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Sporting memories, dementia care & training staff in care homes

A paper for the Journal of Mental Health Training, Education and Practice

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Abstract

Purpose – This paper describes the findings from a pilot and a follow study in which care assistants in care homes were trained to use sporting memories work to better help and engage with residents with dementia and low mood. Care homes have to support increasingly more fragile people and often the range of activities in the homes do not offer the best engagement between residents and staff to benefit the residents. This is for reasons of time to run activities in a busy home, and because of the need to find financially viable means of running a range of activities. Care assistants in care homes are a group of non-professionally educated workers and are often overlooked for training beyond basic health and safety training to help them improve their work and the care they provide. This work sought to explore whether sporting memories work was viable as an activity to offer in care homes via the training of care assistants.

Design/methodology/approach – The article discusses the evidence from a pilot and then follow-on project in care homes in one city area. In the pilot observation was made of a training session and follow up interviews were undertaken with care home managers to see how the implementation of sporting memories was going. In the follow-on project the support to those undertaking the training was modified to include 3 learning network sessions. Data were collected on the experience of participants and their use of sporting memories work.

Findings – The findings were that care assistants could be trained in using sporting memories work and they often found it easy to use and fulfilling for them and people they cared for. This was despite the care assistants who participated often not having much interest in sports and little experience in this kind of work. However, practical barriers to maintaining the use of sporting memories work did remain.

Research limitations – The evidence to date is of case studies of training staff in care homes in the use of sporting memories work, which provides good grounding for proof of the concept and key issues, but further research is needed on the costs and impacts of sporting memories work in care homes. The lack of direct feedback about experiences

of care home residents of sporting memories work and its impact on them is a further limitation.

Practical implications – Sporting memories work is a flexible and readily adoptable intervention to engage older people in care homes and the evidence to date is that care assistants in care homes can be trained to use this approach to engaging older people. Practical challenges still remain to using sporting memories work in care homes, notably the issue of time for staff to do the work, but it is an approach for care homes to have available to them to match up to the interests of residents.

Social implications – Sporting memories work can be an important part of meeting some of the challenges society faces with an ageing population profile and to enhancing the care home environment, and care assistants can be trained to use the approach.

Originality/value – This is the first paper to discuss training care home staff in the use of sporting memories work.

Keywords - older people, dementia, reminiscence, sporting memories, care homes, care assistants

Paper type - project evaluation

Introduction

Globally, populations are ageing and there is increased concern about the incidence of dementia, how this will increase and what ought to be the responses of societies (World Health Organisation & Alzheimer's Disease International 2012). The global population of people living with dementia is thought to be over 46 million, and this is forecast to increase to 131.5 million people by 2050 (Prince et al. 2015). The estimate is that by 2025 there will be over 1 million people in the UK with dementia (Prince et al 2014).

Whilst there is debate about the prevalence rate of dementia and how this has and is changing (Brayne et al 2006; Wu et al. 2015; Xu et al. 2015), and there is growing understanding about what people can do to potentially prevent dementia (e.g. Xu et al. 2015; National Institute for Health and Care Excellence 2015), it is clear that dementia is likely to become an ever more significant challenge to societies and their systems of care. The financial impacts of dementia have been calculated globally (Prince et al. 2015) and for the UK (Prince et al. 2014), with the total costs in the UK being £26.3 billion, (an average cost of £32, 250 per person), with £4.3 billion being spent on healthcare and £10.3 billion on social care (publicly and privately funded). Clearly the role of social care and the associated costs are a major part of the challenge for UK society, and care homes are a significant component of this.

Policy makers have responded to these challenges with national strategies, such as those in England (Department of Health (DH) 2009; DH 2012). Yet on the ground there is still much to do to improve the care and support for people living with dementia and their families and carers (Alzheimer's Society 2015; Care Quality Commission 2014).

In this paper we discuss feasibility work exploring whether or not training and support for care assistants in care homes to deliver sporting memories (SM) reminiscence is a viable option to help improve care for people with dementia in this setting. We begin by exploring the significance of care homes in dementia care and some of the challenges to improving this care. We will then discuss SM work and the Sporting Memories Network (SMN) before progressing to discuss the two interlinked projects in using SM in care homes. We will discuss the viability of this approach and highlight lessons learnt to date about training care staff in care homes to undertake SM work.

