

SPECIAL PAPER

A Proposed Care Training System: Quality of Interaction Training with Staff and Carers

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Abstract

Background: Quality of interaction has been applied as a key indicator of quality of care in both institutional and community based settings. Quality of interaction is conceptualized as existing on a continuum between Positive Social to Negative Restrictive, the most to least desirable.

Objective: Quality of Interactions Training as proposed here is applicable and transferable to a range of service user populations and a range of staff as well as, potentially family carers.

Methodology: Theoretically and practically speaking this work sets out the conditions, using systematic role play as the means of delivering and designing a proposed Quality of Interactions Training program.

Results and Conclusions: The Quality of Interactions Training program is also proposed to be cost effective, measurable and flexible enough to mature with the feedback of those taking part.

Key Words: Staff Training, Quality of Interaction Training, Systematic Role Play.

Background and Rationale for Quality of Interactions Training

Previous work has shown that Quality of Interaction between care staff and service users can be reliably and consistently observed and that recorded transcript data can discriminate Quality of Interaction as a phenomenon both between individuals and across differing settings. Specific settings have included Psycho-Geriatric community based and traditional institutional settings (Dean, Proudfoot and Lindsay 1993; Dean, Briggs & Lindsay 1993, Skea & Lindsay 1996, Lindsay and Skea 1997) and community based day centres for adults with Learning Disabilities (Skea, 2007).

Quality of Interaction is given an important role in terms of the observable behaviours shown towards service users and is argued to be a further indicator of quality of life/care for service users. Since the observed service users often have severe communication problems, 'observing' how service users are

treated forms a further indicator of the quality and type of care provided.

The authors Symbolic Interactionist stance (Hewitt 1994), moves away from the behaviourist perspective taken in this type of research where staff are observed as supporting task specific behaviours and engagement in meaningful activities for service users (Collins and Toft 1987, Brooker 1995)), that is behaviour is often reduced to constituent and component parts with little reflection on the internal experiences, meanings and affective consequences for those doing the caring and those being cared for. Concepts such as reflective appraisal are brought into play here (Denzin 1995) where quality of interaction is seen as important in quality of life, since how we are treated effects how we appraise ourselves. The authors previous involvement in evaluation research (Skea & Lindsay 1996, Lindsay and Skea 1997) also included measuring staffs occupational satisfaction as it is proposed that poor quality interaction is

not only inappropriate for those being cared for but also unsatisfying for the carers/staff. Poor quality of interaction may also be a factor in the burden that many carers experience (Cook et al 2001). The author does not seek to criticise the behaviourist perspective (as it has produced a wealth of valuable data) but to acknowledge a complementary and further role for this current perspective.

It is interesting that due to the transcript nature of QUIS data that the material may be useful in Discourse Analytic frameworks (Skea 2014, in preparation)

Quality of interaction is seen as lying on a qualitative continuum from most desirable *Positive Social*, to *Positive Care*, *Neutral*, *Negative Protective* and the least desirable *Negative Restrictive* (Dean, Proudfoot & Lindesay 1993, Skea 2007) types of observed interactions using the Quality of Interactions Schedule (QUIS).

The method for the QUIS is that of pre-prepared pen and paper transcript sheets, giving the categories of interaction listed in the section below. A typical day is made up of discrete 20 minute periods of observation, usually randomly scheduled so that staff do not literally expect the observer at certain times of the day, it is thus important to obtain open access to the observable areas. Only public areas in the care home/hospital/day care centre are observed to retain the privacy of clients. Time, location, the interaction, usually the interactions category and whom the interaction was between are recorded as near as possible to real time on the transcript sheets. Range, Means and chi-square analysis are worked out between units over time and within units over time.

Examples of QUIS Interactions as observed in Day-centres for Adults with Learning Disabilities are listed below (Skea 2007).

Positive Social (PS) (highest scoring)

'Are you going to the cinema tonight then X, the one on y street, down town?'

Positive Care (PC)

'Shall we put that back in your Lunch-box, there you are some cream and jam, here can I

help you with that, you seem to be struggling a bit'

Neutral (Ne)

'You alright' Neutral interactions are usually short, cursory and not very involved with the service user

Negative Protective (NP)

'X don't do that please' rather typical, involves concern/worry over the service user's safety or that of the staff or another service user, though does not explain that concern fully.

