An Evaluation of the HSE National Training Programme in Preventing Elder Abuse

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CONTENTS

Introduction

Following the publication of *Protecting Our Future* in 2002 (Working Group on Elder Abuse, 2002), a seminal policy document that proposed a framework to effectively address elder abuse, a range of intervention services was established under the auspices of the Health Service Executive (HSE). This included a senior case worker service to assess and manage cases of suspected abuse and a national training programme in recognising and preventing elder abuse aimed at front-line care staff.

Since 2007, the HSE has been delivering this training on a nationwide basis and has also supported organisations to be self-reliant in conducting their own training through a train-the-trainers initiative. Data provided by the HSE (HSE, 2012) indicates that the national training programme in preventing elder abuse has been rolled out extensively on a national basis since 2007. In the first six years after the training programme was established, over 41,000 attendees were registered as having attended the HSE training programme; this figure includes both first attenders and training returnees.

The HSE commissioned the National Centre for the Protection of Older People at UCD to conduct an evaluation of the training programme as part of its remit to conduct research into aspects of elder abuse and its prevention. The scope of the evaluation design provided for an analysis of the training materials, the experiences of the trainers and the effectiveness of the training, in terms of improving trainees' knowledge and ability to recognise and respond appropriately to elder abuse.

Aims and objectives

The overall aim of the evaluation of the HSE elder abuse training programme was to establish the programme's suitability and sustainability as a method of staff continuing professional development in relation to their role in recognising and preventing elder abuse in their place of work. The objectives were:

- To determine whether the training materials and resources are valid and fit for purpose
- To explore the experiences of the trainers
- To measure the effectiveness of the training in terms of improving participant's knowledge and ability to recognise elder abuse.

Research methods

The study design identified three key areas as critical to the evaluation:

- Structure: The materials and planning
- Process: The trainer experiences
- Outcomes: The trainee knowledge and ability to recognise elder abuse

This informed the data collection process and resulted in a mixed method, data triangulation approach, which incorporated the following three elements: documentary review; semi-structured interviews; and experimental evaluation design

Documentary review

A review of the individual training materials, including DVDs and supporting materials, was undertaken and a simple rating instrument was employed that provided the research team with a standardised guide with which to assess the materials objectively.

Semi-structured interviews

Trainer experiences were examined using semi structured interviews among those who provided and/or coordinated elder abuse training. A total of thirteen interviews were carried out either in person or, where necessary, by telephone interview. Each interview was conducted on the basis of a simple topic guide, which addressed aspects of the training, including planning and logistics, supports and trainee engagement.

Experimental evaluation design: Within-group quasi experimental design

To measure the effectiveness of a HSE community-care setting training programme, thirty-five home care assistants employed by the HSE to care for an older person in their own home were recruited to the study. Participants' knowledge and ability to recognise elder abuse were measured using the Caregiver Scenario Questionnaire (CSQ). The questionnaire was administered before and after delivery of the HSE training intervention and participant scores were computed.

Experimental evaluation design: Randomised control trial

A within- and between-group experimental design was employed to measure the effectiveness of training within a residential-care setting. A total of 141 nursing students were recruited to the study. All students completed two pre-intervention questionnaires, the Knowledge and Management of Abuse (KAMA) questionnaire and the Caregiver Scenario Questionnaire (CSQ), which measured, respectively, knowledge of elder abuse and ability to recognise abuse. The students were then assigned to a control group and an intervention group. The intervention group received the standardised training intervention, while the control group was provided with a journal article, which described the role of nurses in the recognition and management of elder mistreatment. Both groups completed the CSQ and KAMA after the intervention was delivered to the control group and the scores were computed.

Findings

Training materials

The results of the analysis of the content and quality of the documentary materials demonstrated that, overall, the training materials used to support the training programme were of a very high quality and fit for purpose. A strong feature of the DVD *Open Your Eyes to Elder Abuse in Your Community* was use of accessible language, thereby having the potential to be used in training across a broad constituency of individuals and community groups. The training DVD *Recognising and Responding to Elder Abuse in Residential Care Settings* was also found to be a high quality material resource to support training and was particularly suited to the training audience for which it was designed.

Training experiences

The thirteen interviews conducted among the senior case workers, dedicated officers and train-the-trainers generated a large body of narrative data, from which two broad themes emerged, namely: 'facilitating the training' and 'training effectiveness'.

The first theme 'facilitating the training' described the participants' experiences of delivering, planning and coordinating the training programme. Three subthemes emerged from the interview data: 'Meeting the standards and meeting demand'; 'Barriers and enablers'; and 'Pedagogy'

Meeting standards and meeting demand

The thirteen interviewees spoke about how the training programme was being delivered on a national basis on foot of national policy on the protection of older people and in compliance with HIQA standards. The HIQA standards provided an added imperative on the part of service providers to provide training in elder abuse and this onus on service providers to ensure staff training resulted in a high ongoing demand for training.

Barriers and enablers

Trainers experienced a number of organisational, individual-level and structural barriers to the effective planning and delivery of training. The barriers included employers' difficulty in assuring optimal attendance at training, senior case workers' high workload, poor participant engagement in individual training sessions and limited material resources and equipment for training. A key enabler of effective training was the senior case workers' coalface experience of managing cases of elder abuse, experience which they could bring to the teaching encounter.

Pedagogy

Interviewees identified some additional challenges in terms of the learning profile of training attendees. Differences, in terms of staff grade levels and educational levels, meant that when conducting training sessions, trainers frequently adopted a flexible approach, with a tendency to deviate from the prescribed training schedule and/or training content, in order to take account of trainee needs as well as local circumstances. However, some participants were of the view that such discretion and flexibility in teaching were a threat to the standardisation of training.

Entitled 'training effectiveness', the second theme described the trainers' perspectives on the training effectiveness and consisted of three subthemes: 'Increased awareness and increased referrals'; 'Effectiveness of the training materials'; and 'Going forward'

Increased awareness and increased referrals

Interviews with trainers revealed a shared belief that the training programme had increased awareness of elder abuse among trainees and deepened their understandings of the different forms that abuse can take. In addition, interviewees believed that the effectiveness of the training was evident from the increase in the number of referrals to elder abuse services since the inception of the training programme. Trainers conceded that their own interpretations of training effectiveness were anecdotal and would be complemented by a formalised evaluative framework.

Effectiveness of the training materials

Trainers found the DVDs and supporting materials to be effective in supporting learning within the training sessions. Specifically, interviewees remarked that the use of real-life scenarios in the DVDs increased trainees' engagement with the topic of elder abuse while the workbook and guide further augmented their effectiveness as training resources. However, some interviewees felt that the DVDs failed to capture the nuances of different care-settings, and that the effectiveness of these materials was somewhat reduced when used in refresher training sessions. The use of traditional nursing routines within residential care to illustrate abuse was seen by some as unhelpful.

Going forward

The thirteen trainers identified areas for improving training effectiveness. Trainers spoke of the need for participant feedback and evaluative evidence of training impact. The increased demand for training could be accommodated by increasing the number of trainers available and by creating protected time in trainer work schedules to enable them to deliver training. The trainers proffered suggestions for improvements in the way that the training programme might be organised and conducted in the future. These included: the need for alternative content for returnees; for content to be tailored differently for different grades as a way of preventing training fatigue; and the introduction of a system of CPD credits as a way of ensuring the standardisation of training.

Trainee outcomes

The effectiveness of the training programme was tested using both a within-group quasi-experimental design and a randomised control trial. The within-group quasi-experiment tested the efficacy of the community training intervention among a sample of 35 home care assistants. The randomised control trial tested the efficacy of the residential care setting training intervention with a sample of nursing students undertaking the undergraduate general nursing degree programme at a large urban university nurse training school.

Within-group quasi-experimental design

The data provided by the home care assistants before and following the training intervention demonstrated that the training intervention was effective in terms of increasing their ability to recognise abusive and possibly abusive caregiving strategies, as measured by the Caregiver Scenario Questionnaire CSQ. A statistical comparison of the computed overall mean scores for recognition of possibly abusive caregiving strategies showed a statistically-significant difference between the mean scores before and after the intervention.

Randomised control trial

In the randomised controlled trial, 134 nursing students completed the experimental evaluation, of which number approximately half were randomly assigned to an intervention group (n=66) and half to a control group (n=68). The data provided by the nursing students' intervention and control groups at both points in time, i.e. before and after the training intervention was delivered to the experimental group, demonstrated that the intervention was effective in terms of improved recognition of abusive caregiving strategies, as measured by the CSQ. The group of students who received the intervention scored significantly higher for recognition of abusive caregiving strategies after the training when compared with the control group.

The nursing students' knowledge and management of potentially abusive situations within a residential setting were also measured using the Knowledge and Management of Elder Abuse (KAMA) questionnaire. Analysis of the students' KAMA scores did not show a significant difference in the scores between the intervention and control groups or between the mean scores for the intervention group before and after the training intervention. Additionally, the overall mean KAMA scores of both the control and intervention groups were low, suggesting a general lack of knowledge shared by the students concerning the complexities of managing and responding to elder abuse in a residential setting before the training was delivered and this persisted following the training.

Conclusions and recommendations

The evaluation study provided important evidence relating to the content, delivery and effectiveness of the HSE national training programme. Based on the evidence several recommendations are suggested:

Promoting training standards

While flexibility in approach to training was found to be helpful in tailoring training to the learners' needs, it risked undermining the standardisation of training across sites. A way to obviate such lack of standardisation would be to bring the training within an accreditation framework, either by accrediting and validating training content or awarding credits to trainees for attendance at prescribed training, or both. Accreditation could be developed within a continuing professional development (CPD) model through a recognised and reputable higher education institution. A continuing professional development (CPD) model would address this risk to standardisation and could be designed to incorporate targeted components that would address local training needs and contexts.

Training content

Results from the RCT component of the evaluation indicated that trainees had difficulty identifying some situations where older people were vulnerable to abuse. The role of capacity in an older person and the individual factors that make them vulnerable to abuse should be emphasised in training. Legislation that addresses capacity in decision making relating to care was in development at the time of reporting. Once enacted, this legislation should be used to inform the development of training content.

The documentary analysis of the training materials found that, in relation to the residential care-setting DVD, any future revisions should include a better balance in terms of the way that roles are depicted. In addition, more time could be given to reporting responsibilities and mechanisms and the HSE's own information line could also be highlighted.

Trainee needs

While the content of training should be standardised across all staff grades, at the level of the core message to be transmitted, it is likely that different staff grades have different learning needs that may not be readily accommodated in a training session containing mixed grades. Accordingly, the possibility of having bespoke training content for professional and non-professional grades should be considered. However, consideration should also be given to the important role of interdisciplinary training and shared learning in elder abuse as a way of promoting collaborative working in the area of elder abuse prevention and management.

Trainer needs

The study found that the frontline experiences of senior case workers were an important resource in contributing to training effectiveness. However, senior case workers spoke of the pressure that they encountered in delivering training, given the demands of their case load responsibilities. Providing senior case workers with protected time in their work schedules would serve to reduce this pressure.

Nurse training

Evidence from the RCT component of this evaluation study indicated that all of the nursing students had a low baseline level of knowledge in relation to managing and responding to elder abuse. Accordingly, higher education institutions should review training content as it relates to elder abuse, with a view to improving students' learning in relation to recognising, managing and responding to elder abuse.

Focus of training

In the evaluation, training fatigue emerged as a challenge for training effectiveness, especially with regard to returning trainees. This could be addressed using a targeted training programme that would allow returning trainees to revisit the key messages of the training and then build on previous training content.

While the RCT demonstrated training effectiveness in relation to the recognition of abusive and potentially abusive caregiving strategies, the findings in relation to the effectiveness of training on trainees' ability to effectively respond to elder abuse were equivocal. The training programme could be revised to reflect the interrelation between these two aspects and should also emphasise the role of whistle blowing in the prevention of elder abuse.

The literature indicates that knowledge deficits persist even after the provision of training and hence continuing refresher training may be required in order to ensure that knowledge is retained in the long-term. The need for refresher training in elder abuse and related continuing professional development, in such areas as communication and effectively managing and resolving conflict, should be an integral part of the strategy for training in the prevention of elder abuse.

Pedagogy

The literature indicates that training interventions may incorporate assessment and screening skills, problem-solving skills, strategies for managing conflict, stress and challenging behaviour, relational issues in caregiving, strategies for effectively managing cases of elder abuse and discussions of ethical issues around reporting. These important elements of skill development could be incorporated in advanced training in preventing abuse.

In relation to the role of audio-visual media in training, evidence from the literature supports the use of active learning strategies in promoting retention and application of knowledge to practice. The use of DVDs as part of the HSE training programme in elder abuse should continue.

The train-the-trainer model enables organisations to be self-sufficient in providing training in elder abuse. Accordingly, this model should continue to be the main method of ensuring a sufficient supply of trainers to deliver training.

Resourcing and supporting training

The study findings indicated a number of organisational, individual-level and structural barriers to the effective planning and delivery of training, including: employers' difficulty in assuring optimal attendance at training; senior case workers' high workload; poor participant engagement in individual training sessions; and limited material resources and equipment for training. These barriers could be addressed, in part, by organisations demonstrating commitment to training through ensuring that all grades are provided with the requisite time to attend training and trainers are provided with the essential materials to deliver training effectively.

Further research

There is a dearth of reliable evidence on the effectiveness of training interventions aimed at educating staff in the recognition and management of abuse. There is therefore a need for rigorous objective evaluation studies to determine the effectiveness of education and training on elder abuse prevention and management.

1.1 Introduction

The estimated prevalence of elder abuse among community-dwelling older people in Ireland is 2.2 per cent (Naughton *et al*., 2010) and is similar to prevalence figures reported in the UK, at 2.6 per cent (O'Keeffe *et al*., 2007), and the United States, also at 2.6 per cent (Pillemer & Finkelhor, 1988). The impact of elder abuse on its victims can include physical and mental health problems (McGarry & Simpson, 2011), feelings of loneliness and isolation, loss of the family home and social networks (Lafferty *et al*., 2012), financial loss (Pritchard, 2000) and increased risk of mortality (Dong *et al*., 2009). With the expected growth in the proportion of older people in the wider population and in residential care, and the associated increased risk of abuse, it is important that health and social care professionals are adequately prepared to assume responsibility in identifying, preventing and appropriately managing elder abuse. This requires effective training in the recognition and management of elder abuse.

1.2 Interventions in preventing elder abuse

In response to elder abuse, Governments in developed countries have made efforts to address the problem through a range of interventions, either within health and social care services or through the legal and criminal justice system, or combinations of both approaches. A key part of preventing elder abuse is the use of formal training, usually directed at those caring for older people or those in contact with vulnerable older people. The focus of such training is the development of trainee skills for recognising and preventing abuse through screening and reporting.

The evidence concerning the effectiveness of education and training in changing health and social care professionals' behaviours in relation to elder abuse screening and reporting is equivocal. While some training interventions have demonstrated improved participant outcomes, others reported no improvement in these same outcomes. From the evidence of one study (Richardson *et al*., 2002), it appears that face-to-face delivery of training is a superior mode of training in elder abuse when compared with dissemination of information through printed materials. Overall, it appears that education and training in elder abuse recognition and management is somewhat effective in increasing awareness and knowledge of elder abuse among health and social care professionals.

1.3 Interventions in preventing elder abuse in Ireland

Commissioned by the National Council on Ageing and Older People in 1998, the report entitled *Abuse, Neglect and Mistreatment: An Exploratory Study* (O'Loughlin & Duggan, 1998) presented clear evidence of the abuse and neglect of older people in Ireland. In response, the Irish Government established a Working Group on Elder Abuse to advise it on how it should respond to elder abuse. The Working Group subsequently published a seminal policy document entitled *Protecting Our Future* in 2002 (Working Group on Elder Abuse, 2002), which proposed a framework to effectively address elder abuse.

Based on the report's recommendations, a range of intervention services was established to provide a dedicated elder abuse service under the auspices of the Health Service Executive (HSE). Commencing in 2007, a major element of the service was the introduction of a cadre of registered social workers specially trained to act in the role of senior case worker (SCW) with responsibility for assessing and managing suspected cases of elder abuse referred to the HSE. Dedicated officers for the protection of older people were also appointed with responsibility for staff training, policy development and coordinating training on a regional basis. In addition, train-the-trainers were also introduced to train a cadre of new trainers, with the aim of enabling organisations to be self-sufficient in providing staff training. A key element of the response was the introduction of a structured training programme in detecting and preventing elder abuse aimed at front-line care staff and members of the public. A National Centre for the Protection of Older People (NCPOP) was also established at University College Dublin (UCD) in 2008 to conduct research into elder abuse in Ireland.

Since 2007, the HSE has been conducting the national training programme for all healthcare staff in the recognition and prevention of elder abuse. The programme is aimed at healthcare and other staff working with older people in residential care settings and in the community. The programme consists of two training DVDs. One DVD, entitled *Recognising and*

Responding to Elder Abuse in Residential Care Settings is aimed at staff working with older people in residential care settings and the other, entitled *Open Your Eyes to Elder Abuse in Your Community*, is aimed at those working with older people in the community. Each DVD is accompanied by supporting print materials. These materials include a user guide and workbook, which are designed to generate discussion around the issues raised in the DVDs. The training DVDs and associated learning activities are designed to be delivered in a single training session or 'workshop' lasting approximately three hours. The training programme is aimed at complementing the Health Information and Quality Authority (HIQA) standards in relation to the protection of older adults and vulnerable people. Specifically, the aim of the workshop is to 'increase [the] participant's awareness and knowledge of elder abuse and ensure they are in a better position to recognise it and report concerns' (HSE, 2012).

The HSE commissioned the NCPOP to conduct an evaluation of the training programme as part of its remit to conduct research into aspects of elder abuse and its prevention. Informed by current theory and best-practice principles in the design of training evaluation research, the study incorporated elements of structure, process and outcomes evaluation. A number of sources provided data for evaluation including documentary analysis, qualitative interviews and experimental evaluations. The main objective of the HSE national training intervention is enhanced participant ability to recognise and respond appropriately to elder abuse. Therefore, a key element of the study was to test the programme's effectiveness with reference to trainee outcomes understood to be improved knowledge of and ability to recognise abuse. This report presents the results of the evaluation study.

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2.1 Introduction

It is widely accepted that elder abuse is an underreported and underestimated problem (Radensky & Parikh, 2008; Alt *et al*., 2011; Cooper *et al*., 2012; Sugita & Garrett, 2012). Inaction in relation to elder abuse can produce a range of adverse outcomes for older people. Increased risks of physical and psychological distress, morbidity and behavioural problems can have a detrimental impact on an older person's quality of life that, in the extreme, can result in mortality (McCauley *et al*., 2003; Nolan *et al*., 2008; Cooper *et al*., 2009; Day *et al*., 2010).

Several reasons for the under-recognition and under-reporting of elder abuse have been cited in the literature. Lack of awareness, knowledge and skills in relation to the recognition, reporting and effective management of elder abuse have been identified as significant impediments to tackling elder abuse (Richardson *et al.,* 2002; Cooper *et al.,* 2009; Alt *et al.,* 2011). A significant body of empirical evidence points to deficits in awareness, knowledge and confidence among health and social care professionals in relation to elder abuse and documents the limited provision of education and training in the area (McLaughlin & Lavery, 2000; Richardson *et al*., 2002; Thompson-McCormick *et al*., 2009; Sugita & Garrett, 2012; Pelotti *et al*., 2013). Low levels of awareness and knowledge of elder abuse among professionals are coincident with low levels of training in the topic (McLaughlin *&* Lavery, 2000). In addition, the literature highlights several barriers to reporting abuse, which health and social care professionals experience, including psychological and emotional barriers, and both real and perceived system failures in relation to the management of elder abuse (Bond, 2004; Grainger, 2009; Thompson-McCormick *et al*., 2009; Alt *et al*., 2011).

It is widely accepted that in order to effectively address the growing and pervasive problem of elder abuse, awareness of the extent and nature of the problem and dissemination of knowledge about how to detect, report and manage abuse are essential (Cooper *et al*., 2009; Smith *et al*., 2010; Sugita & Garrett, 2012). The provision of education and training is regarded as one of the key ways by which the management of elder abuse can be greatly improved and by which some of the barriers commonly cited and experienced in relation to reporting can be addressed (McGarry & Simpson, 2007).

This chapter highlights some of the barriers to effective elder abuse management identified in the literature and examines the effectiveness of elder abuse education and training interventions targeted at health and social care professionals, in terms of improving knowledge, practice and outcomes in relation to elder abuse. Best practice approaches and strategies for designing and implementing elder abuse training interventions are also identified.

2.2 Review method

Search strategy

A comprehensive search of published works listed in the databases Cochrane, Medline, CINAHL Plus, ASSIA, Science Direct, PubMed and Wiley was conducted. Additionally Google Scholar was searched for grey literature. The search terms used in various combinations were 'elder abuse', 'education', 'training', 'programme', 'curriculum', 'module' and 'evaluation'.

Search outcome

The search of published works yielded a total of 576 items. The titles, abstracts, report summaries or full papers of retrieved items were screened for relevance. The screening process yielded 48 items that were deemed relevant to the topic.

Data abstraction

The data extracted included methodological details, such as the study design, objectives and population, description of the educational/training intervention, successful elements of the educational/training intervention identified, evaluation outcomes, findings, conclusion and recommendations.

2.3 Barriers to effective elder abuse management

Lack of awareness, knowledge and skills

There is ample evidence that lack of knowledge of the mechanisms, protocols and legal framework around reporting of elder abuse hampers effective elder abuse management (Vinton, 1993; McLaughlin & Lavery, 2000; Richardson *et al*., 2002; Bond, 2004; Cooper *et al*., 2009; Thompson-McCormick *et al*., 2009; Sugita & Garrett,

2012). Many of the barriers to the identification, reporting and management of elder abuse cited in the literature relate to a lack of awareness, knowledge and skills among health and social care professionals (Shefet *et al*., 2007; Alt *et al*., 2011). Detecting elder abuse can be problematic, with clinical symptoms sometimes confounding health and social care professionals who are not familiar with the indicators of elder abuse. In addition, the lack of conceptual clarity around what constitutes elder abuse and the ethical issues that are frequently encountered add to the challenge of identifying elder abuse (McGarry & Simpson, 2007; Cooper *et al*., 2009; Alt *et al*., 2011; Sugita & Garrett, 2012).

Several studies have examined health and social care professionals' ability to recognise elder abuse and reported a lack of competence in identifying abusive care practices (Thompson-McCormick *et al*., 2009; Hempton *et al*., 2011; Pelotti *et al*., 2013). Thompson-McCormick *et al*. (2009) reported that medical students struggled to identify neglectful acts as abusive while Hempton *et al*. (2011) and Pelotti *et al*. (2013) demonstrated that health professionals were more capable of distinguishing non-abusive from abusive care practices.

A small number of Irish studies have examined health and social care professionals' knowledge of elder abuse. McLaughlin and Lavery (2000), who examined elder abuse awareness and knowledge among community health and social care staff in Northern Ireland, found a low level of knowledge and poor perceived competency in relation to identifying and managing elder abuse. They also reported that the knowledge and understanding of some health and social care professionals appeared to be guided more by practice and experience and less by research evidence. Kennelly *et al*. (2007) examined elder abuse awareness and knowledge among non-consultant hospital doctors and medical social workers working at a large urban hospital in Dublin and reported a lack of knowledge and familiarity with guidelines for managing abuse, especially among doctors.

Psychological and emotional barriers

A host of psychological barriers hindering elder abuse detection and management have been identified. Health and social care professionals' lack of knowledge and expertise regarding the definition, diagnosis and reporting of abuse can manifest in a lack of confidence in addressing suspected abuse (Cooper *et al*., 2012).

Another inhibiting factor is fear that the relationship established with the older person might be negatively impacted by addressing suspected abuse or reporting it, especially in cases where the suspected victim denies the abuse (Radensky & Parikh, 2008; Cooper *et al*., 2012).

Consideration of how reporting will affect one's job and one's relationship with colleagues or family members may result in hesitancy in reporting (Grainger, 2009). Feelings of empathy with or sympathy towards the perpetrator or fear of retribution by a suspected perpetrator can also prevent the reporting of abuse (Bond, 2004; Richardson *et al*., 2004; Thompson-McCormick *et al*., 2009). Some health and social care professionals may fear harsh disciplinary action for the perpetrator as a result of their reporting of abuse (Richardson *et al*., 2004). The emotions that professionals can encounter when they suspect abuse, such as, fear, lack of confidence and uncertainty, can lead to avoidance strategies and result in low levels of reporting of elder abuse (Grainger, 2009).

Barriers in the systems and structures for detecting and managing abuse

Health and social care professionals may perceive or experience the structures and resources to support detection and effective management of elder abuse as absent or lacking. Concerns about the efficacy of intervening in elder abuse and the limited intervention options available to address abuse have been expressed by professionals. Disaffection with previous experiences of elder abuse case management, fears of counter therapeutic interventions being implemented and fears of adverse outcomes for abused elders are among the factors which have been identified as barriers to healthcare professionals' reporting of suspected abuse (Weiner, 1991; Vinton, 1993; Tilden *et al*., 1994; Radensky & Parikh, 2008). In addition, beliefs that incidents of abuse are mismanaged through a punitive rather than a supportive approach may also deter reporting (Richardson *et al*., 2004; Thompson-McCormick *et al*., 2009). Under-reporting of elder abuse can also result from a lack of coordinated working among older people's services and among professionals working within them. Thus, a lack of structures, protocols and investment in training to facilitate multi-agency collaboration may result in missed opportunities to tackle elder abuse (Anetzberger *et al*., 2000).

Other barriers

Other barriers to effective management of elder abuse by health and social care professionals include a perceived lack of responsibility in relation to reporting and a lack of time to deal with elder abuse (Richardson *et al*., 2004; Kennedy, 2005; Thompson-McCormick *et al*., 2009; Tilden *et al*., 1994; Gironda *et al*., 2010). For example, Teresi *et al*. (2013) found that while the reporting mechanisms introduced as part of elder abuse training increased reports of elder mistreatment by staff, over time staff experienced the amount of time required to document incidents as burdensome.

2.4 Education and training in recognising and responding to elder abuse

Education and training of professionals in elder abuse is regarded as an important means of ensuring the early identification, prevention and effective management of elder abuse (McGarry & Simpson, 2007; Harmer-Beem, 2005; DeHart *et al*., 2009; Day *et al*., 2010). The broad aims of education and training programmes for professionals are to increase awareness and knowledge of elder abuse and neglect among those working with older people and to improve their confidence and competence to more effectively assess, identify, report and manage suspected cases of abuse (Cooper *et al*., 2009; Smith *et al*., 2010; Thomson *et al*., 2010; WHO, 2011; Sugita & Garrett, 2012).

Several gaps in professional elder abuse education and training programmes have been identified (Tilden *et al*., 1994; Kingston & Penhale, 1997; Seamon *et al*., 2007; Harmer-Beem, 2005; Thompson-McCormick *et al*., 2009; Gironda *et al*., 2010). There is evidence of a lack of elder abuse education among a range of health and social care professionals working with older people (Shefet *et al*., 2007; Gironda *et al*., 2010; Alt *et al*., 2011; Sugita & Garrett, 2012). Tilden *et al*. (1994) found that approximately three quarters of health care professionals in one US state had never received education about elder abuse. Similarly, McLaughlin and Lavery (2000) reported that over four fifths of health and social care professionals surveyed in a health region in Northern Ireland had never received training in elder abuse. Reporting on elder abuse training at a Dublin hospital, Kennelly and colleagues found that none of the hospital's non-consultant hospital doctors had received formal training in elder abuse (Kennelly *et al*., 2007).

Evidence of a lack of quality in elder abuse training programmes has also been reported. Specialist registrars surveyed about their experience of elder abuse training during their post-graduate medical training in the UK rated both the quantity and quality of training received as poor (Thomson *et al*., 2010). Cooper *et al*. (2012) showed that junior doctors who had previously received training on elder abuse performed no better on baseline knowledge scores when compared with those who had no formal training on elder abuse. Hence, the challenge appears to not only reside in the need to provide education and training in elder abuse to health and social care professionals, but also to ensure that the training provided meets key learning objectives and results in better learner outcomes.

The need for training

Increasingly it is recognised that the responsibility for detecting suspected cases of elder abuse is shared across a range of diverse professional disciplines and across a range of sectors in society (Weiner, 1991). Thus, professional groups who have not typically been involved in elder abuse issues require training to alert them to their roles and responsibilities in relation to the prevention and management of elder abuse (Kingston & Penhale, 1997).

The importance of education and training on elder abuse for frontline staff working with older people, in particular, those providing 'hands on' care, has been emphasised. Health and social care professionals who routinely interact and assess older people are best placed to identify those at risk of abuse and also to provide support to those experiencing abuse (WHO, 2011). In Ireland, public health nurses and social workers are seen to have a key role in identifying and assessing older people at risk of abuse (Day *et al*., 2010).

The literature has highlighted the challenges and the heightened training needs of nursing assistants. Several authors have argued that the training provided to nursing assistants does not adequately prepare them for the challenges that they experience in a highly demanding and stressful role. These include: high levels of conflict and abuse; poor pay and conditions of employment; low status and a lack of upward employment mobility; lack of participation and control in decision-making processes and a lack of supervision (Hudson, 1993; Braun *et al*., 1997; Goodridge *et al.,* 1997; Nolan *et al*., 2008; DeHart *et al*., 2009; Smith *et al*., 2010).

The content of training

Educational interventions for professionals tend to focus mainly on the nature and prevalence of elder abuse, training in awareness and recognition of elder abuse as well as training in professional roles and responsibilities in relation to reporting abuse. Additionally, some training interventions may incorporate assessment and screening skills, problem-solving skills, strategies for managing conflict, stress and challenging behaviour, strategies for effectively managing cases of elder abuse and discussions of ethical issues around reporting.

According to Nolan *et al*. (2008), educational initiatives tend to be oriented towards legislative and organisational needs and often neglect relational or emotional issues, especially where resources for training are limited. Encounters with elder abuse may be experienced as emotionally demanding and stressful since they can bring complex ethical and interpersonal issues to the fore (Grainger, 2009; Day *et al*., 2010). It is argued that incorporating training related to these issues into elder abuse educational initiatives may improve people's skills in managing elder abuse and may help to overcome some of the psychological barriers experienced in relation to reporting abuse (Grainger, 2009).