Care Homes and dementia care

One particular area for attention for society is that of experiences of people with dementia in care homes, in which sector the culture has been characterised as one of low expectations (Alzheimer's Society 2007 & 2013). The majority of care home provision in England is through a mixed market of independent sector (private, for-profit providers and third sector, not-for-profit ones), with a little public sector provision, and with a total sector capacity in 2010 of 474,400 beds (Forder & Allan 2011). In comparison, the average daily number of available overnight beds in English NHS hospitals was around 137,000, a figure that has been steadily declining for many years (source: http://www.nuffieldtrust.org.uk/nhs-numbers-0 accessed 22 October 2015).

At the time of death, people with severe cognitive impairment are more likely to be in care homes than in the community (Perrels et al. 2013). The Alzheimer's Society (2013) estimated in England that around 80 per cent of residents in care homes are people living with dementia or significant memory problems. Loneliness amongst residents of care homes in general is a significant issue (Victor 2012), which may be exacerbated if people have dementia. In an assessment of a group of people across care homes in England, Hancock *et al.* (2006) found that although 73% of people's needs were being met, 94% of people had at least 1 unmet need, and 1 in 5 people had 7 or more unmet needs. Significantly, especially in the context of this paper, the most frequent unmet needs were for stimulating daytime activities (76%), psychological distress (48%) and the need for company to address feeling lonely (41%). The unmet need for stimulating daytime activities also included where people had been offered inappropriate activities for their interests or abilities and for which there was no alternative provision. Other's have also argued for more and better activities for people living with dementia in care homes as a basis for engagement and connection with others and a good quality of life (Alzheimer's Society 2007). Low mood has been found to be associated with poor ratings of quality of life for people living with dementia in institutions (Beerens et al 2013).

The number of people working in Care Quality Commission regulated care homes is of the order of 565,000 employees (Skills for Care 2013). Generally across social care the majority, about three quarters, of employees undertake direct care work, whilst managerial, supervisory and professional jobs account for about 13% of employees (Skills for Care 2013). This means that most of those working in care homes are involved in direct care but not in professionally trained and qualified roles. Yet, the work they do cannot be described as 'basic' care (Cavendish 2013). Caring for people living with dementia in care homes, for example, can be very challenging as they frequently have multimorbidity and complex needs. Many may have difficulty expressing their needs which in turn can lead to some needs being unmet, which in turn can lead to dissatisfaction with care and decreased quality of life (Hancock et al. 2006). Care staff, however, are often not well supported in terms of training, and those working with people with dementia have been seen to be often not adequately trained for this work (Talbot & Brewer 2015). It is no surprise, then, that we cannot rely on staff perceptions of residents' quality of life, with staff potentially viewing QoL in relation to dependence and disability rather than to mood and enjoyment (Hoe et al 2006). Resident's own perceptions of their quality of life was mostly linked to their mood, so interventions and activities to improve their mood would most likely have the most impact on improving their quality of life and addressing these points should be a priority for staff in care homes (Hoe et al 2006).

For care assistants in care homes there are problems of training and career development, with both being limited for them and challenges of engaging them in learning activities, yet they are crucial for so much of the delivery care and , hence, for safe and engaging environments for residents (Christie+Co 2015; Willis n.d.; Howat et al. 2015).

With such challenging work and variable, and often so little in the way of, training and development for care assistants, it is perhaps not so surprising that the turnover rate for them in care homes is a very worrying 19% (Cavendish 2013).

These changes in the population are likely to have significant implications for the future workforce in health and social care, with the demand for workers growing faster than the growth in the population, the workforce having to deal with more complex, long-term needs, and the possibility that the demand for non-professionally qualified workers will be great than that for qualified ones (Willis *et al.* 2015). It was estimated that there is a shortage of nursing in social care, with 9% of nursing posts in that sector remaining vacant, 4,000 full time equivalent posts (Christie+Co 2015). There would be a challenge, then, in seeking to place all out plans for more enhanced activities in care homes in the hands of hopes that nurses will take up all the work.

Care home provision is, then, a very significant part of care provision in England, dementia care in them could be improved and, as such, this whole area warrants priority attention to help ensure high quality care for people living with dementia. This, though, requires some level of proportionate investment in improving care.

