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Co-Development of a Mealtime Care Training Programme to Support People Living with Dementia in Care Homes

RESEARCH

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ABSTRACT

Context: People living with dementia are at risk of mealtime difficulties which may impact health and quality of life. In care homes, interaction between carer and resident is key to mealtime care. However, training on mealtime care is variable.

Objective: The aim of this study was to co-develop with stakeholders an evidence-based training intervention for care home staff and to support delivery of mealtime care.

Methods: Three online workshops informed the development of a prototype training intervention. Across the workshops, 17 people participated including a dietitian, speech and language therapists, community nurses, an educationalist, care home staff, and family carers.

Findings: The content of the intervention was distilled into five modules: empowerment and respect; facilitating independence; social interaction; being safe; and careful encouragement, with two cross-cutting themes: tailored care and working as a team. The agreed principles for intervention mode of delivery included ensuring a collaborative two-way experience for trainees and making training applicable to everyday practice. Training outcomes identified as important were staff knowledge, skill and confidence, improved mealtime care, and improved quality of life for residents.

Limitations: Although family carers of people with dementia participated in the workshops, people with dementia did not. However, this population did contribute to the evidence base for the study in different ways. In addition, constraints of time and resources had a bearing on some decisions made in the workshops.

Implications: Future research will test the implementation and impact of the training intervention on care home staff involved in mealtime care.

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INTRODUCTION

Food and nutrition are key determinants of well-being in later life (Leslie and Hankey, 2015), and difficulties with eating faced by people living with dementia can have a profound effect on quality of life, morbidity, and mortality (Abbott *et al.*, 2013). Eating difficulties faced by people living with dementia include difficulty recognising food and drink (Amella, 2002); problems using cutlery (Social Care Institute for Excellence, 2015) and changes in flavour perception and somatosensory perception of foods (Ikeda *et al.*, 2002), in addition to dysphagia. Interaction between the carer and the resident is key to optimal mealtime care, so that the person living with dementia experiences mealtimes that are safe, nutritionally adequate, and enjoyable (Health Education England, 2015).

However, training around this aspect of mealtime care is variable (Aselage, Amella and Watson, 2011; Fetherstonhaugh, Haesler and Bauer, 2019). A study reviewing interventions to indirectly support food and drink intake in people living with dementia found no effective training interventions (Bunn *et al.*, 2016). A recent research priority-setting exercise questioned the effectiveness of current carer/staff training programmes in eating, drinking and dysphagia in dementia (Pagnamenta *et al.*, 2022). The need for better training in broader dementia care was highlighted by the National Institute for Health and Care Excellence (NICE) guidelines on dementia care (NICE, 2018).

A recent systematic review posing the question 'How do we provide good mealtime care for people with dementia living in care homes?' identified evidence supporting social connection, tailored care, empowering the resident, and responding to food refusal as key elements to consider in optimal mealtime care (Faraday *et al.*, 2021). In addition, a recent ethnographic study (Faraday *et al.*, 2024) found that a person-centred approach and good teamwork are essential if carers are to successfully navigate the challenges and ambiguities inherent in mealtime care.

These evidence-based principles have provided insights into what optimum mealtime care should look like for those living with dementia in care homes. However, they must be properly integrated to facilitate real-world implementation of optimal mealtime care. One way to achieve this is through co-development with experts by experience.

Co-development is used in intervention development to describe working with stakeholders to develop the content and mode of delivery of an intervention (Avery *et al.*, 2016). Sometimes the term may be used interchangeably with similar terms like co-production and co-design (Grindell *et al.*, 2022). Some authors, however, differentiate these terms – for example, seeing co-development and co-design as distinct stages in an over-arching co-production process (Fleming *et al.*, 2023). A tangible output is created during this process (White *et al.*, 2022). Working with stakeholders is an important element of healthcare research in general, and intervention development in particular (Craig *et al.*, 2008). It provides valuable insights which help with real-world implementation (Buckley *et al.*, 2018). Thus, researchers or policymakers can develop a more holistic understanding of a context, a problem or a solution (Oliver, Kothari and Mays, 2019). Moreover, it has been argued there is a moral imperative for frontline health and care staff to contribute to research decision-making, because in most cases delivery of interventions involves them (Locock and Boaz, 2019). Having identified from the literature and through ethnography core principles in optimal mealtime care for people living with dementia in care homes, the purpose of this study was to apply this evidence to the co-development of a training intervention to support real-world implementation of best practices.

This paper reports the process and outcomes of the study. The objectives were: (1) to define in an accessible way the evidence base underpinning the intervention, with reference to the literature (Faraday *et al.*, 2021) and qualitative data (Faraday *et al.*, 2024); and (2) to hold a series of three workshops with stakeholders to (a) define the content of the mealtime training intervention including core topic and key messages for each topic (Workshop 1), (b) verify the content and consider the mode of delivery for the training intervention, and to apply this to the content (Workshop 2), (c) develop a prototype of the intervention, and (d) obtain user feedback to inform any necessary refinements and consider issues of implementation (Workshop 3).

METHODS

A favourable ethical opinion was obtained from the Social Care Research Ethics Committee (reference 19/IEC08/0020) in June 2019. Due to restrictions in place because of the COVID-19 pandemic, workshops took place online using the Zoom videoconferencing platform.