In addition to providing training in recognising and reporting elder abuse, training programmes should also focus on the competencies required for protecting older people from abuse. DeHart *et al*. (2009) identified several competencies needed by those working in residential care, including: interpersonal skills, such as communication strategies and coping strategies for effectively managing and resolving conflict; the ability to recognise features of the workplace that contribute to a high risk of mistreatment; the ability to identify those residents most vulnerable to abuse; awareness of age-related illnesses like dementia and the ability to recognise subtle forms of abuse. Teitelman and O'Neill (2000) recommended that training include more information on sexual abuse, demonstrations of interviewing techniques, particularly for people with dementia, and guest presentations by law enforcement officers. Nursing assistants involved in the design of an elder abuse prevention training initiative in Hawaii placed importance on learning strategies of stress reduction as a way of preventing elder abuse (Braun *et al*., 1997). Training should also incorporate education on screening for abuse and differentiating between age-related health changes and markers of abuse (Fraser, 2010).

McLaughlin and Lavery (2000) have highlighted the need for specialist elder abuse training in order for health and social care professionals to develop their assessment and monitoring skills in managing cases of elder abuse. It is recommended that training should focus on issues related to abuse of older people as a cohort; hence basic background information on ageing and issues around ageism and capacity should be incorporated into elder abuse training (Gironda *et al*., 2010). It is also recommended that education and training should aim to foster an understanding of the particular experience of abuse in later life among those working with older people, in order to ensure an empathetic response (Kingston & Penhale, 1997).

Structure and delivery of training

Best practice in the field of elder abuse prevention and interventions should promote interdisciplinary collaboration (Day *et al*., 2010). The importance of multidisciplinary collaboration and multi-agency coordination in the effective prevention and management of elder abuse is widely recognised (Anetzberger *et al*., 2000; McGarry & Simpson, 2007; Nusbaum *et al*., 2007; Day *et al*., 2010). For this reason, an interdisciplinary and multi-agency approach to training in elder abuse is recommended in order to promote collaborative working in the area of elder abuse prevention and management, and to initiate a critically reflective process in which the dynamics and challenges of working in this way are explored (Kingston & Penhale, 1997; Day *et al*., 2010). A shared learning approach to elder abuse training has the potential to improve interdisciplinary working by enhancing different professional groups' understanding of each other's respective roles and responsibilities, as well as attitudes, beliefs and approaches to elder abuse (Kingston & Penhale, 1997; Day *et al*., 2010).

Heath *et al.* (2002) described a model of elder abuse training based on a shared learning approach, involving clinical, community-based interactions between medical students enrolled in a geriatric medical education program and adult protective service (APS) workers in the US. The medical students interacted with APS workers by either providing direct care to clients or in a consultancy capacity. Self-reports from both professional groups indicated that the educational collaboration provided opportunities for interdisciplinary learning that, in turn, benefitted case management, client interactions and medical students' attitudes and skills (Heath *et al*., 2002). In other studies that have involved

multidisciplinary input and multiagency collaboration in the design of elder abuse educational initiatives, cited benefits included identifying all relevant issues and areas in which training is required, fostering an awareness of elder abuse from multiple perspectives and increasing the potential for future co-ordination in the management of elder abuse (Anetzberger *et al*., 2000; Gironda *et al*., 2010).

Training that incorporates active learning strategies is deemed to be more effective in terms of long-term retention and application of knowledge to practice when compared to training approaches that adopt passive learning techniques, such as didactic lecture presentations (Jogerst *et al*., 2004; Nusbaum *et al*., 2007; Gironda *et al*., 2010). This method engages participants in critical thinking and problem-solving which, in turn, facilitates the reinforcement and real-life application of new skills learned (Pillemer & Hudson, 1993; Nolan *et al*., 2008; Gironda *et al*., 2010). Active learning strategies, like role playing and small group exercises, generate discussion, provide stimulation for participants and have the potential to empower participants by allowing them to draw on their own experiences and knowledge in a discursive and reflective process (Braun *et al*., 1997; Teitleman & O'Neill, 2000; Smith *et al*., 2010). By acknowledging and drawing on participants' experiences, such approaches may also enhance their investment in the training and their motivation to learn (Huba *et al*., 2010).

The value of role play is that it can facilitate participants to express their views and practice their responses to different elder abuse scenarios in a safe environment (Huba *et al*., 2010; Gironda *et al*., 2010). The value of case studies is that they present the complexities of elder abuse cases and enable participants to actively engage in and explore approaches and solutions in the context of best practice, policy and legislation (Day *et al*., 2010). Case studies also give participants opportunity for discussion, reflection and feedback (Smith *et al*., 2010). Small group discussions and exercises allow participants to explore how their own values impacts on how they perceive, feel and act in relation to elder abuse (Vinton, 1993). Interactive learning is considered to be the most effective means of learning and it is also the method preferred by adult learners (Smith *et al*., 2010).

Numerous elder abuse training programmes have incorporated the use of audio-visual media (Seamon *et al*., 1997; McCauley *et al*., 2003; Smith *et al*., 2010; Teresi *et al*., 2013). The advantages of using audio-visual media is that it is easy to disseminate, gives consistent information, provides a flexible and convenient form of training for health and social care professionals, and can depict realistic role play scenarios, which demonstrate appropriate approaches to the management of elder abuse (Seamon *et al*., 1997; McCauley *et al*., 2003). Smith *et al*. (2010) reported the benefits of an online elder abuse training programme for students enrolled in a nursing assistant course which consisted of 12 minutes of text and video materials and a reflective online interaction. Post-training trainee comments and online discussions indicated that students were engaged with the course content, demonstrated a growing awareness of elder abuse from an ecological perspective and demonstrated thinking about potential solutions to elder abuse and their role in elder abuse prevention and management.

The provision of training by an internal member of the organisation or service who is knowledgeable about elder abuse is seen as an important factor in the success of elder abuse training (Nusbaum *et al*., 2007; Nolan *et al*., 2008). Some authors assert that the delivery of training by an internal trainer facilitates the development of rapport with participants and provides them with the reassurance that that they can discuss or report any concerns or suspicions of abuse that they may have to a trained person with local knowledge (Pillemer & Hudson, 1993; Radensky & Parikh, 2008).

The importance of designing training materials that are relevant, accessible as well as culturally and linguistically appropriate to the target participants has been highlighted as instrumental to the success of training initiatives (Gironda *et al*., 2010). Several authors agree that involving staff trainees in the design, delivery and evaluation of training programmes enhances the probability of the training being successful. According to this perspective, involvement encourages trainees to focus on their own responsibilities with regard to abuse, enables them to tailor the training objectives to their educational needs and gives them a vested interest in the programme's success (Braun *et al*., 1997; Harmer-Beem, 2005; Nolan *et al*., 2008; Gironda *et al*., 2010). Braun *et al*. (1997) found that an intervention designed for nursing assistants with their input was highly acceptable to them and resulted in self-reported improvements in job

satisfaction and knowledge of stress reduction strategies. Staff involvement in the design may also facilitate the transfer of learning to practice, as staff are best positioned to determine the most viable and appropriate strategies for implementing protocols, guidance and best practices in their own work setting (Teresi *et al*., 2013).

2.5 Evaluations of elder abuse Training interventions

The literature contains several reports of studies to evaluate the effectiveness of elder abuse training interventions targeted at health and social care professionals. The WHO's *European Report on Preventing Elder Maltreatment* identified just two high-quality studies evaluating professional awareness and education on elder abuse (Jogerst & Ely, 1997; Richardson *et al*., 2002). The report defined high-quality studies as those using a quantitative design, including a control group for comparison, and using a sample likely to be representative of the target population (WHO, 2011).

Most studies identified in the literature examined changes in health and social care professionals' awareness and knowledge around elder abuse following training (Vinton, 1993; Uva & Guttman, 1996; Seamon *et al*., 1997; Anetzberger *et al*., 2000; McCauley *et al*., 2003; Cooper *et al.,* 2012; Sugita & Garrett, 2012). Some studies examined whether education and training had an effect on health and social care professionals' practice behaviours with regard to abuse perpetration, screening for abuse and reporting of abuse (Pillemer & Hudson, 1993; Jogerst *et al*., 2004; Nusbaum *et al*., 2007; Radensky & Parikh, 2008; Sugita & Garrett, 2012; Teresi *et al*., 2013; Cooper *et al*., 2012).

Most of the published evaluation studies have reported the effects of elder abuse training using a pre-test-post-test study design (Pillemer & Hudson, 1993; Braun *et al*., 1997; Vinton, 1993; Seamon *et al*., 1997; Nusbaum *et al*., 2007; Sugita & Garrett, 2012). Two studies reported the use of experimental design involving an intervention group and a control group (Richardson *et al*., 2002; Teresi *et al*., 2013). Other evaluation studies included a post-programme evaluation of an education programme immediately following implementation of the training and again six months after the training (Mills *et al*., 2012) and a controlled survey design which assessed the effectiveness of an elder abuse education session (Uva & Guttman, 1996).

Several studies described the development of training modules or workshops for students, which aimed to increase their awareness and knowledge of elder abuse with a particular emphasis on fostering critical thinking through the use of active learning strategies. Evaluation and modification of these educational modules were provided primarily through student feedback (McGarry & Simpson, 2007; Day *et al*., 2010; Smith *et al*., 2010; Gironda *et al*., 2010).

Many studies reported the use of self-report measures of changes in knowledge and behaviour or intention-to-treat to assess the effectiveness of training (Pillemer & Hudson, 1993; Uva & Guttman, 1996; Seamon *et al*., 1997; Anetzberger *et al*., 2000; Nusbaum *et al*., 2007; Mills *et al*., 2012; Sugita & Garrett, 2012). A small number of studies have used objective data to assess the effectiveness of training (Jogerst *et al*., 2004; Radensky & Parikh, 2008; Teresi *et al*., 2013). For example, the Knowledge and Management of Abuse (KAMA) questionnaire, an objective, validated instrument, has been used to assess how professionals would manage possible abuse scenarios presented to them in vignettes (Richardson *et al*., 2002; Richardson *et al*., 2004; Cooper *et al*., 2012). Cooper *et al*. (2012) used the Caregiver Scenario Questionnaire (CSQ) to assess respondents' knowledge about which strategies for managing challenging behaviour in a person with dementia were abusive.

Several authors reported informal evaluations of elder abuse educational interventions through trainee or trainer feedback (Weiner, 1991; McGarry & Simpson, 2007; Teitleman & O'Neill, 2000; Day *et al*., 2010; Smith *et al*., 2010), while others reported evaluations of broader training programs that incorporated an elder abuse component (McCauley *et al*., 2003; Harmer-Beem, 2005; Shefet *et al*., 2007; Desy & Prohaska, 2008). A small number of these studies delineated the results for the elder abuse component of the training.

Evaluations based on objective empirical evidence have identified the most effective training methods for increasing trainee knowledge (Policastro & Payne, 2013). Richardson *et al*. (2002) compared the effectiveness of two methods of elder abuse training. Using the randomised controlled trial method, they demonstrated that attendance at a training course was more effective than the provision of printed educational materials in improving knowledge and management of abuse among nurses and social care staff in a UK-based psychiatry of old age service, particularly among those with lower

baseline knowledge. These researchers also found that having more elder abuse knowledge at the outset resulted in less knowledge gain after the implementation of the intervention, leading them to suggest that for educational interventions to be effective, they should be tailored according to participants' baseline knowledge. In an evaluation of nurses' responses to vignettes of elder abuse in a later adjunct to the study, Richardson and colleagues found that nurses continued to select inappropriate management strategies even after they had received the educational intervention (Richardson *et al*., 2004). The findings of both of these studies are replicated in a more recent evaluation study of an adult protection training programme in Scotland which found that although the brief training programme, which was tailor-designed to take account of participants' baseline knowledge and preferred methods of training delivery, successfully increased knowledge of adult protection among community nurses, trainees who correctly answered questions in the pre-training test answered some of the same questions incorrectly in the post-training test (Campbell *et al*. 2014)

Using a clustered randomised controlled trial, Teresi *et al*. (2013) developed and evaluated the effectiveness of a training intervention on resident-to-resident elder mistreatment (R-REM) for nursing assistants on knowledge, recognition, reporting and management of R-REM over a one-year period. The intervention consisted of a series of oral presentations and a video. The intervention group demonstrated improved R-REM recognition and reporting over time and reported seven times as many incidents of resident-to-resident elder mistreatment at 6 months and ten times as many incidents at 12 months.

Cooper *et al*. (2012) found that an educational intervention, comprising presentations on elder abuse and an elder abuse awareness DVD, improved knowledge and confidence about recognising and managing elder abuse among trainee psychiatrists at three months following the intervention. However, no significant improvement in the participants' routine screening behaviour was reported, suggesting that impediments to screening for abuse persisted, in spite of the intervention. The authors suggested that this might be redressed by introducing a more interactive component to the training intervention.

Pillemer and Hudson (1993) evaluated the effectiveness of an elder abuse prevention curriculum, which focused on increasing awareness about elder abuse and educating staff about appropriate conflict intervention strategies for nursing assistants in US nursing homes. In addition to the programme receiving positive ratings by participants, the authors reported statistically significant reductions in conflict with residents and resident aggression, and a reduction in trainees' own abusive behaviour, which was not statistically significant.

Using a pre-test-post-test design, Seamon *et al*. (1997) evaluated the effectiveness of a training intervention that comprised a 45-minute video on pre-hospital emergency services personnel's knowledge and willingness to report elder abuse. The post-test results indicated significant improvements in participants' knowledge of elder abuse; however, there remained a substantial proportion of professionals who reported a lack of confidence in their ability to recognise abuse and a lack of clarity regarding some aspects of the law in relation to elder abuse.

Nusbaum *et al*. (2007) reported an evaluation of an educational intervention targeted at emergency services personnel and showed that the intervention did not produce lasting attitudinal or behavioural changes with regard to detecting possible abuse and screening for elder abuse and neglect. The authors posited that shifts in organisational norms and attitudes are needed for change to take effect and for the intervention to be embraced. They also suggested that in-service, peer-delivered training and refresher training might be more effective in producing enduring behavioural changes than training delivered by an external trainer.

Sugita and Garrett (2012) investigated whether a symposium on elder abuse involving a panel of experienced multidisciplinary experts would increase oral health care providers' knowledge of and likelihood to report elder abuse. The post-test results indicated that the participants perceived themselves to be more confident in recognising the indicators of elder abuse, more knowledgeable about elder abuse and reporting requirements and procedures, more likely to ask patients about suspected abuse and more likely to report suspicions.

Uva and Guttman (1996) reported the findings of a survey which evaluated the effectiveness of an elder abuse education session targeted at residents in a hospital-based emergency medicine programme. The

participants evaluated the intervention positively and agreed that it should be formally introduced. Following the intervention the participants reported improved confidence in their abilities to recognise elder abuse and improved knowledge of reporting procedures.

Using a pre-test-post-test design, Vinton (1993) evaluated an elder abuse and neglect prevention programme for healthcare professionals. Programme participants were provided with written material on elder abuse, documentary case scenarios, video examples, written materials and an oral presentation. The programme incorporated a broad range of elder abuse topics, including barriers to identifying and intervening in cases of elder abuse and a discussion of ethical dilemmas. The results of the programme evaluation demonstrated a significant improvement in knowledge scores overall for all occupational groups, except law enforcement personnel.

A US study compared pre-test and post-test scores for health and social care professionals who participated in a continuing education initiative which involved viewing a video on interpersonal violence (IPV). The video included information about IPV and a demonstration of skills for identifying, preventing and intervening in IPV. Just a small number of the evaluation questions related specifically to elder abuse and the authors reported no significant improvement in physicians' knowledge of reporting requirements for elder abuse, a finding which the authors attributed to the participants' higher baseline knowledge (McCauley *et al.,* 2003).

Jogerst *et al*. (2004) examined whether investigation and substantiation rates for suspicions of elder abuse in domestic settings improved after the introduction of mandatory training for reporters in the state of Iowa. Pre- and post-training analyses of rates over an 18-year period indicated that the introduction of the training had no impact on detection and reporting of elder abuse, either in the short-term or the long-term.

Anetzberger *et al*. (2000) described the design of a multi-component elder abuse intervention focused on improving identification of elder abuse of people with dementia and improving multiagency collaboration in elder abuse management. The model consisted of a number of core elements, including a stakeholder-designed curriculum that comprised workbooks, teaching instructions, optional interactive exercises, case discussions, screening tools, referral protocols and a handbook for caregivers to aid identification of elder abuse risk factors and community supports and services.

The results of a before-and-after participant evaluation of the intervention showed that participants demonstrated increased understanding in a number of areas, including improved case identification and inter-agency collaboration.

Radensky and Parikh (2008) reported an initiative in which a healthcare provider trained registered nurses to provide training to nursing assistants on the topic of elder abuse recognition and reporting, with the objective of improving early identification of abuse and facilitating improved communication between staff and agencies in the management of abuse. Audits conducted before and after the training intervention showed an increase in reported cases of elder abuse.

In summary, few rigorous evaluations of elder abuse training interventions have been reported. Nevertheless, it does appear that education and training is somewhat effective in increasing awareness and knowledge of elder abuse among health and social care professionals (Vinton, 1993; Uva & Guttman, 1996; Seamon *et al*., 1997; Anetzberger *et al*., 2000; Sugita & Garrett, 2012; Cooper *et al*., 2012). In studies involving participants who had a good baseline knowledge of elder abuse, interventions did not appear to be effective, thereby highlighting the importance of tailoring training programmes to the target participants' baseline knowledge (Richardson *et al*., 2002; McCauley *et al*., 2003).

The literature indicates equivocal evidence concerning the effectiveness of education and training in changing health and social care professionals' behaviours in relation to elder abuse screening and reporting. Several studies demonstrated no improvement in these outcomes (Nusbaum *et al*., 2007; Jogerst *et al*., 2004; Cooper *et al*., 2012), while, others showed improved participant outcomes in these same areas (Anetzberger *et al*., 2000; Radensky & Parikh, 2008; Teresi *et al*., 2013). Despite education and training, some challenges persisted, with health and social care professionals choosing inappropriate dementia care management strategies, lacking confidence in their ability to recognise abuse and lacking clarity on the law in relation to elder abuse (Seamon *et al*., 1997; Richardson *et al*., 2004; Cooper *et al*., 2012). Just one study was uncovered that examined the efficacy of different modes of delivery of elder abuse training (Richardson *et al*., 2002). It would appear that face-to-face delivery of training is a superior mode of training on elder abuse when compared with dissemination of information through printed educational materials.

2.6 Conclusions

The interventions described in the literature varied in terms of content, structure, mode of delivery and methods of evaluation, making it difficult to draw conclusions from cross-study comparisons. However, many cross-cutting themes emerged from the literature in relation to best-practice approaches and strategies for designing and implementing elder abuse training programmes. Multiple studies utilised and espoused the value of interactive methods of training, such as role play, group discussions, and the use of case studies, as a way of engaging participants, ensuring long-term retention of learning and enhancing application of knowledge to practice. The literature underlines the importance of assessing the training needs of healthcare professionals, adapting training content to make it relevant to health and social care professionals' practice and tailoring training programmes to the target audience's baseline knowledge. The literature also emphasises the need for training to equip healthcare professionals with the knowledge and skills to work effectively as part of a multi-disciplinary team in managing elder abuse.

Evidence of the effectiveness of face-to-face training on elder abuse compared to printed educational material alone underscores the need for training on elder abuse. Although many educational interventions demonstrated improved awareness and knowledge of elder abuse, it appears that improved knowledge does not necessarily translate into improved practice. Thus, it seems that significant barriers to managing elder abuse according to best practice guidelines remain in spite of educational interventions.

Evidence that healthcare professionals do not always follow abuse management guidelines and protocols indicates that practice exposure significantly shapes healthcare professionals' perceptions of what are acceptable abuse management strategies. Furthermore, several studies have shown that healthcare professionals who received elder abuse training and had more experience were not more knowledgeable about what constituted abuse when compared to those who had not received training and were more inexperienced. Knowledge deficits that persist even after the provision of training raises a question over the effectiveness of elder abuse training in its current guise. Continuing professional development and refresher training may be required in order to ensure that knowledge is retained in the long-term and that practice exposure does not result in staff adopting inappropriate management strategies.

The extent to which educational interventions are effective in terms of effecting behavioural changes in trainees is associated with several factors. The literature indicates that among the factors are: the quality of the educational intervention, in terms of whether the learning objectives are clear; whether the participants perceive the learning objectives as relevant to their practice needs and are motivated to learn; whether the mode of delivery is appropriate; whether the inputs into the intervention are sufficiently and consistently resourced, planned and implemented; whether the intervention is deemed acceptable and achievable; and whether the organisational culture is receptive to and facilitative of change.

There is a lack of reliable evidence of the effectiveness of education and training interventions to protect older people from abuse or to appropriately manage abuse. Few studies have measured the long-term retention of knowledge as a result of training programmes. Hence, there is a need for rigorous objective evaluation studies to determine the effectiveness of education and training on elder abuse prevention and management and also to determine the most effective way of delivering training in terms of cost, resources and meeting the key learning objectives of long-term retention of knowledge and the application of knowledge to practice.

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3.1 Introduction

This study evaluated the Health Service Executive national training programme in the prevention of elder abuse. This chapter describes the evaluation strategy, including the theoretical foundations that gave rise to the research design and the materials, and methods of data collection and data handling that were used to conduct the evaluation of the national training programme. The evaluation design was informed by current thinking on the theory and practice of programme evaluation, in which an eclectic approach to evaluation design is advocated, involving multiple data sources and multiple data collection methods (Hannum *et al*., 2007).

In setting out the requirements for the evaluation of the HSE elder abuse prevention training programme, the three elements of structure, process and outcomes were identified by the research team as critical to the evaluation. Specifically, the focus of the evaluation was on:

- The documentary materials and resources that are used to support the training programme
- The experiences of those coordinating and facilitating the training programme
- The effectiveness of the programme, as measured by participant recognition of abusive caregiving strategies and their knowledge of appropriate management responses.

A key task was to evaluate the training programme, with reference to its suitability and sustainability as a method of staff continuing professional development in relation to their role in recognising and preventing elder abuse and neglect in their place of work. To that end a mixed methods approach was adopted in which the following tasks were planned as three phases of the study: an analysis of all training materials; a series of individual interviews with trainers; a within-group quasi-experimental design and a randomised controlled trial to establish training effectiveness.

3.2 Evaluation strategy and data sources

In addition to the evaluation framework of structure, process and outcomes, the evaluation was conducted with reference to the major steps suggested by Hannum *et al*. (2007), namely: the training programme aims and objectives; participant experiences; participant outcomes, including specific skills and competencies; stakeholder requirements and wider contribution. This gave rise to a mixed method, data triangulation approach, which aimed to ensure that all those experiencing the programme were represented in the data collection.

The main elements of the evaluation, including the scoping work, and the data design and collection elements were conducted over a one-year period. In developing the evaluation strategy in consultation with the NCPOP Steering Committee, the three key areas of structure (materials and planning), participant (trainer) experiences and participant (trainee) outcomes provided the basis for decisions about the sources and methods of data collection. Hence, the main sources of evaluation data were the training materials (training DVDs and supporting materials) and the participants, and these gave rise to the particular designs for the evaluation of the individual elements of the training programme. Figure 3.1 presents the main study foci and their associated data collection methods.

Figure 3.1 Main approaches to data collection

3.3 Structure element: Documentary review

The training materials, namely the training DVDs and associated workbook and guide, were subjected to documentary review. In addition, further review of the individual training resources was undertaken using a simple documentary analysis (DA) rating instrument (Appendix 1)[1]. The rating instrument was adapted from a measurement tool developed by Fealy *et al*. (2012) to evaluate material resources for a national clinical leadership training programme. The bespoke instrument contained a series of statements presented in four five-point ordinal rating scales. This yielded a consensus numeric score of quality of the materials, with reference to: production, presentation and branding of the training DVDs; the representation of the typologies of abuse within the DVDs; and the consistency with which the key constructs and ideas were represented across both training DVDs and the residential care-setting workbook This included analysis of the language used to convey constructs and ideas within and across the various training materials.

The rating instrument permitted review of the training materials at three levels, as follows:

i. The quality of materials, in terms of their presentation and production;

ii. The content of each individual element of the material, with reference to the language used to represent key constructs and ideas;

iii. The relationship among constructs across the various elements.

The DA rating instrument was developed following a number of iterations and refinements. Each member of the research team and a number of experts in elder abuse independently completed a rating for each individual training element and this was followed by a discussion of the scores yielded in order to arrive at a consensus score for each statement on the four scales and a consensus overall numeric score for each individual training resource.

Procedure for scoring the DA scales

The scale responses yielded from the DA rating instrument were analysed using measures of central tendency and dispersion of scores, specifically the median score and the inter quartile range, respectively. Scales A and C each contained eight items and yielded a score of between 7 and 35; a score of 28 or greater was taken as an index of 'good quality' and a score of 32 or greater was taken as an index of 'high quality'. Scale B contained ten items and yielded a score of between 9 and 45; a score of 36 or greater was taken as an index of 'good quality' and a score of 41 or greater was taken as an index of 'high quality'. The threshold scores of quality were applied arbitrarily and the individual scale items did not carry equal weight and, while the instrument is not validated, it provided the panel of analysts with a standardised guide with which to assess the materials objectively.

3.4 Process element: Interviews

The training programme was examined with reference to participant experiences and, to that end, the main participants were HSE staff who provided the training and those who coordinated the training and trained the trainers. The aim of data collection in relation to the process element was to elicit evidence through self-reports and discussions that would illuminate the type and quality of participant experiences. This data was sought in order to provide evidence of the experiences of delivering the actual training and experiences related to enablers and barriers to implementing the training. Semi-structured interviews were the main data collection method deployed for this element.

A total of thirteen interviews were conducted with those who provided and/or coordinated elder abuse training, as follows: three with dedicated officers who coordinated the training, three with train-the-trainers and seven with senior case workers, who delivered the training programme on a regular basis. The interviews were organised on the basis of regional representativeness and their purpose was to generate rich qualitative data on the experience of the programme coordinators, train-the-trainers and those involved in delivering the training programme (Table 3.1). The majority of interviews were conducted face-to-face in a private office in each participant's place of work and the remainder were conducted by telephone interview. Each interview was conducted on the basis of a simple topic guide (Appendix 2), which addressed aspects of the training, including planning and logistics, supports and trainee engagement.

1 The Open your eyes to elder abuse in your community: A guide to organising a group viewing of the DVD was not subject to review using the DA instrument as it was not available to the panel at the time of the review.

Table 3.1 Interview participants

HSE Region	Dedicated Officer	Train-the-trainer	Senior Case Worker
Dublin	1		
Dublin-Mid Leinster		1	2
South	1		3
West	1	2	2
Totals	**3**	**3**	**7**

Procedures: Ethical approval and participant recruitment

In compliance with the standard procedure for conducting evaluation studies of education and training programmes, exemption from full ethical review was granted by the research team's institutional Human Research Ethics Committee (HREC). This meant that ethical approval was granted for the procedures related to participant recruitment, the conduct of data collection, and the methods of data handling and storage. This included the procedures for obtaining written informed consent and assuring confidentiality and anonymity in the reporting and dissemination of the study findings.

Participants in the qualitative interviews were purposively selected in consultation with the dedicated officers. Each prospective participant was contacted by e-mail and/or telephone and invited to participate in the evaluation study. In the process of issuing participant invitations, the precise reasons for seeking the data were indicated. Each participant was asked to give written informed consent prior to participating in the interview. All participants were assured that their participation in the interview was entirely voluntary and that they were free to withdraw consent and discontinue their participation at any time, either before the agreed time of the interview or during the interview, without prejudice. Participants were also informed that the names of individuals or their organisations would not be recorded or identified in the report and that all data would be stored securely and used solely for the purpose for which it was intended.

Analysis of interview data

Data handling for the interview transcripts was facilitated through the use of NVivo 10 data handling software. Data from the interview transcripts were analysed manually using thematic content analysis in order to permit the extraction of emergent themes in the data. Content analysis involved two members (DP and GF) of the research team reading the interview transcripts independently and identified preliminary categories. Categories and more detailed codes were then allocated and, where appropriate, merged and reallocated, following which consensus on categories and codes was achieved. The outcome of this procedure was a narrative synthesis containing the categories and codes presented as major themes and sub-themes supported with exemplary extracts from the data.

3.5 Outcomes element: Quasi-experimental design and randomised-controlled trial

This phase of the study aimed to test the effectiveness of the HSE training programme. Training aimed at those working in residential care was tested among a sample of nursing students, while training aimed at those working in community care settings was tested among a sample of home care assistants.

Aims and hypotheses

The primary objective of the outcomes element of the study was to measure the effect of the training programmes on the participants' ability to recognise abusive caregiving scenarios. A further objective was to measure the effect of the residential care training programme on the participants' knowledge and management of elder abuse. The effects of the training programmes were assessed using quantitative measures of recognition of abusive caregiving as well as knowledge and management of elder abuse in a residential care setting.

The primary hypothesis that was tested in this phase of the evaluation was that the HSE training programmes will increase the participants' ability to recognise abusive caregiving scenarios. A secondary hypothesis was that the residential care training programme will have a positive effect on the nursing students' knowledge and management of elder abuse. The relevant (residential

care or community) HSE elder abuse training programme constituted the intervention in both of the experimental studies, one of which was a within-participants design and the other a randomised controlled trial design.

The study participants were recruited from two population groups: nursing students and home care assistants charged with providing care and assistance to older people in their own homes. These populations groups were the respective targets of the HSE residential care and community setting national training programmes.

Participants

In order to test the efficacy of the residential care training programme among nurses, a study sample was recruited from third-year nursing students undertaking the undergraduate general nursing degree programme at a large urban university nurse training school. In this way, the sample was homogenous in terms of prior gerontological nursing experience and with reference to education and training in elder abuse recognition and management. Students in the third year of training were chosen as they had attained a significant amount of clinical experience at that stage of their nursing programme and would therefore be expected to have some knowledge of gerontological nursing practice. A total sample of 141 nursing students was recruited for the study and 134 students completed the questionnaires before and after the delivery of the elder abuse training intervention.