One of the ways that the state in England has responded to austerity and cuts in public sector budgets has been Local Authorities reducing the amount they will pay in fees for

placements in care homes (National Audit Office 2014, Care Quality Commission (CQC) 2015). This has contributed to low pay and low skilled employment in the sector (CQC 2015). Recruitment, and staff vacancy and turnover rates are challenging for social care generally (CQC 2015), and high turnover has been argued to have a detrimental impact on dementia care (Manthorpe 2014). This all has implications for developing more activities in care homes and staff development and support to do them. Outstanding social care services are seen as having a culture of continuous staff development and good support for them (CQC 2015), but this becomes harder to maintain when facing the kind of financial and care pressures discussed. At the time of writing, there is growing concern about the financial viability of the care home sector in England. There have been numerous stories in the media, for example, concerning the financial problems facing the care home sector (e.g. http://www.theguardian.com/business/2015/oct/31/care-homes-crisis-dwarf-steel-industry-problems-four-seasons-terra-firma, http://www.theguardian.com/society/2015/oct/31/half-care-homes-could-close-cash-crisis, & http://www.theguardian.com/society/2015/nov/25/osborne-measures-care-homes-meltdown-industry-bosses all accessed 14th May 2016) . This raises, amongst other things, concerns about finances to support staff development (Alzheimer's Society 2013).

Happily, the evidence is that there are good motivations to work with amongst care home providers (Matosevic 2007) and we are learning more about the motivations of care workers in dementia care and what helps and undermines this (Manthorpe 2014; Talbot & Brewer 2015). Relational aspects of working with residents are seen to be particularly important to care staff, so working with them to help them to improve this aspect of care would seem to be a avenue to pursue (Cavendish 2013).

A challenge to the future of care homes has been seen as how to move from more rigid modes of providing activities to ones best matched to individual interests (Burstow 2014). The CQC (2013) has reaffirmed this by stating that a crucial characteristic of successful care homes is that they have a culture of care that puts residents first, ensuring that they are seen as individuals and that their preferences are acted upon to help them live as independently as possible. A flexible approach to programmes of activities would help to adapt to the shifting needs and interests of residents as the population of any one care home changes over time. Hancock et al. (2006:44) have argued:

> "to achieve individualised, good quality, and effective care to meet the needs of people with dementia living in residential care, a person-centred approach is required. This approach involves understanding the vulnerabilities and strengths of the resident, as well as issues relating to staff and the caring environment."

There is now a range of activities that can potentially fill this need, such as cognitive stimulation therapy (Spector et al. 2003; Knapp et al. 2006), a diversity of arts-based activities and reminiscence work (see Alzheimer's Society (2007) & Guss et al. (2014) for overviews and detailed references). Yet, given the diversity of people's lives, interests and needs, combined with the heterogeneity of care home settings, arguably

what we need are a set of relatively readily implementable approaches to organising activities that can be easily applied in individual care homes matched to the needs and interests of people living them at any one time.

Training staff in various health and social care settings in approaches to improve dementia care is in need of more robust research, but we do know that training can be helpful but its impact is also affected by such factors as wider organisational incentives and support and by approaches to sustain the learning and good practice (see Smythe et al (2015) for an overview).

<u>Sporting memories work</u>

Sporting memories work entails using our individual and collective sporting memories as a basis for reminiscence work to engage older people, especially those who are living with dementia. A definition of the wider field of reminiscence is:

> 'the deliberate use of prompts, for example photographs, smells, music and questioning, to promote the recall of pleasant memories. The focus of reminiscence work is to stimulate the person, provide enjoyment and foster a sense of achievement and self-worth. The anticipated outcomes of reminiscence work are enhancement of the person's quality of life, behaviour and mood.' (Dempsey et al 2014:187)

This highlights a number of features of reminiscence work, including its immersive character for all those involved, its multisensory nature, and a focus on enjoyment for participants to contribute to a range of good outcomes for them. The connection and sharing between those discussing reminiscences is likely to be a key factor in achieving these outcomes. It should be acknowledged, however, that negative memories and emotions can be evoked for some people from reminiscences and those working in this area should be prepared and supported to address these if they arise.

Reminiscence work is well established in dementia care, but developing the evidence base involves many challenges, including being clearer about the basis of the reminiscences and the target populations (Dempsey et al 2014: Woods et al., 2005).