Negative Restrictive (NR) (lowest scoring)

'X come and sit down' always said in a negative way, control based interactions where the service user/respondent is given no explanation.

Quality of care is seen as involving physical needs but over and above this, as the development and maintenance of social interaction and this social interaction can be observed as falling into the categories highlighted above. Ideally this quality of interaction takes place within a sustained relationship between the carer and the cared for, a relationship that is consistent over time; and that is with a specific member of staff (given the high turnover seen in many care sectors this is recognised presently as somewhat an ideal scenario).

It has long been recognised in medicine (Hargie et al 1997) that effective interpersonal communication is essential to a good quality of health care delivery. Hill & Lent (2006) point out that in psychotherapy and counselling training, modelling/role play techniques outperform instruction and feedback. More generally Lane & Rollnick's (2007) review points out interactive methods such as role play and use of simulated patients to develop communication skills are more efficacious than purely didactic methods & that the use of 'simulated' patients is now gaining popularity in nursing. This technique allows for increased experimentation, adjustment and replaying the required skills, the obvious further dimension is that those in the role of 'cared for' can feedback their experiences to the

carer; this is intrinsic to the proposed Quality of Interactions Training Schedule.

Training & awareness raising of issues of quality of interaction need not be the exclusive territory of health care professionals and front line care staff. The method could be used in support groups for those who care for their relatives suffering from Dementia for instance. Cooke et al's (2001) review mentions that caregiver burden in this population is getting increased recognition and the method may allow for support per se for relatives and increased information and help with dealing with relatives. The method is also adaptable for dealing with problem behaviours specific to the target populations.

It needs to be made clear that the method is adaptable to a range of differing target populations, though so far quality of interactions observational data is available for Learning Disabilities populations (Skea 2007) and Psycho-geriatric care environments (Dean, Proudfoot and Lindsay 1993; Dean, Briggs & Lindsay 1993), it could be applied to adult and child mental health environments and as highlighted above applied as an additional resource for direct family carers.

Role play fits particularly well with accepted knowledge in learning theory (Kolb 1984, in Currie 1995) mainly & fundamentally that new skills (and in this case particular interpersonal skills) are very difficult to learn in a rote manner. In Kolb's (1984) learning cycle the stages are delineated by the provision of new experience, followed by analysing key experiences/learning points then planning and trying out new or changed behaviours. This process of checking and modifying what has been learned and people's reflections is embedded in the program (see below) and is an inherent part of role play methodology (Ments 1999).

The present work seeks to set out a case for applying the Quality of Interactions Schedule (QUIS) as the material for training, in the shape of two inter-related processes below.

- Raising the awareness of staff regarding the role quality of interaction has in quality of care/life for service users

- A Quality of Interactions Training Programme applying systematic role play, linked to the above (Ments, 1989, 1999).

The case is for both to be applied & combined in this proposed Quality of Interactions Training Schedule.

Raising Staffs Awareness of Quality of Interaction. (Pre Role Play Session)

Practically speaking the raising of staff's awareness would be in the form of a simple 15 – 20 minute session in which the findings of previous research using the Quality of Interactions Schedule would be simply presented using actual observation transcript examples. Staff will become acquainted with the idea of quality of interaction and how it can be viewed as types of interaction namely positive social, positive care, neutral, negative protective and negative restrictive types, as observed in various settings, emphasised by what was said and done by staff within these settings. Within this brief talk the context will be set in which current and past knowledge consistently points to a paucity of interaction between staff and clients in a number of sectors of care.

The aim here is to draw attention to the above factors in the minds of staff rather than cast any judgement on this consistent finding. Indeed it would be posited that results like these are likely without the adequate provision of staff training; the awareness raising session and accompanying role play being the purpose of the sessions/programme.

Method

The Quality of Interactions Training System

Figure 1 below leads the reader through the varying and necessary and sufficient stages involved in systematic role play training, the blue print for this is the work of Ments (1989, 1999) using the systematic method.

Firstly one of the Quality of Interactions Training Schedule objectives is to follow on from the awareness raising talk, participants should be 'primed' and receptive to the fundamental issues in quality of interaction and have had the chance to meet one another, feel at ease and ask questions.

Though strictly a pragmatic issue the use of a suitable 'space' for the role plays to occur is very important and is an important feature to ensure that enough space is allowed and noise pollution does not give issues (see below and fig.1 overleaf on types and structure of role play/s).