STUDY PARTICIPANTS FOR WORKSHOPS

The study sought to include representation from stakeholders in mealtime care including: family carers of people with dementia; care home assistants (who directly provided mealtime care); care home managers (who made decisions which inform mealtime care); and health and social care professionals involved in mealtime issues for residents with dementia, including, for example, speech and language therapists, dietitians, and community nurses. In addition, a participant with expertise in the field of vocational education and training (an educationalist) was included (DC).

RECRUITMENT OF WORKSHOP PARTICIPANTS

Bespoke channels were used to circulate a publicity flyer providing brief details of the study and the researcher's contact details. In the case of family carers, these channels were the North East Dementia Alliance (NEDA: a partnership of health, social care, voluntary and private sector organisations (https://www.dementiaaction.org.uk/north_east)), and VOICE [a community of members of the public, patients, and carers (https://www.voice-global.org/)]. For care home staff, a regional care homes interest group was targeted. To reach healthcare professionals, various professional mailing lists were used including the North East Dysphagia Discussion Group, the British Dietetic Association Older People Specialist Group, and the regional Clinical Research Network (https://local.nihr.ac.uk/lcrn/north-east-and-north-cumbria/). An experienced educationalist was recruited through the local NIHR Clinical Research Network. This person had significant (more than 15 years) experience as a learning and organisational development facilitator. This experience included designing and delivering a range of training interventions in health and social care settings. Potential participants who responded were sent a Participant Information Sheet and consent form. Due to COVID-19 restrictions, the consent process was conducted remotely, using email, electronic documentation, and telephone calls where necessary.

STAKEHOLDER WORKSHOPS

The educationalist worked with the research team to design the online workshops. A series of three workshops were held that operated in a sequential way, such that Workshop 2 built on the results of Workshop 1 and Workshop 3 built on the results of Workshop 2. Each workshop also had a discrete theme and objectives (Workshop 1: content; Workshop 2: mode of delivery; and Workshop 3: implementation). Figure 1 sets out the sequence of workshops and accompanying work. Participants could attend one, two, or all three workshops as the aim was to seek a broad diversity of experiences and perspectives and to bring fresh voices and challenges in each workshop, whilst also generating a sense of continuity and teamwork among participants (Madden *et al.*, 2020). Theoretical sampling (Butler, Copnell and Hall, 2018) was used to identify participants for successive workshops, considering who had already participated, what results had so far been obtained, and whether there were any gaps to be addressed in representation or knowledge. Each workshop aimed to have approximately seven participants, allowing for slightly more than this if it enabled better representation. Without specific guidelines on group size in work of this kind (Slattery, Saeri and Bragge, 2020), small group sizes were chosen based on related research contexts (Cortini, Galanti and Fantinelli, 2019; Leung and Savithiri, 2009).

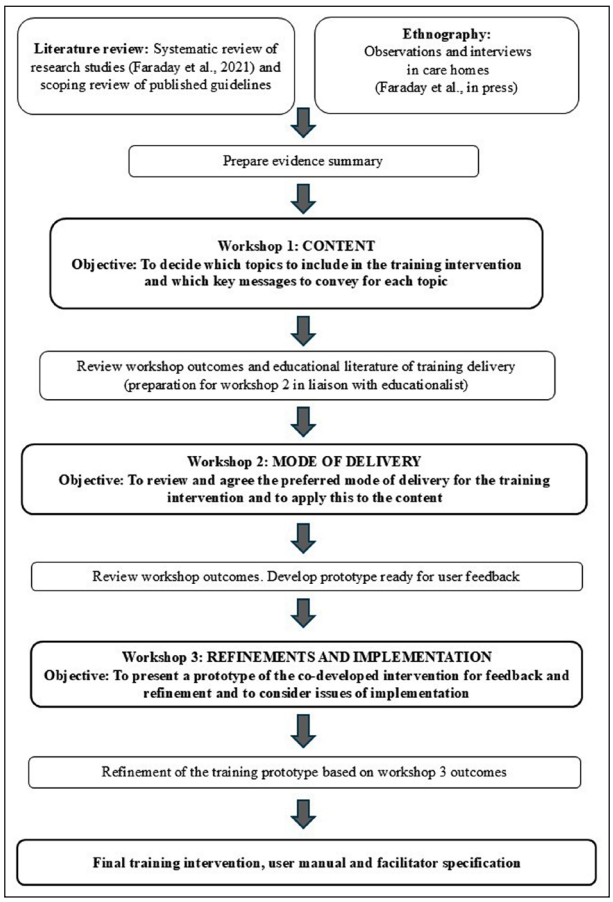

Figure 1 Overview of the systematic, sequential approach to training intervention co-development.

With a view to helping participants feel comfortable taking part and able to contribute their thoughts and ideas, the researcher made individual contact with each participant by email or phone prior to the workshops to build rapport. Participants were offered a practice-run Zoom session before their first workshop in case they were unfamiliar with the technology. A pre-meeting briefing note was sent out in the days leading up to a workshop to enable participants to prepare. Workshops were planned to last 2 h 15 min (allowing for a short halfway comfort break) and were held approximately 3 to 4 weeks apart.

Each workshop had the same overall structure. The running-order document for Workshop 1 is shown in Figure 2 as an example. Following the co-development model described by Moynihan and colleagues (2018), after introductions and a warm-up activity, the relevant evidence was presented and then participants worked together to discuss key issues and make decisions about the training intervention. This approach enables concepts emerging from the evidence base to be developed with the assistance of stakeholders' experience and insights. The output from the workshops was an agreed set of principles for intervention content and mode of delivery.