The sample of home care assistants consisted of carers employed by the HSE to provide care and assistance to older people in their own homes in a rural setting in the West of Ireland. This sample was homogeneous in terms of their prior experience of working as home care assistants and in terms of their previous training in relation to elder abuse awareness and recognition. A total sample of 35 home care assistants employed by the HSE to deliver home help to older people was recruited for the study. All 35 of the assistants completed the questionnaire before and after the delivery of the training intervention.

Procedures: Recruitment and intervention for home care assistants

In July 2013, a member of the research team from the National Centre for the Protection of Older People (NCPOP) attended two scheduled training sessions delivered by a HSE dedicated officer for the protection of older people to two groups of home care assistants employed by the HSE to deliver home help to older people. The sessions were delivered in a rural setting in the West of Ireland as part of the national elder abuse training and awareness-raising programme. Before the commencement of the training session, the training programme attendees were provided with a verbal explanation of the study, including details of their role in the study. They were invited to participate in the study by completing a questionnaire before and immediately after the training sessions in a within-participants experimental design.

All of the home care assistants taking part in the training sessions gave verbal consent to participate in the study. A total of 20 participants (Group 1) in the first training session and 15 participants (Group 2) in the second session completed the pre and post training questionnaire. The questionnaire gathered demographic information on the participants' gender, age and whether they currently provide home care and assistance to older people. Recognition of abusive caregiving strategies was measured using a parallel form instrument which facilitated collection of baseline recognition scores as well as change in scores post-intervention (Selwood *et al*., 2007, Cooper *et al.,* 2012). The parallel form method minimises the carryover effect or the risk that responses from the pre-training intervention questionnaire might influence responses on the post-training intervention questionnaire. Carryover effect may compromise test-retest reliability in a repeated measures design that uses the same construct measures at both time points. In order to increase internal validity, version A of the parallel form was administered to Group 1 before the intervention and to Group 2 after the intervention. Version B was then administered to Group 1 after the intervention and to Group 2 before the intervention. Figure 3.2 illustrates the data collection procedures for the quasi-experimental within-subjects design.

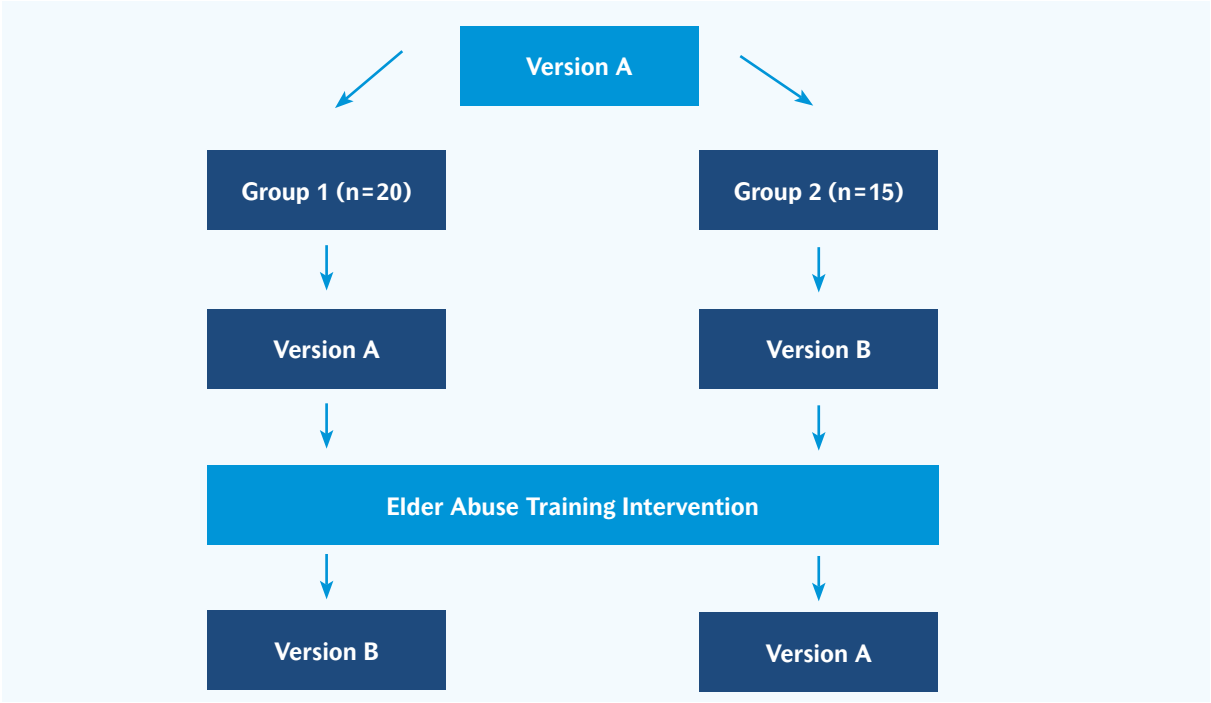

Figure 3.2 Group allocation for within group quasi-experimental design (pre- and post- intervention)

Procedures: Recruitment and intervention for nursing students

In April 2013, researchers from the NCPOP team attended the formal teaching for students in the third year of the general nursing degree programme at a large urban university school of nursing. The students were provided with an information leaflet (Appendix 3) and were invited to attend a training session on the recognition and management of elder abuse. The students were informed that the training session would be delivered by an external trainer from the HSE and they were given information as to the purpose of the study as well as details regarding the date, time and location of the training session.

A total of 141 nursing students presented for the training session. Upon entry into the training venue all of the students were randomly assigned with an identification label and were presented with a pre-intervention questionnaire. The questionnaire collected demographic information on the participants' gender, age and whether they currently worked with older people outside of their nursing programme, for example as a care assistant or with a care agency. The questionnaire also measured recognition of abusive caregiving strategies using a parallel form instrument (Selwood *et al.,* 2007, Cooper *et al.,* 2012) and knowledge and management of elder abuse in an institutional setting using another parallel form instrument (Richardson *et al.,* 2003).

Upon completion of the pre-intervention measures the students were randomly assigned to a control or intervention group. The control group (n=68) remained in the venue and the intervention group (n=66) were allocated to one of three seminar rooms where a standardised training intervention was delivered by three HSE dedicated officers for the protection of older people. The control group did not attend the training intervention, but instead was provided with and asked to read a journal article, which described the role of nurses in the recognition and management of elder mistreatment (Baker and Heitkemper, 2005). From the total number of students who completed the initial baseline measurements (N=141), seven (4.9%) withdrew from the study at follow-up, reducing the final total sample to 134.

Recognition of abusive caregiving as well as knowledge and management of elder abuse in a residential care setting were measured in both the control and intervention groups before and after the training intervention using parallel form methods. The parallel form method reduces the risk of carry-over effect understood as the risk that responses from the pre-training intervention questionnaire might influence responses on the post-training intervention questionnaire. Carry-over effect may compromise test-retest reliability in a repeated measures design that uses the same construct measures at both time points. In

order to increase the internal validity of the between-and-within groups experimental design, version A of the parallel instruments was administered to approximately one half of the control group before reading the journal article and it was administered to the other half of the control group after they had read the journal article. Version B was administered to approximately half of the control group before they read the article and to the other half after they had read it. Similarly, for the intervention group, approximately one half received version A of the parallel instruments before they had undergone the training intervention and the other half received version A after the training intervention. Version B was administered to approximately one half of the group before the training intervention and the other half received it after the training. Figure 3.3 illustrates the process of random group allocation and the flow of participants through the randomised controlled-trial experimental design.

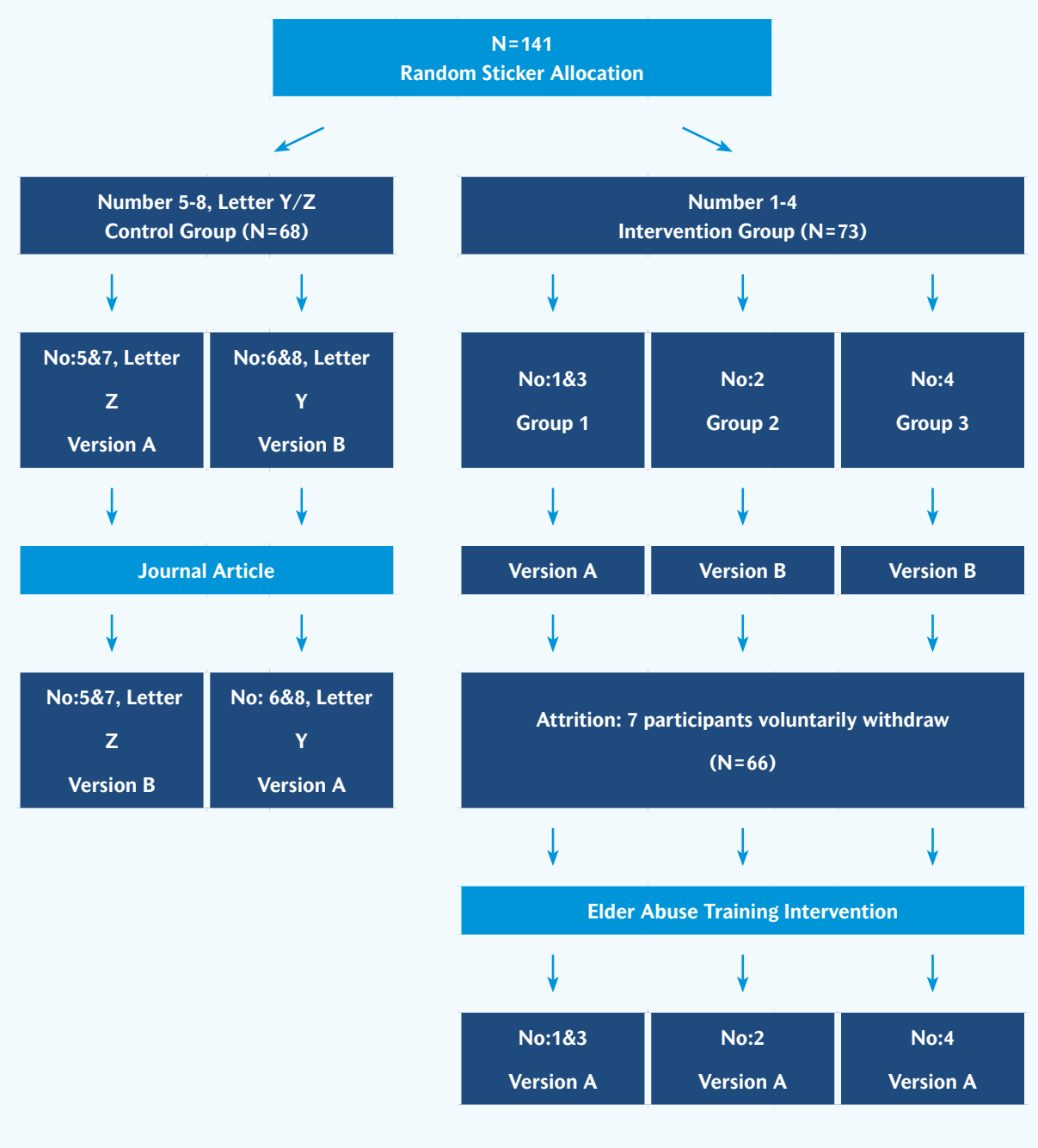

Figure 3.3 Randomisation and group allocation for the between and within group experimental design

Instrumentation

In order to assess efficacy of the training programmes, the ability to recognise abusive caregiving scenarios was measured before and after the training intervention in both the sample of home care assistants and the sample of nursing students. In addition, knowledge and management of elder abuse in an institutional setting was measured before and after the training session with the nursing students. Two vignette-based instruments were adopted to measure these outcomes, The Caregiver Scenario Questionnaire (CSQ) and the Knowledge and Management of Abuse (KAMA).

The Caregiver Scenario Questionnaire (CSQ) is a vignette-based instrument originally developed by Selwood *et al*. (2007) to measure recognition of abusive caregiving strategies for managing challenging behaviour in a person with dementia (Appendix 4). A vignette describing a challenging caregiving situation involving an older care recipient with dementia and their informal caregiver (son or wife) was presented to the participants. The scenarios were followed by a list of 14 management responses or strategies and the participants were asked to rate each strategy on a 6-point Likert scale. Possible responses were: 'good idea and helpful'; 'possibly useful'; 'not sure'; 'unlikely to help'; 'bad idea but not abusive' or 'abusive'. Four of the strategies were abusive, as defined by the World Health Organisation Centre for Interdisciplinary Gerontology and judged by an expert panel (Selwood *et al*., 2007), five were judged to be possibly abusive and five were not abusive. A parallel form version was adopted for this study. This parallel form was created with a similar structure and marking scheme as the original version (Cooper *et al*., 2012).

The Knowledge and Management of Abuse (KAMA) is a parallel form instrument, developed by Richardson *et al*. (2003) to measure staff-applied knowledge and practice regarding identification and management of potentially abusive situations in an institutional setting (Appendix 5). Participants were asked to describe how they would manage each of seven scenarios involving potentially abusive situations and their responses were scored using a structured marking scheme. Higher scores indicated that respondents gave more correct answers, demonstrating greater knowledge. The abusive scenarios were adapted from the clinical experience of a panel of researchers and experts and from a review of the literature (Richardson *et al*., 2003). Minor adaptations to the wording for the scenarios and for the structured marking scheme were made by the research team in order to make the instrument more applicable to nurses working in an Irish context.

Data management: Caregiving Scenario Questionnaire (CSQ)

The procedures for analysing the results of the CSQ data were replicated from a study reported by Cooper *et al*. (2012). In both versions A and B of the CSQ three types of abusive strategies were identified: restriction of an older person's liberty, neglect and physical abuse. In both versions there were two items related to restrictions of liberty and one item on neglect. In version A one item described a physically abusive strategy, whereas version B contained two items which described a physically abusive strategy.

Following the procedures outlined by Cooper *et al*. (2012) a total score for the correct identification of the items, which described physical abuse was computed. Respondents were deemed to have correctly identified an item as abusive if they selected the 'abusive' response option. Two points were allocated for correctly identifying the single item describing physical abuse in version A of the questionnaire and one point for identifying all the other strategies describing physical abuse. This resulted in a combined total score for recognition of physically abusive strategies, in either version A or version B, which ranged between 0 and 5, with higher scores indicating a greater degree of recognition. Version A of the CSQ contained five strategies describing possibly abusive actions and version B contained three strategies that were possibly abusive. Replicating Cooper *et al*.'s (2012) procedures, three points were awarded for each possibly abusive strategy correctly identified in version A and five points for each possibly abusive strategy correctly identified in version B. A strategy was considered to have been correctly identified as possibly abusive if the respondent considered it to be 'abusive' or 'a bad idea but not abusive'. This resulted in a combined total score for recognition of possibly abusive strategies, in either parallel version, which ranged from 0 to 15, with higher scores indicating a greater degree of recognition.

Data management: Knowledge and Management of Abuse (KAMA) questionnaire

The procedures for scoring the KAMA questionnaire were adopted from the procedures reported by the instrument developers (Richardson *et al*., 2003). Standard answers were developed by Richardson *et al*. (2003) based on *No Secrets*, the policy document which guides adult protection and elder abuse policy in England (Department of Health, 2000). Individual points were given equal weighting and there was no negative marking.

In order to assure inter-rater agreement, two researchers (DOD and TOC) independently rated the replies to a random selection of 20 completed questionnaires, 10 of each version A and B. The intra-class correlation coefficient for a comparison of the researchers' ratings was 0.873 and the Cronbach's Alpha was 0.870. Following discussion of the criteria for interpreting and grading responses, a second round of independent ratings for a further random selection of 20 questionnaires, 10 of each version A and B, was undertaken in order to improve the degree of inter-rater agreement. In the second round, the intra-class correlation coefficient for a comparison of their ratings increased to 0.947 and the Cronbach's Alpha increased to 0.946, indicating a high degree of inter-rater agreement. This was considered to be a sufficient level of agreement between the raters to allow for independent scoring for the remaining 228 completed questionnaires. The total possible score for instrument B was higher than A, therefore, total scores were expressed as percentages. Higher percentage scores indicate that the respondents gave more correct answers, demonstrating more knowledge.

Reliability and validity of data collection instruments

Although the Caregiving Scenario Questionnaire (CSQ) instrument has been used in previous studies as a measure of recognition of abusive caregiving strategies, its validity and reliability have not been documented (Selwood *et al*., 2007, Thompson-McCormick *et al*., 2009, Cooper *et al*., 2012). However, content validity for the items was demonstrated through professional consensus and adequate parallel-form reliability was demonstrated by Cooper and colleagues (Cooper *et al*., 2012). Since the KAMA and CSQ have been used in previous similar studies that assessed the impact of an educational intervention on recognition, knowledge and management of elder abuse, it was considered appropriate to deploy them together in the present study (Cooper *et al*., 2012).

The Knowledge and Management of Abuse (KAMA) instrument has been widely used in studies measuring knowledge and management of elder abuse since its development over a decade ago (Richardson *et al*., 2002, Richardson *et al*., 2004, Cooper *et al*., 2012). The original authors of the KAMA instrument demonstrated good reliability assessments for the parallel version, as follows: internal consistency was Cronbach's Alpha >0.79; split-half reliability was >0.61; parallel form reliability was >0.84; inter-rater reliability, Kappa correlation was >0.98 and test-retest reliability correlation coefficient was > 0.69 (Richardson *et al*., 2003). Concurrent validity was also demonstrated by comparing scores on each parallel version with years of experience, correlation was >0.44 with associated p-values greater than 0.01.

Ethical considerations

The research team's institutional Human Research Ethics Committee (HREC) granted ethical approval for the quasi-experiment and randomised controlled elements of the study. In the course of participant recruitment, all participants were informed about the study and what their participation in the study involved. They were also informed that they were free to withdraw from participating in the study at any time without prejudice. Participants were assured that no identifying information would be collected and that, when not in use by the research team, all completed questionnaires would be stored securely in a locked cabinet. They were informed that all computer datasets associated with the study would be stored in a password-protected computer. Attendance at a training session and the return of completed questionnaires was taken to indicate participants' informed consent to participate in the study.

Treatment of results

Analysis of data from the completed questionnaires was undertaken using SPSS version 20 software (IBM Corp, 2011). Data analysis involved a series of descriptive statistical tests as well as comparison of mean scores. For the data provided by the sample of home care assistants a within-group analysis (repeated measures) was performed on the CSQ assessment of recognition of abusive caregiving scenarios. Scores were computed for recognition of abusive strategies and possibly abusive strategies and a comparison of dependent means was undertaken. For the sample of nursing students a

within- and between-group analysis (repeated and independent measures) was performed on the CSQ assessment of recognition as well as the KAMA measure of knowledge and management of elder abuse within residential care settings. A total percentage score was computed for the KAMA instrument and comparison of dependent means was undertaken between the pre- and post-intervention groups. A comparison of independent means was undertaken for the control and intervention groups. Similarly, a total score was computed for recognition of abusive caregiving strategies as well as possibly abusive caregiving strategies and comparison of means was undertaken between the pre- and post-intervention groups as well as the control and intervention groups.

In order to determine whether to proceed with a parametric (t-test) or non-parametric comparison of mean scores, the distribution of residual scores for the within-group comparisons and individual group scores for the between group comparisons were examined. The criteria by which a normal parametric distribution could be assumed included the following: A measure of skewness and kurtosis close to 0 and not exceeding plus and minus 2, and a Shapiro-Wilk statistic with an associated probability value greater than 0.05. Furthermore, visual inspection of histogram and Q-Q plots were undertaken to confirm a parametric or non-parametric distribution of residual or individual group scores.

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4.1 Introduction

This study evaluated the Health Service Executive (HSE) national training programme in the prevention of elder abuse. The programme is aimed at raising awareness, increasing understanding and encouraging actions around elder abuse. The study design incorporated evaluation of the structure, process and outcomes elements of the programme, with a focus on: the content and quality of the documentary materials and resources that are used to support the training programme; the experiences of those coordinating and facilitating the programme; and the effectiveness of the programme, with reference to participant outcomes in relation to knowledge and recognition of abuse. This chapter presents the findings of the structure and process elements of the evaluation.

4.2 Training programme structure and programme quality

The elder abuse training provided by the HSE comprises two half-day courses, the *Level 1 elder abuse awareness raising workshop* (3 hours) and a supplementary elder abuse awareness raising workshop. In addition the HSE provides *Train the Trainer* (TtT) courses delivered by the elder abuse service personnel to enable services and organisations to become self-sufficient in providing elder abuse training to their staff.

Data provided by the HSE (HSE, 2012) indicates that the national training programme in preventing elder abuse has been rolled out extensively on a national basis since 2007. In the first six years after the training programme was established in 2007, there were 41,007 attendees of the HSE training programme; this figure includes both first attenders and training returnees (Table 4.1).

Table 4.1 Breakdown of training attendees by HSE administrative area*

HSE area	2007	2008	2009	2010	2011	2012
HSE South	2358	2264	1896	1456	1404	2055
HSE West	847	1618	2039	2945	2735	1214
HSE Dublin mid-Leinster	779	1352	2662	2039	2311	1733
HSE Dublin North-East	200	828	718	1686	2597	1244
Total	**4184**	**6062**	**7315**	**8126**	**9074**	**6246**

**The figures represent both single attendances and re-attendances*

The breakdown of training attendees by HSE administrative area is presented in Figure 4.1.

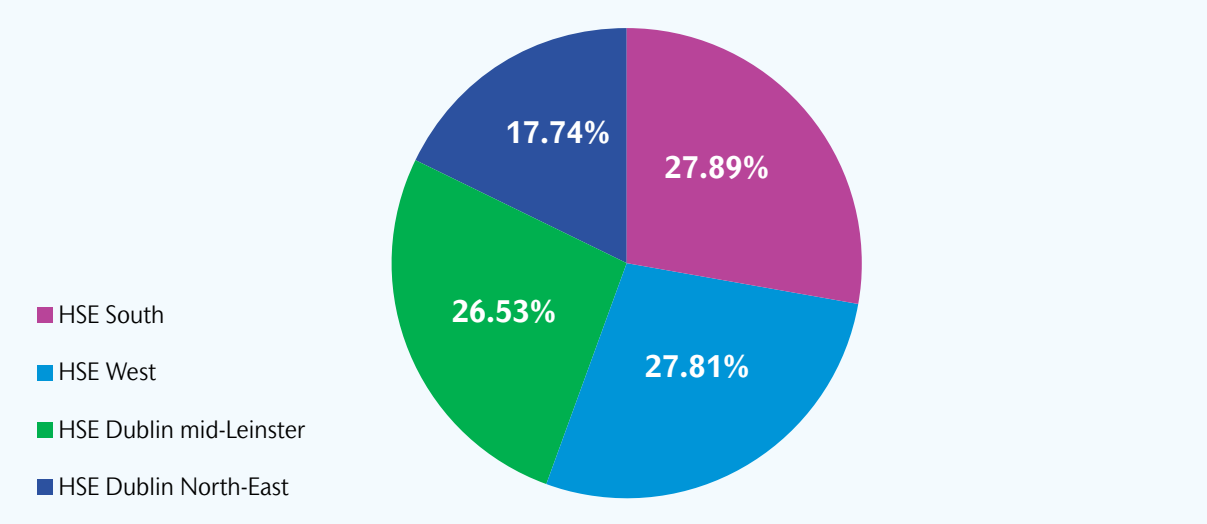

Figure 4.1 Percentage breakdown of training attendees by HSE administrative area, 2007–2012

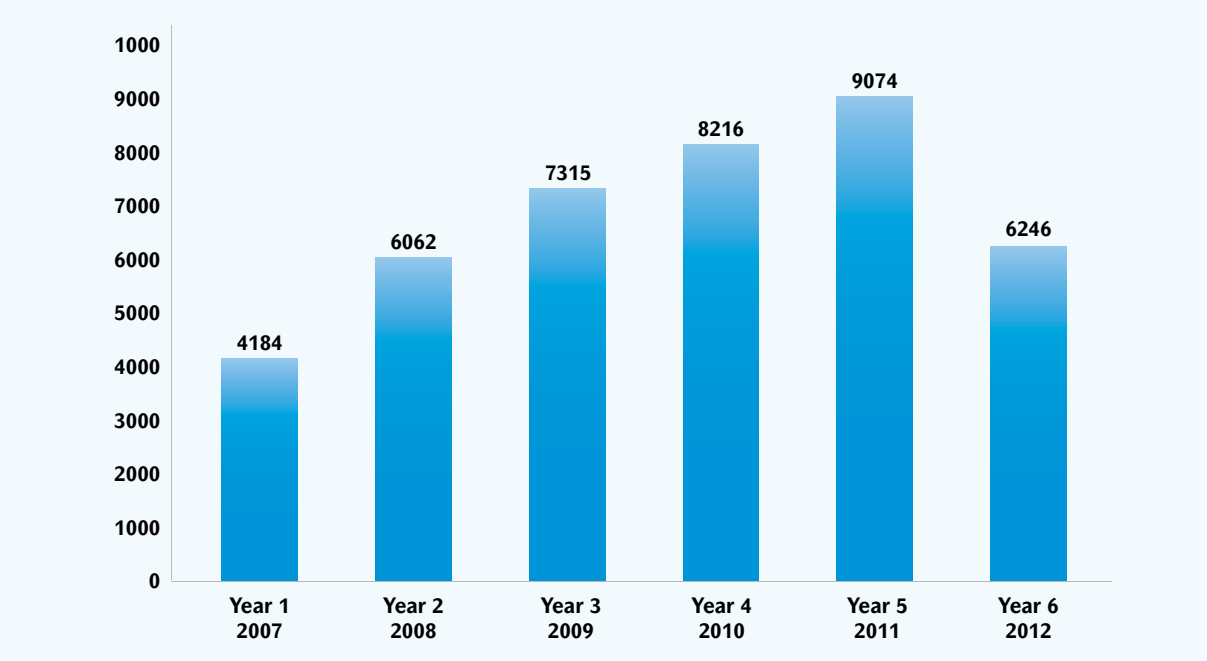

Figure 4.2 Numbers attending training by year

The data also indicates that in rolling out the programme there have been year-on-year incremental increases in training delivery in the first five years and a tapering off [2] in 2012, the sixth year of the programme for which figures are available (Figure 4.2).

The training service provided by the HSE covers a wide spectrum of staff from across the public, voluntary, community and private sectors. Nationally, the profile of those attending training showed that 43 per cent of attendees were HSE staff, 31 per cent were private sector employees, 11 per cent represented the community sector, and 11 per cent the voluntary sector (HSE, 2012). The largest proportion (47%) of attendees at training were support workers, including home helps, home care workers, care assistants and nurses' aides, followed by nurses at 24 per cent (HSE, 2012). While this general profile of trainees has remained consistent over the first six years, there was a marginal increase in the numbers attending from the community sector in 2012.

Supplementary data from one HSE Region (HSE West) provides a breakdown of the numbers attending training with reference to sectors of the health services from which trainees were drawn (Table 4.2) for the years 2008 to 2011, inclusive.

Table 4.2 Sector from which trainees were drawn by year *

Sector (HSE West)	2008	2009	2010	2011	Total	%
HSE Employee	1104	965	1612	832	4513	57.75
Statutory	22	6	13	8	49	0.75
Private sector	142	456	325	648	1571	20.09
Community sector	207	118	242	157	724	9.26
Voluntary sector	190	106	81	519	896	11.46
Other	4	12	39	10	65	0.83
Total	**1669**	**1663**	**2312**	**2174**	**7818**	**100**

**The figures represent both single attendances and re-attendances (HSE West)*

[2] The potential impact of constraints on resources, the travel ban and training saturation should be noted.

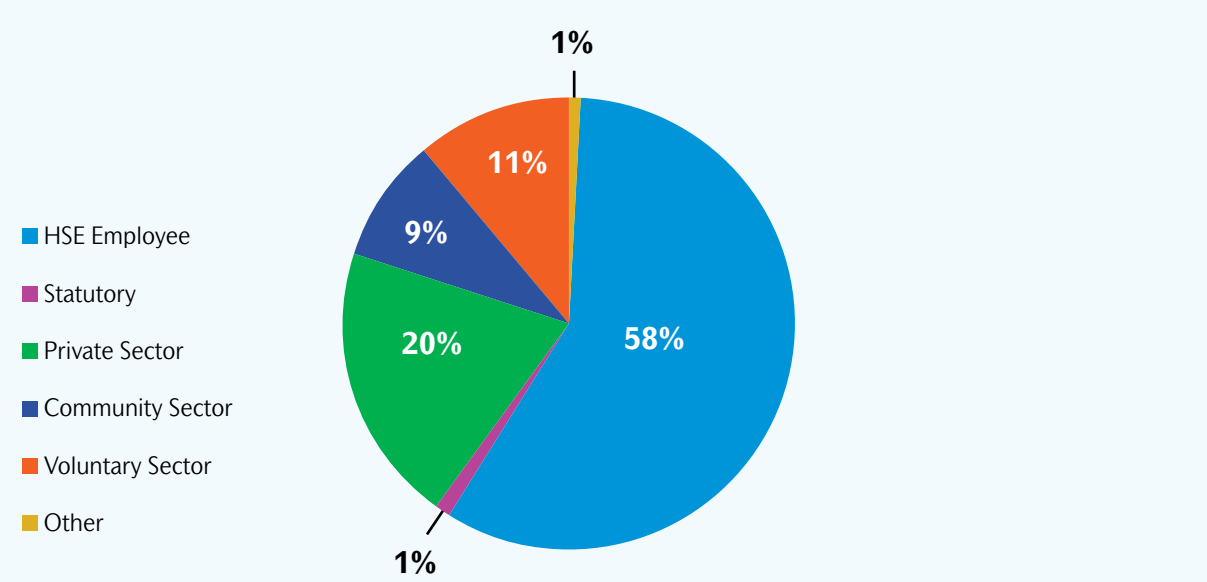

Figure 4.3 Percentage breakdown of sectors from which trainees were drawn (HSE West, 2008–2011)

The data indicates that while HSE employees represented the greatest proportion of trainees (58%), one fifth (20%) were from the private sector (Figure 4.3).

Supplementary data from HSE West also provides a breakdown of the numbers attending by staff grade (Table 4.3).

