was that you hadn't done any education like in a long time, do you know, that you haven't been in a classroom setting like and you wonder like, would you be able for it, do you know. Even though the topic is very interesting like, you'd be wondering would you be able for the assignments." [L5, Focus group 1]

5.6 Number of programme intakes was low

The programme was delivered eight times during the pilot phase, which was much lower than the planned 18 programme intakes per annum (see Table 3). Implementing the pilot programme took a lot longer than expected, due mainly to delays to the start dates of programmes.

"And there's constantly things pushing out, so it took a lot longer than we expected." [SH001]

Data are available only on actual start dates of programmes, and without data to compare planned versus actual start dates, it is hard to know the length of time that programmes were delayed and if there were differences across areas. However, participants identified three main factors contributing to delays: the Covid-19 pandemic, delays in recruiting learners, and difficulties recruiting and retaining supervisors.

The Covid-19 pandemic caused major delays to the commencement of programmes. The first case of Covid-19 was confirmed in Ireland at the end of February 2020, shortly after piloting of the education programme had commenced. As programme delivery had been planned with a face-to-face format, the Covid-19 pandemic unsurprisingly had a significant impact on the delivery of the programme.

> “I think I was asked two or three months before it ever began. Well, a good shot before that, because I think Covid put paid to it. I actually didn’t even think it would still happen. I think I got asked an awful long time before it actually happened.” [L7, Focus group 1]

While a decision was taken to move one programme that had already commenced online, it proved to be extremely difficult to continue delivering the programme that way. An exacerbating factor was that there were learners who did not have the IT facilities to access online training and there was also concern that the day-long duration of the units was unsuitable for online training.

> “Because the cohort of learners that we're targeted towards, a lot of them wouldn't have access to a laptop or the facilities to attend online training and plus online training for that duration it's too long. We kind of acknowledged that so we kind of paused for a bit and didn't really drive it as much as we could …” [SH017]

The second factor causing delays to the start of programmes was the time it took at local level in some areas to identify and recruit staff. HSMs in some areas were able to put processes in place for identifying and recruiting Healthcare Assistants (Home Support) quite quickly. In other areas this seems to have been much more protracted and took a longer time to identify staff to participate. Participants attributed this in part to the busy working environments and workloads of HSMs who have many competing and often changing priorities but also to the value they placed on dementia and dementia-specific training.

> “Some of the home care managers really got it and got how important this was in terms of providing care for people with dementia. And then it's like others didn't really rate it or value it, or see it as that important, because you know, they're busy as well. and they have so many people pulling off them.” [SH018]

Processes have now been put in place in the pilot areas to support future roll-out of the programme, and these can be adopted by other areas that have yet to participate in the programme. A further issue contributing to the small number of programme intakes was that delivery of the programme only took place once in each area. Some HSMs would like to have been able to run the programme on an ongoing basis during the pilot phase and were

disappointed that they had not been given the opportunity to do so. This would have increased the number of programme intakes.

> "We were hoping it would be ongoing training so that we would have places all the time." [SH010].

The third factor causing delays was the supervisory element of the programme. While the Covid-19 pandemic slowed down programme delivery in the initial stages, the supervisory element of the programme proved to be a major challenge throughout the pilot. The next section covers the issues encountered.

5.7 Lessons learned about the supervisory element of the programme

The supervisory element, a key component of the Dementia Care and Support: Home Care Education Programme, aims to enhance the effectiveness of the training. This element of the programme makes it distinct from other QQI Level 5 programmes for care workers. When the programme was originally designed, it was planned to have HSRMs facilitate the supervisory sessions, but this proved unworkable, indicating that supervision is clearly an organisational challenge in Home Support, as has been noted elsewhere (Leverton et al., 2019). In the pilot programme, nurses or allied health professionals who have at least two years' experience of supporting people with dementia facilitated supervision. Supervisors were required to have completed the Facilitator Training Programme associated with the programme or have a clinical nursing background. As part of programme delivery, supervisors have an hourly online meeting with a group of learners, which takes place on a weekly basis between in-person day-long sessions.

Programme implementers anticipated from the outset that implementing the supervisory element of the programme would be extremely challenging.

> "I said … 'I think that that's going to be really challenging piece to implement', because I was aware of the pressures that are on the supervisors and the people who work in that area and I just said that you know my experience of trying to get people to take on a role that is in addition to their own very busy roles is really, really challenging." [SH001]

It turned out to be even more challenging than had been anticipated, with stakeholders describing it as the 'number one challenge' [SH018]. The NDS took responsibility for identifying and recruiting supervisors. Interest from health professionals to train to become programme supervisors had initially been high. However, there were strict eligibility criteria to become a supervisor, which reduced the pool of health professionals from which the NDS could draw. Some health professionals who had completed the training were not available to take on the role of supervisor when a programme was about to commence. These challenges in recruiting health professionals to take on the role of supervisor delayed the start of programmes, affecting the number of intakes.

Once health professionals had been recruited, there was the ongoing difficulty of retaining supervisors. When a new programme commenced, supervisors were allocated a cohort of learners with whom they had to make contact and organize the weekly, online supervisory sessions. According to supervisors, arranging and scheduling supervisory sessions was

hugely time consuming and incredibly challenging, especially the first time around as there was no processes in place for this and it was often difficult to find a time that suited both supervisors and learners. This was in the context of health professionals taking on the role as supervisor in addition to their existing workload, which had become increasingly pressurised because of the Covid-19 pandemic. It was not unusual for supervisors to withdraw halfway through a programme driven by the burden that administration placed on their time, lack of clarity around supervisor role and commitment required of learners, the existing workload demands of health professionals and sometimes personal reasons. Lack of engagement with supervision on the part of some learners was also a contributing factor. There was no reimbursement for the time supervisors they gave, and it became possible to deliver the programme only by relying on the 'favours' of a small pool of health professionals, which became less practicable as time went on.