The workshops were facilitated by a researcher (JF), with assistance from the educationalist who managed any technical difficulties and summarised some of the discussions. All workshops were audio recorded and transcribed automatically using Zoom functionality, and transcripts were subsequently checked, corrected, and anonymised.

QUALITY CONTROL

In lieu of any guidance specific to co-development work, established principles on how to conduct rigorous qualitative research were followed. After each workshop, the researcher reviewed the transcripts and reflected on the discussions and decisions and made reflexive notes (McGrath, 2021). Next, the researcher and educationalist met for a debriefing session, in which consistency in the understanding of decisions and agreed actions were checked. Moreover, at the subsequent workshop, summary decisions and actions from the previous workshop were presented, to give participants the opportunity to challenge or refine these – a process akin to member-checking (Johnson, Adkins and Chauvin, 2020). This was made possible due to continuity in workshop participants.

WORKSHOP 1: CO-DEVELOPING THE INTERVENTION CONTENT

The objective of Workshop 1 was to define intervention content (i.e., the topics to include in the training intervention), and which key messages to convey for each topic.

In line with work by O'Brien and colleagues (2016), participants were presented with a summary of good practice based on the evidence derived from previous evidence synthesis (Faraday *et al.*, 2021) and ethnography (Faraday *et al.*, 2024), summarised in Table 1. This was achieved using words and visual representation, to facilitate a variety of learning styles. Participants were asked to consider which topics to include and to suggest other topics. Next, participants were asked to consider the chosen topics in detail and identify for each one the key messages to be conveyed in the training intervention. The discussion was guided by the following prompt questions: (1) what new knowledge and skills would help staff here? (2) what lessons can we learn from good practice? (3) why does not good practice always happen? and (4) what are the key messages we want to communicate?

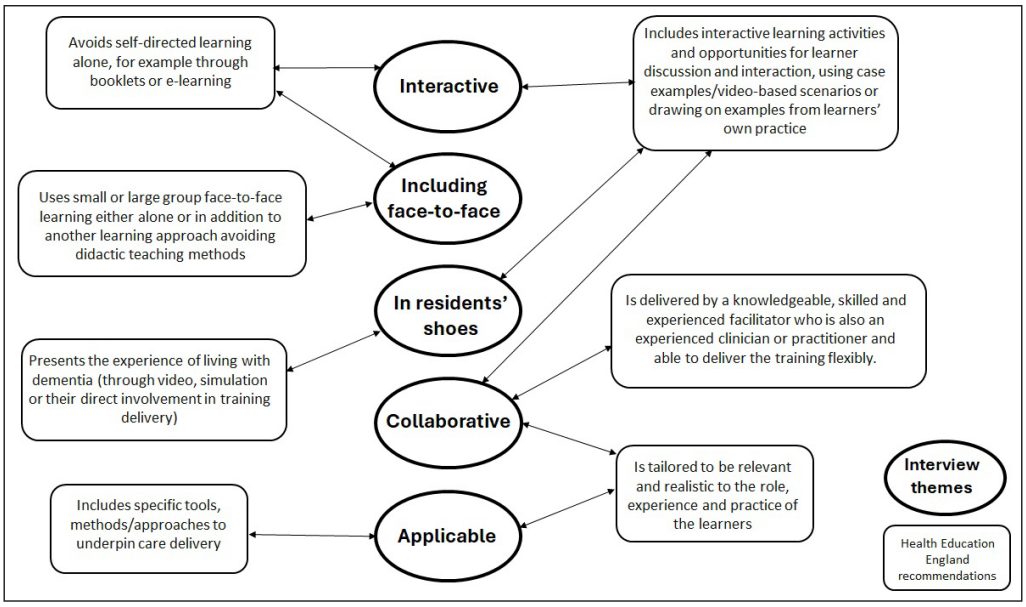

Figure 2 Interview themes mapped to Health Education England recommendations.

TERM	DESCRIPTION
Empowerment and respect	Residents make their own decisions, where possible. Understand residents' preferences and respect their choices.
Facilitating independence	Vary the amount and the type of assistance at mealtimes, depending on individual need. Setting up the mealtime in the right way also promotes independence. The best kind of assistance helps residents to be as independent as possible.
Social interaction	Build relationship with residents through social interactions with them. Interactions are tailored to the person or the situation. Understand the social dynamics between different residents and encourage positive interactions between them. Join in with residents, sometimes eating with them, which helps to model eating and drinking.
Being safe	Keep residents safe at mealtimes. Check they are alert enough and in a good position to eat and drink. Make sure food and drink is in suitable temperature and consistency. Help residents eat at the right pace, with the right size of mouthfuls.
Careful encouragement	Use skill and judgement to respond to food refusal and poor oral intake. Try various techniques and consider underlying causes. Get the balance right, carefully encouraging the resident but not forcing them.
Tailored care	Focus on the person and provide care that is tailored to the resident's needs, skills, and preferences.
Working as a team	When carers work together, mealtimes work better. Share information about residents' preferences and needs. Work together to run mealtimes smoothly. Have fun and enjoy each other's company, in a way that is inclusive of the residents and creates a positive atmosphere.