Table 4.3 Grade from which trainees were drawn by year *

Grade type (HSE West)	2008	2009	2010	2011	Total	%
Dental/medical	9	17	1	25	52	0.72
Nursing	365	594	473	204	1636	22.85
Allied health	149	91	54	221	515	7.19
Management/administration	139	74	60	89	362	5.05
Support worker	510	750	815	1065	3140	43.87
GP	0	0	0	0	0	0
Practice nurse	0	0	0	5	5	0.06
Pharmacist	0	0	0	0	0	0
Other	168	237	279	367	1051	14.68
Missing	340	47	9	0	396	5.53
Total	**1680**	**1810**	**1691**	**1976**	**7157**	**100**

**The figures represent both single attendances and re-attendances (HSE West)*

It is evident that 'support staff' represented the largest proportion (43.87%) by grade, followed by the nursing grade (22.85%) and that while the grade of staff was not available for a small proportion of attendees (5.53%), the data indicate that no GP or pharmacist attended training (Figure 4.4).

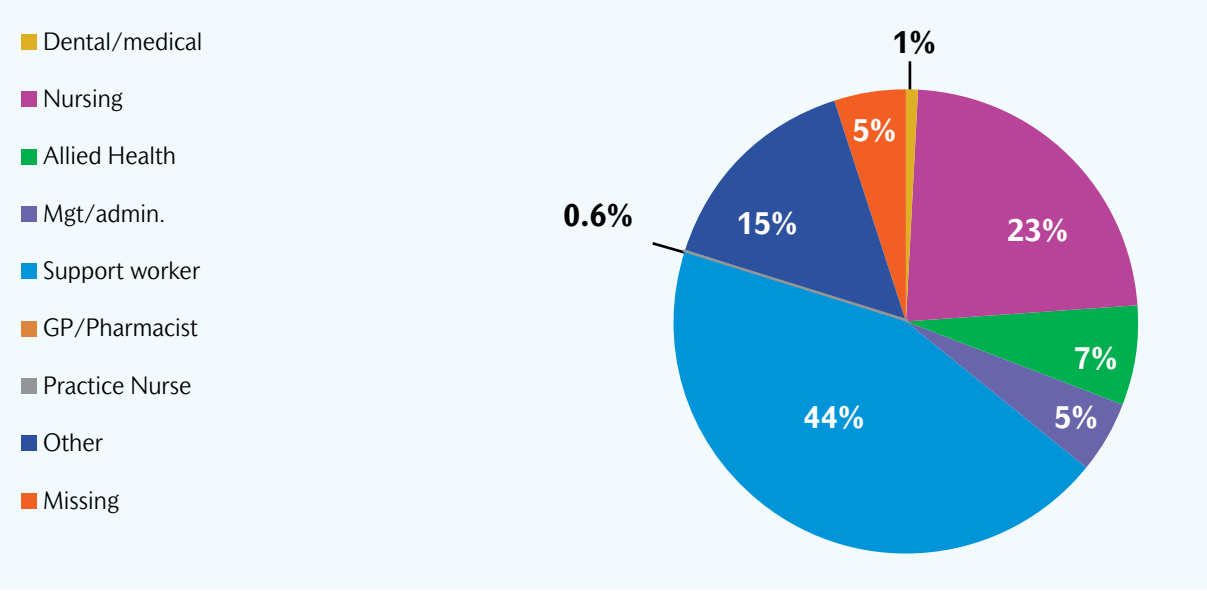

Figure 4.4 Percentage of staff grade from which trainees were drawn (HSE West, 2008–2011)

Content and quality of supporting materials

The training materials were subjected to a documentary review. A bespoke DA rating scale was also used to review three elements of the training materials, namely a training DVD and corresponding workbook related to elder abuse in residential care and a training DVD related to elder abuse in the community (Table 4.4).

A panel of seven researchers, all familiar with the elder abuse training programme reviewed the training materials. The focus of the review was at the following three levels:

i. The quality of materials, in terms of their presentation and production;

ii. The content of each individual element of the material, with reference to the language and the representation of the key constructs and ideas;

iii. The relationship among constructs across the various elements.

4.3 Training programme structure: Narrative description of materials

Recognising and responding to elder abuse in residential care settings (DVD)

The training DVD entitled *Recognising and responding to elder abuse in residential care settings* is a 39-minute video presentation, set in a residential care setting and depicting several scenarios that represent instances of abuse of older residents. Using actors to play the various roles, scenes depict situations involving staff-on-resident abuse and visitor-on-resident abuse. The scenarios depict all of the major categories of abuse, including, physical, psychological, financial, sexual and neglect. The presentation is punctuated periodically by voiceovers that describe and explain the types of abuse represented in each scene and these voiceovers are complemented by on-screen textual explanations, typically of the nature of summary points. The opening and closing credits clearly contain the HSE branding.

Table 4.4 Materials analysed using DA instrument

Training materials analysed	Author	Type of material	DA rating Section
Recognising and responding to elder abuse in residential care settings	HSE (2008)	DVD	B
Recognising and responding to elder abuse in residential care settings: The workbook	HSE (2008)	Training workbook to accompany the DVD	C
Open your eyes to elder abuse in your community	HSE (2010)	DVD	A

Recognising and responding to elder abuse in residential care settings: The workbook

The workbook that accompanies the training DVD is presented as a booklet and is designed to complement and act as a companion to the DVD. It contains a Trainer's Section to provide guidance for the trainer on how to conduct a training session and a Participant's Section that addresses all the main types of elder abuse in residential care that were depicted in the training DVD. The material is presented in a series of modules and includes headings like: 'aims of the training programme', the 'learning outcomes of the training session' and 'discussion points', which relate to each form of abuse depicted. The discussion points constitute learning activities for the trainees and are the basis for group discussions that should take place during a training session.

Accompanying materials provided by the HSE indicate that a single training session should be scheduled for a morning or afternoon lasting 3.5 hours in total (Table 4.5). The workbook is clearly branded with HSE insignia and a distinctive font and colour scheme.

Open your eyes to elder abuse in your community (DVD)

The training DVD entitled *Open your eyes to elder abuse in your community* is a 39-minute video presentation, set in the community in a number of individual private residences and depicting several scenarios that represent instances of abuse of older persons. Using actors to play the various roles that include an elderly male parent, a woman with dementia, a care giver, a public health nurse, and so forth, the video depicts situations involving, for example spouse-on-spouse abuse and carer-on-older care recipient abuse. The scenarios depict all of the major categories of abuse including physical, psychological, financial, sexual and neglect. The presentation is punctuated periodically by explanations of the type of abuse being depicted; this is achieved by some of the main protagonists (e.g. public health nurse) exiting the role and speaking directly to camera. These asides are complemented by on-screen textual explanations that, like the residential care DVD, are summary points. The opening and closing credits clearly contain the HSE branding.

Table 4.5 Proposed schedule of a training session

Activity	Timing: AM	Timing: PM
Welcome and Introductions *10mins*	09.30–09.40	14.00 –14.10
Group contract *10mins*	09.40 – 09.50	14.10–14.20
DVD Workbook break after each module (10mins each minimum) Coffee break (10mins) half way through DVD modules *2 hours and 30mins*	09.50–12.20	14.20 –16.50
Roles and responsibilities under your organisations' elder abuse policy Include discussion of other relevant polices *30mins*	12.20 –12.50	16.50 –17.20
Q&A Evaluation *10min*	12.50–13.00	17.20 –17.30
Close	13.00	17.30

Source: HSE

Open your eyes to elder abuse in your community: A guide to organising a group viewing of the DVD

The guide that accompanies the training DVD is presented as a 20-page booklet designed to complement and act as a companion to the DVD. It is available online as a PDF document and also as a bound hard copy document. The guide is aimed at community-based facilitators of training in the recognition and prevention of elder abuse and it contains instructions on how to conduct a training session. It is divided into four main sections, each describing the required steps to be taken when leading an elder abuse awareness session using the DVD. It also contains information on additional materials and resources that may be sourced. The guide is clearly branded with HSE insignia and a distinctive font and colour scheme.

4.4 Analysis of materials: Rating of materials

The two training DVDs and the residential care-setting workbook were subjected to a documentary review using a documentary analysis instrument that provided a panel of reviewers with a standardised guide with which to assess the materials objectively. The instrument measured several aspects of the quality of the training DVDs and the workbook, including the degree of representation of the typologies of elder abuse and the consistency with which the main constructs and ideas were represented within and across the workbook and training DVDs.

A panel of seven reviewers independently reviewed and scored the training materials and subsequently met in a discussion forum aimed at arriving at a consensus regarding the rating scores for each element of the training material. Aggregate, median and interquartile range scores for each element of material were agreed and are described in the following sections.

Section A: Open Your Eyes to Elder Abuse in Your Community (DVD)

The *Open Your Eyes to Elder Abuse in Your Community* DVD was assigned a consensus score of 31 out of 35 (median = 35, IQR =28–35), indicating that it was found to be of good quality and fit for purpose.

It was noted that the content of the DVD correctly identified that the most likely perpetrator of abuse was a family member and therefore reflected the statistical evidence concerning elder abuse and community-dwelling older people.

Section B: Open Your Eyes to Elder Abuse in Your Community: A guide to organising a group viewing of the DVD

The supporting guide for the DVD entitled *Open Your Eyes to Elder Abuse in Your Community* was a relatively new element of training support material and was not subjected to the rating instrument. However, the consensus was that it was found to be of good quality and fit for purpose. A particularly strong feature of this resource was the use of accessible language, thereby having the potential to be used in training situations across a broad constituency of individuals and community groups. The reviewers believed that it might be helpful to include some indication of the timeframe and duration of sessions using the DVD.

Section C: Recognising and Responding to Elder Abuse in Residential Care Settings (DVD)

The review panel assigned a consensus score of 31 out of 35 (median = 31, IQR =14–28) to the DVD *Recognising and Responding to Elder Abuse in Residential Care Settings*, indicating that it was found to be a good quality material resource to support training and fit for the purpose for which it was designed. However, the review panel agreed that three issues could be addressed in future revisions of the DVD, in order to enhance its quality. First, the DVD concentrates on nursing responsibilities and roles to a greater degree than other occupational or disciplinary groups. As a consequence this may limit the connection to and engagement with other disciplines during training and may portray elder abuse in residential settings as the preserve of a single group of caregivers. This could be detrimental to the message that elder abuse prevention is an issue for all grades. Second, the time dedicated to reporting responsibilities and mechanisms is somewhat limited in the DVD. While it is recognised that this may be highlighted in individual training sessions, the reviews suggested that the DVD could do more to address this aspect of the video. Third, the review panel suggested that greater use should be made of the opportunity to publicise the HSE information line on both the DVD cover and on the final frame of the DVD itself.

Section D: Recognising and Responding to Elder Abuse in Residential Care Settings (The Workbook)

The workbook supporting the DVD entitled *Recognising and Responding to Elder Abuse in Residential Care Settings* was assigned a consensus score of 44 out of 45 (median = 45, IQR =36–45), indicating that it was also found to be a high quality training resource and fit for purpose. Given that it was produced a number of years ago, it was suggested that some of the statistical information could be out of date.

Conclusion

The scores indicate that the consensus view of the reviewers was that overall the training materials were fit for purpose and of a good or high quality, with each one of the training resources obtaining a consensus aggregate score above the threshold score for either 'good' or 'high quality'. Scores for the training materials are summarised in Table 4.6.

4.5 Trainer experiences

The training programme[3] was examined with reference to the experiences of the programme facilitators, including the HSE staff who provided the training and those who coordinated the training, including train-the-trainers personnel. The key informants for this element of the evaluation were therefore senior case workers, dedicated officers and those responsible for training-the-trainers (from here on referred to as 'train-the-trainers'). The aim of this element of the evaluation was to generate information through self-reports and discussions, in order to understand the range of experiences of those who facilitated and/or coordinated the training, including their perspective on the programme's effectiveness at the levels of process and outcomes. Data for this element was generated through the interview method.

A total of thirteen interviews were conducted with those who provided and/or coordinated elder abuse training, as follows: three dedicated officers who coordinated the training, three with train-the-trainers and seven senior case workers, who delivered the training programme on a regular basis (Table 4.7).

Table 4.6 Rating scores following documentary review

		Rating values		
Scale category (document)	**No. of items**	**Aggregate**	**IQR**	**Median**
Open your eyes to elder abuse in your community (DVD)	7	31/35*	28–35	35
Recognising and responding to elder abuse in residential care settings (DVD)	7	31/35*	14–28	31
Recognising and responding to elder abuse in residential care settings: The workbook	9	44/45**	36–45	45

* 'Good quality'; ** 'High quality' (The rating scale was 1–5)

Table 4.7 Interview participants

HSE Region	Dedicated Officer	Train-the-trainer	Senior Case Worker
Dublin	1		
Dublin-Mid Leinster		1	2
South	1		3
West	1	2	2
Total	**3**	**3**	**7**

[3] In the main, 'training programme' in this section of the report refers to the training materials pertinent to recognising and responding to elder abuse in residential care settings.

During the interviews each participant talked about their experiences of delivering the training, including their views on its effectiveness and their ideas concerning its ongoing development and refinement. The interviews generated a large body of qualitative data. These data provided rich and detailed information, which was reduced and categorised into two broad themes, each with a number of sub themes (Figure 4.5).

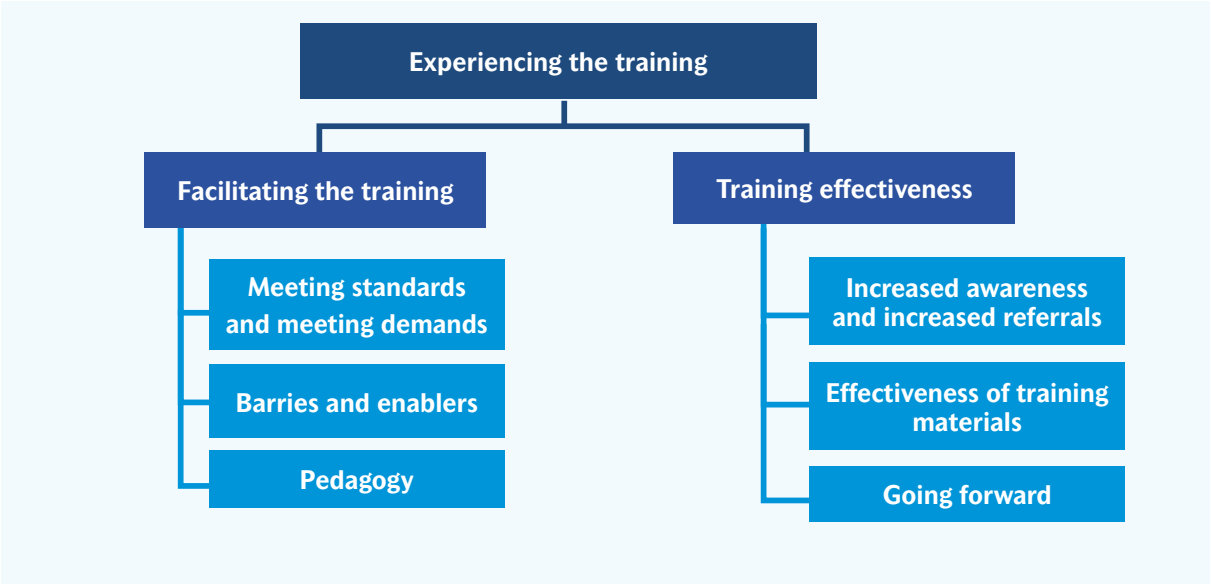

Figure 4.5 Findings from interview data: Themes and subthemes

4.6 Theme one: Facilitating the training

This theme describes the participants' experiences of delivering the training programme. This pertains to their experiences of planning and coordinating individual sessions, strategies for planning and facilitating individual sessions and the factors that restricted and enabled effective delivery of training. The overarching theme comprised three sub themes, as follows: 'meeting standards and meeting demand', 'barriers and enablers' and 'pedagogy' (Figure 4.6).

Figure 4.6 Theme 1: Facilitating the training

Meeting standards and meeting demand

Most participants referred to the *raison d'être* of the training programme and its genesis in national policy on elder abuse. Several spoke about how the programme originated out of a need to standardise the ad hoc programmes that were being facilitated throughout the Irish health service up to c.2008. One dedicated officer (DO) stated that a decision was made to develop a formal training programme on elder abuse based on extant policy documents, notably *Protecting our Future*, and informed by the content of existing ad hoc programmes:

So we might have been doing awareness-raising sessions up to then, but in 2008 we looked at actually formalizing it because we knew we were [all] doing similar things. We looked at the training that had gone on before, the elder abuse pilot studies that had been done [sic] out of *Protecting our Future*, we looked at what the training was involved in those, and we also looked at some of the training that had been provided by a consultancy firm in Ireland as well on behalf of the HSE. So looking at those kinds of aims and objectives, we knew it was broadly similar to what we were doing ourselves and [we] just wrote that up into a proposal which we brought to the national committee and then got agreement and started delivering it (DO).

The evident need for a standardised training programme resulted in the development of a programme that grew to meet the quality standards required of providers of care services, as set down by the Health Information and Quality Authority (HIQA), the statutory regulatory authority. This, in turn, ensured large-scale buy in to the programme by service providers who wished to meet HIQA national standards in the area of elder abuse. Service providers were now required to provide training against these standards, as one DO observed:

> So they (HIQA) are saying to nursing homes … "well it is not enough that your staff have looked at the DVD … or it is not enough that they have undergone some training provided by you … we want to know that you have been trained by the HSE to deliver the training" … it has helped us in terms of getting people to sign up for the three and a half hours (DO).

One senior case worker (SCW) similarly highlighted the imperative of providing training with reference to the HIQA standards and the idea of having the training provided on an ongoing basis:

> We had HIQA in doing an inspection in March and they were saying that ideally they would like to see people getting this training [on a] per annum [basis], which I suppose puts an onus on us to deliver that now (SCW).

However, the practical challenge of meeting the HIQA standard and meeting the demand was vividly captured by one senior case worker:

> HIQA have a stipulation that you do the training, but then you have a refresher two years later … now two years later you haven't all the staff done and you are going back, supposedly to do a refresher (SCW).

The HIQA standards were driving the demand for training, but also the type of training that was being demanded, as one dedicated officer remarked: 'A lot of people, I feel, are now looking to meet HIQA standards … so they are looking for a shorter version, an update rather than the whole programme' (DO). This demand for shorter training was related to ensuring that all staff in an organisation or service could be facilitated in attending training, given the budgetary constraints that most services were experiencing, as the same dedicated officer acknowledged: 'I suppose we have to be mindful in these times to get staff released and all that goes with that' (DO).

Others spoke of the importance of the visibility of the training programme to services, through its availability to all grades of staff, irrespective of the service area in which they are employed. One dedicated officer affirmed this by listing the range of staff grades that typically complete the training programme:

> In the HSE it would largely be nursing staff and support staff … care assistants, nurses' aides and activity staff … But in our nursing units, anybody who is working with older people is expected to do elder abuse training. So porters, maintenance men, we have had some priests that have been part of it. So it is literally anyone (DO).

A senior case worker also described the range of staff grades to which training was delivered at a private residential care home, including nurses, care assistants, catering assistants, administration staff, everybody in the nursing home' (SCW). Another senior case worker spoke about their role in training members of An Garda Síochana and solicitors. For the senior case workers, the fact that the training was delivered to such a range of staff, including older people, highlighted the relevance of the training for older people and those who worked in older people's care and support services:

> [I] deliver training to our own staff, both residential and community … [and] training to other areas of the HSE, like mental health, disabilities … as well to the voluntary sector … and I would do sessions with older people themselves (SCW).

Participants spoke of the need to meet the demand for training from across a wide variety of sectors and services. A dedicated officer spoke about the 'huge demand for information about elder abuse'. The senior case worker interviewees talked about their experiences of facilitating the training to several different types of staff grades and to older people and of the issues and challenges experienced by them in meeting the 'endless demand' for training in elder abuse:

> In our community nursing unit … we would have 300 staff … and if you were running a session, [in] most sessions there would be something between 15 and 25 people so you can imagine trying to get through 300 staff … we would also have done sessions with older people in the day services and people coming in, and even on the units. So that it is endless demand. You could be doing training all day every day (SCW).

Another senior case worker similarly outlined the large volume of staff that required training initially and how, with the roll out of the programme, this number had reduced somewhat: 'I would say that [first] year I probably met 1,000 people, and it has decreased significantly since … I continue to do a variety of training … [and] this year alone I had done maybe 300 people, [most] external to the HSE' (SCW). A train-the-trainer also referred to the volume of trainees:

> We run the programme continuously so if people miss out they can get to come again and I run it usually from 10am to about 2.30 or 3pm and that facilitates people coming in the morning and they are off for the rest of the day (TtT).

A dedicated officer graphically captured the challenge of meeting the demand in the following terms:

> The challenge is the demand … There is some massive number of staff [in the HSE] … but we are also delivering training to the private sector, nursing home sector, voluntary sector, the community groups. It is huge. It is overwhelmingly big and I feel I will be in this job for 100 years and I won't have reached everyone (DO).

Meeting the demand for training meant responding to requests, which came from a variety of sources, including internally from the HSE and from agencies and organisations outside of the HSE. Requests came in a variety of ways and were the basis for a lot of the training that was proffered. While much of the demand was from sources outside of their remit, such as the private sector, senior case workers acceded to these demands and provided the training, as the following three extracts show:

> Organisations would come to me and say: "could you do some training?" For example, I am after getting a request … to do refresher training in … community residential units and that seems to be coming down from HIQA through our own organisation (SCW).

If somebody wants training … [and] if it is an organisation within the HSE, I am obliged to do it. If it is a private nursing home … and if I can fit in an hour and a half there … I have no problem with that (SCW).

> There was a private nursing home and I did two sessions for four days over a two or three-week period. I didn't tell anyone until afterwards because I am not officially supposed to do it, but I felt I would do it because it would reduce the number of … phone calls I would get about things (SCW).

Barriers and enablers

While acknowledging the factors which enabled effective delivery of the training, the interviewees spoke about the challenges of organising and delivering training, challenges which sometimes presented barriers to effective delivery of training. They discussed the steps that could be taken to ensure more effective delivery, with reference to optimizing attendance and optimizing trainee outcomes. These barriers and enablers were related to the training structures and resources, the context in which training occurred, the capacities of those providing the training and trainee engagement.

Meeting the demand for training involved having to respond to the training needs of a wide variety of services and sites by a dedicated group of facilitators. The senior case workers spoke about the difficulties they encountered in responding to the demands for training from multiple sources while, at the same time, delivering a front-line elder abuse case management service, as the following extracts illustrate:

> As the clinical work has increased and the complexity of the cases has increased, my capacity to do training has reduced to some extent so I tend to operate on a request-[only] basis (SCW).

> As time has gone on the clinical work has increased and the complexity of [the] work has increased. So the amount of time I have to prepare for sessions and to debrief afterwards and think about what went right and what went wrong has decreased (SCW).

The challenge of time restriction was not only an issue for the trainers, but also for the trainees. Two senior case workers observed that it is now rare that large numbers of staff are released for training at any one time. This meant that the time period allotted for delivering the training was frequently reduced due to pressure on the time of those attending: 'getting staff released for a four-hour session rarely happens anymore' (SCW); 'so you might be talking about an hour, staff will come in on their lunch hour for example … but what you can do in an hour really is very limited' (SCW).

A train-the-trainer made reference to the effect that the Government moratorium on recruitment in the public service appeared to be having on attendance levels at training in elder abuse:

> One of the challenges that we have is getting participants released to attend programmes … and we have had to cancel numerous [training] programmes … last year because it was such poor uptake and that is all part and parcel of the moratorium … people are not being released (TtT).

However, the same participant acknowledged that it was difficult to determine the extent of the problem or its real impact on training numbers overall, since many who cancelled due to work pressures tended to book a place on the next available training session. This practice, in turn, indicated the importance of having accurate records of attendances, so that individual service providers could substantiate their claims of meeting HIQA standards in the matter of staff training in elder abuse:

> I keep a record and send them in, because we also send in form 5s and 6s on cases [of abuse] on an ongoing basis. So I would tend to have an envelope on my desk that they would go into and any training returns go into it as well (SCW).

> If I go to a day centre with a group of old[er] people I don't tend to take names. I will return saying that I have been there, … but, other than that, yes I would look for names to return … and I take a copy of that (the signed attendance sheet) and return it … I think it is important to record the level of training that is done (SCW).

Hence, in addition to the challenges of a high demand for training and restrictions on the time available for training, was the added challenge of limited trainer capacity to deliver the training, given the competing demands of their role. This latter challenge was a major barrier to the effective provision of training. In practice, it appeared that the dedicated officers could do little to increase the numbers attending for training within services or to increase the frequency of training provision by individual senior case workers. This rendered numerical returns of training attendance of limited value to dedicated officers themselves, since they were limited in their powers to act on them, as one dedicated officer remarked: 'I don't have any authority to say "we have got a request in from this nursing home or community nursing unit, will you do it?" I mean I can ask, but they can say "yes or no or whatever"' (DO).

While delivering training was only a small part of the role of the senior case workers, it was evident from the interview data provided by the dedicated officers that training represented a critical and substantial part of their professional remit. For example, the dedicated officers spoke about having oversight of all the services in a large geographical area for which they are responsible, including oversight of the patterns of training and lists of attendees:

> I keep the stats … on training and, I suppose, as part of that I identify where the HSE community nursing units and residential units don't seem to have done the requisite training to meet HIQA standards … and just prompting them for training and a certain amount of communication around that (DO).

The training returns were important in providing dedicated officers with evidence of regional variation in training provision and of lacunae in particular local areas for which a senior case worker was responsible: 'I can

look at the training returns and know that there are some case workers who are doing no training' (DO). However, one dedicated officer commented on the limited nature of statistical returns, since there was 'a good chunk of private nursing homes that wouldn't be part of the stats that are returned … That is a hole in the stats … a piece that the stats just don't address' (DO). Another dedicated officer questioned the wider value of maintaining statistics on attendances:

> In terms of maintaining the database, I am not sure how useful it is at the end of the day. I think it does serve a use, in terms of chasing up our own HSE units, it serves a bit of a use in that, and it serves some use … but does it affect referrals or has it done and stuff like that? How useful it is beyond that, I am not sure is the simple answer (DO).

Despite these reservations, in describing their involvement in the training since its inception, all dedicated officers conveyed a sense of responsibility for and ownership of the training programme nationally, as this extract demonstrates:

> In my role we would have set up the training modules that we have, I'd be one of the four dedicated officers to do that … and I started at the inception of the service in 2007, so I was very much there at the beginning, designing the training modules and materials, and I would have been involved in the design of the two DVDs, the script for the DVDs and the workshops that we have developed, and in the last six years I would have been delivering elder abuse training maybe twice or three times a week (DO).

Another logistical barrier was the availability of suitable venues and/or equipment with which to provide training. One dedicated officer remarked: 'Sometimes we don't have suitable venues … [and] that has been a problem … I have no venue that I can bring people to' (DO). A number of senior case workers commented on the barrier of limited or absent teaching equipment. One spoke about venues not being properly 'set up' with basic infrastructure to support teaching and another spoke about having to borrow a projector to facilitate training in the absence of proper funding for teaching equipment. Another similarly experienced this paucity of basic infrastructure and materials: 'I have to beg, borrow or steal an overhead projector if people don't have it [and] I had to go and buy some quality paper because the HSE doesn't do quality paper' (SCW). Another senior case worker spoke about having to rely on others for teaching equipment:

> I asked for [a] projector and there was no money to buy it … sometimes I borrow … sometimes I get one from a friend and sometimes people provide them (SCW).

Interviewees spoke about attendances being below what they should be. In addition to poor attendance levels at some scheduled training sessions, senior case workers also experienced the added problem of a lack of proper engagement or commitment on the part of those attending training, as one senior case worker commented:

> During the session what I am noticing is some staff are actually asleep and some staff are actually very, very engaged. So you get quite a mixed response. Some staff are complaining that they shouldn't have to be here, that it is nothing to do with them, that they don't come into contact with older people. But then later on in the session they are actually describing incidents where they did come into contact with an older person. So you are trying to work on their motivation to the best of your ability to encourage or to help them [to] highlight the relevance of the session to them (SCW).

Dedicated officers also experienced this lack of engagement from trainees. One observed that '[about] two thirds … of the participants are engaged with you, are interested in elder abuse (DO)' and another commented: 'Most people are good, but … I have come across a number of staff, I mean some people have been asleep in the training, some people have left their phones on and [have] actually taken a phone call during the training' (DO).

A number of the participants discussed efforts to overcome the barriers to effective provision of training. For example, the challenge of staff not being released for training could be overcome by a pragmatic approach, as one train-the-trainer instanced:

> We are not getting all the staff … [so] in order to address this deficit, what the hospital has done is they have actually asked [the] night duty shift manager, coordinators and people like that to actually deliver the training at night (TtT).

One solution to the problem of senior case workers having insufficient time to conduct training was that a proportion of the senior case worker's time could be given to delivering training. This recommendation had been proffered by National Committee on Elder Abuse, as one dedicated officer commented:

> The National Committee have (sic) always made the case … and tried to make the case that, regardless of case numbers, there should be some proportion of your time dedicated to training … and that [it] is for senior case workers to agree with their managers locally but there should be some decision that even 10 per cent of your time or whatever, as opposed to just saying "I am not going to do any [training]" (DO).

An enabler to good and effective training lay in the quality of instruction provided by the trainers and, in that connection, participants spoke in very positive terms about the important role that the senior case workers played in the elder abuse service and in staff training. The effectiveness of the training provided by senior case workers was a function of their unique experiences of dealing with real-world cases of abuse. One train-the-trainer remarked that the senior case workers were a 'valuable resource' in delivering the training, since they had the requisite 'expertise from the cases that they manage to be able to share that with participants [in training]' (TtT), while a dedicated officer acknowledged the 'very considerable amount of training' that the senior case workers provided to 'all kinds of groups out there in the community' (DO). An enabler to the provision of training was the support offered by service managers, who worked to ensure that the delivery of the training was optimised, as one dedicated officer observed:

> My own managers have [placed] a real emphasis on training. They are very keen for me to continue with the training despite the difficulties with the travel and everything. They are very, very keen that I am out there doing as much training as I can. They have a real commitment to it (DO).