The theoretical underpinning of SM work is one of a psychosocial model (e.g. Spector & Orrell 2010). Crucially, this considers the interactions between psychological and social aspects of a person's life.

Clark *et al.* (2015) have described the use of SM work and lessons drawn from work so far in community and institutional settings. It provides for a multisensory approach including discussions, the use of pictures, sounds and sports objects and memorabilia, and even sports related foods and drinks. It is a highly flexible approach to reminiscence and engaging with people living with dementia. It can be used one-to-one or in groups, and in different settings.

Whilst a key early premise of SM work was that it would be most applicable to men in care homes, it has been seen to be much more widely appealing. Whilst men may have traditionally formed longer-term interests and associations with sports and sports clubs, many women have also done so. Also, sport is such an integral part of our shared

cultural history that many people who have not had a life-long interest in particular sports and clubs can also join in discussions of great sporting icons and moments, such as 1966 and England winning the football world cup, or hosting the 2012 London Olympic Games. In addition, people may well have personal memories of people in their families who were keen on sports or of school sports events. Sports are a rich source of starting material for reminiscence of family and social history.

The Sporting Memories Network (SMN) was established to promote the wider use of SM work as a means to engaging with and providing better outcomes for many people living with dementia. The SMN provides a tailored approach to training and supporting staff to be able to do this in care institutions and in community settings. The resources, available form the network, include training packages, a comprehensive resource pack, packs of sporting reminiscence photographs, and a weekly *Sporting Pink* that includes a Spot the Ball competition. In addition, the network shares extensive experience of how to train and support staff and how to deliver sporting memories work, this built up from extensive work across the UK. In particular, two interlinked projects across Leeds in the north of England provided an opportunity to more systematically reflect on work to train and support staff in a group of care homes to be able to implement sporting memories work. It is these that provide the empirical basis of this paper, and to which we now turn.

The Sporting Memories in care homes projects

The SMN received grant funding from Skills for Care (a body with responsibility for skills development across the social care sector) to undertake a feasibility pilot of training care home staff in a group of care homes in Leeds. The project began in October 2012, and ran until the end of March 2013. With an initial target of 15 care homes to participate, 16 were offered the chance to participate in the half-day SM training and to receive the usual SMN support materials and support via SMN staff over telephone or email if people wanted to use it. 15 care homes took up the offer and attended the training.

Following successful completion of the pilot project the SMN secured further grant funding from Skills for Care's Workforce Development Innovation Fund to do an extension pilot across a wider network of care homes in Leeds. This follow-on project also occurred over a relatively short time, from the first training sessions in September 2013 to the final learning set meeting at the end of February 2014. This project widened out to include people from organisations working in community settings, such as dementia cafes. Ultimately 50 organisations from Leeds and Kirklees had joined the network by the project's end, often with 2 or 3 people from each organisation participating. In this paper, however, we will focus on the experiences of those who worked in care homes.

Lessons from the pilot were taken in to the follow-on project. The delivery and content of the training and SM materials were not changed, but the extension project gave an opportunity to develop more formalised and slightly longer-term implementation support in the form of a learning set for those who attended the training. In addition to the range of materials, training and support offered to members of staff participating in

the pilot project, the extension project included 3 learning set meetings and an online knowledge exchange forum to support people to implement and develop their sporting memories practice. The learning sets were developed directly from the experience of the pilot project. The idea for online support came from discussions at a learning set meeting.

Evaluation

Evaluation was included in the funding proposals to Skills for Care for both the pilot and the extension projects. In both cases, this meant that the evaluation was limited in terms of scale and time by the funding and the requirements from the funder for the date of the report (very soon after the projects completed). It was not possible to examine directly the impact of the sporting memories work on people living with dementia in the care homes. As the projects were proof of concept work to examine whether this type of approach was viable in care homes, and to examine the best means of delivering support to initiate SM work, the scale and scope of the evaluation was valid and illuminating.

The formative evaluation aimed to develop a better understanding of how to implement sporting reminiscences in residential care, particularly for people with dementia and those with depressed mood. This was in line with guidance for evaluating complex evaluations (e.g. MRC 2008; Evans et al. forthcoming). This approach suggests a gradual and iterative approach to researching complex interventions to develop a fuller theoretical model underpinning the intervention and how it is expected to work, a better understanding of practical issues of delivery and research, and, hence, working towards the most robust methodology for evaluating the intervention as possible. Developing this theoretical and methodological rigour is much needed in research in to psychosocial interventions in dementia care (Moniz-Cook et al. 2011).