Thirdly, listing critical factors (see fig. 1) basically entails noting, confirming and elaborating (since this will have been initially discussed in the pre role-play session) the roles of the key players and the types of interaction found with examples taken from 'real world' research of each of the types of interaction. This stage naturally leads up to and includes a demonstration by the trainer of each of the types of interaction, with verbal and non-verbal components typically seen in Positive Social, Positive care, Neutral, Negative Protective & Negative Restrictive interaction types. The reflection will include seeking further empathic understanding for how it may/can feel to be treated in the above ways. The brief (see fig 1) is inherent in the pre role play session and by this time though participants will not yet have attempted role play they should be reasonably familiar with the materials in the form of types of interactions, their structure, verbal and non-verbal components, length, between who and typically where they are likely to be enacted.

The sine qua non of this work is the running of the session, making sure this works out is absolutely crucial to the efficacy of the program.

Though not without potential problems the author believes having the session in multiple groups of three where one person is always observing one always playing carer and one always playing cared for and where all 3 participants rotate roles so everyone in the triadic arrangement gets an opportunity to experience all roles. The author has some experience of applying this with undergraduate psychology students regarding learning semi-structured interviewing techniques (see below). In this manner a number of identical role plays take place simultaneously.

One advantage of this is to minimise audience size (1 or 2 observers) and thus

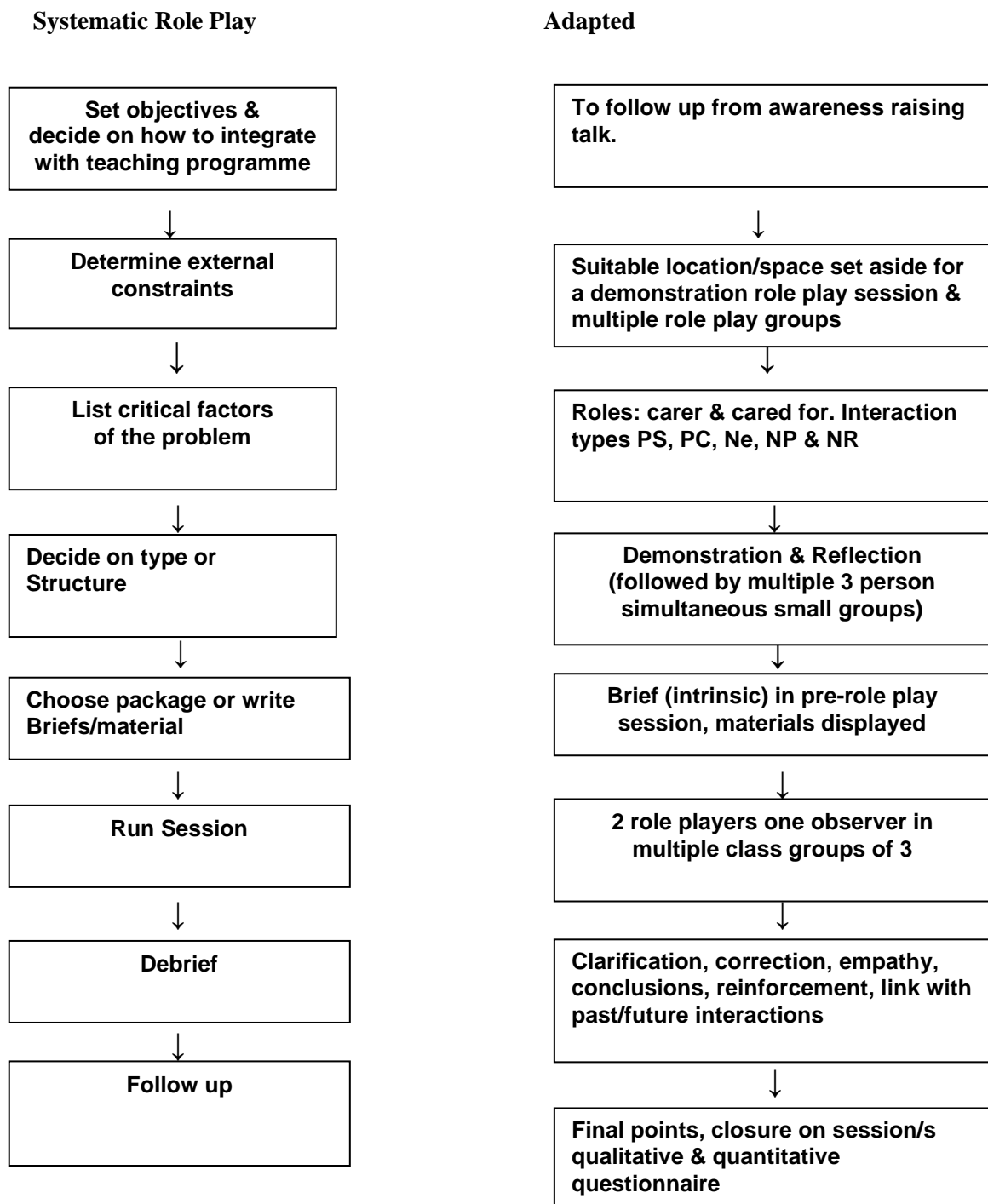
reduce feelings of exposure or embarrassment. It would be expected that the observer (which everyone in the triad gets a chance to be) will make brief notes on the types of interactions observed. Though very cost effective (only one trainer, but ideally two, see later) one disadvantage acknowledged here is the trainer/s cannot observe all role plays simultaneously & one of the points of this is to get people to reflect, change and try out new behaviours. The systematic approach outlined above (see fig 1) and the pre-role play awareness raising session as vital to help counteract this criticism since the emphasis on reflection and observation should help to prime players & observers to get a good deal more out of the multiple role play session. Another way is to include another trainer observer in the multiple role play session & use well trained observers (Ments 1999).