Table 1 Terms and descriptions for evidence summary in Workshop 1.
Based on evidence synthesis (Faraday *et al.*, 2021) and ethnography (Faraday *et al.*, 2024).

WORKSHOP 2: CO-DEVELOPING THE INTERVENTION MODE OF DELIVERY

Workshop 2 was concerned with the mode of delivery of the intervention. Participants were asked to review the evidence and agree on the preferred mode of delivery for the training intervention, and to apply this to the content that was defined in the first workshop.

A summary of relevant underpinning evidence was prepared by mapping evidence principles from the Health Education England study 'What works in dementia education and training' (Surr and Gates, 2017; Surr *et al.*, 2017; Surr *et al.*, 2020) onto the previously derived qualitative data (Faraday *et al.*, 2024) (Figure 2). This was used as the basis of discussion in Workshop 2. Participants for the second workshop were selected following principles of theoretical sampling, in particular aiming to recruit care home managers and community nurses – roles which had not been represented at Workshop 1. Participants were asked how closely the evidence statements aligned to their own experience, and whether there were any aspects they disagreed with, would modify, or add. Workshop 2 also included a recap of the decisions made in the previous workshop, to verify with participants the intervention content. Participants worked together to think in detail about how to apply the agreed delivery methods to the agreed content. Each content topic was considered in turn, using PowerPoint slides to prompt discussion.

DEVELOPMENT OF A PROTOTYPE FOR TRAINING AROUND MEALTIME CARE

A prototype of the training intervention was developed by the authors, based on the set of principles for intervention content and mode of delivery from Workshop 2, and guided by the literature on collaborative learning (see Table 2). This approach aimed to encompass collaborative learning while applying evidence-based best practices; sharing experiences and solving problems rooted in the participant's own context.

In regards to format, the first section of the prototype was a 'warm-up' section, to provide an opportunity for the facilitator to build rapport and credibility with the learners, and to encourage a sense of team. This comprised introductions, ground rules and housekeeping, and ice-breaker activities.

Next, to allow for possible tension between evidence-based practice and approaches such as emancipatory practice development (Ball and Regan, 2019; Fairbrother *et al.*, 2015) and the variation in the level of experience, knowledge and self-direction of learners, a section was included which communicated theoretical content. Care was taken to ensure that the content would be conveyed in an interactive way by inviting contributions from learners. This section was informed by the principles for intervention content agreed upon in previous workshops.

The theory section was presented prior to a subsequent section on problem-based scenarios, to enable learners to apply this while discussing care scenarios, and to enable facilitators to refer learners back to relevant theoretical principles during discussions.

The final section of the prototype was a summary section, to enable the facilitator to reiterate learners' key learning points from both the theory and the scenarios sections. Learners would be given handouts covering all material from the session, which included links to relevant online resources. Thus, the structure of the prototype intervention comprised the following sections: (1) warm-up, (2) theory, (3) scenarios, and (4) summary.

The content for the prototype intervention was organised into five discrete modules based on the topics identified in previous workshops (see Figure 3). Each module followed the four-stage structure described above. Each module was planned to last 2 h, guided by evidence on optimal duration times for dementia care training sessions (Surr *et al.*, 2017; Surr *et al.* 2018). To build flexibility into the delivery, modules could be delivered together in a block (e.g., spread over 2 days), or separately in a series (e.g., one session per week for 5 weeks).

In Workshop 3, one of the five topics was presented as an example of a module, to illustrate the proposed structure and key aspects of the training intervention. A facilitator manual was drafted.

WORKSHOP 3: PRESENTING A PROTOTYPE AND CONSIDERING IMPLEMENTATION

The purpose of the third workshop was to obtain feedback on the training prototype, the person specification for a training facilitator, and the expected outcomes of the training package.

To increase the chance of a broad representation of participant categories, 16 people were invited to Workshop 3. In the workshop, a recap of previous decisions made about intervention content and mode of delivery was delivered. Next, the prototype intervention, comprising the facilitator's manual and accompanying PowerPoint slides, was presented and verbal feedback was invited. The facilitator role was also discussed using prompts such as who could be a facilitator, what would be the criteria for a facilitator, and how much direction would a facilitator need. Feedback on the perceived acceptability of the intervention and its amiability to embed in practice were explored using prompts informed by normalization process theory (NPT) constructs (May and Finch, 2009) including: (1) what is more likely to make this training happen? (relevant NPT constructs: *coherence*, *cognitive participation*, and *collective action*); (2) what would make

THEORY	LEARNING PRINCIPLE	REFERENCES
Emancipatory practice	Supports open, safe communication, and critical enquiry to empower rather than direct practice change	Peet *et al.* (2019)
	Expert facilitation is an important component	Shaw (2013)
Action leaning	Involves collaborative problem-solving and leaning	Lamont *et al.* (2010)
	Critical thinking and reflection are essential to learning	Lamont *et al.* (2010)
	Leaning happens when working in a group (group support) on real problems	Dewar and Sharp (2006)
Andragogy	Adults approach learning as problem-solving	Knowles (1977)
	An expanding pool of experience can be used as a resource for learning around problem solving	Cox (2015)
	Instructors adopt role of facilitator through group work and use of scenarios	McGrath (2009)
	Learning takes place in an environment which is respectful, trusting, supportive, and collaborative	Henschke (2011)

Table 2 Principles of collaborative learning identified from the literature.