Data for the pilot project were collected through:

- An interim survey was distributed to all homes shortly following the Sporting Memories Network training to gain feedback on initial reaction to the guide, the resources supplied, progress and plans.
- pen portraits of each home from their CQC profiles and inspection reports to understand the contexts of the homes in which the project was taking place.
- Interviews were offered to a lead person from each of the participating homes. These were planned to be telephone interviews at the convenience of the person. Not everyone felt they could do a telephone interview and so were offered the chance to reply via email to the interview schedule.

Data for the evaluation of the extension project were collected through:

- Participant observation by the evaluator in training events and the three learning set meetings, and, at specific slots in the first and final learning set meetings, to facilitate reflection on and discussion about the whole project and their experiences of it.

- A postal survey of participants in the project after the final learning set meeting.

The data were then thematically analysed by the evaluator to identify themes to assess implementation of the SM approach in the participating care homes. These are discussed next.

Findings

In this section we will discuss the main findings from the pilot project, and then the extension project, including how the lessons from the first undertaking informed the approach to the second.

THE PILOT PROJECT

The pen portraits showed that in the main these were judged to be good care homes, having generally good CQC inspection reports. Nine of the homes had been assessed as meeting all 5 of the CQC headline standards that care homes ought to be meeting. Although other homes needed action to improve on some standards, none were deemed to be requiring enforcement action by CQC. They ranged in size from providing accommodation to around 30 people, to one that could accommodate 184 people. They were a mixture of care homes in terms of services provided. In some respects, then, the care homes were diverse, but it is difficult to claim they were representative of the sector as a whole, particularly as they all had good CQC reports at the time of the project.

The interim survey following the training only produced three replies, but there were encouraging signs from these for the use of SM work. Respondents reported being enthusiastic about its use, being able to start doing SM work quickly, and seeing benefits for residents. In one home, for example, staff had run 4 SM sessions, with 2-5 people attending each. They reported finding SM a meaningful activity helpful in bringing 'the chaps' together for discussions. Another home reported that the work had already produced residents' memories of things that staff in the home were unaware of and had 'generated lots of laughter'. The third respondent reported how they soon noticed the overlap between sports memories and other things (such as foods, prices and other historical events) and how this potentially brought people in to the discussions who were not primarily interested in sports.

Key themes emerging from the interviews following the pilot project were:

i) *enthusiasm* – those interviewed were very enthusiastic about the SM work in their care homes. They signed up to participate in the training because the idea appealed to them as an additional activity to run in their homes. As one person said, many of the current activities in her home were mainly likely to appeal to ladies, so finding something that could appeal to men was very exciting. Their enthusiasm had been supported by the training and the materials from the SMN and was further fuelled by seeing the early beneficial results of using the SM approach. People reported that they intended to continue to use the work in their homes.

ii) *readily implementable and integrated in to the life of the care home* – the respondents had found no real problems in implementing the work following the training. Time was said by someone to be a problem, but she

also noted that it always is no matter what you are talking about in relation to running the home, and added that it was not an insurmountable one. Where people had tried to do so they had been able to speedily pass on the training to others in their homes. Learning could be adapted to local needs, with flexible approaches to, for example, the size of discussion groups. Flexibility was also evident in how some used SM work in one-to-one sessions rather than groups, or left the SMN materials around the home so that they could be used in spontaneous, natural conversations when the time suited individuals. Having the SM materials was reported to give staff with no interest in sports the confidence and a starting point to begin SM work. One home reported that after discovering through the work that one gentleman had enjoyed playing bowls, they now had someone come in to the home with a carpet bowls kit and several residents now enjoyed this activity. Another example was how watching sporting events on the television was now written in to the weekly activity diary for the home.

iii) *inclusive* – people reported that the Sporting Memories work was helping to include people in socialising and in the life of the care home who were previously not inclined to participate in activities. The work had generally been thought to be most of interest to men, but also proved to be of interest to some female residents. The work was adaptable to include people of various ages (ages of participants was reported to be usually in the range from 80 to over 100); and people with different needs/diagnoses, including dementia, stroke and frailty. In the early stages there was little experience of trying to include people from different ethnic minority groups, but this reflected the populations of the participating homes, rather than anything about the staff and the use of SM.