Pedagogy

All interviewees reported that they were involved in delivering the training programme. As already noted, senior case workers reported that they provided training to staff within their own service organisation, to staff from other services and also to older people themselves. This sub theme describes the participants' accounts of their experiences of actually delivering the training, including their experiences of the preparation required of them and the pedagogical strategies that they employed. Their experiences of delivering the training included experiences related to planning for teaching and the more practical considerations in facilitating an individual training session. While participants were positive about the fact that all grades take part in the training, a practical issue for those delivering the training was how to facilitate learning in a single session among a disparate range of staff grades with disparate learning needs. In highlighting this concern, one senior case worker remarked that it was important to know the profile of the attendees and their learning needs in advance:

> Not everybody in the audience is a nurse or not everybody comes across elder abuse or doesn't really understand it. So you have to kind of pitch it [to all attendees]. So I normally just ask a few questions previous to the training just to clarify who is coming (SCW).

The importance of knowing the profile of the trainees in advance was also stressed by train-the-trainers. One train-the-trainer remarked that 'a lot of people we are talking about, they have such varying levels of education … I mean some you are talking about have [the] Leaving Cert [and] some may not' (TtT) and another similarly observed:

> You have nurses and you have care assistants mixed in the one group … so your nurses, you are hoping that they have more knowledge, they have more experience … so you are trying to make the session interesting for them as well and at the same time not overload people with information (TtT).

The training programme involved the use of a training DVD, didactic instruction and guided discussions supported by a workbook. The participants spoke about using a variety of teaching approaches, with the aim of making the training as effective as possible; this included taking account of the trainees' learning styles and taking steps to make the training sessions as interactive as possible. One senior case worker described in detail the strategy for ensuring that the teaching style took account of the needs of the particular group in a training session:

> No two sessions or no two groups are exactly the same … so I would try and tailor what I am doing or what I am saying or how I am delivering it to that particular group … [and] there are a number of factors. The time factor is number 1 … the second

> thing is who I am delivering it to … I suppose what we deliver in terms of residential [care] training is very different anyway … the four-hour training session with the DVD and workbook … that would form the basis of the residential [care] sessions … whereas the community stuff tends to be more flexible (SCW).

Some senior case workers spoke about how they strive for optimum quality in the way that they provide instruction in the training sessions, with some referring to the use of multiple pedagogical strategies which they employed in individual training sessions. Connected to this, a number of senior case workers spoke about how they used discretion in the way that they planned and facilitated an individual training session. In this way, they were able to take account of local circumstances like time, setting and trainee profile, as the following extracts suggest:

> I personally try to make it as interactive as possible (SCW).

> I do the regular PowerPoint presentation that I amend depending on the group … and then I do a visual and oral presentation of self-neglect, which I devised [myself] because I don't think people get it (SCW).

The available time and type of setting were major factors in how a session was conducted, as these extracts indicate:

> A number of day centres wanted training and I decided that their training needs to be specific to the day centre [setting] because they have people coming in, the relationship is different. None of them are trained so there is no professional background there (SCW).

> [For] the community DVD I use the scenarios. I just go straight to the scenarios and play whatever number, and again it is time dependent … I suppose there is more flexibility with them because there is no work book, the series of questions you ask and information you can draw out tends to be more flexible (SCW).[4]

Similarly, a senior case worker spoke about having to direct teaching content onto very precise aspects of elder abuse in instances when the allotted time for training was greatly restricted:

> If I am asked to give a … very brief talk, maybe 20 minutes … I generally tend to give a talk outlining the definition, categories, rates of referral, prevalence in Ireland, where abuse occurs, issues for older people, issues for the person concerned, barriers to detection … and then a detailed piece on the role of the senior case worker, what we do and how we respond to elder abuse (SCW).

While the local circumstances determined the degree of discretion used, some senior case workers saw that flexibility was needed to ensure effective learning; one senior case worker referred to the challenge of having to be creative in order to ensure the active engagement of trainees:

> I have done the DVD, I have done the case, I have done the scenarios, [and] I have done the table quiz. What am I going to do next? … What am I going to do to get people, to stimulate them, to get them doing a lot of the work? (SCW).

Another similarly reflected on how training sessions could be facilitated differently:

> Maybe I could be delivering it in a different way. I have thought about delivering the training differently, for example maybe incorporating case discussion and small group work … I would need to pilot it and see if it works and I am not sure if it is being done around the country (SCW).

One train-the-trainer spoke about not slavishly adhering to the training materials in a session: 'I have found the workbook and the DVD to be of benefit certainly, but working *with* it as opposed to religiously *to* it' (TtT). A dedicated officer observed that when the training materials were first introduced, there was uncertainty as to how the training DVD would be used: 'I don't even know that there was a definite plan … I think the intention was that people would view it and that would be their elder abuse training' (DO).

As the foregoing extracts indicate, the evident degree of discretion and flexibility in planning and delivering an individual training session suggested that the training was not standardised, at the levels of content, duration and pedagogical methods. However, not all of the participants approved of discretion in the delivery of training. One senior case worker spoke of the need for a greater level of consistency in how the training programme was facilitated:

4 At the time when the interviews were conducted, the guide associated with the community DVD was a recent addition to the training resources.

> We are probably all delivering it differently … but I actually do like the idea of things being consistent across the country … I think the whole point of the HSE commissioning DVDs like this was that the training would be delivered nationwide, be it [in a] public, voluntary or private unit … I think we need to be delivering something that is seen as best practice, that has been researched, like these DVDs, that is seen to deliver the key information (SCW).

Another called for standardised guidelines in the way that training should be delivered: 'I think there is room maybe for guidelines or setting some kind of standard for the training that we can stand over' (SCW). A dedicated officer also spoke of the need for consistency in the way that training should be delivered:

> I think even with the residential [care] training it is being rolled out in some cases where it is not being given that time and people are free to deliver it whatever way they want. How do we control it? I think we need to have parameters set more strictly (DO).

Another dedicated officer spoke of the need for monitoring and quality control in relation to the process of training-the-trainers and the subsequent practice of trainers:

> The tension between where you train the trainers and let them off then to provide the training, the quality control … gets lost or reduces in that kind of scenario (DO).

One senior case worker who advocated the use of standardised training was nevertheless cautious that over standardization of the way training was delivered risked stifling 'the more interactive stuff' (SCW).

Summary of findings, Theme one: Experiencing the training

The national training programme on recognising and responding to elder abuse was being delivered on a country-wide basis on foot of the recommendations stipulated in 'Protecting our Future' and in compliance with HIQA standards.

Trainers, including senior case workers, dedicated officers and train-the-trainers, experienced a number of organizational, individual-level and structural barriers to the effective planning and delivery of training. The barriers included employers' difficulty in assuring optimal attendance at training, senior case workers' high workload, poor participant engagement in individual training sessions and limited material resources and equipment for training. A key enabler of effective training was the senior case workers' coalface experience of managing cases of elder abuse, experience which they could bring to the teaching encounter.

The thirteen participants also spoke about the way that they planned and facilitated training sessions. They spoke about the importance of good planning for each training workshop, in particular the need to take account of trainee needs and differences. Several participants indicated that in conducting training sessions they frequently adopted a flexible approach, with a tendency to deviate from the training schedule and/or training content, in order to take account of local circumstances and trainee needs. This suggested an open approach to the way that training was being conducted; however, some participants were of the view that such discretion and flexibility in teaching were a threat to the standardization of training.

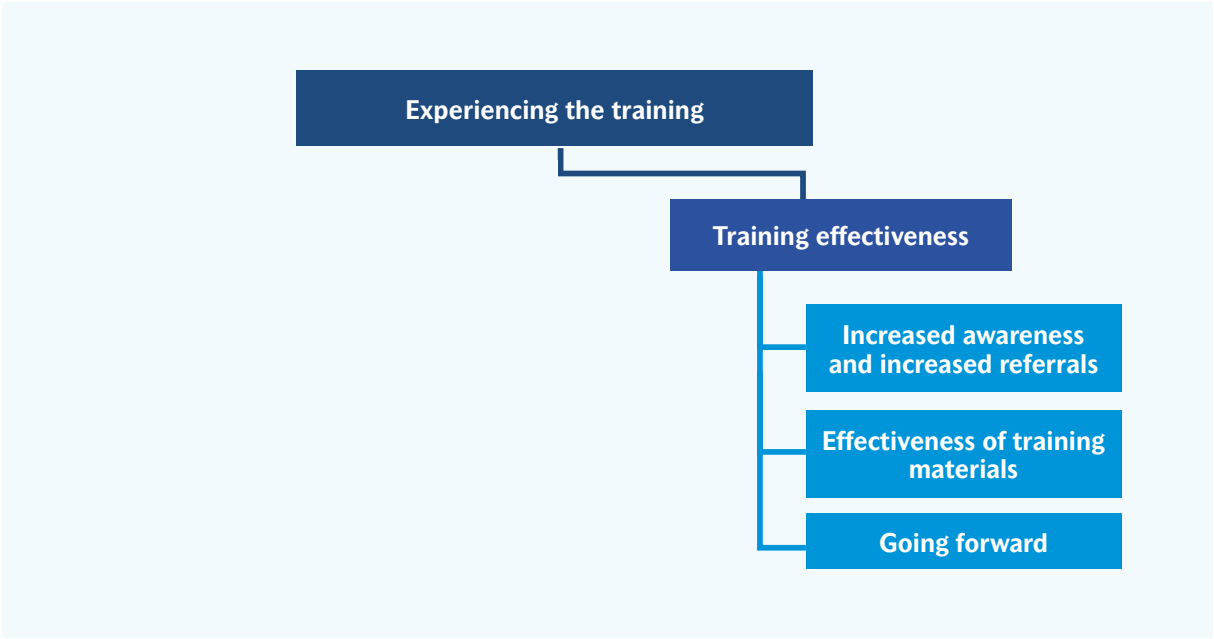

Figure 4.7 Theme 2: Training effectiveness

4.7 Theme two: Training effectiveness

This theme describes the trainers' experiences of delivering the training programme, with particular reference to their perspectives on training effectiveness. The theme comprised three subthemes, as follows: 'increased awareness and increased referrals', 'effectiveness of training materials' and 'going forward' (Figure 4.7).

Increased awareness and increased referrals

This subtheme describes participants' accounts of their experiences with reference to the effectiveness of the training in raising awareness of abuse, which resulted in increased referrals to elder abuse services. The interviewees talked about the potential benefits of the training programme, in terms of raising awareness of elder abuse among trainees and enabling trainees to recognise abuse in their everyday practice. These important outcomes of the training were based on the interviewees' interpretations of anecdotal evidence garnered during training sessions and not necessarily on any formal evaluative evidence. Indeed some interviewees believed that their own interpretations of the programme's effectiveness would be strengthened if more formal feedback data were available from those who attended the training. Nevertheless, as the following extracts indicate, the senior case workers believed that the training was effective in achieving the intended trainee outcome of raising awareness among staff across several different care settings:

> It definitely makes people more aware … when I started off I don't think people [knew about elder abuse] … most people didn't know what elder abuse was (SCW).

> By virtue of the very fact that you go out and stand in front of people and say you are who you are … you raise awareness … particularly [among] public health nurses who work in very isolated settings (SCW).

> [I] have done a good bit of training with the private nursing homes … [and] I think their level of awareness has increased … but again it would be anecdotal … I would be much happier with the level of awareness in these places than I was at the start (SCW).

> I remember after the community ones … there did seem to be a greater awareness of the issue, not in terms of more referrals, but people were ringing saying "can I just run this by you or can I ask you about X?" … there was (sic) more information[-seeking] phone calls (SCW).

Some dedicated officers and train-the-trainers also spoke about the training programme's effectiveness in realising the key learner outcome of increased awareness of elder abuse. One dedicated officer believed that awareness of elder abuse among care staff had greatly increased as a result of the introduction of the training programme and that this, in turn, had improved staff confidence:

> I do believe people are more knowledgeable afterwards. I believe there genuinely is better awareness of the issues [following training] and I think one of the, intended or otherwise, consequences is that staff are a bit more confident (DO).

A train-the-trainer was similarly positive about the benefits of the training, which, she believed 'opens things that they didn't know would be a type of abuse … routines and organisation and things like that can be seen as a form of abuse … it opens their eyes to that sort of thing' (TtT). However, another train-the-trainer cautioned that the training programme in isolation was not sufficient to raise awareness levels among care staff:

> I think it is a combination of factors … I think the training helps but other things help as well … so it is impossible to isolate it out completely, but at the same time I think the training … it is far better to have the training there as it is than not have it (TtT).

A train-the-trainer cautioned that while the training was effective in changing behaviour, individual behaviour could not be changed by training alone, observing: 'I would say overall it is effective, and I think it does change people's behaviour, but you have to work on that (the behaviour) from other angles as well' (TtT). A senior case worker was encouraged by the overall effectiveness of the training nationally: 'I think a lot is actually being done in terms of addressing elder abuse in Ireland' and argued that the national effectiveness of the training should be publicised: 'I think it is important to be recording it and publicising it' (SCW).

All participants spoke about the effectiveness of the training in terms of increasing the number of referrals to the elder abuse service and this was seen as a key measure of the success of the training. The referrals were seen to be the result of increased awareness of abuse and increased understanding of the referral process among care staff and a number of senior case workers made the link between training provision and referrals. One senior case worker mentioned their own experience of dealing with annual increases in the rates of referrals: 'I had 22 referrals the first year I was here and last year I had 81 … so every year there has been an increase in referrals' (SCW). Another senior case worker observed a similar increase, particularly from community hospitals:

> I noticed in our community hospitals, the rate of referral and the type of referral has increased over the years … I can't say numbers wise, but certainly in comparison to the first couple of years I have got regular requests to come and deal with cases [of abuse] in the community hospital (SCW).

A third senior case worker made a direct link between the pattern of referrals and the provision of training, noting:

> The only way I can measure its effectiveness is after every input I get an influx of referrals, so that to me is effective … but there is a trend, I do a workshop today in the community, in a week I will have 10 to 15 referrals. It happens every time (SCW).

Dedicated officers also remarked on the increase in the number of referrals, one commenting that 'it does seem that relatively high levels of training led to relatively high referrals' (DO) and another stating:

> I have had loads of phone calls that would follow up after training and we have always an increased link to referral numbers after training sessions. So that is a really good way of measuring this … every senior case worker in my area will tell you: "every time you do a training session we get more referrals in" (DO).

Sources of referrals included community hospitals and community groups: 'I would get a number of referrals, particularly from community groups or individuals, on the basis of them having heard me speaking somewhere' (SCW). One dedicated officer bemoaned the fact that while the number of referrals increased with training and got reported 'in the stats', the fact that training was being provided on such a vast scale tended to get overlooked: 'the training numbers have never evoked the same interest [as the referral numbers]' (DO).

Effectiveness of the training materials

The participants discussed the training materials, specifically the DVD and workbook, and they spoke about the value of the materials in terms of supporting their teaching methods. In general, participants were positive about the effectiveness of the materials in supporting learning and a number referred specifically to the fact that the workbook augmented the training DVD. The training DVD, in particular, was seen as being 'very helpful' in a number of respects: its content was based on situations in residential care settings and reflected real-life instances of elder abuse and it also provided a useful anchor with which to structure an individual training session. One senior case worker stated: 'the situations [portrayed in the DVD] are very realistic [and] I think it portrays elder abuse quite well … and gets people talking and thinking' (SCW) and another similarly remarked:

> I have … seen other training DVDs from different countries. I actually think it is very good, because it is based in an Irish setting as well [and] I think the staff watching it can relate to it. I think the scenes being portrayed are actually very realistic; the responses are quite realistic (SCW).

Train-the-trainers were similarly positive about the value of the supporting materials. One spoke about how the scenarios in the residential-care DVD were useful in 'keeping people's attention' and another mentioned the value of the workbook associated with the DVD as a device for generating discussion among trainees:

> Usually the discussion that I would ask staff would be, what types of elder abuse or what issues concerning you would you have noticed in that section of the DVD? What would you have done if you were the staff member in the scenario? (TtT).

A third train-the trainer similarly highlighted the added value of the workbook: 'I think [it] is a really, really good DVD … but I think what makes it good is the workbook' (TtT).

Notwithstanding these positive evaluations of the training materials, some participants saw limitations in them; one senior case worker referred to the fact that the DVD could not capture the nuances of individual clients and care settings:

> I think the DVDs have been helpful, but I think they were trying to roll out some sort of blueprint … and to be honest I don't think that would work … it wouldn't work for me because I see every client group differently, so I need to tailor it towards them … so if I was doing the same thing for the FETAC level 5, their presentation, compared to maybe the community hospital, it would just be totally different (SCW).

One train-the-trainer suggested that the residential care DVD portrayed nurses and care assistants in a negative light – 'I think that the DVD is quite negative from a nursing and care assistant point of view, it is extremely negative' – and went on to suggest that it might be used as a vehicle for promoting a more positive image that would benefit nurses and care assistants in their role of protecting older people:

> I feel you have to work on building their self-esteem and helping them to realise that the work that they do is important … helping them to understand that their behaviour is extremely important too (TtT).

Train-the-trainers mentioned the fact that, when undertaking retraining, trainees frequently 'don't want to see the video again' (TtT) and, when conducting retraining sessions, the trainer felt obliged to 'keep the interest going instead of going back over old ground' (TtT). Train-the-trainers also commented on the inordinately large volume of material contained in the DVD, suggesting that there was 'an awful lot covered' (TtT), which made it difficult for trainees to retain information, as one train-the-trainer remarked: 'it is actually hard for people to recall what they have seen because there is so much; there are so many incidents that it is kind of jam packed with stuff' (TtT). This same train-the-trainer was critical of the DVD in terms of how it portrayed abusive situations in residential care, commenting: 'part of me doesn't like the emphasis on the institutional behaviours because I think it is very much exaggerated' and commented that the DVD 'portrays [institutional] care in a very task-orientated and ritual way … [depicting] the old institutional behaviours [and] the rituals, like queuing up for the toilet and things like that' (TtT). However, she also suggested that focusing on the ritual aspects of care was vital in showing trainees how central some ritual activities are in the provision of close interpersonal care:

> I think it helps them to understand what ritualised care is … when they have to go and turn residents who are in bed and change incontinence wear … those intimate relationships where the person is not communicating with them but they must still communicate with the person (TtT).

For one senior case worker, the challenge with the training DVD was less to do with its content and more with the fact that it could quickly lose its impact on trainees, particularly after they viewed it more than once: 'I still see it as a pretty good tool, but I wouldn't stick rigidly to it. I think the first time people see it I think it has a huge impact … it does get a bit stale [after that]' (SCW). A train-the-trainer spoke about a different aspect of impact; she spoke about the problem encountered when presenting the DVD on abuse in community settings among large groups, where the scenes depicted were capable of generating emotional responses for community-based trainees:

> I think the community-based DVD is problematic in a big group … it brings up too many issues for the people present … I have had too many follow-up phone calls … I have had too many tears … too many people walking out … I think it is perfect for two or three people and I have used it in small groups (TtT).

Going forward

At the conclusion of each interview, each participant was asked to consider whether they believed that the training in elder abuse ought to be improved and, if yes, in what ways. Participants proffered several comments and suggestions for improvements in the way that training might be organised and conducted in the future.

Some senior case workers called for the provision of trainee feedback to trainers, thereby enabling them to better understand their own skills of facilitation and presentation and to find out what particular groups wanted from the training. One senior case worker stated that 'the feedback would be good to find out what people want because a lot of them would have their experiences [of the training]' (SCW). The same senior case worker also suggested that feedback should be solicited from older people with reference to their perspective on the benefits of the training for older people's services. Another senior case worker called for evaluative evidence of the wider impact of the training: 'It would be interesting to know the impact and the type of impact it has had and that would inform whatever we do going forward' (SCW). A dedicated officer similarly spoke of the importance of trainee feedback and also the need to measure 'in some way' trainee knowledge.

Several participants spoke about the need for additional trainers and/or the need to provide protected time within the senior case worker's work schedule to conduct training. Two senior case workers pondered the possibilities of increasing training capacity in the system, including the idea of more trainers:

> So how do we [manage a case load] … and deliver a quality training programme as well? … it was fine three or four years ago; I had 60 or 50 cases, it was fine … I had time to sit down and work stuff out … I haven't got that time now … I don't know is it we need dedicated trainers or dedicated training time … but if you do that you need to limit what we are doing clinically and that is hard to do as well (SCW).

> How do you get people to do it, how do you present it on demand? … If you are going to do that do you need more people to do it? (SCW).

Dedicated officers also proffered the notion of additional trainers to meet the ever-increasing demands for training, as these two extracts illustrate:

> There isn't capacity within the HSE to deliver training to all residential settings in the country, [so] we have to enable them to be able to deliver it themselves in-house. I 100 per cent believe that (DO).

> The challenge is the demand [for training] … So it feels like a mountain and you just have to keep your head down and stay with your two or three days a week because otherwise it is overwhelming. And I just think there needs to be more of us; it is as simple as that (DO).

In considering the way forward, some participants cautioned that there was a risk that the over provision of training was resulting in training fatigue. This risk was particularly evident where care staff were required to undertake mandatory training in several different areas of continuing professional development (CPD):

> [I] have found the initial response to the elder abuse training very, very positive in that people would have been very pleased that they were being asked to be involved in it … but you would find them a little more jaded now because there is a huge number of courses that are meant to be run every two years from hand hygiene to CPD to fire safety (SCW).

The same senior case worker argued that, given this demand, training in elder abuse should receive priority, since staff were likely to encounter it: 'I think personally that should be prioritised in terms of what the particular member of staff is likely to encounter' (SCW). Another senior case worker also cautioned that interest among staff would wane, given the multiple and competing demands on them to attend training:

> I felt that some of the initial good will and initial interest was kind of diluted by the fact that people were just like, you have to be at this, you have to be at that and you have a bit of paper saying you were there and that you have done it (SCW).

Key to maintaining staff interest, according to another senior case worker, was ensuring that the training was stimulating and not boring:

> I think most training is boring, I think most courses that I have ever done myself are boring, I think you need a really good trainer … and I think you need variation and deviation from the PowerPoint and written word … I have been to two trainings in 40 years that I would say were worthwhile and it was because it was a variety of methods used and a variety of people (SCW).

Other ways of overcoming training fatigue would be to build on previous training, rather than repeat the same training on several occasions or providing bespoke training for different care settings. Some senior case workers suggested these possibilities as a way of ensuring trainee re-attendance and trainee engagement, as these extracts show:

> At the moment all the nurses have had all their training so they are looking for another level … [they] would like for the awareness to move onto another bit of training, which would be around building up their skills … [like] communication: how do you communicate with somebody who might be abused? (SCW).

> It needs to move on now or we need to have different forms of training so people can build up their skill base (SCW)

> I would love to see specific change for the different levels … day centres scenario, residential scenario, respite scenario … just all the different areas, more specific [to them] (SCW).

Dedicated officers also talked about the need to build on previous training by providing 'a more detailed and a deeper and better level of elder abuse course for certain people' (DO), rather than repeating the same training programme for 'returnees':

> I think one of the big things at this stage is a need to look at that for returnees, so be it a … higher-level training or be it a shorter and somehow more specific … rather than re-sitting the whole original (DO).

A dedicated officer saw a particular need to have training tailored to particular grades: 'for the clinical grades I think that maybe we might need the biggest [sic] look at our materials that we use because perhaps it is not pitched right' (DO). Train-the-trainers also talked about the importance of ensuring ongoing training through 'refreshers' and proposed the use of e-learning in advance of attendance at retraining so that retraining sessions could be more focused and delivered over a shorter time period.

One senior case worker proposed the adoption of continuing professional development (CPD) credits as a way of ensuring good attendance at training – 'the staff would probably be happy to get CPD points' – but observed that this had inherent risks in as much as it might reduce the need to deliver retraining to someone with acquired CPD credits. A dedicated officer also saw merit in assigning credits to training in that it would ensure a particular standard and suggested that this could be achieved by having the training aligned to an accrediting body:

> What we probably need to look at is some sort of accreditation body that we can align ourselves and have our elder abuse training [accredited]. So that takes away that whole notion of "I will just tweak it or I will just deliver it in an hour instead or I will just let them watch the DVD". I think we need the power or strength of accreditation behind it (DO).

As already observed above under the sub-theme 'pedagogy', several participants spoke about the need to ensure that training was standardised at the level of delivery, with some participants seeing this as an important requirement going forward, as this extract exemplifies:

> I would wonder about some of the training that is done. You will send something out to a nursing home and they will come back and say "oh we do our own

> training". I don't know what the training is like. So maybe something [is required] around standardization (SCW).

Finally, in contemplating the way forward, some senior case workers spoke about the need for more training in the skills for conducting a training session. One senior case worker suggested that all trainers 'could do with training around presenting' and remarked that the topic of training required particular skills:

> What I find with delivering the elder abuse [training] sometimes, it is a topic which doesn't evoke a whole load of jokes or laughs so I would love to be able to deliver it in a way where I would [be able to] hold people's interest (SCW).

Another senior case worker similarly called for training in presenting so as to be more confident, particularly among trainees who were external to the organisation:

> I am very conscious when I go out, maybe not so much … among my own peers … but when I am going out externally and maybe if I am presenting in front of the Gardaí … I am very conscious I am representing the HSE … and I would like to be doing that in the most professional and competent way possible (SCW).

Summary of findings, Theme two: Training effectiveness

The participants provided their perspectives on the effectiveness of the training, suggesting that it was effective in two key areas. These key areas were raising awareness of elder abuse, so as to enable them to recognise abuse in their everyday practice, and increasing the number of referrals to the elder abuse service. The participants believed that their own interpretations of the programme's effectiveness would be strengthened if more formal feedback data were available from those who attended the training.

The participants discussed the value of the materials in terms of supporting their teaching methods and promoting desired learner outcomes. Overall, the participants were positive about the effectiveness of the materials in supporting learning. They viewed the materials as being 'very helpful' in a number of respects including: accurately depicting real-life instances of abuse; promoting trainee engagement; and promoting discussions. However, participants saw some limitations in the DVDs, such as overload of information in the community-care DVD and over-emphasis on traditional nursing practices in the residential-care DVD.

Participants proffered suggestions for improvements in the way that the elder abuse training programme might be organised and conducted in the future. These included the need for alternative content for returnees and for content to be tailored differently for different grades as a way of preventing training fatigue. Some participants saw the introduction of a system of CPD credits as a way of ensuring the standardization of training.

5.1 Introduction

This study evaluated the Health Service Executive national training programme in the prevention of elder abuse. The evaluation design included methods to test the effectiveness of the programme with reference to participant outcomes. It incorporated an experimental evaluation design that tested the effectiveness of the programme in terms of participants' knowledge and recognition of abusive caregiving strategies. The participants comprised a sample of nursing students and a sample of home help assistants. The study design included a within group quasi-experimental design and a randomised controlled trial to establish training effectiveness. The within-group quasi-experiment tested the efficacy of the community training intervention among a sample of home care assistants. The between-and-within group experimental design tested the efficacy of the residential care setting training intervention with a sample of nursing students. This chapter presents the findings of this element of the evaluation.

5.2 Community training intervention: Within-group quasi-experimental design

In this element of the experimental evaluation a sample of home care assistants was assessed with reference to their ability to recognise abusive caregiving strategies before (time 1) and after (time 2) they received the elder abuse training intervention. A total of 35 home care assistants participated in the within-group quasi-experiment. The mean age of the sample was 53.23 years (SD =9.37, range =32–73 years). All of the participants were female and all were employed to provide care or assistance to an older person living in their own home at the time of data collection.

Recognising caregiving strategies by home care assistants at times 1 (T1) and 2 (T2)

The Caregiver Scenario Questionnaire (CSQ) was employed to assess recognition of abusive caregiving strategies among the sample of home care assistants before the intervention (hereafter time 1 or T1) and after the intervention (hereafter time 2 or T2). The CSQ was designed to measure recognition of potentially abusive caregiving strategies for managing challenging behaviour in persons with dementia (Selwood *et al*. 2007). A total of nine abusive strategies were identified from the parallel versions of the CSQ questionnaire. These were sub-categorised into restriction of liberty (4 items), neglect (2 items) and physically abusive strategies (3 items). The possible responses to each of the strategies were as follows: 'good idea and helpful', 'possibly useful', 'not sure', 'unlikely to help', 'bad idea but not abusive', and 'abusive'. The first four responses were merged into a single category named 'other' and frequencies were calculated for the following categories: 'abusive', 'bad idea' and 'other'.

Table 5.1 displays the percentage frequency distribution for the each of the nine abusive caregiving strategies according to three merged response categories at T1 and T2.

The frequency distribution of home care assistants' responses to the abusive caregiving strategies demonstrated an increased proportion of time 1 (T1) responses that correctly identified the strategies as abusive when compared with time 2 (T2) responses. Two strategies which describe acts of neglect were noted for the relatively low percentage of respondents correctly identifying them as abusive caregiving strategies at T2. In both instances, less than half of the respondents recognised that accepting the client's choice not to be clean (21%) and accepting a client's refusal of help in attending to his personal hygiene needs (38%) were abusive caregiving strategies. Furthermore, the percentage of respondents who correctly recognised that accepting a client's choice not to be clean is an abusive caregiving strategy reduced from 41% at T1 to 21% at T2.