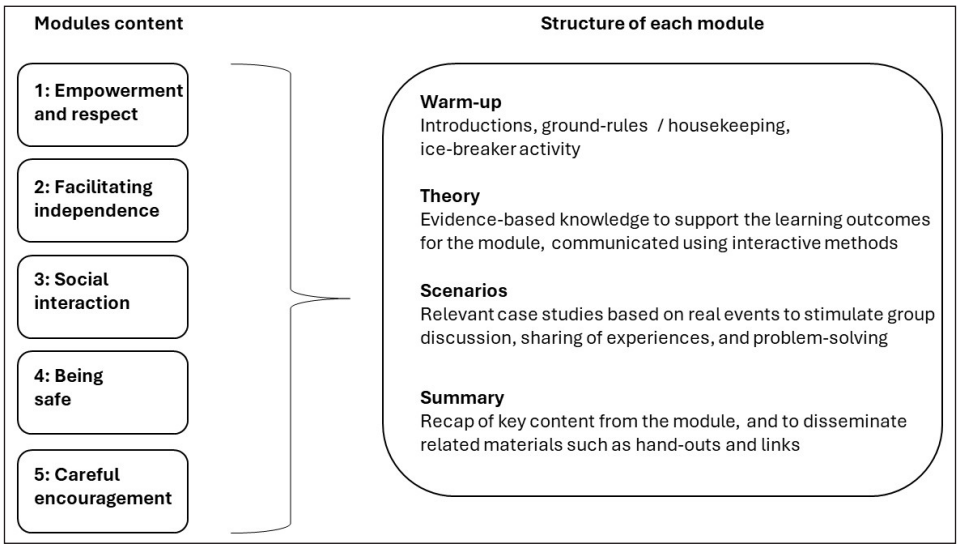

Figure 3 Content and structure of the prototype intervention.

it easier to run the training? (relevant NPT constructs: *cognitive participation* and *collective action*); (3) what do you think about the duration of the training? (relevant NPT constructs: *collective action*); (4) what would make the intervention more likely to change practice? (relevant NPT constructs: *coherence* and *reflexive monitoring*); (5) how would we know it had changed practice? (relevant NPT constructs: *reflexive monitoring*); (6) what kind of organisational support would be needed? (relevant NPT constructs: *cognitive participation* and *collective action*).

REFINING THE PROTOTYPE

A full prototype was developed encompassing five modules based on the feedback from Workshop 3, and further feedback on this was obtained from the educationalist and the wider research team. Aspects of the prototype intervention not resolved during the workshops and those remaining ambiguous and requiring further decision-making were considered with reference to the literature.

RESULTS

RESULTS FROM WORKSHOP 1

Seven of 11 invited participants attended the workshop including: a dietician, a speech and language therapist, an educationalist, two care home assistants (from the same care home), and two family carers with experience of caring for a person with dementia.

All proposed topics (summarised in Table 1) were accepted as relevant and important for the intervention. A number of additions were made to the topic content, these were: in *empowerment and respect*, an understanding of mental capacity and the best-interests process; in *facilitating independence*, the use of adaptive and appropriate equipment, and accessible foods such as finger foods; in *social interaction*, involving family, and capitalising on special occasions and festivals; in *being safe*, monitoring for difficulties and changes, including kitchen staff, and clear communication with healthcare professionals; in *careful encouragement*, referring to personalised care plans, liaising with family, and knowing when and how to engage external support. The output of the workshop was a set of principles for intervention content based on the verified evidence statements and ideas generated in the workshop (Table 3).

RESULTS FROM WORKSHOP 2

Seven of 13 invited participants attended Workshop 2 including: a dietician, a speech and language therapist, an educationalist, two care home assistants, and two family carers with experience of caring for a person with dementia (both also had relevant professional experience). Three participants also attended Workshop 1.

Empowerment and respect • Know residents' preferences • Provide and respect choice • Enable decision-making • Understand mental capacity and best-interests process
Facilitating independence • Varied assistance • Set up for success • Adaptive equipment, for example, plate-guards • Appropriate crockery/cutlery, (e.g., colour, pattern, and ease of use) • Tailored food, for example, finger foods
Social interaction • Build relationship • Tailor to the person • Understand the social dynamics • Facilitate resident–resident interaction • Involve family • Capitalise on special occasions
Being safe • Monitor for difficulties/changes • Consider alertness and positioning • Check pacing and bolus-size • Correct consistency and temperature • Involve kitchen staff • Clear communication with GP and speech and language therapist (e.g., regarding thickener)
Careful encouragement • Skill and judgement • Encourage, do not force • Consider underlying factors, for example, oral health • Personalised care plan • Liaise with family • Know when and how to engage other professionals

Table 3 Co-developed principles for intervention content from Workshop 1.

The ideas relating to *tailored care* and *working as a team* are threaded through each of the other topics. In the case of *tailored care*, examples are knowing residents' preferences in *empowerment and respect* and providing varied assistance in *facilitating independence*; in the case of *working as a team*, examples are involving family in *social interaction* and engaging other professionals in *careful encouragement*. Teamwork should encompass the working relationships of all involved in residents' care, including management staff, kitchen staff, family carers, and healthcare professionals.

Four care home managers, a community nurse and a family carer did not respond or were unable to attend.

Through discussion in the workshop, a set of principles for intervention mode of delivery were agreed. These largely reflected the presented evidence (Figure 2), except it was decided that *include face-to-face* could usefully be subsumed under *interactive.* The resulting principles for the intervention mode of delivery are summarised in Table 4.