iv) *personal* – interviewees felt that the work fitted with and helped enable a person-centred approach to care. Some reported how the work opened up aspects of people's lives that staff and other residents had not known about, and which had not been uncovered through other avenues, such as life book work. An interviewee said that people might come to you after a reminiscence session to share another sports memory – increasing the interaction and enhancing social life of the home. It was also seen as a beneficial approach to helping some new residents to settle in to the home. Some people reported that relatives of residents had begun to bring in sports related certificates and trophies, building the connections between residents, care home staff and relatives. Sharing sporting memories was thought to help some residents to build connections and trust, important aspects to feeling safe and a sense of belonging in a new environment. Interviewees had not been able to quantify improvements in people's wellbeing nor identify changes in their care arrangements, but there was a feeling that being able to run things of interest to people and engage with them would be beneficial to their wellbeing. Care assistants may think that care quality for people living with dementia is valued in terms of tasks performed, processes and legislative requirements, rather than the

interpersonal and relational aspects of care, but relational aspects are important to residents and family carers and are likely to be significant for the motivations and job satisfaction of care assistants (Talbot & Brewer 2015; Manthorpe 2014).

v) *sparking creativity amongst staff* – although the SM work was still novel to the homes, signs were reported of people using it as a starting point for thinking more creatively about how to stimulate and engage with residents. Carpet bowls is one example. People were also thinking about what other sporting related materials and artefacts they could begin to collect for future use. Building sporting related connections to the world outside the home, such as links to other organisations, and bringing in volunteers, was something that people were thinking about.

This formative evaluation identified that the SM work was a promising, practical tool to train staff in care home. These encouraging signs were taken in to the extension project. As this project was beginning to be developed it became clearer that interviewees in the evaluation of the pilot phase had perhaps underestimated some of the challenges with initiating and sustaining SM work, no matter how much the enthusiasm. Consequently, more support for participants was built in to extension project to help address this, namely the learning set meetings.

THE EXTENSION PROJECT

The themes and lessons from the pilot project were replicated in the extension project. People reported enthusiasm for wanting to learn a new approach to use as initial motivation for doing the training, and that the training had encouraged this enthusiasm. There was a range of experiences amongst participants with regard to SM work. Some had facilitated group work with their clients before. Some were keen sports fans, whilst others felt they knew very little about sport. This meant that some reported feeling more confident than others about doing their first SM work, but, amongst those who stayed engaged in the learning set, they had all begun to run sessions soon after their initial training session. Given the different starting points of the participants in the training sessions, it is encouraging to know that people with quite different extents of relevant experience and interests can fairly quickly be prepared and supported to begin doing SM work.

At the first learning set meeting it was striking how much and how vividly people could recall things from the training sessions. They remembered specific information about reminiscence work and facilitating SM sessions. They also recalled the kinds of memories and powerful emotions they had shared with each other at the training sessions, and how much energy and enthusiasm there had been during the training sessions. This demonstrates *the power of the experiential learning approach underpinning the SM training*. It seems to i) bring the whole SM work to life for participants and immediately demonstrates to them its potential for engaging others, ii) is then likely to help motivate them to start SM work, and iii) helps them to remember skills and information to help them effectively run SM work in their organisations.

The *biggest challenge some had found to starting SM work was finding the time in their organisations*. This seemed to be more of an issue than was reported in the pilot project. There was an example of someone who was going back to the care home on days off to run the SM sessions, which, though not necessarily to be encouraged as the primary model of implementation, demonstrated the commitment of the person and the motivating potential of SM work.

People found the *learning set meetings were helpful, being* a good place to hear and learn from others about how they were doing SM work and addressing some issues. The number of meetings (3) and the format (half a day) were seen as about right.

Participants at the first learning set requested use of an on-line forum to share practise and ideas, however this was not accessed or used by most of the participants in the network. This may have been because of time and, as one person noted, it couldn't be accessed from their workplace.