> "We would have a supervisor that would take on a cohort of learners, and halfway through saying 'I can't do this anymore,' and … I'd have to ring other supervisors and say 'Please, can you take … another one of these,' and I felt I was always drawing on the same people. As much as we had their support, I could see we were nearing the end of the favours we were being given." [SH017]

Finding replacement supervisors was very onerous for the staff in the NDS who were tasked with the responsibility of recruiting supervisors and it required a large investment of their time. In addition to the challenges recruiting and maintaining supervisors, learners had mixed experience of supervision, even within local areas.

> "Our mentor was very good, and she was there for every session. She was very supportive, and she didn't interfere with what we learned but she did help to guide us in different situations. She was a very good, a very, very good mentor. It was very beneficial, and we actually looked forward to some feedback and some affirmation that were doing okay and so on and so forth." [L1, Focus group 1]

> "In my group, the three people that I have … my mentor, we barely saw our mentor. The first one disappeared, personal reasons, work reasons, I don't know. And then what appointments we did have afterwards … fair enough one of us wouldn't be able to make it or something, but it would have gone ahead with the other two, but we had a lot of our sessions cancelled. I'd be brutally honest with you, and I didn't cancel any, I'd say I had two, three." [L7, Focus group 1].

Some found that there was a disconnect between the classroom and supervisory session. This could lead to learners receiving conflicting messages. Learners would like to see more collaboration between the tutors and supervisors to address this.

> "When the first day was over, you did a Zoom call with your mentor. You write down your notes from the class, and then the mentor will say something totally different, so it's not really related, you know. Going forward, there should be more communication towards the classroom based and the mentor." [L5, Focus group 1]

It was well recognised by participants that the supervisory element of the HSE Dementia Care and Support: Home Care Education programme was extremely challenging and

needed reworking. The SOLAS-funded iteration of the programme (see pp. 20-21) allowed ITT to introduce and trial three main changes to the supervisory element. The first change was to include dedicated time for supervision on the timetable, with specific dates for supervision allocated before a programme commenced, thereby removing the responsibility from organising dates and times from the supervisors. The second change was to allow tutors who had completed the training programme to work as supervisors and vice versa, with the stipulation that the supervisor allocated to a learner would not be the same person facilitating that learner's training. Third, a payment for supervisors at the same rate as tutors was introduced. According to ITT, the supervisory element is working very well in the SOLAS-funded programme following changes made. The NDS plans to incorporate the same changes into the HSE-funded programme when they roll it out nationally.

5.8 Programme take-up targets mostly achieved

A minimum and maximum group size of between 17 and 20 learners was specified for running a programme. Table 5 shows the number of learners recruited to each of the eight programmes delivered between November 2021 and April 2023.

Table 5: Programme take-up, completion, and retention rates by area

CHO area	Local area	Learners registered (n)	Learners completing the programme (i.e. awarded Certificate)	Retention rate (%)
1	Donegal (Buncrana)	18	17	94
1	Donegal (Letterkenny)	19	14	74
1	Sligo	9	7	78
1	Cavan/Monaghan	15	10	67
4	Cork (Cork City)	20	15	75
4	Cork (Bantry)	21	18	86
4	Kerry	19	19	100
5	Kilkenny	18	16	89
Total		**139**	**116**	**83**

Source: Irish Times Training

The minimum number of learners specified was achieved for programmes delivered in most areas. One HSM as well as some learners indicated that more places could have been filled if they had been available:

> "If we had another five places we would have filled it, do you know." [SH010].

> "I think there were limited places. So, I think our names were put in a hat, so it was a kind of a lucky dip." [L1, Focus group 1]

The number of learners registered was below the minimum specified in Cavan/Monaghan and reached only about 50% in the Sligo area. It was believed that take-up would be less of a problem when the programme is run a second time in these areas, as the cohort of Healthcare Assistants (Home Support) who have completed it would be available to share their experience of participating with Healthcare Assistants (Home Support) coming onto the programme and be there to reassure them and be a source of peer support. It may be that

as a new programme becomes embedded in an area, take-up increases. Nevertheless, participants identified a range of other factors important for successful take-up as outlined next, but the extent to which these were responsible for producing the actual differences in take-up among areas is not clear.

Organisational support was perceived to be an especially important factor. This included HSMs placing a value on the work of Healthcare Assistants (Home Support) and implementing changes to demonstrate that. For example, one area had introduced structured annual leave for Healthcare Assistants (Home Support) with locums to cover leave, and participants perceived this to be leading to Healthcare Assistants (Home Support) feeling more valued, and in turn more open to training. Organisational support also included having area managers (HSMs and HRSMs) with a positive attitude towards education and who place a high value on education and training of Healthcare Assistants (Home Support) generally and dementia-specific training specifically.

> “So, we like the staff to get every opportunity that ourselves will get and I think there's a very good interest in staff, and you don't always get that … we try and invest in them, you know.” [SH010]

> “If you have a manager that's very proactive, that people want to work for them, generally they’ll have a good staff retention and possibly that might make it easier for them to release staff for programmes like this.” [SH019]

Participants believed that in the pilot programme this translated into HSRMs identifying and recruiting the required number of Healthcare Assistants (Home Support) for participation, as, for example, they put much effort into ensuring that staff could be released. Other issues related to organisational support included the involvement of HSRMs in decision-making; goods relationships and high levels of engagement between HSRMs and Healthcare Assistants (Home Support) including HSRMs being available to meet with Healthcare Assistants (Home Support) to motivate them to take part in training, provide information about the programme, and offer reassurance and support.

> SH018: “I would say in places where there was no hassle, the homecare manager was really invested in the area of dementia, and really saw the importance of it, in other areas and I just think …”
>
> I: “Do you think that made a difference [to take-up]?”
>
> SH018: **“**Yeah, yeah, I think so. It's like everything yourself, you know, if you're interested in something, you're going to put more work into it, you know, and then some areas just, I think the home care managers are just so stretched they can't find people. They're just everyone is calling and pulling at them. And I think it might have been like ‘Oh, God! Another thing for us to do, do you know and organize,’ and it was like ‘Oh my God, I'm going to have like 15 to 20 people missing one day a week for four more like ‘No, I can't do that, you know’. So, it was just … but by and large I have to say the homecare managers were fabulous.”