Table 5.1 Home care assistants' T1 and T2 percentage frequency distribution for the abusive caregiving strategies

	Restriction of liberty		
	Abusive	**Bad idea**	**Other**
	Lock her in the house while he is at work		
T1	70.6%	29.4%	0%
T2	100%	0%	0%
	Sit her in an armchair with a table over her lap		
T1	64.7%	23.5%	11.8%
T2	86.7%	6.7%	6.7%
	Lock him in the house while she goes shopping		
T1	78.6%	21.4%	0%
T2	95.0%	5.0%	0%
	Lock herself in the bedroom when he is asking repeatedly to go out		
T1	53.8%	38.5%	7.7%
T2	68.4%	21.1%	10.5%
	Neglect		
	Abusive	**Bad idea**	**Other**
	Accept that it is her choice not to be clean		
T1	41.2%	41.2%	17.6%
T2	21.4%	50.0%	28.6%
	Accept that he refuses help attending to his personal hygiene needs		
T1	8.3%	58.3%	33.3%
T2	37.5%	18.8%	43.8%
	Physically abusive		
	Abusive	**Bad idea**	**Other**
	Force her to have a bath even if it leaves a mark on her skin		
T1	89.5%	5.3%	5.3%
T2	86.7%	13.3%	0%
	Push him back into his chair when he is hitting her		
T1	53.3%	6.7%	40.0%
T2	70.0%	20.0%	10.0%
	Ask their son to hold him down while she showers him		
T1	66.7%	20.0%	13.3%
T2	85.0%	15.0%	0%

(N=35)

A total of eight possibly abusive strategies were identified in the parallel versions of the CSQ questionnaire. The possible responses to each of the strategies were: 'good idea and helpful', 'possibly useful', 'not sure', 'unlikely to help', 'bad idea but not abusive', and 'abusive'. The first four responses were merged into a single category named 'other' and frequencies were calculated for the following categories of responses: 'abusive', 'bad idea' and 'other'. Table 5.2 displays the T1 and T2 percentage frequency distribution for the each of the eight possibly abusive caregiving strategies according to three merged category responses.The percentage frequency distribution for responses to the possibly abusive caregiving strategies demonstrate that the proportion of respondents identifying these strategies as abusive increased at T2 when compared with T1. The categories of 'abusive' and 'bad idea but not abusive' together accounted for the majority of responses at both time points. Furthermore, the percentage of respondents who recognised the strategies to be 'abusive' or 'a bad idea' increased at T2. A somewhat different trend was observed in relation to the two items which pertained to hiding tablets in the client's food; approximately half of the participants did not recognise these two items as being either 'abusive' or 'a bad idea' at T2 (53% and 47% respectively). While these T2 responses demonstrated a reduction on T1 responses for the two items (66% and 86% respectively), there remained a considerably higher number of respondents failing to recognise these strategies as 'abusive' or 'a bad idea' at T2 compared with the other possibly abusive strategies.

Table 5.2 Home care assistants' T1 and T2 percentage frequency distribution for the possibly abusive caregiving strategies

Abusive	Bad Idea	Other
Not answer her when she asks about the pension book		
22.2%	27.8%	50.0%
40.0%	33.3%	26.7%
Tell her that she cannot have her breakfast until she has had a bath		
68.4%	10.5%	21.1%
66.7%	26.7%	6.7%
Tell her that if things continue the way they are going then she will have to live elsewhere		
57.9%	26.3%	15.8%
73.3%	26.7%	0%
Hide the tablets in her morning cereal		
16.7%	16.7%	66.7%
26.7%	20.0%	53.3%
Not take her to family gatherings if she is likely to behave in an embarrassing way		
50.0%	33.3%	16.7%
86.7%	6.7%	6.7%
Tell him that he cannot watch any TV until he has had a wash		
13.3%	33.3%	53.3%
75.0%	20.0%	5.0%
Tell him that if things continue the way they are going he will have to live elsewhere		
42.9%	35.7%	21.4%
90.0%	5.0%	5.0%
Hide the sedative tablets in his morning cereal or tea		
6.7%	6.7%	86.7%
47.4%	5.3%	47.4%

(N=35)

A total of eleven non-abusive strategies were identified in the parallel versions of the CSQ questionnaire. The possible responses to each of the strategies were: 'good idea and helpful', 'possibly useful', 'not sure', 'unlikely to help', 'bad idea but not abusive', and 'abusive'. Three categories were created from the available responses by merging 'good idea and helpful' with 'possibly useful', into a category called 'possibly a good idea'. The responses 'not sure', 'unlikely to help' and 'bad idea but not abusive' were merged into a category named 'other'. The third category, 'abusive' remained from the original response options. Table 5.3 displays the T1 and T2 percentage frequency distributions for the each of the eleven non-abusive caregiving strategies according to the three possible category responses.

Table 5.3 Home care assistants' T1 and T2 percentage frequency distribution for the non-abusive caregiving strategies

	Possibly good idea and useful	Abusive	Other
	Arrange for his mother to wear an ID bracelet		
T1	100%	0%	0%
T2	100%	0%	0%
	Camouflage the door		
T1	27.8%	11.1%	61.1%
T2	33.3%	20.0%	46.7%
	Ask her Doctor about medication		
T1	94.7%	0%	5.3%
T2	93.3%	6.7%	0%
	Contact local services to request day care		
T1	100%	0%	0%
T2	93.3%	0%	6.7%
	Put a daily chart in her room reminding her to have a bath		
T1	42.1%	0%	57.9%
T2	60.0%	13.3%	26.7%
	Arrange for him to carry a mobile phone with GPS tracker		
T1	93.3%	0%	6.7%
T2	70.0%	0%	30.0%
	Arrange for tele-care so that he hears a recorded message of her voice		
T1	71.4%	0%	28.6%
T2	45.0%	0%	55.0%
	Ask the Doctor about reviewing his medication		
T1	80.0%	0%	20.0%
T2	100%	0%	0%
	Contact local services to request day care		
T1	85.7%	14.3%	0%
T2	100%	0%	0%
	Request advice from CHN on how to manage his aggression		
T1	100%	0%	0%
T2	100%	0%	0%
	Keep a diary of his behaviour to identify certain times of the day that are better for him to be washed		
T1	100%	0%	0%
T2	100%	0%	0%

(N =35)

The data showed that the majority of respondents described the non-abusive caregiving strategies as 'a good idea and helpful' or 'possibly useful' at both time 1 and time 2. Of particular note was the fact that at T2 20% of the respondents believed that camouflaging the door to prevent the client from wandering outside might potentially be an abusive caregiving strategy.

Comparing recognition of abusive caregiving strategies by home care assistants at T1 and T2

Following the procedures outlined in Chapter 3 and adopted from Cooper *et al*. (2012), a combined total score was computed for the recognition of abusive caregiving strategies. The total score ranged between 0 and 5, with higher scores indicating a greater degree of recognition of abuse. Table 5.4 displays overall mean scores for the sample of home care assistants for time 1 (T1) and time 2 (T2).

Table 5.4 Home care assistants' overall mean scores at T1 and T2

	N	Mean	Std. Dev
T1	35	3.03	1.27
T2	35	3.57	1.17
Residuals	35	-.67	1.90

(N=35)

At time 1 the mean score for the respondents' recognition of abusive caregiving strategies was 3.03 (SD=1.27). The overall mean score increased to 3.57 (SD=1.17) at time 2. A Wilcoxon W non-parametric comparison of dependent sample means was performed. Results of the Wilcoxon W comparison are displayed in Table 5.5.

The non-parametric dependent sample comparison of the mean scores for recognition of abusive caregiving strategies at T1 and T2 did not demonstrate sufficient evidence to reject the null hypothesis that the long-run population mean of the residuals was equal to 0, Z(33)= -1.87, p=.061 (two-tailed). However, the associated probability value was approaching significance, indicating that with increased power a significant difference may have been detected. A post-hoc power calculation indicated an observed effect size of 0.35 and just over 50% power (0.51) to detect a significant difference at 33 degrees of freedom and a critical alpha level of 0.05 using a two-tailed non-parametric comparison of dependent sample means. Thus it was concluded that the intervention was effective in increasing the home care assistants' ability to recognise abusive caregiving strategies, and while the effect approached statistical significance, it was not statistically significant.

Comparing recognition of possibly abusive caregiving strategies by home care assistants at time T1 and T2

Following the procedures outlined in Chapter 3 and adopted from Cooper *et al*. (2012) a combined total score was computed for the respondents' recognition of possibly abusive strategies as being either 'abusive' or 'a bad idea but not abusive'. The total score ranged from 0–15, with a higher score indicating greater recognition of possibly abusive strategies. Table 5.6 below displays the T1 and T2 mean scores for the sample of home care assistants.

Table 5.5 Non-parametric within-group comparison of the home care assistants' ranked mean scores for abuse recognition at T1 and T2

	N	Mean negative rank	Mean positive rank	Z	Sig (two-tailed)
T1 by T2	35	9.4	15.4	-1.87	0.06

(N=35)

Table 5.6 Home care assistants' scores for recognition of possibly abusive strategies at T1 and T2

	N	Mean	Std. Dev
T1	35	8.32	4.47
T2	35	12.09	3.53
Residuals	35	-3.68	5.77

(N=35)

At T1, the mean score for the respondents' recognition of possibly abusive caregiving strategies was 8.32 (SD=4.47). At T2 the mean score increased to 12.09 (SD=1.17). A parametric t-test comparison of dependent sample means was performed. Results of the dependent samples t-test are presented in Table 5.7.

The dependent samples t-test comparison of the T1 and T2 mean scores for recognition of possibly abusive caregiving strategies provided sufficient evidence to reject the null hypothesis that the long run population mean of the residuals was equal to 0 at a critical alpha level of 0.01, t(33) = -3.71, p=.001 (two-tailed). The 95% confidence interval for the long run population mean of the differences between the two samples was between -5.69 and -1.66, indicating that there was a statistically-significant difference between the T1 and T2 mean scores for the recognition of possibly abusive caregiving strategies. On that basis, it may be concluded, with 99% confidence, that the long run population mean of the post intervention group was statistically significantly higher than the pre intervention group. The effect size (d=0.64) was found to exceed Cohen's (1988) convention for a medium effect size (d=0.5).

Thus it was concluded that the intervention was effective in increasing the home care assistants' ability to recognise possibly abusive caregiving strategies and the effect was statistically significant.

Summary of key findings from the within-group quasi-experimental design

In summary, the data provided by the home care assistants before and following the training intervention demonstrated that the intervention was effective in terms of increasing their ability to recognise abusive and possibly abusive caregiving strategies as measured by the CSQ.

There was an observed increase in the percentage proportion of respondents correctly identifying strategies as abusive following the intervention at time 2. The non-parametric statistical comparison of the respondents' computed overall mean scores for recognition of abusive caregiving strategies showed that the difference between the mean scores before and after the intervention were approaching statistical significance. It was therefore concluded that, with increased power in the experimental design, a statistically-significant difference between the scores may be indicated. Furthermore, there was an observed increase in the percentage proportion of respondents correctly identifying strategies as possibly abusive following the intervention at time 2. A dependent samples t-test comparison of the computed overall mean scores for recognition of possibly abusive caregiving strategies showed a statistically-significant difference between the mean scores before and after the intervention.

The relatively low proportion of home care assistants correctly identifying acts of neglect as abusive following the training intervention was noted from the frequency distribution of responses to the CSQ items. Similarly, the two items which described hiding tablets in food also demonstrated a relatively low proportion of home care assistants correctly identifying these strategies as possibly abusive following the intervention.

Table 5.7 Dependent samples parametric (t-test) comparison mean scores for home care assistants' recognition of possibly abusive strategies at T1 and T2

	N	Confidence Interval		T	DF	Sig (two-tailed)
		Lower	Upper			
T1 by T2	35	-5.69	-1.66	-3.71	33	.001**

**Significant at the critical alpha level of 0.01 (1%)

(N=35)

5.3 Residential care training intervention: Within and between-group experimental design

This element of the experimental evaluation involved the application of a within and between-group design in which the effectiveness of the residential care training intervention was tested at two points in time. A sample of nursing students undertaking the undergraduate general nursing degree programme at a large urban university nurse training school was recruited. A total of 134 nursing students completed the experimental evaluation. The participants were randomly assigned to either an intervention (n=66) or control group (n=68). The intervention group attended the training intervention while the control group did not. In lieu of the training, the control group was provided with, and requested to read, a journal article which described the role of nurses in the recognition and management of elder mistreatment. Both groups completed the Caregiver Scenario Questionnaire (CSQ) and the Knowledge and Management of Abuse (KAMA) questionnaire at time 1 (T1), which was before the intervention or reading of the journal article and at time 2 (T2), which was after the training intervention or reading the article. The CSQ measured recognition of abusive caregiving strategies for managing challenging behaviour in a person with dementia (Selwood *et al*., 2007). The KAMA measured the students' applied knowledge and practice regarding the identification and management of potentially abusive situations in a residential setting (Richardson *et al*. 2003).

The mean age of the participants in the control group was 22.46 years (SD= 4.09, range=20:42). The majority (n=66) of the control group was female, with just two males. Of the 68 students in the control group, less than half (45%, n=31) described themselves as currently working with older people outside of their nurse training programme. The mean age of the participants in the intervention group was 23.30 years (SD=4.68, range=19:34). Similar to the control group, the majority of the intervention group was female (n=63), with just three males in the group. Of the 66 students who experienced the training intervention, 50% (n=33) described themselves as currently working with older people outside of their nursing programme.

Recognition of caregiving strategies by the nursing students intervention group at T1 and T2

A total of nine abusive strategies were identified in the parallel versions of the CSQ questionnaire. These were sub-categorised into restriction of liberty (4 items), neglect (2 items) and physically abusive strategies (3 items). The possible responses to each of the strategies were as follows: 'good idea and helpful', 'possibly useful', 'not sure', 'unlikely to help', 'bad idea but not abusive', and 'abusive'. The first four responses were merged into a single category called 'other' and frequencies were calculated for the following categories: 'abusive', 'bad idea' and 'other'. Table 5.8 displays the percentage frequency distributions of the intervention group responses at times 1 and 2 for each of the nine abusive caregiving strategies, according to three merged response categories.

Table 5.8 Nursing student intervention group percentage frequency distribution for the abusive caregiving strategies at T1 and T2

	Restriction of liberty		
	Abusive	**Bad Idea**	**Other**
	Lock her in the house while he is at work		
T1 Intervention Group	81.5%	14.8%	3.7%
T2 Intervention Group	82.1%	10.3%	7.7%
	Sit her in an armchair with a table over her lap		
T1 Intervention Group	92.3%	7.7%	0%
T2 Intervention Group	100%	0%	0%
	Lock him in the house while she goes shopping		
T1 Intervention Group	71.8%	15.4%	12.8%
T2 Intervention Group	92.6%	7.4%	0%
	Lock herself in the bedroom when he is asking repeatedly to go out		
T1 Intervention Group	33.3%	38.5%	28.2%
T2 Intervention Group	88.9%	7.4%	3.7%
	Neglect		
	Abusive	**Bad Idea**	**Other**
	Accept that it is her choice not to be clean		
T1 Intervention Group	29.6%	22.2%	48.1%
T2 Intervention Group	25.6%	20.5%	53.8%
	Accept that he refuses help attending to his personal hygiene needs		
T1 Intervention Group	31.6%	26.3%	42.1%
T2 Intervention Group	26.9%	23.1%	50.0%
	Physically Abusive		
	Abusive	**Bad Idea**	**Other**
	Force her to have a bath even if it leaves a mark on her skin		
T1 Intervention Group	100%	0%	0%
T2 Intervention Group	97.4%	2.6%	0%
	Push him back into his chair when he is hitting her		
T1 Intervention Group	60.5%	13.2%	26.3%
T2 Intervention Group	77.8%	7.4%	14.8%
	Ask their son to hold him down while she showers him		
T1 Intervention Group	79.5%	7.7%	12.8%
T2 Intervention Group	96.3%	3.7%	0%

(N=66)

In general, the nursing student intervention group demonstrated a greater proportion of responses at T2, which correctly identified the strategies as abusive, when compared with their responses at T1. However, the two strategies in the CSQ which describe acts of neglect yielded a relatively low percentage of respondents who correctly identified them as abusive caregiving strategies at T2 and at T1. At T2, just 25.6% of respondents identified that accepting the client's choice not to be clean was abusive and 26.9% identified accepting the client's refusal of help in taking care of his personal hygiene needs was abusive, despite the fact that in both vignette cases the client had reduced capacity.

The largest percentage increase in recognition of abuse among the intervention group between T1 to T2 was demonstrated in relation to the two abusive strategies which involved restricting the client's liberty. At T1, just one third (33.3%) of the intervention group recognised that locking oneself in the bedroom when the client is asking repeatedly to go out was an abusive strategy and the proportion who correctly recognised the strategy as abusive increased to 88.9% at T2. This result demonstrated a percentage increase of 55.6% at T2 over T1. The next largest percentage increase was demonstrated in the intervention group's responses to the strategy of locking the client in the house in order to go shopping. At T1 71.8% recognised that this strategy was abusive compared with 92.6% at T2, representing a percentage increase of 20.8%.

A total of eight possibly abusive strategies were identified in the parallel versions of the CSQ questionnaire. Possible responses to each of the strategies were: 'good idea and helpful', 'possibly useful', 'not sure', 'unlikely to help', 'bad idea but not abusive', and 'abusive'. The first four responses were merged into a single category called 'other' and frequencies were calculated for the following categories of responses: 'abusive', 'bad idea' and 'other'. Table 5.9 displays the percentage frequency distribution for each of the eight possibly abusive caregiving strategies according to three merged category responses at T1 and T2.

Table 5.9 Nursing students intervention group T1 and T2 percentage frequency distributions for the possibly abusive caregiving strategies

	Abusive	Bad idea	Other
	Not answer her when she asks about the pension book		
T1 Intervention Group	22.2%	48.1%	29.6%
T2 Intervention Group	47.4%	18.4%	34.2%
	Tell her that she cannot have her breakfast until she has had a bath		
T1 Intervention Group	77.8%	14.8%	7.4%
T2 Intervention Group	71.8%	15.4%	12.8%
	Tell her that if things continue the way they are going then she will have to live elsewhere		
T1 Intervention Group	70.4%	25.9%	3.7%
T2 Intervention Group	61.5%	10.3%	28.2%
	Hide the tablets in her morning cereal		
T1 Intervention Group	44.4%	18.5%	37.0%
T2 Intervention Group	44.7%	13.2%	42.1%
	Not take her to family gatherings if she is likely to behave in an embarrassing way		
T1 Intervention Group	33.3%	55.6%	11.1%
T2 Intervention Group	59.0%	17.9%	23.1%
	Tell him that he cannot watch any TV until he has had a wash		
T1 Intervention Group	30.8%	15.4%	53.8%
T2 Intervention Group	80.8%	11.5%	7.7%
	Tell him that if things continue the way they are going he will have to live elsewhere		
T1 Intervention Group	43.6%	15.4%	41.0%
T2 Intervention Group	88.9%	3.7%	7.4%
	Hide the sedative tablets in his morning cereal or tea		
T1 Intervention Group	21.1%	2.6%	76.3%
T2 Intervention Group	56.0%	20.0%	24.0%

(N =66)

In three of the eight possibly abusive strategies, the nursing student intervention group demonstrated an increased proportion of responses at T2, correctly identifying the strategies as either abusive or a bad idea compared with responses at T1. Furthermore, for six of the eight strategies the data showed an increased proportion of students identifying them as abusive at T2 when compared with T1.The largest increase from responses at T1 was demonstrated by the possibly abusive strategy of telling a client that he cannot watch any TV until he has had a wash. At T1 53.8% of the respondents identified this strategy as one of the 'other' responses; however this decreased to 7.7% at T2, with 92.3% of respondents correctly recognising this strategy as either abusive or a bad idea. Similarly, at T1 41.0% of the respondents identified telling a client that if things continue the way they are going they will have to live elsewhere as one of the 'other' responses and this decreased to 7.4% T2.

A total of eleven non-abusive strategies were identified in the parallel versions of the CSQ questionnaire. Possible responses to each of the strategies were: 'good idea and helpful', 'possibly useful', 'not sure', 'unlikely to help', 'bad idea but not abusive' and 'abusive'. Three categories were created from the available responses by merging 'good idea and helpful' and 'possibly useful' into a category called 'possibly a good idea'. The responses 'not sure', 'unlikely to help' and 'bad idea but not abusive' were merged into a category called 'other'. The third category, 'abusive' remained from the original response options. Table 5.10 displays the percentage frequency distribution for the each of the eleven non-abusive caregiving strategies according to the three possible category responses at T1 and T2.

Table 5.10 Nursing students intervention group T1 and T2 percentage frequency distribution for the non-abusive caregiving strategies

	Possibly good idea and useful	Abusive	Other
	Arrange for his mother to wear an ID bracelet		
T1 Intervention Group	88.9%	0%	11.1%
T2 Intervention Group	92.3%	2.6%	5.1%
	Camouflage the door		
T1 Intervention Group	7.4%	7.4%	85.2%
T2 Intervention Group	10.3%	28.2%	61.5%
	Ask her Doctor about medication		
T1 Intervention Group	100%	0%	0%
T2 Intervention Group	94.9%	0%	5.1%
	Contact local services to request day care		
T1 Intervention Group	100%	0%	0%
T2 Intervention Group	100%	0%	0%
	Put a daily chart in her room reminding her to have a bath		
T1 Intervention Group	96.3%	0%	3.7%
T2 Intervention Group	84.6%	0%	15.4%
	Arrange for him to carry a mobile phone with GPS tracker		
T1 Intervention Group	59.0%	0%	41.0%
T2 Intervention Group	65.4%	3.8%	30.8%
	Arrange for tele-care so that he hears a recorded message of her voice		
T1 Intervention Group	56.4%	0%	43.6%
T2 Intervention Group	59.3%	7.4%	33.3%
	Ask the Doctor about reviewing his medication		
T1 Intervention Group	94.9%	0%	5.1%
T2 Intervention Group	100%	0%	0%
	Contact local services to request day care		
T1 Intervention Group	100.0%	0%	0%
T2 Intervention Group	96.3%	0%	3.7%
	Request advice from CHN on how to manage his aggression		
T1 Intervention Group	100%	0%	0%
T2 Intervention Group	100%	0%	0%
	Keep a diary of his behaviour to identify certain times of the day that are better for him to be washed		
T1 Intervention Group	100%	0%	0%
T2 Intervention Group	100%	0%	0%

(N =66)

The data showed that the majority of respondents described the non-abusive caregiving strategies as 'a good idea and helpful' or 'possibly useful' both before (T1) and after the intervention (T2). Of particular note was the fact that at T2, 28.2% of respondents believed that camouflaging the door to prevent the client from wandering outside may potentially be an abusive caregiving strategy.

Recognition of caregiving strategies by the nursing students control group at T1 and T2

A total of nine abusive strategies were identified in the parallel versions of the CSQ questionnaire. These were sub-categorised into restriction of liberty (4 items), neglect (2 items) and physically abusive strategies (3 items). Possible responses to each of the strategies were: 'good idea and helpful', 'possibly useful', 'not sure', 'unlikely to help', 'bad idea but not abusive', and 'abusive'. The first four responses were merged into a single category called 'other' and frequencies were calculated for the following categories: 'abusive', 'bad idea' and 'other'. Table 5.11 displays the percentage frequency distribution of the control group's responses for the each of the nine abusive caregiving strategies according to three merged response categories at T1 and T2.

Table 5.11 Nursing students control group T1 and T2 percentage frequency distribution for the abusive caregiving strategies

	Restriction of Liberty		
	Abusive	**Bad Idea**	**Other**
	Lock her in the house while he is at work		
T1 Control Group	91.4%	8.6%	0%
T2 Control Group	88.2%	8.8%	2.9%
	Sit her in an armchair with a table over her lap		
T1 Control Group	88.6%	11.4%	0%
T2 Control Group	88.2%	5.9%	5.9%
	Lock him in the house while she goes shopping		
T1 Control Group	74.2%	16.1%	9.7%
T2 Control Group	82.4%	11.8%	5.9%
	Lock herself in the bedroom when he is asking repeatedly to go out		
T1 Control Group	25.8%	48.4%	25.8%
T2 Control Group	47.1%	41.2%	11.8%
	Neglect		
	Abusive	**Bad Idea**	**Other**
	Accept that it is her choice not to be clean		
T1 Control Group	34.3%	37.1%	28.6%
T2 Control Group	29.4%	17.6%	52.9%
	Accept that he refuses help attending to his personal hygiene needs		
T1 Control Group	31.3%	18.8%	50%
T2 Control Group	34.3%	34.3%	31.4%
	Physically Abusive		
	Abusive	**Bad Idea**	**Other**
	Force her to have a bath even if it leaves a mark on her skin		
T1 Control Group	100%	0%	0%
T2 Control Group	97.1%	2.9%	0%
	Push him back into his chair when he is hitting her		
T1 Control Group	62.5%	12.5%	25.0%
T2 Control Group	58.8%	17.6%	23.5%
	Ask their son to hold him down while she showers him		
T1 Control Group	71.0%	19.4%	9.7%
T2 Control Group	94.1%	5.9%	0%

(N=68)

Overall, the nursing student control group demonstrated a static distribution of responses to the abusive CSQ items in their responses at T1 and T2, with very little change demonstrated in the percentage proportions.

A total of eight possibly abusive strategies were identified in the parallel versions of the CSQ questionnaire. Possible responses to each of the strategies were: 'good idea and helpful', 'possibly useful', 'not sure', 'unlikely to help', 'bad idea but not abusive', and 'abusive'. The first four responses were merged into a single category called 'other' and frequencies were calculated for the following categories of responses: 'abusive', 'bad idea' and 'other'.

Table 5.12 displays the percentage frequency distribution of the control group's responses for each of the eight possibly abusive caregiving strategies according to three merged category responses at T1 and T2.

Overall, the nursing student control group demonstrated a static distribution of responses to the possibly abusive CSQ items in the questionnaires at T1 and T2, with very little change demonstrated in the percentage proportions.

A total of eleven non-abusive strategies were identified in the parallel versions of the CSQ questionnaire. Possible responses to each of the strategies were: 'good idea and helpful', 'possibly useful', 'not sure', 'unlikely to help', 'bad idea but not abusive', 'abusive'. Three categories were created from the available responses by merging 'good idea and helpful' with 'possibly useful' into a category called 'possibly a good idea'. Responses 'not sure', 'unlikely to help' and 'bad idea but not abusive' were merged into a category called 'other'. The third category, 'abusive' remained from the original response options.

Table 5.12 Nursing students control group percentage frequency distribution for the possibly abusive caregiving strategies at T1 and T2

	Abusive	Bad Idea	Other
	Not answer her when she asks about the pension book		
T1 Control Group	20.0%	22.9%	57.1%
T2 Control Group	14.7%	23.5%	61.8%
	Tell her that she cannot have her breakfast until she has had a bath		
T1 Control Group	71.4%	11.4%	17.1%
T2 Control Group	70.6%	5.9%	23.5%
	Tell her that if things continue the way they are going then she will have to live elsewhere		
T1 Control Group	62.9%	20.0%	17.1%
T2 Control Group	50.0%	32.4%	17.6%
	Hide the tablets in her morning cereal		
T1 Control Group	25.7%	8.6%	65.7%
T2 Control Group	23.5%	26.5%	50.0%
	Not take her to family gatherings if she is likely to behave in an embarrassing way		
T1 Control Group	37.1%	31.4%	31.4%
T2 Control Group	38.2%	47.1%	14.7%
	Tell him that he cannot watch any TV until he has had a wash		
T1 Control Group	40.6%	21.9%	37.5%
T2 Control Group	40.0%	40.0%	20.0%
	Tell him that if things continue the way they are going he will have to live elsewhere		
T1 Control Group	34.4%	25.0%	40.6%
T2 Control Group	47.1%	29.4%	23.5%
	Hide the sedative tablets in his morning cereal or tea		
T1 Control Group	25.8%	9.7%	64.5%
T2 Control Group	34.3%	8.6%	57.1%

(N =68)

Table 5.13 displays the percentage frequency distribution of the control group's responses for each of the eleven non-abusive caregiving strategies according to the three possible category responses at T1 and T2.

In general, the nursing student control group demonstrated a static distribution of responses to the non-abusive CSQ items at T1 and T2 with very little change demonstrated in the percentage proportions.

Table 5.13 Nursing students control group T1 and T2 percentage frequency distribution for the non-abusive caregiving strategies

	Possibly good idea and useful	Abusive	Other
	Arrange for his mother to wear an ID bracelet		
T1 Control Group	82.4%	2.9%	14.7%
T2 Control Group	97.1%	0%	2.9%
	Camouflage the door		
T1 Control Group	17.1%	17.1%	65.7%
T2 Control Group	35.3%	11.8%	52.9%
	Ask her Doctor about medication		
T1 Control Group	94.3%	2.9%	2.9%
T2 Control Group	97.1%	0%	2.9%
	Contact local services to request day care		
T1 Control Group	100%	0%	0%
T2 Control Group	100%	0%	0%
	Put a daily chart in her room reminding her to have a bath		
T1 Control Group	100%	0%	0%
T2 Control Group	97.1%	0%	2.9%
	Arrange for him to carry a mobile phone with GPS tracker		
T1 Control Group	87.5%	0%	12.5%
T2 Control Group	88.2%	0%	11.8%
	Arrange for tele-care so that he hears a recorded message of her voice		
T1 Control Group	50.0%	0%	50.0%
T2 Control Group	71.0%	0%	29.0%
	Ask the Doctor about reviewing his medication		
T1 Control Group	96.9%	0%	3.1%
T2 Control Group	100%	0%	0%
	Contact local services to request day care		
T1 Control Group	100%	0%	0%
T2 Control Group	97.1%	0%	2.9%
	Request advice from CHN on how to manage his aggression		
T1 Control Group	100%	0%	0%
T2 Control Group	100%	0%	0%
	Keep a diary of his behaviour to identify certain times of the day that are better for him to be washed		
T1 Control Group	100%	0%	0%
T2 Control Group	94.3%	0%	5.7%

(N =68)

Comparison of recognition of abusive caregiving strategies between the nursing students control and intervention groups at T1

Following the procedures outlined in Chapter 3 and adopted from Cooper *et al.* (2012), a combined total score was computed for the recognition of abusive caregiving strategies. The total score ranged between 0 and 5, with higher scores indicating a greater degree of recognition of abusive caregiving strategies. Table 5.14 displays the overall mean scores for both the intervention and control groups at T1.

Table 5.14 Nursing students' (intervention and control groups) scores for recognition of abusive caregiving strategies at T1

	N	Mean	Std. Dev
Intervention group (T1)	66	3.26	1.17
Control group (T1)	68	3.37	1.30

(N=134)

The intervention group mean score for recognition of abusive caregiving strategies was 3.26 (SD=1.17) at T1. The mean score for the control group for recognition of abusive caregiving strategies was 3.37 (SD=1.30) at T1. A Mann-Whitney non-parametric comparison of independent sample means was performed. Results of the Mann-Whitney comparison are displayed in Table 5.15.

The independent samples non parametric (Mann-Whitney) comparison of the intervention and control mean scores for recognition of abusive caregiving strategies at T1 provided insufficient evidence to reject the null hypothesis that the long run population means of the two groups are the same; Z (132) = -795, p=.427 (two-tailed). On that basis it was concluded that there was a statistically insignificant difference at a critical alpha level of 0.05 between the intervention and control groups' mean scores for the recognition of abusive caregiving strategies at T1.