The materials that fit into each type of interaction as typically observed using the Quality of Interactions Schedule would be provided to each group with the explicit instructions that they are a guide (see appendix 1, for examples reproduced from Skea 2007). This allows people to try out further variations and derivations of the types of interactions, since, for instance, there are many situations where Positive Care interactions can be observed, that is social interaction which is considered positive in nature but the main point of it is to support an explicit care behaviour, feeding, dressing, protecting from harm, dependent on the client group. The same applies to Positive Social interactions, the main feature of these being explicit socialising with the person, reminiscing, talking of their family, an outing and many others. Neutral interactions as stated elsewhere (Skea 2007) are short cursory interactions with no apparent motive that could be considered as caring or socialising, though they are not negative either. Negative protective interactions are often seen when the carer wants to protect from harm, they are negative though due to a lack of explanation given and generally how they are delivered eg. and sometimes seen 'don't do that' 'come back here, where are you going?' and such like, note the most likely motive is to protect from harm, some

would say perhaps cynically to contain, the receiver is left in the dark though as to why they are being interacted in this manner. The least desirable on this continuum of types of interactions is that described as Negative Restrictive these function without

explanation to restrict and give no explanation, they are rarely seen in observational studies across various settings (Dean, Proudfoot & Lindsay 1993, Lindsay and Skea 1997, Skea 2007).

Fig. 1 Training in Quality of Interaction



Adapted from Ment's (1989, 1999)

Debriefing (fig. 1) serves an important function and it is noted by Ments (1999) that many tutors relax at this point and have a fairly loosely structured discussion. Debriefing should include a clarification of what has happened a correction of misunderstandings and mistakes a dissipation of anxiety/tension, a bringing out of assumptions, feelings and changes which have occurred, an opportunity for self observation, a drawing of conclusions about behaviour a link with previous and the providing of a plan for future learning, players need importantly to be able to get a sense of closure with the role/s performed (adapted from Ments 1999). Further factors important to debriefing are not containable within the size of this paper.

Further importance should be given at this debriefing stage regarding allowing people to express any increases in empathic understanding of what it must feel like to be looked after and how it feels to be treated in varying ways enacted in the role play session/s. This is one of the fundamental aims of the session and one which it is hoped would lead to long term changes in behaviour and increased quality of interaction for those and with those looked after.

Finally for the continued development of the method and to improve what is known generally a questionnaire would be given to participants. One result of this could be suggestions from participants themselves as to how the program/schedule could be a better experience for them. Part of this would include a statement of what they think they have learned and what they may take away with them from the experience.

The author believes the program is cost efficient since other than basic materials, a room and an instructor, nothing else is required.

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Appendix 1.

Examples of QUIS Interactions as observed in Day-centres for Adults with Learning Disabilities (Skea 2007).

Positive Social (PS) (highest scoring)

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