Section 5.5. outlined the motivating reasons given by Healthcare Assistants (Home Support) who took part in the programme. This study did not include any Healthcare Assistants (Home Support) who chose not to or were not selected to participate in the study. However, other participants suggested a wide range of reasons for why Healthcare Assistants (Home Support) might not take part in the programme, but these would not explain the differences in take-up across areas. The reasons included early school leaving; low qualification levels; age; lack of confidence; and anxiety and apprehension about participating in a QQI level 5 programme. Limited educational experience and low qualification levels and skills are known to specific learning barriers for the homecare workforce that impact on staff attitude, confidence and motivation towards training and education (Cunningham et al., 2020). Other perceived learning motivation barriers identified by participants included the time pressures that Healthcare Assistants (Home Support) are under due to the nature of their work; the time commitment required to complete the programme including travelling to the venue but particularly for completing assignments; family/life responsibilities; non-requirement for continuous professional development; low pay; the low value placed on home support; and lack of opportunities for career progression and lack of other incentives such as increases in pay. Some participants put themselves in the shoes of Healthcare Assistants (Home Support) to try and understand the barriers to participating on the programme and their contribution to perceived problems with take-up.

> “I think people were shying off because, you know, the online [supervision] bit, a lot of people were put off by that. Anyway, there didn’t want to do it online and they didn’t want to do the written essays etc. so that stopped, discouraged people. But at the same time, there was an interest in learning anyway, yeah.” [L8, Focus group 2]

> “… if I'm a healthcare support assistant and I'm under pressure, going from call to call, to call to call, when am I going to fit this programme in, drive to the area to do it and then coming back. I have to learn my homework, do my homework, do my assessments. I also have to meet my supervisor and still see my clients and run my home. It’s a difficult ask of people.” [SH017]

> “You know, it's … they're in a job, they're going out into the homes. There's no progression if you like. So, it's kind of like ‘I don't have to do this course. Why should I do this course? It's not going to further my career. Do I really need to do it?” [SH018]

The use of IT by Healthcare Assistants (Home Support) in their jobs is low and HSMs pointed out that they do not have use of a HSE phone or access to HSE email. Participants perception was that low literacy levels and poor IT skills have become less of an issue over time, but they believed that these and poor access to IT continued to be an issue for some Healthcare Assistants (Home Support). IT abilities have been identified as motivational barriers to learning and particularly relevant in rural locations (Cunningham et al., 2020). Low literacy and poor IT skills are issues that the contracted education provider has a lot of experience with and offers support to learners through dedicated support officers, but there seemed to be little awareness among most of the study participants of ITT’s expertise in this area.

Research reviews have highlighted a range of other barriers for the homecare workforce that impact on their learning motivation and their professional development, but these were not cited by individuals participating in this study. These barriers include low job satisfaction, burnout, emotional strain combined with limited emotional support and lack of preparation for death and end-of-life clients, which may be heightened for the homecare workforce supporting people with dementia (Cunningham et al., 2020). While the need for home care workforce to have emotional training and preparation to manage the intimacies of close-caring, personal boundary issues alongside self-care has been highlighted by Cunningham et al. (2020), 'workforce stress, low satisfaction and burnout enhanced negative learning motivation and individual capacity for extended learning' (p. 2795).

In one area with low take-up, Healthcare Assistants (Home Support) reported being criticised by other Healthcare Assistants (Home Support) for taking part in the education and training programme.

There was a perception among some stakeholders that the programme (i.e. QQI level 5) was pitched at too high a level for the cohort targeted, but again this would not explain differences in take-up across areas.

> "There are some staff that it does not suit because of the level that it's at, it's a QQI and the commitment is high and that's a standard qualification and it's a great achievement when they do it, but …" [SH009]

> "We'd be very conscious that with our staff cohort there's some people, not everyone, no, I wouldn't say that, but to take into account that some people may struggle with the more theoretical academic side of it [the programme]." [SH009]

> "I mean I've had phone calls where the healthcare support workers are ringing me and they're like 'I don't even have a Junior Cert.' 'I've never been to school.' 'I finished school at 14', and now they're expected to do all of this coursework and just sometimes it's a bit too difficult." [SH018]

There were contradictory views on the influence of staff shortages and ability to release staff on take-up of the programme. Those at national level argued that these were significant issues.

> "They're [HSMs] in very busy roles so even releasing staff to attend the programmes was a huge challenge, you know, there would be a lot of toing and froing about people, you know, coming on the programme and then not coming on the programme and huge challenge in getting people released to attend the programmes." [SH001]

However, from the perspective of HSMs participating in the study, staff shortages do not seem to be a major factor influencing take-up. Only one LHO area reported experiencing difficulties with staff recruitment and retention, but this turned out to be the area with the highest take-up. Some HSMs reported that releasing staff could be challenging but was manageable. In two of the LHO areas, HSMs had introduced a rota system, which means that in each area managed by a HSRM, half of the Healthcare Assistants (Home Support)

are on duty and half are off at any one time, making it very easy for HSMs to release staff for education and training. A HSM in one of these areas stated that: “releasing staff is not a problem when you have rosters in place.” They argued that introducing a rota system could help overcome problems other areas might be having with staff release. As mentioned earlier, backfill funding was not taken up by any of the pilot sites, which, according to HSMs, was because it was largely irrelevant.

> “It's [the backfill funding] never been a factor into whether we've gone with it [the programme] or not. It’s not that. The contribution is helpful, but it doesn't make any difference in that it doesn't sort out the scheduling or the rostering. As a cost towards in terms of finding the cover, in theory yes, but in a practical operational way no. We never considered that.” [SH009]

5.9 Learners are well supported on the programme, but not always well prepared

While some learners confirmed that they had being well prepared for the programme, this was not the case for all.

> “We were given a printed-out couple of sheets that outlined the format of the course, and did tell us what would be involved … I’m sure that we were quite well prepared with the information on the paper we had.” [L1, Focus group 1]

Trainers and supervisors affirmed that only some learners were fully registered and fully prepared when they joined the first session. Learners who were not fully registered did not have access to emails or the learner manual and other materials available to them on the ITT online portal. Some were poorly informed of what the programme involved.