Comparison of recognition of abusive caregiving strategies between the nursing students control and intervention groups at T2

Scores for recognition of abusive caregiving strategies were computed for the nursing students' intervention and control groups at T2. Table 5.16 displays the overall mean scores for both the intervention and control group at T2.

Table 5.16 Nursing students' (intervention and control groups) T2 scores for recognition of abusive caregiving strategies

	N	Mean	Std. Dev
Intervention group (T2)	66	3.91	.872
Control group (T2)	68	3.54	1.12

(N=134)

Table 5.15 Between-group comparison of the intervention and control groups' T1 ranked mean scores for recognition of abusive caregiving strategies

	N	Mean rank	Mann-Whitney U	Z	Sig (two-tailed)
Intervention group (T1)	66	64.41	2040.00	-.795	.427
Control group (T1)	68	69.55			

(N=134)

In the intervention group, the mean score for the respondents' recognition of abusive caregiving strategies at T2 was 3.91 (SD=.872). In the control group the mean score was 3.54 (SD=1.12) at T2. A Mann-Whitney non-parametric comparison of independent sample means was performed. Results of the Mann-Whitney comparison are displayed in Table 5.17.

The independent samples non parametric (Mann-Whitney) comparison of the intervention and control overall mean scores for recognition of abusive caregiving strategies at T2 provided evidence to reject the null hypothesis that the long run population means of the two groups are the same at a critical alpha level of 0.05, Z (132)= -1.98, p=0.05 (two-tailed). We can be 95% confident of a statistically significant difference between the long run population means of the intervention and the control groups' T2 scores. The mean score of the intervention group at T2 was statistically significantly higher than that of the control group. The effect size for the difference between the two groups (d=0.29) was found to exceed Cohen's (1988) convention for a small effect size (d=0.2). Thus it may be concluded that the intervention was effective in increasing the nursing student intervention group's ability to recognise abusive caregiving strategies when compared with the nursing students in the control group.

Comparison of scores of the nursing students intervention group for recognition of abusive caregiving strategies at T1 and T2

Scores for recognition of abusive caregiving strategies were computed and compared for the intervention group of nursing students at T1 and T2. Table 5.18 displays the intervention group's overall mean scores for recognition of abusive caregiving strategies, as well as the residuals at T1 and T2.

Table 5.18 Intervention group T1 and T2 mean scores for recognition of abusive caregiving strategies

	N	Mean	Std. Dev
Intervention group (T1)	66	3.26	1.17
Intervention group (T2)	66	3.91	.87
Residuals	66	.65	1.50

(N=134)

At T1, the mean score for the intervention group's recognition of abusive caregiving strategies was 3.26 (SD=1.17). At T2 the mean score increased to 3.91 (SD=.87). A Wilcoxin W non-parametric comparison of dependent sample means was performed. Results of the Wilcoxon W comparison are displayed in Table 5.19.

Table 5.17 Between-group comparison of the intervention and control groups' ranked mean scores for recognition of abusive caregiving strategies at T2

	N	Mean rank	Mann-Whitney U	Z	Sig (two-tailed)
Intervention group (T2)	66	74.45	1851.5	-1.98	0.05*
Control group (T2)	68	61.83			

*Significant at an alpha level of 0.05 (5%)
(N=134)

Table 5.19 Non-parametric within-group comparison of the T1 and T2 ranked mean scores for recognition of abusive caregiving strategies

	N	Mean negative rank	Mean positive rank	Z	Sig (two-tailed)
Intervention group (T1) by intervention group (T2)	66	24.32	23.9	-3.22	.001**

**Significant at an alpha level of 0.01 (1%)
(N=134)

The non-parametric dependent sample comparison of the intervention mean scores for recognition of abusive caregiving strategies at T1 and T2 provided sufficient evidence to reject the null hypothesis that the long run population mean of the residuals was equal to 0 at a critical alpha level of 0.01, Z(64)= -3.22, p=.001 (two-tailed). It may be concluded, with 99% confidence, that the long run population mean of the intervention group's scores at T2 was statistically significantly higher than their scores at T1. The effect size (d=0.43) was found to exceed Cohen's (1988) convention for a small effect size (d=0.2). Thus it may be concluded that the intervention was effective in increasing the nursing student intervention group's ability to recognise abusive caregiving strategies between T1 and T2.

Summary of key findings from the within and between group experimental design: Recognition of abusive caregiving strategies

In summary, the data provided by the nursing students' intervention and control groups at both points in time demonstrated that the intervention was effective in terms of the recognition of abusive caregiving strategies, as measured by the CSQ. There was an observed increase in the proportion of the nursing student intervention group correctly identifying the abusive caregiving strategies after undergoing the training (T2). This increase was not observed in the control group, which demonstrated relatively static response proportions between both time points.

A non-parametric comparison of the control and intervention group's overall mean scores for recognition of abusive caregiving strategies at T1 yielded an insignificant difference between the two group means. This indicated that the groups shared statistically similar baseline scores at T1. The non-parametric comparison between the mean scores for recognition of abusive caregiving strategies at T2 showed a statistically significant difference between the nursing student control and intervention groups. This indicated that a statistically significant difference between the two groups emerged following the intervention. The group of students who received the intervention scored significantly higher for recognition of abusive caregiving strategies after the training compared with the control group. Furthermore, a non-parametric dependent samples comparison of the intervention group mean scores for recognition of abusive caregiving strategies at T1 and T2 showed a statistically significant difference between the scores at each time point. The intervention group had higher scores for recognition of abusive caregiving strategies following the training intervention.

Additionally, a number of findings related to recognition of abusive and neglectful caregiving acts were noteworthy. The relatively low proportion of the nursing students from the intervention group correctly identifying the two acts of neglect as abusive following the training intervention was noted from the frequency distribution of responses to the CSQ items. A further observation was made in relation to the two CSQ items, which described abusive acts involving restriction of the client's liberty. These items demonstrated the largest percentage increase in the proportion of the intervention group correctly identifying them as abusive strategies following the training when compared to their baseline pre-training scores.

Comparison of recognition of possibly abusive caregiving strategies between the nursing students control and intervention groups T1

Following the procedures outlined in Chapter 3 and adopted from Cooper *et al*. (2012), a combined total score was computed for the recognition of possibly abusive caregiving strategies as being either 'abusive' or 'a bad idea but not abusive'. The total score ranged from 0–15, with higher scores indicating a greater recognition of possibly abusive strategies. Table 5.20 below displays the overall mean scores for both the intervention and control groups at T1.

Table 5.20 Nursing student's (intervention and control groups) T1 scores for recognition of possibly abusive caregiving strategies

	N	Mean	Std Dev
Intervention group (T1)	66	8.83	5.59
Control group (T1)	68	8.61	4.64

(N=134)

The mean score for the intervention group for recognition of possibly abusive caregiving strategies at T1 was 8.83 (SD=5.59). The mean score for the control group for recognition of possibly abusive caregiving strategies at T1 was 8.61 (SD=4.64). A Mann-Whitney non-parametric comparison of independent sample means was performed. Results of the Mann-Whitney comparison are displayed in Table 5.21.

Table 5.21 Between-group comparison of the intervention and control groups' T1 ranked mean scores for recognition of possibly abusive caregiving strategies

	N	Mean rank	Mann-Whitney U	Z	Sig (two-tailed)
Intervention group (T1)	66	68.92	2084.0	-.579	.562
Control group (T1)	68	65.10			

(N=134)

The independent samples non parametric (Mann-Whitney) comparison of the intervention and control mean scores for recognition of possibly abusive caregiving strategies at T1 provided insufficient evidence to reject the null hypothesis that the long run population means of the two groups are the same; Z (132) =-.579, p=.562 (two-tailed). On that basis it may be concluded that there was a statistically insignificant difference at a critical alpha level of 0.05 between the intervention and control groups' mean scores for the recognition of possibly abusive caregiving strategies at T1.

Comparison of recognition of possibly abusive caregiving strategies between the nursing students control and intervention groups at T2

Scores for recognition of possibly abusive caregiving strategies were computed for the intervention and control groups of nursing students at T2. Table 5.22 displays the overall mean scores for both the intervention and control group at T2.

Table 5.22 Nursing students' (intervention and control groups) T2 scores for recognition of possibly abusive caregiving strategies

	N	Mean	Std Dev
Intervention group (T2)	66	11.47	3.96
Control group (T2)	68	9.91	4.05

(N=134)

In the intervention group, the mean score for recognition of possibly abusive caregiving strategies was 11.47 (SD=3.96) at T2. In the control group the mean score was 9.91 (SD=4.05) at T2. A Mann-Whitney non-parametric comparison of independent sample means was performed. Results of the Mann-Whitney comparison are displayed in Table 5.23.

The independent samples non parametric (Mann-Whitney) comparison of the intervention and control overall mean scores for recognition of possibly abusive caregiving strategies at T2 provided evidence to support the rejection of the null hypothesis that the long run population means of the two groups are the same at a critical alpha level of 0.05, Z (132)=-2.19, p=0.03 (two-tailed). We can be 95% confident that there is statistically significant difference between the long run population means of the intervention and the control groups' T2 scores. The mean score of the intervention group at T2 was statistically significantly higher than the control group. The effect size for the difference between the two groups (d=0.29) was found to exceed Cohen's (1988) convention for a small effect size (d=0.2). Thus it may be concluded that the intervention was effective in increasing the nursing student intervention group's ability to recognise possibly abusive caregiving strategies when compared with the nursing students in the control group.

Comparison of scores of nursing students intervention group for recognition of possibly abusive caregiving strategies at T1 and T2

Scores for recognition of possibly abusive caregiving strategies were computed and compared for the intervention group of nursing students at time point one (T1) and time point two (T2). Table 5.24 displays the intervention group's overall mean scores for recognition of possibly abusive caregiving strategies, as well as the residuals at T1 and T2.

Table 5.23 Between-group comparison of the intervention and control groups' T2 ranked mean scores for recognition of possibly abusive caregiving strategies

	N	Mean rank	Mann-Whitney U	Z	Sig (two-tailed)
Intervention group (T2)	66	75.32	1794	-2.19	.029*
Control group (T2)	68	61.00			

*Significant at an alpha level of 0.05 (5%)
(N=134)

Table 5.24 Nursing students intervention group mean scores for recognition of possibly abusive caregiving strategies at T1 and T2

	N	Mean	Std Dev
Intervention group (T1)	66	8.83	5.59
Intervention group (T2)	66	11.47	3.96
Residuals	66	2.64	6.88

(N=134)

At T1, the mean score for the intervention group's recognition of possibly abusive caregiving strategies was 8.83 (SD=5.59). At T2 the mean score increased to 11.47 (SD=3.96). A parametric (t-test) comparison of dependent sample means was performed. Results of the dependent samples t-test are displayed in Table 5.25.

The parametric (t-test) dependent samples comparison of the intervention mean scores for recognition of possibly abusive caregiving strategies at T1 and T2 provided sufficient evidence to reject the null hypothesis that the long run population mean of the residuals was equal to 0 at a critical alpha level of 0.01, t(65) = -3.11, p=.003 (two-tailed). The 95% confidence interval for the long run population mean of the differences between the two samples was between -4.328 and -.945, indicating that there was a statistically significant difference between the intervention group T1 and T2 scores for the recognition of possibly abusive caregiving strategies. We can conclude, with 99% confidence, that the long run population mean of the intervention group's scores for the recognition of possibly abusive caregiving strategies at time two was statistically significantly higher than at time one. The effect size (d=0.38) was found to exceed Cohen's (1988) convention for a small effect size (d=0.2).

Summary of key findings from the within and between group experimental design: Recognition of possibly abusive caregiving strategies

In summary, the data provided by the nursing students' intervention and control groups at both time points demonstrated that the intervention was effective in terms of the recognition of possibly abusive caregiving strategies, as measured by the CSQ.

Following the delivery of the training (T2), in three out of the eight possibly abusive strategies there was an observed increase in the proportion of the nursing student intervention group identifying the strategies as either abusive or a bad idea. Furthermore, for six of the eight possibly abusive strategies the data demonstrated an increased proportion of students in the intervention group identifying the strategies as abusive following the training intervention (T2) when compared to scores before the training intervention (T1). This observed increase in the proportion of the nursing students in the intervention group correctly identifying the possibly abusive caregiving strategies at T2 was not observed in the responses of the control group of students. The control group demonstrated relatively static response proportions between both time points.

Table 5.25 Parametric within-group comparison of the T1 and T2 ranked mean scores for recognition of possibly abusive caregiving strategies

	N	Confidence Interval		T	DF	Sig (two-tailed)
		Lower	Upper			
Intervention group (T1) by intervention group (T2)	66	-4.328	-.945	-3.11	65	.003**

**Significant at an alpha level of 0.01 (1%)
(N=134)

A non-parametric comparison of the control and intervention group's overall mean scores for recognition of possibly abusive caregiving strategies at T1 found an insignificant difference between the two group means. This indicated that the groups shared statistically similar baseline scores at T1. However, at T2 a statistically significant difference was found between the scores of the intervention and control group for recognition of possibly abusive caregiving strategies. This indicated that the difference between the two groups emerged at time point 2, after the delivery of the training to the intervention group. The group of students who received the intervention scored significantly higher for recognition of possibly abusive caregiving strategies after the training compared with the control group. This was supported by the findings of a parametric comparison of dependent sample means which provided evidence for a statistically significant difference between the intervention group scores at time one (T1) and time two (T2). The intervention group had significantly higher scores for recognition of possibly abusive caregiving strategies following the delivery of the training (T2) compared with before (T1).

The largest increase in the proportion of the intervention group correctly identifying the strategy as either abusive or a bad idea following the training was demonstrated by the possibly abusive caregiving item of telling a client that he cannot watch TV until he has had a wash. This was followed by telling a client that if things continue the way they are going they will have to live elsewhere. Of note was the relatively static response between T1 and T2 that was observed for the possibly abusive strategies of telling a client that she cannot have her breakfast until she has had a bath and hiding tablets in her morning cereal.

Comparison of knowledge and management of elder abuse between the nursing students control and intervention groups at T1

Following the procedures outlined in Chapter 3 and adopted from Richardson *et al*. (2003), a combined total score was computed for the responses obtained from the Knowledge and Management of Elder Abuse (KAMA) questionnaire. Total scores were expressed as percentages and therefore range from 0–100. Higher scores indicate that the respondents gave more correct answers, demonstrating greater knowledge. Table 5.26 displays the overall mean KAMA scores for both the intervention and control groups at T1.

Table 5.26 Nursing students' (intervention and control groups) T1 scores for knowledge and management of elder abuse

	N	Mean	Std Dev
Intervention group (T1)	66	21.87	6.32
Control group (T1)	68	21.35	5.78

(N=134)

At T1 the intervention group mean KAMA score was 21.87 (SD=6.32). The control group mean KAMA score at T1 was 21.35 (SD=5.78). A parametric (t-test) comparison of independent sample means was performed. Results of the independent samples t-test are displayed in Table 5.27.

Table 5.27 Between-group parametric comparison of the intervention and control groups' ranked mean KAMA scores at T1

	N	Confidence Interval		T	DF	Sig (two-tailed)
		Lower	Upper			
Intervention group (T1)	66	-1.55	2.59	.498	132	.619
Control group (T1)	68					

(N=134)

Levene's test for equality of variance indicated equality could be assumed, F(1,132) = .650, p= .421, owing to this a t-statistic assuming homogeneity of variance was computed. The independent samples t-test comparison of the intervention and control groups mean KAMA scores at T1 provided insufficient evidence to reject the null hypothesis that the long run population means of the two groups were the same at a critical alpha level of 0.05, t(132) = .498, p=.619 (two-tailed). The 95% confidence interval for the long run population mean of the differences between the two groups was between -1.55 and 2.59, indicating that there was a statistically insignificant difference between the intervention and control groups for their KAMA scores at T1.

Comparison of knowledge and management of elder abuse between the nursing students control and intervention groups at T2

KAMA scores were computed for the intervention and control groups of nursing students at T2. Table 5.28 displays the overall mean KAMA scores for both the intervention and control groups at T2.

Table 5.28 Nursing students' (intervention and control groups) scores for knowledge and management of elder abuse at T2

	N	Mean	Std Dev
Intervention group (T2)	66	21.71	6.07
Control group (T2)	68	20.57	6.19

(N=134)

At T2 the intervention group mean KAMA score was 21.71 (SD=6.07). The control group's mean KAMA score at T2 was 20.57 (SD=6.19). A parametric (t-test) comparison of independent sample means was performed. Results of the independent samples t-test are displayed in Table 5.29.

Levene's test for equality of variance indicated equality could be assumed, F(1,132) = .112, p= .739, owing to this a t-statistic assuming homogeneity of variance was computed. The independent samples t-test comparison of the intervention and control groups' mean KAMA scores at T2 provided insufficient evidence to reject the null hypothesis that the long run population means of the two groups were the same at a critical alpha level of 0.05, t(132) = 1.073, p=.285 (two-tailed). The 95% confidence interval for the long run population mean of the differences between the two groups was between -.956 and .322, indicating that there was a statistically insignificant difference between the intervention and control groups for their KAMA scores at time point two.

Comparison of T1 and T2 scores of the nursing students intervention group for knowledge and management of elder abuse

KAMA scores were computed for the intervention group of nursing students at T1 and T2. Table 5.30 displays the overall mean scores for the intervention group at both time points, as well as the residuals.

Table 5.30 Nursing students intervention group T1 and T2 mean scores for knowledge and management of elder abuse

	N	Mean	Std Dev
Intervention group (T1)	66	21.87	6.32
Intervention group (T2)	66	21.71	6.07
Residuals	66	-.163	8.44

(N=134)

At T1, the intervention group's mean KAMA score was 21.87 (SD=6.32). At T2 the intervention group's mean KAMA score was 21.71 (SD=6.07) A parametric (t-test) comparison of dependent sample means was performed. Results of the dependent samples t-test are displayed in Table 5.31.

Table 5.29 Between-group parametric comparison of the intervention and control groups' ranked mean KAMA scores at T2

	N	Confidence Interval		T	DF	Sig (two-tailed)
		Lower	Upper			
Intervention group (T2)	66	-.956	.322	1.073	132	.285
Control group (T2)	68					

(N=134)

Table 5.31 Parametric within-group comparison of the T1 and T2 ranked mean KAMA scores for the intervention group

	N	Confidence Interval		T	DF	Sig (two-tailed)
		Lower	Upper			
Intervention group (T1) by intervention group (T2)	66	-1.92	2.24	.157	65	.876

(N=134)

The dependent samples t-test comparison of the intervention group's mean KAMA scores at T1 and T2 provided insufficient evidence at an alpha level of 0.05 to reject the null hypothesis that the long run population mean of the difference between the two groups was equal to 0, t(65) = .157, p=.876 (two-tailed). The 95% confidence interval for the long run population mean of the differences between the two groups was between -1.92 and 2.24 indicating that there was a statistically insignificant difference between the intervention group KAMA scores at T1 and T2.

Summary of key findings from the within and between-group experimental design: Knowledge and management of elder abuse

In summary, insignificant differences were found between the mean scores of the control and intervention groups for knowledge and management of elder abuse at both time points. Similarly, an insignificant difference was observed between the mean KAMA score of the intervention group at T1 and T2. This indicates that the experimental study provided insufficient evidence to reject the hypothesis that the training intervention had no effect on the nursing students' knowledge and management of elder abuse in a residential setting. Of particular note, however, were the low baseline and T2 scores shared by both the control and intervention groups. The mean KAMA score achieved by the students at both time points was 21.4 (SD=6.1). This low overall mean score suggests a general lack of knowledge shared by the students concerning the management of elder abuse in a residential setting before the training was delivered and this persisted at T2 in both groups.

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6.1 Introduction

An important part of health and social care strategies in preventing elder abuse is the use of training in elder abuse. The focus of such training is the development of knowledge and skills for recognising and preventing abuse, and responding appropriately when abuse is suspected or observed. Key to prevention is the promotion of greater awareness of the problem among health and social care staff. Accordingly, training is generally targeted at those involved in the direct care of older people, whether in residential care or community settings.

Since 2007, a standardised national training programme for all healthcare staff in the recognition and prevention of elder abuse has been in place in Ireland. Developed and implemented by the Health Service Executive (HSE), the programme is aimed at healthcare and other staff working with older people in residential care settings and in the community. It is coordinated by a number of regional dedicated officers in the prevention of elder abuse and delivered by senior case workers who also have a clinical remit for managing cases of elder abuse. In addition, a number of HSE elder abuse service personnel are involved in providing training to those with responsibility for delivering the programme within their own organisations. Those who facilitate individual training sessions are provided with a number of material resources, including DVDs and supporting materials. The training is designed to be delivered in a single training session lasting approximately three hours.

This study evaluated the HSE national training programme in the prevention of elder abuse. The evaluation design incorporated evaluation of the structure, process and outcomes elements of the programme, with a focus on: the content and quality of the documentary materials and resources that are used to support the training; the experiences of those coordinating and facilitating the training; and the effectiveness of the training, with reference to trainee outcomes, notably knowledge of and ability to recognise abuse. A mixed methods approach was used in which the following tasks were completed: a review of training materials; individual interviews with trainers and training coordinators; a within-group quasi-experimental design and randomised controlled trial to establish training effectiveness. This chapter discusses the study findings with reference to the study design, other research in the field and the implications of the findings for policy and practice.

6.2 Study design

The methods and materials that were used to gather data for this evaluation study were informed by literature on illuminative evaluation research. The methods were selected to generate reliable evaluative data with which to make valid judgments about important aspects of the training programme's structures, processes and outcomes. A key aim of the study design was to generate information on the training effectiveness.

Design and instrumentation

The design for the evaluation study consisted of a range of data collection methods that generated data from a variety of sources. These included documentary analysis, interviews, experiments and quasi-experiments. The overall evaluation design and its associated methods of data collection are well supported in the literature on programme evaluation (Hannum *et al*., 2007; Fealy *et al*., 2012).

The overarching evaluation design consisted of data triangulation, which ensured that study data were generated from the main stakeholders associated with the training programme, notably training coordinators, trainers and trainees. Along with generating information on the experiences of those most closely involved in delivering the training, the study design also generated additional evidence of the effectiveness of the training on trainee learning. The evaluation design used in the present study is well supported in similar evaluation studies of elder abuse training, notably those reported by Pillemer and Hudson (1993), Seamon *et al*. (1997), Nusbaum *et al*. (2007), Sugita and Garrett (2012), Richardson *et al*. (2002) and Cooper *et al*. (2012). Similar to the present study, two studies in particular reported the use of the experimental design involving an intervention and control group (Richardson *et al*., 2002; Teresi *et al*., 2013)

The use of valid and reliable methods to measure primary outcomes of training is widely supported in empirical studies that evaluate the effectiveness of training programmes, including training in elder abuse. The use of validated instruments to measure trainees' knowledge and ability to recognise elder abuse has been reported in several published studies (e.g. Pillemer & Hudson, 1993; Nusbaum *et al*., 2007; Mills *et al*., 2012; Sugita & Garrett, 2012). The present study used self-report instruments to measure changes in trainees' knowledge and ability to recognise elder abusive caregiving strategies and the management strategies of healthcare professionals. The

Caregiver Scenario Questionnaire (CSQ) as reported by Selwood *et al.* 2007 and Cooper *et al.* 2012, was adopted to measure recognition of abusive caregiving strategies. In order to measure knowledge and management of elder abuse by healthcare professionals before and after the training intervention, the study adopted the Knowledge and Management of Abuse (KAMA) questionnaire from previous studies (Richardson *et al*., 2002; Richardson *et al., 2004*).

As noted in Chapter Two, there have been several evaluative studies of the effectiveness of elder abuse training interventions targeted at health and social care professionals. The WHO's *European Report on Preventing Elder Maltreatment* cited the work of Jogerst & Ely, (1997) and Richardson *et al*. (2002) as representing two high-quality evaluation studies on professional awareness and education on elder abuse. The use of a quantitative trial design involving a control group for comparison and a sample likely to be representative of the target population were acknowledged by the WHO report as indicators of high-quality evaluation research (WHO, 2011). Therefore, a particular strength of one element of this present study design was the use of intervention and control groups for testing training effectiveness. Evaluating training outcomes among a group of nursing students using a randomised controlled trial design enhanced the validity of the evidence concerning the effectiveness of the HSE training intervention.

A major part of the study's design involved qualitative approaches that resulted in rich narrative data from key participants about their experiences of coordinating and/or facilitating elder abuse training. The use of a design to generate detailed narrative accounts of those most intimately familiar with the training programme added considerably to the overall quality of the study data by providing first-hand accounts of the barriers and enablers to delivering the training on a day-today basis. In so doing, the study addressed the key research questions around training processes and aspects of training effectiveness.

Sampling and response rates

Since the two main samples for the training effectiveness element of the study were purposively selected, comparisons of the demographic profile of the participants with that of a national sample of nurses and care staff were not indicated. The emphasis of the study design was to increase internal validity by accessing relatively homogenous purposive samples. In this way, potential mediating or confounding variables could be controlled for. Such mediating variables are associated with a more externally valid, representative sample, for example: previous exposure to training; prior knowledge of elder abuse; as well as differences associated with inter and intra-professional experience, knowledge and expertise. The use of a within-group quasi-experimental design and a randomised controlled trial ensured that the focus was on measuring evidence for training effectiveness through emphasising internal validity and not on establishing national representativeness. The recruitment strategy for the interviews was aimed at ensuring maximum input from among the small number of dedicated officers, train-the-trainers and senior case workers nationally. While the sampling strategy for the interviews was also purposive, it is possible that the study sample represented the national sample of dedicated officers and, given the relatively small number of senior case workers employed by the HSE and the geographic spread of interviewees, also provided a high degree of representativeness of the senior case workers' experiences nationally.

Documentary review

In analysing the materials that supported the training, the research team developed a bespoke documentary analysis tool. This tool enabled the development of an index of quality for each of the four training material artefacts. The tool was developed from a similar instrument, the Documentary Analysis Rating Instrument (DARI), developed by Fealy and colleagues for analysing documentary materials used in a clinical leadership training programme (Fealy *et al.,* 2012). Like the DARI instrument, the present rating instrument incorporated a rating scale and allowed for a qualitative analysis through a reviewers' panel discussion.

6.3 Training structure and trainers' experiences

The aims of elder abuse training for those working with older people are to increase trainees' awareness and knowledge of abuse and improve their competence in recognising abuse and responding appropriately to suspected cases of abuse (Cooper *et al*., 2009; Smith *et al*., 2010; Thomson *et al*., 2010; Sugita & Garrett, 2012). Staff training is therefore an important means of ensuring

that elder abuse is detected, prevented and effectively managed (McGarry & Simpson, 2007; Harmer-Beem, 2005; DeHart *et al*., 2009). In its content and design, the HSE national training programme meets these key aims and constitutes a major element of the policy response of the Irish Government in preventing elder abuse.

Training structures

The training provided by the HSE comprises two half-day courses, the *Level 1 Elder Abuse Awareness Raising Workshop* (3 hours) and a supplementary E*lder Abuse Awareness Raising Workshop*, provided by the elder abuse service. In addition *Train the Trainer* (TtT) courses are provided by HSE elder abuse service personnel to enable services and organisations to become self-sufficient in providing elder abuse training to their staff. Indeed the success of the Train-the-Trainer courses is reflected in the fact that almost half of all training is delivered by individuals who have been trained and are now facilitating training in their own place of work (HSE, 2012).

The World Health Organisation suggests that health and social care professionals who routinely interact with older people are best placed to identify those at risk of abuse (WHO, 2011). Therefore, these professionals have a key role in identifying abuse (Day *et al*., 2010). The HSE has ensured the widespread dissemination of information on elder abuse to key groups by providing targeted training on a national basis to those carers working most closely with older people, namely nurses and care workers. Additionally, by providing training to professionals across a wide range of sectors, including the medical, legal, financial and policing professions, training in elder abuse recognition has been extended to a much wider constituency of key stakeholders with responsibility for protecting older people. A shared learning approach to elder abuse training can improve interdisciplinary working by enhancing different professional groups' understanding of each other's respective roles and responsibilities in relation to elder abuse (Kingston & Penhale, 1997; Day *et al*., 2010). An interdisciplinary approach to training in elder abuse is therefore recommended as a means of promoting collaborative working in the area of elder abuse prevention and management (Kingston & Penhale, 1997; Day *et al*., 2010). However, the various professional groups and care workers in Ireland have, for the most part, received training within their discrete individual grades and disciplines. Nevertheless, the fact that all the key stakeholder groups and disciplines are being exposed to training is likely to result in a net overall benefit in terms of enhancing knowledge and skills among those who are best placed to recognise and respond to elder abuse.

The data provided by the HSE on the number of training sessions delivered to date (HSE, 2012) indicate that the programme has been rolled out extensively on a national basis since 2007. There has been incremental increases year-on-year in the first five years and a tapering off in 2012. This tapering off might be explained by the fact that there has been widespread saturation across the services. The data suggest a high level of demand for training and a commensurate high level of training provision. This high level of demand was confirmed by the dedicated officers, train-the-trainers and senior case workers who were interviewed for this study. While figures for similar training programmes internationally are not available for comparative purposes, the evidence provided by the HSE points to a high level of exposure to training, relative to the total population of nurses and care workers in Ireland. Additionally, the training figures from the HSE do not account for the training provided within the country's fourteen nurse training schools.

The HSE elder abuse training programme is essentially a short attendance workshop in which a variety of learning experiences are facilitated. Richardson *et al*. (2002) reported that attendance at a training course was more effective in improving knowledge and management of abuse among nurses and social care staff than simply disseminating printed educational materials. Furthermore, attendance at a training event was particularly effective for those trainees with low pre-training baseline knowledge.

The review of documentary materials supporting the training demonstrated that the training materials were fit for purpose in terms of containing the relevant information on the types of elder abuse and the ways of responding appropriately. There is a tendency for training content to emphasise legislative and organisational needs at the expense of relational or emotional issues surrounding elder abuse (Nolan *et al*., 2008). However the training materials used by the HSE had a strong focus on the relational and interpersonal, particularly in the DVD scenarios depicting elder abuse. This approach is supported in the literature where it is suggested that by drawing attention to the interpersonal and ethical aspects of abuse, trainees are more likely develop improved skills in managing elder abuse and overcome

some of the psychological barriers experienced in relation to reporting abuse (Grainger, 2009).