In considering how to apply these principles to the intervention content, participants refined them further and articulated how they might be enacted. For example, to portray residents' experience as authentically as possible, it was agreed that vignettes or case studies should be based on real-life (but anonymised), with

PRINCIPLES FOR INTERVENTION MODE OF DELIVERY
Interactive • Not just didactic teaching • Group discussion • Exercises and activities • Include face-to-face (online or in person)
In residents' shoes • Present the residents' experience • Videos, vignettes, simulation, and in person
Collaborative • Two-way approach • Incorporating trainees' experience • Tailored to the situation • Involving staff in delivery of training
Applicable • Applying classroom theory in practice • Real-world tools and methods • Learning from colleagues

Table 4 Principles for intervention mode of delivery derived from Workshop 2.

potential input from residents and family. To ensure the training was directly applicable to the local context, it was decided there should be an opportunity for staff to discuss relevant situations from their own practice – and to address pragmatically any barriers to good mealtime care. To help learners engage positively with intervention content, there was consensus they should be encouraged to interact with and learn from one another – and should feel comfortable in doing so (e.g., role-play activities were discounted).

Participants seemed to focus on the principle *collaborative* more than others. For example, there was agreement that many aspects of the training intervention content were not straightforward, but nuanced and multifaceted and as such did not lend to didactic teaching. It was acknowledged that the training intervention should provide participants time and 'a safe space' to engage with this complexity together – and that a skilled facilitator was key to this. It was suggested that 'training' may not necessarily be the most appropriate term for this kind of intervention, and that 'learning' or 'education' may describe it more accurately. Participants also raised issues of evaluation, implementation, and organisational support for training and these data were captured and considered in Workshop 3.

RESULTS FROM WORKSHOP 3

Fourteen participants attended including: a dietician, two speech and language therapists, an educationalist, a care home manager, a care home regional manager, a care home senior carer, two care home deputy managers, two community nurses, and three family carers with experience of caring for a person with dementia (in the previous workshops, potential participants had sometimes dropped out at short notice, due to busy and unpredictable schedules. For this reason, relatively large numbers were invited to attend Workshop 3–16 people in total – in the expectation that some, but not all, would have to drop out.). Some of the participants were new, bringing challenges and new ideas to the process (specifically, the care home staff and the community nurses); the other seven participants had attended previously. Results are reported below in relation to the prompt questions used in the workshop.

What is more likely to make the training happen? Regarding the acceptability of the training intervention to care home staff and managers, flexibility in approach and training venue was suggested; for example, a mix of e-learning and in-person content; hosting the intervention either in care homes, or other venues.

What do you think about the duration of the training? The predominant view from care home staff was that the proposed duration (10 h in total) was ambitious because managers may find it difficult to release staff for this length of time. However, others argued that shortening the duration risked diluting the intervention's effectiveness.

What would make it easier to run the training? With regard to scalability, transferability, and sustainability of the training intervention, a train-the-trainer model was advocated, with appropriate ownership, accreditation, and recruitment. It was also suggested the training intervention could be connected to existing competency frameworks, such as the Care Certificate (Skills for Care, 2015), or other competency frameworks developed for use specifically in dementia care (Tsaroucha *et al*., 2013) and in care homes (Thompson *et al*., 2018).

What would make the intervention more likely to change practice? Feedback confirmed that the prototype intervention had an appropriate balance between delivery theory and space for creativity. Participants recommended that materials remain succinct to avoid 'information overload'. Supplementary materials were recommended, including example posters and prompt sheets for use in dining rooms, as well as signposting to relevant external resources.

Participants advised an emphasis on mealtime relevance in the theory section (to differentiate it from more generic training), and that the section be sufficiently interactive to keep learners engaged. Participants agreed that the case scenarios presented were relevant and thought-provoking, and would likely capitalise on learners' previous experiences – which they considered an important aspect of the mode of delivery, deserving of its prominence in the prototype intervention. They recommended that the scenarios should include cases of advanced-stage dementia and end-of-life care.

Discussion around the characteristics and criteria for the intervention facilitator resulted in a person specification being sketched out. It was agreed the facilitator would not need to be a healthcare professional

but would need: (a) adequate knowledge and experience of the subject matter, (b) interpersonal skills to build rapport, (c) a high level of facilitation skills, and (d) to be able to maximise contributions from learners whilst keeping on track and covering core content.

How would we know the training had changed practice? Participants agreed that important immediate outcomes were increased staff knowledge, skill and confidence, improved mealtime care and improved quality of life of residents as a significant yet longer-term outcome. There was less certainty about the relevance, in this context, of outcomes such as resident weight and nutritional intake, or their connection to quality of life.

What kind of organisational support would be needed? Endorsement from senior care home management was agreed as critical to the chances of implementation.

REFINING THE PROTOTYPE

Following the third workshop, refinement of the prototype included adjustment of the duration of the training intervention. Published evidence about training and education in dementia for the health and social care workforce proposes an optimum duration of at least 8 h (Surr *et al.* 2017; Surr *et al.* 2018). Equally, NPT promotes that interventions should be easily integrated into existing work (May and Finch, 2009). Some participants felt the proposed training duration (10 h) could be too long to be easily integrated. Following discussion, the duration was modified to 8 h in total, by reducing each module to 75 min (except for the first module, which was extended to 90 min to allow more time for the introduction). The modules are conducive to delivery altogether in 1 day, or in two half-day sessions.