> **“**The biggest problem you had on Day 1 is that people were signed up for the course, they were told to come on the course, and maybe they weren’t prepared properly a lot of the time, and they weren’t aware of what was expected of them. They were aware it was four days in the classroom but they weren’t aware of the assessment criteria and the fact that they would have to do an assignment and the fact that … after every module there was going to be a 500 word reflection and also to be told on Day 1 that on the final day they were going to be recorded doing a skills demo. A lot of that came as a shock to a lot of the students.” [SH004]

> “The one problem I has with it was in the beginning because we didn’t get the manual until we got there and I found that very hard, you know, because the instructor was starting the course and she thought that we had read through the first part of it. We hadn’t because we hadn’t got it.” [L6, Focus group 1]

Trainers and other participants reported that the anxiety levels of some learners were high when they joined the programme. Learners had access to a range of supports for reassurance and help with any issues that they encountered on the programme and staff worked hard at supporting learners. Reassurance and support were offered by trainers, supervisors and student support officers in ITT who are dedicated student support staff

available to learners by phone, email, or text and on hand to support learners with any issues they encounter. At times staff in the NDS provided reassurance and support.

> "you spent a lot of time on Day 1 actually I suppose reassuring them of your support, that you were going to work through this with them, guide them through it step by step, that you would be there for them and that there could be other ways around it … so, you were constantly trying to keep people with you, because of that need for reassurance. Not them all, but there was quite a bit of that on Day 1." [SHO04]

5.10 Overall retention rates are high, but vary geographically

Out of a total of 139 learners registered to the programme, certificates were awarded to 116 Healthcare Assistants (Home Support). Some stakeholders expressed concern about poor retention on the programme, and HSMs were often not aware of the actual level of attrition in their respective areas,

> "… the numbers starting is one thing, but the numbers finishing is even less, and that that is a big concern." [SH019]

Despite these concerns, the overall retention rate on the programme was high at 83%, although there were marked variations among areas. Retention rates varied from 67% to 100%, an indication that retention was an issue in some areas.

The NDS or other stakeholders involved in delivering the programme did not collect data on when or why learners dropped out of the programme. However, interviews and focus groups revealed that there are two critical points when learners tend to drop out. The first is at the very start of the programme, the key reason seeming to be that learners decided after attending the first or second session that the programme was not for them.

> "Now I think we had one or two dropouts from the original one as well, so, that would have been partly … people realizing the commitment and the level of [the programme] and saying, 'that's not for me,' you know. So, you had that feedback at one stage, which was 'yeah look, no, it's a bit of a step too far in the kind of the learning from it'." [SH009]

> "They [learners] found it tough, I suppose. They didn't think there was that much in it, but there was a lot, there was. It was a heavy enough course." [L11, Focus group 3]

While it is possible that drop-out is linked to learners not being fully informed or prepared for the programme, participants identified a host of other reasons preventing learners returning after the first session such as contracting Covid-19, attending to a sick child, having a bereavement, or attending a funeral. Missing a session early in the programme participants suggested may have influenced decisions about returning to complete the programme.

> "We would get messages then where the learner had rung in … Oh they had Covid or they had to go to a funeral, or their child was sick, or they're trying … but you know, there was those issues that arose, and then that person never came back the week after." [SH017]

> “And you know, if you miss one or two modules, then I’d say people get despondent, you know, ‘what is the point of continuing at this stage?’” [SH019]

Some participants expressed a concern that the programme might be pitched at too high a level for Healthcare Assistants (Home Support), leading to some learners dropping out.

> “I also think a reason is a lot of our learners don't continue to engage in the programme is it is written at a very high level, and probably too high a level for the cohort that it's aimed at, without any career progression for it or any CPD points or anything.” [SH018]

Participants reported that other learners dropped out of the programme at a later stage for a variety of reasons including personal issues such as bereavement, ill-health, or challenges in combining work and family responsibilities; difficulties with assignments; anxiety about doing the demonstration; or leaving the HSE for another job.

> “even though it was agreed in the contract with the homecare manager and the learner assigned that they would be allowed a supervision hour, a lot of the learners told us that they were trying to do it in their own time, and they’re trying to do it in the evening when they’re cooking with the kids. I think that also needs to be like … if the home care manager is signing up to release them for the hour it needs to be during one of their slots.” [SH017]

> “Then some people didn’t come back and do the exam. Remember the girl that didn’t come back to do the exam. I think they were more anxious about doing the last pierce of it [the demonstration].” [L12, Focus group 3].

All learners who submitted their assignments (N=116) were awarded a certificate. It is possible that there were some learners who attended sessions throughout the programme but did not submit their assignments or complete the skills demonstration and therefore were not granted an award for completing the programme. More information is needed on the timing of and reasons for attrition if this is to be addressed when the programme is rolled out in the future.

Stakeholders wanted to know how much of an issue attrition is in other similar programmes, what is an acceptable level of attrition, and what are the best strategies to adopt for increasing retention and reducing attrition. Participants suggested actions to improve learner retention. Chief among these was ensuring that learners were fully informed about and prepared for the programme. While it is the responsibility of ITT and LLTM to ensure that learners are fully informed about what is involved and fully prepared before joining the programme, not all stakeholders were aware of this. This study shows that HSRMs also play a role in informing and preparing learners. If this is to be part of HSRMs role during the future roll out of the programme, they need to be better equipped to do this. In any case, roles around informing and preparing leaners needs to be more clearly defined.

Participants also suggested better organisational support for learners while they are on the programme as a strategy for retaining learners, as illustrated by the following quote:

> "They [the learners] have to be supported by their home care manager to continue with the programme if issues arise and have an open relationship that you like 'I find this difficult' and that the home care manager is able to say 'Listen we could support you here'."

There was a lot of confusion among stakeholders as to where the responsibility for supporting learners on the programme lies. Stakeholders wanted clarity around what are the roles and expectations of HSMs, HSRMs, staff in ITT and its support officers, trainers, and supervisors. Having the respective role and expectations and what supports practically and realistically they can offer to learners clearly outlined would be useful for all stakeholders.