The aspect of the work that seemed to be most daunting to some participants was wondering how they were going to lead a discussion about sport when they had little knowledge of or interest in it – but they felt comforted and prepared by the training sessions, the experience of these broader discussions about families and social life, and by the SM resources, and reported that they found it easy to engage people. Experiencing how quickly SM discussions can be started, how enjoyable they can be, and how they can encompass a wide range of social history and experience probably helped people to feel more confident about capitalising on the training and resource pack and begin doing SM work. Some found that it was only men who were interested in SM work, though this was not always the experience. Some reported that they could not engage residents in SM work for long, and that 15 minutes was the maximum for some, but it is worth noting that even these shorter times of engagement may be enjoyable and beneficial for people.

A lesson from the feedback from staff using SM work was the importance of always considering the context and clients for any SM work and to adapt accordingly, and to not presume that one specific format for SM work always works, nor that individuals will/not want to engage. The flexibility of SM work and the ability to gently explore a person's interest and engagement should be used to the maximum to allow for this kind of reflective approach to using it.

Lessons were learnt about including carers/family members in the SM work. Three of the respondents to the survey had done this. One had lent material to a carer to use in their own interactions with their loved one. The other two respondents had mixed experiences of involving carers, sometimes finding that it worked well and sometimes that the carer was too preoccupied with other things to engage. Occasionally the carer was felt to be limiting the involvement of the resident, such as being over-protective. Again, the need for experience and careful reflective practice in using SM work with carers is needed for each occasion, and perhaps the Sporting Memories Network (SMN) would be able to develop more instructions to help people do this most effectively.

People found many ways to adapt the SM work and resources provided, often employing a mixture of means in their homes., similar to experiences reported in the pilot work.

This adaptation shows the development of a more reflective means of using SM work developing in the care home staff. The learning set meetings seemed to encourage and facilitate this experimentation, reflection and sharing of experiences. As people reported positive experiences and demonstrated enthusiasm from doing so, others were also encouraged to try new things.

Reminiscence work can be very powerfully evocative of emotions. At the beginning of a reminiscence session it is not clear where the discussion will go and what kind of emotions will be stirred. These issues were all discussed at the training sessions and people were helped to be prepared for them as best as one can in training. On these occasions, and when people are wary of whether or not to join in a SM discussion, the SM work allows for a gentle exploration of the degree to which a person may become engaged in discussion. Sometimes this may stay at a low level of engagement, or perhaps not lead to any further engagement, but the SM work can allow for gentle exploration of this and other sensitivities, rather than assuming a specific course of conversation or level of engagement as a minimum.

Some participants said that doing the SM work, especially when carers and family members came in, was *a way of showing the good care work they did*. It was something very visible to visitors to a care home to see people engaged in discussion about their sporting memories. In addition, it was something that some participants in the network said *helped them to feel good about the work they did*. This may have been amplified by attending the learning set meetings and reflecting on the work they had done.

<u>Conclusion</u>

Care for people living with dementia in care homes can often be very good and much appreciated by residents and their families (Alzheimer's Society 2007 &2013), as is much social care in general (CQC 2015). Yet there is a clear case for improvement, especially with regard to enjoyable activities for people and opportunities for engaging with other people.

Reminiscence is an established, powerful means of engaging some people and helping to improve the quality of life of some older people. Sporting memories provide a means of tapping in to reminiscences and engaging with a range of people about specific sports memories, but also about a wider spectrum of family and social history. Often this can engage people who might not otherwise take part in activities in care settings, and may be helpful in developing a more diverse discussion group than initially thought, particularly through the wider social history memories.

The approach to rolling out the SM work in these projects seems to have been a very effective one. The training sessions are very evocative and effective experiential learning events. The support materials (sporting pink and resource pack) were seen as very helpful. Together with the training they seemed to equip people to begin SM work immediately.

The learning set meetings also seem to have been helpful to those who attended. It helped them reflect on their individual experiences, realise success they might otherwise not have been so aware of, and to air challenges and learn from the

experiences of each other. It seems likely that these meetings helped to reinforce motivation and ability to undertake SM work, thereby ensuring a more effective impact from the training and resources.

Ideas were gleaned from the experience of the project and the responses of participants that can help to further evolve a model for implementation.

In short, SM work offers an approach that is fairly inexpensive and quick to begin and seems to offer benefits for members of staff doing it (enjoyment, motivation and validation and positive feeling good about their work) as well as the reported benefits to older people in community and care settings.

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