There were also different opinions expressed in the third workshop about whether training sessions should be attended by staff all from the same care home, or staff from more than one care home. However, on considering the advantages and disadvantages of both approaches, and in the absence of definitive evidence to direct a decision, it was decided to provide flexibility, allowing for either approach to be adopted.

The outcome of this co-development process was the blueprint for the training intervention, ready for evaluation. The key features of the final training intervention are:

- The content comprises five modules: *Empowerment and respect; Facilitating independence*; *Social interaction*; *Being safe*; *Careful encouragement*. Two concepts with general relevance to mealtime care – *Tailored care* and *Working as a team* – are integrated into each of these modules.
- Each module is delivered in four sections. W*arm-up* is a time for the facilitator to make introductions, agree on ground-rules, explain housekeeping, and set the tone for collaborative learning. *Theory* provides evidence-based knowledge to support the learning outcomes for the module, communicated using interactive methods. *Scenarios* use relevant case studies based on real events to stimulate group discussion, sharing of experiences, and problem-solving. *Summary* gives opportunity for the facilitator to recap the key content from the module, and to disseminate related materials such as hand-outs and links.
- The facilitator is recommended to be someone with adequate knowledge and experience of the topics addressed by the intervention (e.g., a speech and language therapist, a dietician, a care home manager, or a senior carer). The facilitator should have strong interpersonal skills so that they can build rapport with learners, to elicit rich contributions and discussions. They also need good chairing skills, to ensure all core content is covered.
- The recipients are any staff member in a care home setting involved in mealtime care. This may include (but not be limited to) care assistants, senior carers, management staff, nurses, kitchen staff, and domestic staff. Recipients may be all from the same care home, or from several different care homes.
- Each module lasts for 75 min (except for the first module, which is 90 min). The modules can be delivered altogether in one day. In this configuration, it is suggested that three modules are delivered in the morning, and two are delivered in the afternoon. If 10-min breaks are taken between each module – and an hour for lunch – the total duration of the training day is 8 h. Alternatively, the modules can be delivered in two half-day sessions spread across different days – with three modules delivered on one half-day, and two modules delivered on another.
- The venue may be a room within a care home, or it may also be at a different location, such as a community centre, or health care setting.

DISCUSSION

This study describes the co-development of an evidence-based training intervention on the topic of mealtime care for people living with dementia. Workshops were initially planned to take place in person, therefore recruitment from the outset focussed on regional channels and networks. However, workshops were subsequently moved to be online, due to COVID-19 lockdown restrictions. This shift was advantageous in some ways, for example, making it easier for people from different geographical locations to participate. However, the online format may have been less conducive to team building, lacking the natural spaces for informal conversation afforded by in-person meetings. Careful facilitation was important to enable all participants to contribute, sometimes using strategies specific to the online context (Allam *et al.*, 2021).

In recruiting to the workshops, the objective was to bring together people with complementary experience and knowledge of the topic. Initial planning for the workshops began prior to the COVID-19 pandemic, therefore recruitment from the outset focussed on regional channels and networks, with a view to arranging in-person meetings. Following lockdown restrictions, meetings instead took place online, on Zoom. Whilst this did facilitate participation from further afield, most (though not all) participants were from within one geographical area, due to the nature of the recruitment strategy. Nevertheless, a variety of relevant perspectives was obtained, through the inclusion of different types of care home staff and healthcare professionals, from multiple different organisations, and family carers with a range of different experiences.

The approach taken maps to training intervention components (TIC) taxonomy (Perryman, 2014), which divides training into three phases: pre-training, training delivery, and post-training. Perryman's terminology considers content and training methods (or mode of delivery) and the characteristics of the training provider/facilitator, characteristics of the recipients, length/duration, and characteristics of the setting (or venue). All three phases of this taxonomy were relevant to the current co-development process, and clearly of interest to workshop participants. For example, the first phase in the taxonomy – pre-training – includes consideration of barriers to implementation, and tailoring content to be relevant to practice. The third phase – post-training – includes evaluation, managerial support, and helping learners transfer skills into practice (Illing *et al.*, 2018; Surr *et al.*, 2020). These elements have informed the development of the prototype intervention and can inform a future feasibility study. However, this study pertains most closely to the third phase: training delivery.

The training intervention can also be assessed in relation to recommended features of effective training, as summarised by Surr and colleagues (Surr and Gates, 2017; Surr *et al.*, 2017; Surr *et al.*, 2020); see https://www.leedsbeckett.ac.uk/research/centre-for-dementia-research/what-works/. These recommended features encompass content, duration, delivery, and context. The training intervention is consistent with all features of content, duration, and delivery (although written vignettes were used rather than videos; see section Limitations). Some features of context (such as culture and leadership) are outside the scope of the training, but others (such as dedicated training space) are referenced in the facilitator manual. In addition, the training intervention is auditable against the Dementia Training Design and Delivery Audit Tool (DeTDAT) (Surr *et al.*, 2018), and it is recommended by the DeTDAT authors that this includes observation of delivery.