5.11 Programme content and delivery highly regarded

While this study did not set out to evaluate the programme itself, all participants who were familiar with it rated the programme content very highly. The consensus among these participants was that the content of the course was 'fantastic.' As one supervisor, a highly experienced practitioner in dementia care, put it: I love the programme, really love it, and I love the handbook that they [the learners] get" [SH016]. Participants also regarded the delivery of the programme by ITT and the trainers highly. According to participants, the programme filled a significant gap in dementia training and specifically training targeted at Healthcare Assistants (Home Support). They perceived the programme to be beneficial for Healthcare Assistants (Home Support) and their clients with dementia. The specific focus on the role of Healthcare Assistants (Home Support) in supporting people with dementia was particularly valued.

> "… historically, home helps had to join in on other programmes … but this was the first course that I felt everything in it and every exercise to enhance learning was specific and geared towards home helps. They were all scenarios from the house. Even the participants themselves fed back how excellent that was. They felt their role was valued, the exercises were all targeted to them, they were familiar with every scenario we threw up. They either had faced it before. To me, from a positive perspective there was a lot of learning, and it is very much focused to the home help, very focused." [SH004]

Participants considered all six modules to be highly relevant for Healthcare Assistants (Home Support). They singled out the module on self-care as being especially important for promoting emotional wellbeing and avoiding stress and burnout.

> "It actually focuses more around the worker, which I think is really, really important, their needs and then integrates the whole piece around relationships and relationships with people living with dementia." [SH006]

> "The self-care aspect of it., you know. I fell like a lot of us forget that we've to take care of ourselves in this kind of work. I really took a lot of that from the course." [L7, Focus group 1]

Learners welcomed the ethics modules, but some found it challenging. Learners particularly valued the focus on promoting person-centred care and relationship building with the person with dementia.

> "I think it was very practical and little bits like that. If you took nothing from it, you know, seeing the person was the main thing I took from it, like, you know the person behind the dementia. Because when I started, I thought it was going to be very technical you know and very scientific. It was very, very practical." [L4, Focus group 1]

Another learner explained how it had changed her perspective on dementia and approach to work:

> "I found the most valuable thing about this course was it changed my viewpoint. I was coming … I was looking for answers like from a biomedical perspective. I thought I was going to come to this course and have answers to 'how do we know the difference between the different types of dementia?' and 'what's the prognosis?' and 'Is it hereditary?' Those were the questions that I thought I was going to get answers to. But by the end of the course, I realised those questions weren't even important. What is important is dealing with the client in the here and now and you know learning how to maximise, yeah, the positive things that they have going on for them and how to relate to them." [L9, Focus group 2]

Several stated that the programme has increased their confidence.

> "I spoke with a colleague of mine and we talked about the course and the content and so on and she said she recommended it. It has really increased her confidence and I would say I have to agree with that in that it certainly does give you the tools such as learning to, you know, use those open-ended questions and you know various little things like that. And yeah, I did find it very useful and beneficial." [L10, Focus group 2]

Learners gave examples of the difference being on the programme made to their work on a day-to-day basis and the benefits for people with dementia:

> "I have a client with kind of an early dementia. It was very hard on her like she was talking incessantly, and you know I would be putting on her clothes and she'd be taking off her clothes. Well, I kind of leaned actually if you went straight in front of her to undo buttons or something like that to get her in the shower, she'd back off in a frightened way and I learned if I sort of approached her from the side a little bit and kind of talk to her, then turned around, she allowed me then to take off her pyjamas and if I held her like to the side, put my hand under her hand and led her towards the shower, she'd come easily with me, rather then sort of like you know trying to push her towards …" [L8, Focus group 2]

For those with a long number of years of experience, the course helped reinforce good practice:

> “I thought it was very informative. A lot of this stuff we know already, just from working in the industry for so long, with so many different clients, with different levels and types of dementia. But it reinforced a lot of what we were already doing. Reminded us to do more of what we were already doing, and we learned new things as well …” [L1, Focus group 1]

One learner explained that Healthcare Assistants (Home Care) learned about providing care to people with dementia on the job, mostly from more experienced care workers. However, it was only after learning on the course about the theories and supporting evidence underpinning the approaches and techniques the learner had seen used that healthcare Assistants (Home Support) understood why these approaches and techniques should be used and where and when to use them.

> “I never did a course in dementia. I learned through working with people with dementia. It kind of separated things for me a little bit. Like I kind of put them in little places of their own, like where and when to use the techniques and stuff, because even though we all knew them and how to do them … I support we didn’t really know when to implement them and stuff.” [L7, Focus group 1]

The programme comprised six units delivered over four months. Leaners had very different opinions about the length of time the programme took to complete. Some liked that it took place over four months.

> “I think we need it. We definitely needed the four months. We definitely did as there was so much, you know, detail in it. And look it was only once a month, so it was grand.” [L11, Focus group 3]

Some would like to see it condensed into a shorter length of time, so as keep what they were learning alive in their minds and help to maintain momentum.

> “I thought it could be done quicker. Like I know it was one session in a month, but if they just condensed it like cause it’s in your head. It’s not even to finish it more quickly, I think it is in your brain and then it is more fluid.” [L4, Focus group 1]

> “The only critique I would have had, not necessarily with the information and you know the content was wonderful, but just kind of dipping in and out on a monthly basis. I thought … look for me, I would have rather gone two nights a week over three weeks or something like that you know that kind of way.” [L10, Focus group 2].

> “I think the month was almost too long, because it felt like as if you had forever [to write the assignment]. Maybe if it was once a week or once a fortnight, I might have actually have had the momentum to do the [written assignments for] the individual modules in between, so that might have helped.” [L9, Focus group 2].

Others would like to see it spread out over a longer period to allow one unit at each session instead of two. Learners also wanted the timing of the programme to be chosen carefully, as, for example, one programme ran on a Friday over the summer months, which learners found challenging.