Several elder abuse training programmes incorporate the use of audio-visual media (e.g. McCauley *et al*., 2003; Smith *et al*., 2010; Teresi *et al*., 2013). This use of audio-visual media is seen as being advantageous in that it provides consistent information, depicts realistic role play scenarios, is easy to disseminate and offers a flexible and convenient form of training for health and social care professionals (Seamon *et al*., 1997; McCauley *et al*., 2003). The fact that over 40,000 session attendees have been registered since 2007 suggests that the use of a standard training approach incorporating a DVD provides a method of training that is capable of being delivered on a large scale. The DVDs present case scenarios depicting the various types of abuse and suggesting the range and complexities of elder abuse and so enable trainees to discuss and explore issues arising from the cases (Day *et al*., 2010). The evidence from the thirteen interviews suggests that the training provides opportunities for discussion, reflection and feedback, features of interactive learning (Smith *et al*., 2010). Small group discussions and exercises allow participants to explore how their own values impact on how they perceive, feel and act in relation to elder abuse (Vinton, 1993). This type of interactive learning, which the training promotes, is seen as the most effective form of learning and the method preferred by adult learners (Smith *et al*., 2010).

Training in elder abuse in residential care should incorporate training in the competencies needed for protecting older people from abuse. These competencies include: communication and coping strategies for managing and resolving conflict; the ability to recognise work-place risk factors for abuse; and the ability to identify those residents most vulnerable to abuse and to recognise subtle forms of abuse (DeHart *et al*., 2009). The HSE training materials contained information on all the various forms of abuse, including the more subtle forms like exclusion from social activities. The trainers interviewed in the study attested to the effectiveness of the training in improving trainee awareness and increasing the number of referrals to the elder abuse service. Although the training programme did not contain explicit content for developing communication and conflict resolution competencies, trainers reported using pedagogical approaches that focused on the learning needs of particular groups.

Designing training materials that are relevant, accessible and culturally and linguistically appropriate to the target trainees is seen as important to the success of training in elder abuse (Gironda *et al*., 2010). The training materials used to support the HSE training programme met these criteria in the way that the DVDs contained Irish actors and depicted scenarios in residential and community settings in Ireland. Additionally the HSE training initiative also incorporates a train-the-trainer component aimed at enabling organisations and services to become self-reliant in providing elder abuse training. This approach of using an internal member of the organisation or service to facilitate training is seen as an important factor in the success of elder abuse training (Nusbaum *et al*., 2007; Nolan *et al*., 2008).

Trainers' experiences

The value of obtaining the perspective of trainers in any educational intervention is recognised in the literature on training evaluation. The thirteen senior case workers, dedicated officers and train-the-trainers provided rich narrative accounts of their experiences of coordinating and facilitating training. Of note were their accounts of the barriers and enablers encountered when planning and delivering the training. They spoke of organizational, individual-level and structural barriers to the effective planning and delivery of training. Barriers included employers' difficulty in ensuring optimal attendance at training, senior case workers' high workload, poor participant engagement in individual training sessions and limited material resources and equipment for training. A possible explanation for these barriers is the challenges faced by organisations in balancing the need to meet statutory staff training requirements and the need to ensure safe staff-resident ratios. This latter need was particularly pertinent at the time of data collection, when many healthcare organisations were experiencing staff shortages in the face of an embargo on recruitment in the public service in Ireland.

The participants, notably the senior case workers who were interviewed, spoke of their experiences of competing demands on their time in having to manage their caseload and respond to multiple requests to provide training. The experience of having to manage the burden of competing demands on their time was reflected in an earlier study of senior case workers' experiences. This study reported that senior case workers experienced high demands on their time due to their different role requirements, which included 'an

overwhelming caseload' and being responsible for providing training and raising awareness (O'Donnell *et al*., 2012).

Any teaching-learning event involves the learner, the teacher, the subject matter and the context in which the event happens, and none of these four elements is reducible into any other (Schwab, 1973). The thirteen participants spoke about the importance of good planning for each training session/workshop, in particular the need to take account of the individual trainees' needs and differences. The study participants' approach in this regard is consistent with a key tenet of education, that is, the need to begin teaching with an understanding of the learner. This tenet was proposed by Ausubel in his classic Assimilation Learning Theory, in which he proffered his famous axiom: 'the most important single factor influencing learning is what the learner already knows' (Ausubel, 1968).

Several participants indicated that in conducting training sessions, they frequently deviated from the training schedule and/or training content, in order to take account of local circumstances and trainee needs. This flexible approach to the way that training was being conducted suggests a willingness to adapt to local conditions, including trainee differences. As a pedagogical strategy, this flexibility should result in more effective learning, since it is responsive to the needs of the learners. This form of 'differentiated instruction' recognises that learners are different and that teaching needs to be adjusted to take account of these differences. The approach is based on the view that there is variability among any group of learners and that teachers should adjust instruction accordingly (Tomlinson, 2003).

However, some study participants believed that applying discretion in the way that the training was facilitated presented a threat to the standardisation of the training. Far from being a deliberate pedagogical strategy, it was seen by some as running counter to the intended structure and delivery of the training workshops, particularly when training was truncated due to time constraints. The risk in this open approach is that all the planned learning objectives might not be achieved and, consequently, trainees might miss out on key points of information or a new competence needed for practice.

O'Donnell and colleagues reported on the wide range of experiences that senior case workers have in managing cases of abuse, including dealing directly with the myriad types of elder abuse, responding to referrals, managing cases and evaluating case outcomes (O'Donnell *et al*., 2012). In the present study, it seems that a key enabler of effective training was the senior case workers' coalface experience of managing cases of elder abuse, experience which they could bring to the teaching encounter.

6.4 Training effectiveness

The effectiveness of elder abuse training interventions in bringing about behavioural changes in trainees is associated with several factors. These include: the quality of the training; the perceived relevance of the learning objectives to trainees; the trainees' motivation to learn; the mode of delivery; the adequacy of the materials; resources and planning; the perceived acceptability of the intervention; and the receptiveness of the organisational culture to change. The evidence concerning the effectiveness of education and training in changing health and social care professionals' behaviours in relation to elder abuse screening and reporting is equivocal. While some training interventions have demonstrated improved participant outcomes (e.g. Radensky & Parikh, 2008; Teresi *et al*., 2013), others reported no improvement in these same outcomes (e.g. Jogerst *et al*., 2004; Nusbaum *et al*., 2007; Cooper *et al*., 2012). From the evidence of one study (Richardson *et al*., 2002) it appears that face-to-face delivery of training is a superior mode of training in elder abuse when compared with dissemination of information through printed materials. Overall, it appears that education and training in elder abuse recognition and management is somewhat effective in increasing awareness and knowledge of elder abuse among health and social care professionals (e.g. Sugita & Garrett, 2012; Cooper *et al*., 2012).

The training intervention that was used in the present study was the bespoke training programme developed by the HSE for staff working with older people, including home care assistants and nurses. The intervention showed that the training was effective with the home care assistant cohort in a number of respects. Although statistically insignificant, there was an increase in the home care assistants' ability to recognise abusive caregiving strategies after the training intervention. Furthermore, there was an observed increase in the home care assistants' ability to recognise possibly abusive caregiving strategies following the training intervention, and the effect was statistically significant. In respect of

the nursing student sample, before the training intervention there was no statistically significant difference between the intervention and control groups in their ability to recognise abusive and possibly abusive caregiving strategies. However, following the intervention a statistically significant difference between the groups was observed. The intervention group obtained statistically significant higher scores for recognition of abusive and possibly abusive caregiving strategies post intervention compared with their pre-intervention scores as well as the control groups' scores. The finding that the intervention was effective in improving trainees' ability to recognise abusive caregiving strategies is consistent with similar studies reported by Teresi *et al*. (2013), Cooper *et al*. (2012), Sugita and Garrett (2012) and Seamon *et al*. (1997).

Using the CSQ and a similar training intervention, Cooper *et al*. (2012) found that a training package, comprising presentations on elder abuse and an elder abuse awareness DVD, improved knowledge and confidence about recognising abuse among a cohort of trainee psychiatrists. Where Cooper *et al*.'s study differed was the fact that the primary trainee outcomes were measured at three months and not immediately following the training. Thus an assessment of trainee outcomes at a later point in time would provide for a more valid comparison with Cooper *et al*.'s (2012) study and would also permit an assessment of retention of knowledge and ability over time. The use of a longer post-training time period, such as that used by Teresi *et al*. (2013), who tested the effectiveness of a training intervention on nursing assistants' knowledge, recognition, reporting and management of abuse over a one-year period, could provide more robust evidence of training effectiveness.

Similar to the present study, Seamon *et al*. (1997) used a pre-test-post-test design to test the effectiveness of a training intervention involving a 45-minute video on knowledge and willingness to report elder abuse. They reported significant improvements in trainees' knowledge of elder abuse. However, Seamon *et al*. (1997) also found that a substantial proportion of professionals continued to report a lack of confidence in their ability to recognise abuse, a finding that was echoed in the present study in which a relatively low proportion of the home help assistants correctly identified acts of neglect as abusive following the training intervention. Sugita and Garrett (2012) also used a pre-test-post-test design to examine the effectiveness of elder abuse training involving oral health care providers; although the method of training – a symposium on elder abuse – differed to the HSE method, the post-test results were somewhat similar, showing that trainees were more confident in recognising the indicators of elder abuse and more knowledgeable about elder abuse.

Using the KAMA instrument, Richardson and colleagues found that nurses continued to select inappropriate management strategies even after they had received an elder abuse training intervention (Richardson *et al*., 2004). Of particular note in the present study were the low baseline and time 2 scores shared by both the control and intervention groups. The mean KAMA score achieved by the students at both time points was 21.4 (SD=6.1). This low overall mean score suggests a general lack of knowledge shared by the nursing sample concerning the management of elder abuse in a residential setting before the training was delivered and this persisted at time 2 in both groups. It is worth noting that compared with the CSQ, the KAMA instrument measures higher-order knowledge pertaining to professionals' ability to identify appropriate management responses to cases of elder abuse. This suggests that the training intervention demonstrated more success in increasing participants' recognition of abusive strategies than their ability to manage and respond to abuse. However, more robust research is required to substantiate this claim; in particular, there is a need for further investigation in relation to the measurement of knowledge regarding elder abuse management in residential settings. Furthermore the degree of knowledge that is present among the population of nursing students and the broader population of qualified nurses and healthcare professionals with experience of delivering care to older people in residential care requires further exploration. Further research would also contribute to the development of appropriate educational and training interventions which would address knowledge deficits in this population if the evidence continues to suggest that the deficits exist.

The two experimental evaluation elements of this study that empirically tested the effectiveness of the HSE elder abuse training intervention among home care assistants and nursing students contribute to the body of evidence concerning elder abuse training effectiveness. The literature indicates equivocal evidence concerning the effectiveness of elder abuse training in changing trainees' behaviours in relation to elder abuse screening and reporting, with several studies demonstrating no improvement in trainee outcomes (Nusbaum *et al*., 2007;

Jogerst *et al*., 2004; Cooper *et al*., 2012). However, the present study suggests that the HSE training programme has demonstrable effectiveness in improving trainees' ability to recognise abusive caregiving strategies.

6.5 Limitations

While the strategy in designing this study was to evaluate the HSE training programme in the prevention of elder abuse from several aspects, the study design was not without limitations. Foremost among these was the limitation inherent in the use of non-probability purposive samples, which were the main sources of data for both the qualitative interviews and the effectiveness trials. Claims of generalizability of findings to the total population of interest are not possible in studies involving non-probability samples. With regard to the qualitative interviews, this limitation was somewhat counteracted by the fact that the total population of trainers, particularly the senior case workers and dedicated officers, is small and hence a relatively large proportion of the population of interest was included in the study. Moreover, since the aim of the within-group quasi-experimental design and the randomised controlled trial was to measure evidence of training effectiveness by emphasising internal validity of the design, the external validity of the findings was therefore less critical in this study.

The method used for the documentary analysis was another limitation of the study design. Specifically, the validity of the bespoke documentary analysis tool was not established; for example, the items in each of the four subscales of the instrument did not carry equal weight in terms of measuring the quality and purpose of the training material that was being analysed. Additionally, while individual ratings were conducted independently, consensus scores were used to report on the 'quality' of the training materials. The cut-off scores for 'good quality' and 'high quality' were also somewhat arbitrary.

This evaluation study examined the broad structure, process and outcomes elements of the HSE training programme. It did not examine the more micro-level aspects of the training, such as the effectiveness of the train-the-trainers component or the more minute process elements of individual training sessions from the perspective of trainees.

The study design did not incorporate exit evaluation reports of trainee experiences. Nor did it include more detailed interviews with trainees concerning their experiences of the training. While the effectiveness of the training intervention was measured at a single point in time, namely immediately following the intervention, the study did not examine the primary outcomes of interest at a second or subsequent point in time. This approach would have enabled measurement of the extent of knowledge decay and/or the decay in ability to recognise and respond appropriately to abuse over time and might also have indicated the optimum time for refresher training. The nursing student cohort was a relatively homogenous group, in terms of prior knowledge and experience, and this provided a good degree of control of intervening variables in the RCT; however, the use of students was also a study limitation. Given their limited experiential knowledge, relative to registered nurses, the nursing students were not representative of the wider population of nurses who receive the standard training programme in elder abuse.

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This evaluation study examined the HSE national training programme in recognising and preventing elder abuse using several complementary methods that were designed to illuminate the structure, process and outcomes aspects. While the study design had some limitations, overall the study provides important evidence concerning the content, delivery and effectiveness of the training programme. This chapter presents a number of recommendations, which are not ordered according to priority.

Promoting training standards

The evidence from the trainers' experiences of delivering training suggests that in conducting training sessions, trainers frequently deviated from the prescribed training schedule and/or training content, in order to take account of local circumstances and trainee needs. This suggested a flexible approach that resulted in a lack of standardisation of the training within and across sites. A way to obviate such lack of standardisation would be to bring the training within an accreditation framework, either by accrediting and validating training content or awarding credits to trainees for attendance at prescribed training, or both. This would involve setting requirements and standards for minimum training and a process of site and/or trainer accreditation. Accreditation could be developed within a continuing professional development (CPD) model through a recognised and reputable higher education institution; this would provide a one-stop shop for training oversight and academic governance.

Forms of training

In order to address the particular needs of organisations in relation to capacity to support training and to take account of local circumstances, training could be developed and refined with the aim of developing two forms of the training, one an accelerated or expedited form and the other a 'complete' form that would meet prescribed requirements and standards. An expedited form would focus on a limited number of learning outcomes and include key messages in its content. No trainee could receive CPD credits for training without first attending the 'complete' form of training.

Training content

The evidence from the effectiveness trials indicated that trainees had difficulty in recognising and differentiating situations and circumstances of older people that rendered them as vulnerable to abuse and neglect. Training should therefore incorporate content that emphasises the importance of capacity in an older person and the individual-level factors that render them as vulnerable.

At the time of writing, legislation regarding the capacity of individuals to make decisions about their treatment and care was at an advanced stage of development. Once this legislation is completed and enacted in the statute book, the provisions of the legislation as they pertain to older people and decision making should be examined. Particular attention is required to ensure that training in preventing elder abuse addresses those aspects of older persons' autonomy in the matter of decision making.

The training DVD entitled *Recognising and responding to elder abuse in residential care settings* depicted institutional practices, notably regimented behaviours in the way care is organised in residential settings. These practices and behaviours create the circumstances in which abuse and neglect can arise and are in and of themselves potentially abusive acts. Hence, when using the training DVD in question, trainers should draw attention to the fact that institutionalised practices in residential care, as depicted in the training DVD, are a potential form of abuse. The institutionalised practices depicted provide an ideal pretext for generating discussion and reflection among trainees, so as to increase their awareness of the ways that the care setting itself may be a source of abuse.

In any planned revisions of the DVD, consideration should be given to achieving a better balance in the depiction of the role of the various occupational groups in relation to the perpetration and management of abuse and more time dedicated to reporting responsibilities and mechanisms. In addition greater use could be made of the opportunity to publicise the HSE information telephone helpline on both the DVD cover and on the final frame of the DVD itself.

Trainee needs

Training that is provided to training returnees should first reprise the key messages about how to recognise and respond to abuse and thereafter build on previous training content. That is, training should build knowledge and skills incrementally. For example, elder abuse is complex and expressed in subtle forms and training should incorporate reference to this complexity, incrementally building on previous content.

While the content of training should be standardised across all staff grades, at the level of the core message to be transmitted, it is likely that different staff grades have different learning needs that may not be readily accommodated in a training session containing mixed grades. Accordingly, the possibility of having bespoke training content for professional and non-professional grades should be considered. However, consideration should also be given to the important role of interdisciplinary training and shared learning in elder abuse as a way of promoting collaborative working in the area of elder abuse prevention and management.

Trainer needs

Senior case workers have played a key role in delivering training over many years in several different care settings and among several different grades. The added value of senior case workers' involvement in training is related to their first-hand experience of individual cases of abuse, which they can bring to bear in enhancing the quality of training content. The competing demands of the senior case worker's role in managing cases of abuse and providing training in response to high demand should be acknowledged. The possibility of affording each senior case worker protected time to conduct training within the role should be considered.

Nurse training

The evidence from the effectiveness trial involving the nursing students demonstrated a significant effect in students' recognition of abusive and possibly abusive caregiving strategies. However, data from their responses to the KAMA failed to provide evidence for a significant effect of the intervention. Additionally, the students had low baseline KAMA scores, indicating that they had relatively low level of knowledge concerning the complexities of managing and responding to elder abuse. These complexities would include issues like ritualistic abuse within care settings as well as reporting and responding to abuse. On that basis, the findings of this study, as they apply to undergraduate training content, should be brought to the attention of deans and heads of school responsible for undergraduate training, with the view to reviewing training content, so as to ensure that it addresses the complexities and subtleties of elder abuse.

Focus of training

The evidence from the effectiveness trials indicated that training was effective in meeting one of its main outcomes; that of enabling trainees to recognise abuse. The evidence as to the programme's effectiveness in appropriately responding to abuse is somewhat equivocal. Training should emphasise these two related aspects of staff competence in preventing abuse. Responding appropriately to abuse may involve whistleblowing and training content should include the important role of whistleblowing in highlighting instances of abuse, whether it occurs at the organisational or individual level.

The literature indicates that training interventions may incorporate several elements that seek to develop trainee knowledge and skills. Training may address the following: assessment and screening; problem-solving; strategies for managing conflict, stress and challenging behaviour; relational issues in caregiving; strategies for managing cases of abuse; the influence of care settings, power dynamics among staff; and the complexities of reporting. These important elements of skill development could be incorporated in advanced training in preventing abuse.

The literature also indicates that knowledge deficits persist even after the provision of training and hence continuing refresher training may be required in order to ensure that knowledge is retained in the long-term. The need for refresher training in elder abuse and related continuing professional development in such areas as communication and effectively managing and resolving conflict, should be an integral part of the strategy for training in the prevention of elder abuse.

Pedagogy

Based on the evidence from the literature it is recommended that training should incorporate active learning strategies, such as role play and case studies, as these are considered to be more effective in terms of long-term retention and application of knowledge to practice when compared to training that uses passive learning techniques, such as didactic lecture presentations. The use of audio-visual media as an element in elder abuse training has several advantages, including ease of dissemination, dissemination of consistent information, flexibility and convenience, and realistic depictions of abuse scenarios that can also demonstrate appropriate responses. The use of the training DVD as a key element in the training should therefore continue.

The train-the-trainer model has provided a cadre of trainers that enable organisations to be self-sufficient in providing training in elder abuse. This model should continue to be the mainstay for ensuring a sufficient supply of trainers to deliver training.

Resourcing and supporting training

Evidence provided by those conducting training indicated that they experienced a number of organisational, individual-level and structural barriers to the effective planning and delivery of training. These included: employers' difficulty in ensuring optimal attendance at training, senior case workers' high workload, poor participant engagement in individual training sessions and limited material resources and equipment for training. Notwithstanding the challenges associated with inadequate staffing and resources, organisations could demonstrate commitment to training by ensuring that staff are provided with sufficient time to attend training and trainers are provided with the essential material resources with which to deliver training effectively and efficiently.

Further research

There is a lack of reliable evidence of the effectiveness of education and training interventions aimed at educating staff in the recognition and management of abuse. Few studies have measured the long-term retention of knowledge as a result of training programmes. Hence, there is a need for rigorous objective evaluation studies to determine the effectiveness of education and training on elder abuse prevention and management and also to determine the most effective way of delivering training in terms of cost, resources and meeting the key learning objectives of long-term retention of knowledge and the application of knowledge to practice.

DOCUMENTARY REVIEW

Documentary Analysis Rating Instrument

Please complete the following rating scale, with which you are asked to rate the quality and content of the various training materials supporting the Health Service Executive elder abuse training programme. Rate the various elements of the materials in general. You may make additional notes to support your scores.

SECTION A: 'OPEN YOUR EYES TO ELDER ABUSE IN YOUR COMMUNITY': TRAINING DVD

Below is a list of statements about the content of the **community** training DVD. Indicate the extent to which you *agree* or *disagree* with each statement on the list, using the scale:
1= Strongly disagree; 2=Disagree; 3=No opinion; 4=Agree; 5= Strongly agree

		tick [✓] ONE number only for each statement				
		1	**2**	**3**	**4**	**5**
1	The training DVD presents examples of all the main types of elder abuse	☐	☐	☐	☐	☐
2	In general, the scenarios depicting elder abuse offer realistic portrayals of elder abuse in the community	☐	☐	☐	☐	☐
3	In general, the explanations (e.g. voice overs) that accompany each scenario depicting a type of elder abuse are clear	☐	☐	☐	☐	☐
4	In general, the key constructs (e.g. abuse, neglect) are used consistently throughout the training DVD	☐	☐	☐	☐	☐
5	The content of the training DVD is a suitable resource to support training for care givers in the community	☐	☐	☐	☐	☐
6	The content of the training DVD is a suitable resource to support training for other health professionals (e.g. GPs)	☐	☐	☐	☐	☐
7	In general, the quality of production (e.g. visual and sound quality) of the training DVD is good	☐	☐	☐	☐	☐

In the space below, please provide additional comments on *any* aspect of the **community training DVD**

SECTION B: 'RECOGNISING AND RESPONDING TO ELDER ABUSE IN RESIDENTIAL CARE SETTINGS': TRAINING DVD

Below is a list of statements about the content of the **residential care** training video. Indicate the extent to which you *agree* or *disagree* with each statement on the list, using the scale:
1= Strongly disagree; 2=Disagree; 3=No opinion; 4=Agree; 5= Strongly agree

		tick [✓] ONE number only for each statement				
		1	**2**	**3**	**4**	**5**
1	The training DVD presents examples of all the main types of elder abuse in residential care	☐	☐	☐	☐	☐
2	In general, the scenarios depicting elder abuse offer realistic portrayals of elder abuse in residential care	☐	☐	☐	☐	☐
3	In general, the explanations (e.g. voice overs) that accompany each scenario depicting a type of elder abuse are clear	☐	☐	☐	☐	☐
4	In general, the key constructs (e.g. abuse, neglect) are used consistently throughout the training DVD	☐	☐	☐	☐	☐
5	The content of the training DVD is a suitable resource to support training for care givers in residential care	☐	☐	☐	☐	☐
6	The content of the training DVD is a suitable resource to support training for other health professionals (e.g. doctors)	☐	☐	☐	☐	☐
7	In general, the quality of production (e.g. visual and sound quality) of the training DVD is good	☐	☐	☐	☐	☐

In the space below, please provide additional comments on *any* aspect of the **residential care training DVD**

SECTION C: 'RECOGNISING AND RESPONDING TO ELDER ABUSE IN RESIDENTIAL CARE SETTINGS': TRAINING WORKBOOK

Below is a list of statements about the content of the **residential care** training workbook. Indicate the extent to which you *agree* or *disagree* with each statement on the list, using the scale:
1= Strongly disagree; 2=Disagree; 3=No opinion; 4=Agree; 5= Strongly agree

		tick [✓] ONE number only for each statement				
		1	**2**	**3**	**4**	**5**
1	Overall, the training workbook is presented in distinct, easy-to-follow sections	☐	☐	☐	☐	☐
2	The Trainer's Section provides clear guidance for the trainer on how to conduct a training session	☐	☐	☐	☐	☐
3	The Participant's Section addresses all the main types of elder abuse in residential care	☐	☐	☐	☐	☐
4	The 'aims of the training programme' are presented in clear language	☐	☐	☐	☐	☐
5	The 'learning outcomes of the training session' are presented in clear language	☐	☐	☐	☐	☐
6	In general, the learning activities (referred to as 'discussion point') in each module are related to the training DVD	☐	☐	☐	☐	☐
7	In general, the tasks set for the trainee in the discussion points within each module are presented in clear language	☐	☐	☐	☐	☐
8	The key constructs (e.g. financial abuse, discrimination) are used consistently between the workbook and the training DVD	☐	☐	☐	☐	☐
9	In general, the quality of production (e.g. paper quality, typesetting, use of colour and graphic) is good	☐	☐	☐	☐	☐

In the space below, please provide additional comments on *any* aspect of the **residential care training workbook**

INTERVIEW TOPIC GUIDE

INTERVIEW TOPIC GUIDE

What has been your involvement in training to date?

Specific areas:
- Providing training
- Providing training for trainers
- Organising training
- Strategic oversight of training

What are your views as to how training is structured?

The structure of the training sessions themselves
The structure of the training initiative overall

What are your views on the processes involved in the rollout of the training since it commenced?

Organisation of training sessions
Issues around accommodation/teaching resources
Issues around staff release to training sessions
Issues around staff participation in training sessions
Record keeping of training participants

How effective do you think the training is in meeting its stated aims on an individual level and on an organisational level?

Increase knowledge and understanding of what elder abuse is
Help staff/carers identify care practices that might lead to or contribute to elder abuse
Help staff/carers recognise elder abuse
Explain the actions that need to be taken if it is suspected that elder abuse is taking place

Have you noticed any discernible difference or changes the training has made in any particular areas?

What do you think are the main positives and advantages the training programme?
What do you think are the main negative and challenges of the training programme?
What recommendation or ideas would you have for future training in this area?

Close

Thank the interviewee for his/her contribution to the evaluation study

-oOo-

STUDENT INFORMATION LEAFLET

National Centre for the Protection of Older People

Evaluating training for the prevention of elder abuse

NCPOP
National Centre for the Protection of Older People

It is estimated that 2.7% of older people (circa 4 million individual older people) in Europe are subject to some form of elder abuse. In order to combat this, the HSE have put in place training and awareness programmes for health care professionals in Ireland. The National Centre for the Protection of Older people (NCPOP) is currently undertaking a project to evaluate the effectiveness of these training programmes.

We are inviting you to participate in this evaluation study. This will involve completing 2 questionnaires about elder abuse prior to and following undergoing a training session. This will take place within your normal class time and we will be serving refreshments and food during the training sessions. The sessions will be interactive and interesting and will be facilitated by experts in the field of elder abuse.

We are recruiting participants to take part in this study and would very much appreciate your help in evaluating this very important area of nursing and healthcare education. If you wish to learn more about this project please contact:

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The National Centre for the Protection of Older People (NCPOP) at University College Dublin was established in October 2008 and is funded by the Health Service Executive (HSE).

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CAREGIVER SCENARIO QUESTIONNAIRE (CSQ)

Brief description of CSQ instrument

The Caregiver Scenario Questionnaire (CSQ) is a vignette-based instrument originally developed by Selwood *et al*. (2007) to measure recognition of abusive caregiving strategies for managing challenging behaviour in a person with dementia. A vignette describing a challenging caregiving situation involving an older care recipient with dementia and their informal caregiver (son or wife) is presented to the study participants. The scenarios are followed by a list of 14 management responses or strategies and participants are asked to rate each strategy on a 6-point Likert scale. Possible responses are: 'good idea and helpful'; 'possibly useful'; 'not sure'; 'unlikely to help'; 'bad idea but not abusive' or 'abusive'. Four of the management strategies are abusive, as defined by the World Health Organisation Centre for Interdisciplinary Gerontology and judged by an expert panel (Selwood *et al*., 2007), five are judged to be possibly abusive and five were not abusive.

A parallel form version was adopted for this study. This parallel form was created with a similar structure and marking scheme as the original version (Cooper *et al*., 2012). Content validity for the items in the CSQ has been demonstrated through professional consensus and adequate parallel-form reliability was demonstrated by Cooper *et al*. (2012).

References

Cooper, C., Huzzey, L. and Livingston, G. (2012) 'The effect of an educational intervention on junior doctors' knowledge and practice in detecting and managing elder abuse'. *International Psychogeriatrics*, 24 (9): 1447–53.

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KNOWLEDGE AND MANAGEMENT OF ABUSE (KAMA)

Brief description of KAMA instrument

The Knowledge and Management of Abuse (KAMA) is a parallel form instrument, developed by Richardson *et al*. (2003) to measure staff-applied knowledge and practice regarding identification and management of potentially abusive situations in an institutional setting. Participants are asked to describe how they would manage each of seven scenarios involving potentially abusive situations and their responses are scored using a structured marking scheme. Higher scores indicate that respondents give more correct answers, demonstrating greater knowledge. The abusive scenarios in the KAMA were adapted from the clinical experience of a panel of researchers and experts and from a review of the literature (Richardson *et al*., 2003).

The KAMA instrument has been widely used in studies measuring knowledge and management of elder abuse since its development over a decade ago (Richardson *et al*., 2002, Richardson *et al*., 2004, Cooper *et al*., 2012). The original authors demonstrated good reliability assessments for the parallel version, as follows: internal consistency was Cronbach's Alpha >.0.79; split-half reliability was >0.61; parallel form reliability was >0.84; inter-rater reliability, Kappa correlation was >0.98 and test-retest reliability correlation coefficient was > 0.69 (Richardson *et al*., 2003). Concurrent validity was also demonstrated by comparing scores on each parallel version with years of experience, correlation was >0.44 with associated p-values greater than 0.01.

Minor adaptations to the wording for the scenarios and for the structured marking scheme were adopted by the research team in order to make the instrument more applicable to nurses working in an Irish context.

References

Cooper, C., Huzzey, L. and Livingston, G. (2012) 'The effect of an educational intervention on junior doctors' knowledge and practice in detecting and managing elder abuse'. *International Psychogeriatrics*, 24 (9): 1447–53.

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