In the prototype, the theory section was presented first, to enable learners to apply this while discussing subsequent care scenarios, and to enable facilitators to refer learners back to relevant theoretical principles during discussions. Thus, the intervention was different in some ways to problem-based learning, but there were similarities – in accordance with Wood (2003), who contends that 'a small number of lectures may be desirable to introduce topics or provide an overview of difficult subject material in conjunction with the PBL scenarios' (Wood, 2003, p. 329). In considering the communication of the theoretical content, care was taken to ensure that the content would be conveyed in an interactive way by inviting contributions from learners. This complies with guidance that dementia care education and training should provide knowledge-based/theoretical content alongside other learning methods (Surr *et al.*, 2017).

The skills and attributes of the facilitator identified in Workshop 3 align with those identified in the literature (Hmelo-Silver and Barrows, 2006; Salinitri, Wilhelm and Crabtree, 2015; Tsimane and Downing, 2020), supporting the idea that facilitators do not need to be a healthcare professional but must have adequate knowledge and experience of the subject matter, as well as good interpersonal and facilitation skills.

The outcomes of the training that participants noted as important can be mapped to Kirkpatrick's levels of evaluation (Kirkpatrick, 1998). For example, immediate outcomes such as increased staff knowledge, skill and confidence pertain to Level 2 (Learning), improved mealtime care maps to Level 3 (Behaviour), and improved quality of life of residents relates to Level 4 (Results). However, the lower level of certainty about the relevance of Level 4 outcomes such as resident weight and nutritional intake is of note, since achieving adequate nutritional intake is considered a core element of mealtime care (Health Education England, 2015).

The train-the-trainer model, suggested in the workshops for enabling sustainability, has been successfully trialled for other training interventions in care homes. Lee and Scott (2009) reported the effective use of a train-the-trainer package to cascade teaching on the Malnutrition Universal Screening Tool across care homes in a UK region, while Mayrhofer *et al.* (2016) found that a train-the-trainer programme of education on end-of-life care had good outcomes – particularly in care homes with organisational stability. Testing this model with the current intervention should form part of future research.

LIMITATIONS OF THE STUDY

The participants comprised a broad range of care home staff and others involved in mealtime care. However, although people with dementia participated in the ethnographic study which informed the co-development

workshops, they did not participate in the workshops. Instead, the decision was taken to recruit family carers of people with dementia. Family carers provided relevant insight into the experience of caring for a person with dementia at mealtimes and were able to represent and advocate for their loved ones to an extent. On reflection, it could have been preferable to also hear directly the voices of people with dementia in the workshops. Moreover, some eligible participant types proved difficult to recruit. Community nurses and care home managers were in this category, and intentionally over-booking these participants was a useful strategy to ensure adequate representation.

Some decisions about the intervention were made outside the workshops. The intervention type (a training programme) was decided at the inception of the project, based on available evidence and nationally identified research priorities [see, e.g., Bunn and colleagues (2016) and Pagnamenta and colleagues (2022)]. Evidence summaries, collated prior to the workshops, were used to inform workshop discussions and decision-making. Whilst this is in line with common approaches to co-production and co-development (O'Brien *et al.*, 2016), it is important to consider whether more could be done in this process to ensure 'different knowledge bases, experiences and perspectives … are afforded equal respect and value' (National Institute of Health and Care Research, 2024).

Some decisions about the intervention were made on practical grounds. For instance, due to time and resource constraints, written vignettes were used, as opposed to the suggestion (from Workshop 2) to use video vignettes to illustrate the resident experience. Similar constraints also dictated that in Workshop 3 only one module (*Empowerment and respect)* was presented as an example, to illustrate the proposed structure and delivery of the training intervention. However, this approach was likely helpful in facilitating honest and constructive feedback; if participants had reviewed all five modules they may have been more reluctant to suggest significant changes to a larger body of work.

In general, there was broad consensus in the workshops on many aspects of the intervention. This may be because there were genuinely few divergent viewpoints, or it may be that a more formal structure, such as Nominal Group Technique (Harvey and Holmes, 2012), would have elicited more differences in opinion, and a clear process to resolve these.

FUTURE RESEARCH

Future research will test the feasibility and acceptability in the real-world setting including evaluation of the intervention, for example, by measuring recipients' knowledge, skill and confidence, and by collecting qualitative data on recipients' experience of the intervention and their perception of its impact on their practice. This will provide data on the amenability of the intervention to embed in everyday practices, and enable evaluation of the components of a future trial, including measures relating to recruitment, attendance and retention. This work will prioritise the involvement and consultation of residents, including in the research design.

CONCLUSION

In conclusion, an evidence-based training intervention on mealtime care for people living with dementia in residential aged care has been co-developed with stakeholders. The intervention comprises five modules: *empowerment and respect*; *facilitating independence*; *social interaction; being safe*; *careful encouragement*, with two cross-cutting themes: *tailored care* and *working as a team*. The mode of delivery aims to provide a collaborative experience which makes training applicable to everyday practice. Training outcomes identified as important were staff knowledge, skill and confidence, improved mealtime care, and improved quality of life for residents. The prototype will be evaluated in real-world settings in future studies.

DATA ACCESSIBILITY STATEMENT

Requests to access the data should be directed to the corresponding author.

ETHICS AND CONSENT

A favourable ethical opinion was obtained from the Social Care Research Ethics Committee (reference 19/IEC08/0020) in June 2019.

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

All authors contributed to the co-development concept and design. JF and PM wrote the manuscript, and all authors reviewed the final draft for publication.

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