6: Perspectives on the future of the programme

This chapter reports on the participants' views on the future of the programme under five key themes identified from data analysis. These are support for the future national roll-out of the programme; making the programme mandatory; the format of the programme; the target population and other dementia care training options. It draws on interviews with staff involved in the implementation and delivery of the programme and on focus groups with learners.

6.1 Strong support for future roll-out of the programme in most areas

There was widespread support for the future roll-out of the programme.

> "So. there is an absolute need that we continue this programme, you know, and roll it out to every member of staff, you know, and support the ones that might have the few challenges with it, you know absolutely. I mean definitely … we would be very interested in having it again." [SH010]

> "100 percent. I would welcome it again in the area. Yeah." [SH012]

Learners reported that other Healthcare Assistants (Home Support) in their area had expressed an interest in the programme.

> "A couple of people have asked, when I did it, they've asked me, you know, is it coming up again? But it hasn't been offered again. I haven't seen it coming through texts anyhow." [L8, Focus group 2]

However, because of concerns about staff shortages and challenges releasing staff as well as concerns about the learning motivation barriers facing Healthcare Assistants (Home Support), a HSM in one area questioned the feasibility of trying to roll out the programme to all Healthcare Assistants (Home Support) in the area and would welcome having the option of a short non-accredited version of the dementia education programme to offer to Healthcare Assistants (Home Support).

6.2 Making the Programme mandatory

Some participants would like to see the HSE's Dementia Care and Support: Home Care Education Programme be made mandatory for all Healthcare Assistants (Home Support), either as a standalone programme, or by incorporating it into an accredited QQI level 5 Care of the Older Person programme that Healthcare assistants (Home Support) are required to complete.

> "I am delighted that this programme is QQI level 5 and would be even more delighted if it was mandatory." [SH007].

> "I was hoping even from doing the course I was saying it would be great if it was mandatory like and rolled out for everybody." [L4, Focus group 1].

The benefits of making it mandatory were twofold. First, participants believed that making it mandatory would give dementia training the same weight as other training that is currently mandatory such as fire safety or manual handling training. This, they believed would demonstrate that the HSE is serious about and values dementia care training. Second, participants believed that making the programme mandatory would increase uptake of the programme and attendance at training sessions. However, none believed that the programme was likely to become mandatory. They were aware of the concern raised by others such as the (Department of Health, 2022) that introducing mandatory training and qualification requirements could affect recruitment, as it could discourage some prospective care-workers from applying for employment as a Healthcare Assistant (Home Support). In addition, it would be vying with many other training programmes to become mandatory.

6.3 Strong preference to continue with the in-person format

The collaborative team designed the programme as a blended model, with the four day-long sessions provided in-person in a classroom setting and the supervision taking place online via Zoom. While accreditation permits some day-long sessions to be provided online, many stakeholders and all learners expressed a strong preference for the day-long sessions to continue to be delivered in-person face-to-face. Participants made a variety of arguments to support this view. Learners liked being present in the classroom, valued the human connection and interaction with other people that it offered, argued that it led to higher quality learning, and created a safer environment than online learning.

> “Me personally, I quite liked being in the classroom setting and having the comradeship from people around you, recognising some of the people that you’ve worked with before. It was nice to get out of the town that we work in one day of the month.” [L1, Focus group 1].

> “Yeah, I agree too. If I was put in front of a computer like I am now, would have had to have done a nine to four, I’m afraid I wouldn’t have done as well because you just … you’re not present, like you’re not there. Some people love the computer. I’m a doer and not a looker.” [L7, Focus group 1]

> “I found the face-to-face absolutely brilliant. You know, I found the tutor, like, so informative, knowledgeable and not just that but so positive, warm and encouraging and I don’t think you’d have the same if you weren’t [in person] and of course the role plays and being able to interact with the people around us. One to one, I think … I don’t think any kind of online format could have replaced that for value.” [L9, Focus group 2].

> “I couldn’t fault the face to face or the classroom scenario.”

Trainers spoke about the difficulty of maintaining engagement online, especially when it is a day-long session. As one trainer who had delivered the programme online during Covid-19 explained:

> “…but if it does [go online], you need to know your material really well to hold a room. It's very difficult … there are certain things you have to do, do you know what I mean,

> to make sure that you're engaged in the same way. It's a lot harder to deliver over Zoom, nearly impossible." [SH006]

The programme is designed around group work, collaborative learning, and peer to peer support, which is difficult to facilitate online, and many participants argued that the quality of the engagements, questions and interactions would suffer if it were moved online. Another argument in favour of delivering the programme face-to-face related to the challenges that Healthcare Assistants (Home Support) as a cohort encounter with online training including low IT literacy, lack of access to IT facilities, lack of office space in their homes or some living in areas with poor IT connection. It was not unusual for participants to report that some learners had to rely on family members to help them access online supervisory sessions.

> "… in the context of online platforms for training, in general, in theory, yes. It's ideal in terms of the mandatory training and stuff like that. It still poses a challenge for our staff cohort, who are lone workers, don't have access to offices and IT, are relying on the phones if they have them, and the daughter's computer at home." [SH009]

Supervisors who facilitated their supervisory sessions online also highlighted these issues.

> "… it was online and so some people just weren't or hadn't the capacity to work online, and that was always a bit of a rush and a struggle, and their daughter was coming into maybe to set it up or so there was some issues there." [SH016]

Participants cited the fact that Healthcare Assistants (Home Support) most frequently perform their job as 'lone workers' as another reason to support in-person delivery. Working as a lone worker means that Healthcare Assistants (Home Support) have very few opportunities to meet and share learning with colleagues. The in-person sessions provided an opportunity to fill this gap. HSMs argued that face-to-face adds value by offering an opportunity for Healthcare Assistants (Home Support) to discuss and share learning within the local team, and thereby contributing to team building that would not be possible online.

> "So, for this, it's a breakaway for the day from the norm, working with their colleagues, getting to know colleagues from a different area, getting to share stories, you know. So, it's a shared learning." [SH012]

Personal experience is much harder to share online. Healthcare Assistants (Home Support) reported that peer support was an important support for helping them complete the programme.

> "I don't think you'd get anybody doing it if it was a case that you were doing it online." [L12, Focus group 3].

Some participants suggested that it may be better to hold the day-long sessions online as Healthcare Assistants (Home Support) would not have to travel to venues and it could potentially lead to increased take-up as it would be open to Healthcare Assistants (Home Support) from across the country rather than restricted to Healthcare Assistants (Home Support) in a particular area, especially for areas where releasing staff is a problem. However, learners expected that take-up would be much lower if the programme was

delivered online. This view is supported by evidence from research, which indicates that module completion rates are low and attrition rates are high when dementia training for the health and social care workforce is delivered online, especially when off-line group work is limited or non-existent (Cunningham et al., 2020).

6.4 Extending the programme to HSMs and HSRMs

One HSM expressed an interest in participating in the programme themselves. Some HSMs and others were in favour of some or all HSRMs completing the programme. The HSRM who had participated on the programme also made this suggestion and supported this by explaining how much it had changed their approach to work.

> "When I go out to my assessment visits, you know, before it was pretty much a spouse putting them in a corner and gesturing, showing that they weren't quite with it. I felt I had much more confidence to actually deal with them, speak to them, to use those communication skills that we role played so often, to do the mirroring and the reflecting and I found it so beneficial that I found by the end of the visit I actually connected with the person and I've got a much better idea of who the perfect carer would be to send to the, you know, based on their personality and their interests you know. I'd go to someone who would suddenly get up and start dancing and then I'd have the confidence to actually get up with them and dance along with them and then knowing that I need to find someone who will be able to do that with them. That is so beneficial." [L9, Focus group 2]

6.5 A short, non-accredited version of the programme as an alternative option

A number of participants suggested that, alongside the accredited Dementia Care and Support: Home Care Education Programme, it would be useful to also have the option of a short, non-accredited version of the programme. This could be delivered at a single session where the key messages of the accredited programme would be condensed and communicated to Healthcare Assistants (Home Support).

There were three main arguments put forward by participants in favour of a short, non-accredited version of the programme. The first argument was that it would address the issue of slow roll-out of the programme as happened in the pilot programme. In one area where there was strong support for rolling out the four-day programme to all Healthcare Assistants (Home Support) but frustration at its slow roll-out, a two-hour dementia-specific module had been developed by an educational instructor from the area as a means of bringing the key lessons from the accredited four-day programme to those who had not attended. It is being delivered as an add-on module when other training, e.g. Manual Handling training, is being delivered to Healthcare Assistants (Home Support). According to the HSM, this is working well and is currently being evaluated. A short, non-accredited version of the programme was also appealing to a HSM in another area but in this case the argument for it related to concerns about staff shortages and releasing staff for four full days. The third argument, put forward by a number of participants including learners was based on the view that the Dementia Care and Support: Home Care Education Programme may not be suited to all Healthcare Assistants (Home Support). Some participants believed that there are a cohort of Healthcare Assistants (Home Support) who, for a variety of reasons, will never sign up for or complete the accredited programme. Having a short, non-accredited version of the

programme would address this issue and be particularly beneficial in areas with lower levels of programme uptake and high attrition rates.

> "I'd love to see that [a short, non-accredited version]. I'd love to have everyone on my team having had the benefit of the content and I think, I'd say they would all be interested." [L9, Focus group 2]

This suggestion must be considered in relation to how effective a short two-hour or half-day module would be in comparison to the four-day Dementia Care and Support: Home Care Education Programme, especially when the latter incorporates most of the key features of effective dementia education programmes, as shown in Chapter 4. In their systematic review of reviews, in which they provide an overview of dementia training and education accessible to the homecare workforce, Cunningham et al. (2020) found that education programmes with a strong focus on face-to-face group work and shared-team work have been identified as being more successful at facilitating learning, whereas 'one-off, single-delivery, traditional and more theory-led teaching methods were reported to be less effective, whether online or offline' (p. 2794). Having an opportunity to share and exchange new learning and liaise with peers have been identified as good teaching methods (Cunningham et al., 2020). The importance of reflection within teaching and learning, including timely learning refresh, feedback or booster sessions, as provided by the supervision sessions in the Dementia Home Care Education Programme, has also been underlined (Cunningham et al., 2020). Nationally recognised accreditation of programmes has been identified as a key workforce incentive (Cunningham et al., 2020). These features would be missing from a short, non-accredited version of the programme. This highlights the importance of an understanding of the available research evidence on dementia training for the home care workforce for any future development of the Dementia Care and Support: Home Care Education Programme.

Others suggested incorporating the programme into generic QQI Level 5 care skills programmes.

7: Discussion and conclusions

The Dementia Home Care Education Programme was specifically designed for Healthcare Assistants (Home Support) supporting people with dementia to live well as home. It has all the features that make dementia education and training programmes more effective. The programme is very highly regarded by trainers delivering the programme and by healthcare professionals facilitating supervisory sessions. It has been well received by Healthcare Assistants (Home Support) who participated as learners on the programme and who reported that it changed how they approached their day-to-day work, leading to an improvement in the lives of people with dementia as well as making their work easier.

The NDS piloted the programme in eight LHO areas drawn from three different CHOs areas, i.e., CHO 1, CHO 4, and CHO 5. Implementing the pilot programme took much longer than planned due to a combination of challenges including the Covid-19 pandemic; putting processes in place to identify and recruit learners at local level in some areas; and ongoing problems with the recruitment of healthcare professionals to facilitate supervisory sessions. Because of these problems, there was only eight programme intakes, much fewer than anticipated at the start of the pilot. It is expected that changes to supervision trialled in the delivery of the programme facilitated by the Education and Training Board will resolve the challenges of recruiting and retaining supervisors when the NDS roll out the programme in the future. However, to avoid delays in the future, there needs to be more detailed planning of programme implementation, with role and responsibilities clearly defined, and best practice guidance developed for HSMs and HSRMs. HSRMs are line managers for Healthcare Assistants (Home Support) and involving them in decision-making and having their buy-in is critical.

The perception of many participants was that there was a problem with programme uptake, but this is not borne out by the data, which show that the minimum programme uptake was achieved in most areas. While it is not clear what produced the differences in uptake among areas, participants speculated that organisational support was a key factor. Organisational attitudes are a key predictor of educational success (Cunningham et al., 2020). Personal and work-related reasons motivated Healthcare Assistants (Home Support) to participate in the programme. However, participants suggested that there are likely to be a range of barriers hindering programme uptake by some Healthcare Assistants (Home Support). These are barriers that research reviews have highlighted as having an impact on attitudes, confidence, and motivation of the home care workforce towards education and training. They include low educational levels, low qualification levels and IT abilities. We do not have detailed information about the skills and qualification levels of Healthcare Assistants (Home Support) in Ireland. Participants did not mention a range of other learning motivation barriers for Healthcare Assistants (Home Support) including low job satisfaction, burnout, emotional strain. However, participants did acknowledge that Healthcare Assistants (Home Support) have more limited access to training than other healthcare staff, are poorly paid, and often undervalued.

There is widespread support for the future roll out of the programme and while it was argued by some that the accredited programme should be delivered to all Healthcare Assistants (Home Support), there may be merit in having a shortened non-accredited version of the programme available to be offered as an alternative, given the range of learning motivation

difficulties for Healthcare Assistants (Home Support). As Cunningham et al. (2020) have pointed out, understanding the current research evidence will be important for providing guidance on how dementia training and education programmes for Healthcare Assistants (Home Support) in Ireland could be designed and delivered in future.

Staff shortages that make it difficult to organise cover for those who wish to participate in the four-day Dementia Care and Support: Home Care Education Programme is a key organisational challenge in some areas and could potentially become more pronounced in the future. A shorter non-accredited version of the programme may be attractive to HSMs in areas experiencing staff shortages.

8. Recommendations

The findings of this qualitative study provide a rich and nuanced perspective on the Dementia Care and Support: Home Care Education Programme for Healthcare Assistants (Home Support) and its implementation on the ground, the challenges encountered during programme implementation and what changes are needed to optimise implementation. The findings can be used to support strategic and operational decision-making for enhancing programme implementation within the HSE, and can also be used to inform training, including dementia specific training, for home care workers more widely in Ireland. There is a strong preference for a face-to-face format, and this report recommends that the programme continues to be delivered in-person without any substantive changes to the format, once a national implementation plan had been developed and considering other recommendations outlined below.

- *Develop an overarching implementation plan*
  The national implementation plan would include: a realistic target for the number of programme intakes per annum per CHO area and per LHO area; timelines for delivery of programmes clearly stated including agreed programme commencement dates that should remain fixed; more detailed information about the target population and clarity around targeting for recruitment; roles and responsibilities of organisations and actors involved in implementation clearly stated.

- *State and clearly define the roles and responsibilities of all organisations and actors involved in the implementation of the programme*
  The NDS should not have any responsibility for the day-to-day operations of implementing the programme and its role restricted to strategic planning, oversight, monitoring, review, and evaluation.

- *Develop local implementation plans*
  In accordance with a national implementation plan, the NDS could develop implementation plans for agreement at local level. Development of implementation plans should take place in consultation with HSMs and with input from HSRMs. Whether the implementation plan is to be agreed at CHO or LHO level is yet to be decided. While there should be consistency across the country, some flexibility could be built in, for example, allowing HSMs to choose between two alternative forms of implementation plan.

- *Develop best practice guidelines to support implementation at local level*
  The NDS in conjunction with the LLTM could develop best practices guidance to support HSMs and HSRMs with the implementation of the programme at local level. Areas to be covered include programme promotion; identification and recruitment of learners including more clarity around the target population for the programme; staff release; organizational attitudes towards training and culture; organizational support for learning.

- *Better prepare Healthcare Assistants (Home Support) for participation on the programme*

It must be ensured all learners are fully informed and fully prepared before joining the programme. There needs to be more clarity on where the responsibility for this lies. If this is to be part of the responsibility of HSRMs, they need to be better equipped for this and aware of the expectations of them.

- *Monitor and evaluate how well the planned changes to the supervisory element of the programme, as trialled by ITT in the SOLAS-funded iteration of the programme, are working. Checks should be in place to ensure that no learner gets the same person acting as both trainer and supervisor. Time should be scheduled in to promote and enable tutors and supervisors to collaborate when they are supporting learners on a programme.*

- *Encourage and support the development of a strong organisational ethos supporting continued training and education, included dementia-specific education, for Healthcare Assistants (Home Support) within the HSE and among approved home support providers*

- *Monitor programme implementation on an ongoing basis, and review regularly*
  Monitoring of programme implementation should be ongoing and include the collection of data on planned and actual programme start dates; and the collection of data to learn when and why learners are dropping out of the programme. Programme implementation should be reviewed regularly, with the NDS taking a leadership role.

- *NDS to consider supporting the development of a short, non-accredited version of the Dementia Care and Support: Home Care Education Programme for Healthcare Assistants (Home Support)*
  Informed by the existing research evidence and in consultation with the programme developers in DCU, consideration could be given to the development and implementation of a shortened, non-accredited version of the programme to meet the training needs of Healthcare Assistants (Home Support) experiencing diverse learning motivational difficulties and to accommodate areas experiencing staff shortages.

- *Findings of present study could usefully inform research led by the Department of Health aimed at gaining a better understanding of the experiences of care* workers
  To more effectively implement QQI level 5 training including the Dementia Care and Support: Home Care Education Programme, greater understanding is needed of the educational experiences of Healthcare Assistants (Home Support), their levels of qualification, literacy and IT skills, attitudes and motivations towards education and training, levels of confidence, and others learning facilitators and barriers. The Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants has pointed out that little is known about Healthcare Assistants (Home Support) or other care workers. With a view to filling the evidence gaps, the Department of Health has engaged a research body to conduct a national survey of the experiences of home support workers and healthcare assistants. The Department of Health's survey is currently under development (Department of Health, 2024). The findings from this present review could usefully inform the survey development and

contribute to filling the evidence gap in relation to the experiences of home support workers and healthcare assistants in relation to dementia-specific training.

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