An Evaluation of an HIV Awareness Training Pilot in Nursing/Residential Homes in Wirral

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1. Introduction

1.1. Background to the Evaluation

An HIV/AIDS Needs Assessment was conducted in Wirral in 2010 and identified that older people living with HIV are worried about having to move into a residential or nursing home. They were concerned that they will encounter prejudice, ignorance and discrimination from staff working within the nursing/residential home. The majority of the older HIV population in Wirral are gay or bisexual men so raising awareness of sexual orientation was also thought to be important. NHS Wirral commissioned a pilot of an HIV and lesbian, gay, bisexual and transgender (LGBT) awareness training course aimed at all staff working within the homes. The bespoke course was developed by Sahir House and delivered in three residential/nursing homes in Wirral:

- Home A - nursing home providing care for approximately 20 patients.
- Home B - dual registered nursing and residential home with approximately 30 beds. The organisation also provides supported living and residential accommodation for older people in property adjacent to the nursing home.
- Home C – residential home for approximately 50 residents, mainly classed as elderly mentally infirm (EMI).

The NHS commissioner asked the Research and Development Team at NHS Wirral to evaluate the pilot training course to see if it is effective, fit for purpose and appropriate to deliver to other residential/nursing homes in 2012/13.

A comprehensive review of the published literature relating to HIV in older people and people living with HIV in care homes found that there was no evidence of existing HIV training in care or residential homes in the UK. However, such work may be in place, but not being evaluated and/or published. The literature review can be found in the appendix.

At the evaluation planning stage a logic model was developed to identify the inputs, activities and intended short-, medium- and long-term outcomes of the training course. This was used to prioritise areas for evaluation. The logic model can be found in the appendix.

The training included interactive sessions and exercises that provided the attendees with information, challenged myths and addressed prejudices. The session ended with one or two guest speakers; HIV positive services users who talk about what it is like living with HIV. A timetable of topics covered by the training is included in the appendix.

1.2. Aims of the Evaluation

The evaluation aimed to determine whether:

- the training course increases and improves the HIV-related knowledge of attendees (staff working in residential or nursing homes).
- the training course improves the attitudes and reduces/eliminates prejudice and discrimination amongst attendees – both in relation to people living with HIV and LGBT people
- the training course has a positive impact on the culture and policies of the nursing/residential home as a whole
- staff feel confident and equipped to care for people living with HIV

1.3. Objectives of the Evaluation

- To assess short term improvements in knowledge, attitudes and practice (KAP) of people attending the HIV Awareness Training
- To explore longer term impact on the KAP of people attending.
- To explore the longer term impact on the homes as a whole.

2. Evaluation Methodology

2.1. Before the Training

2.1.1. Interviews with managers

To explore the culture and policies specific to HIV and LGBT residents, a semi-structured telephone interview was conducted with a senior or deputy manager at each residential/nursing home within the 3 days preceding the training. The interview questions included: why the manager had taken up the offer of training; how they thought staff would react if they were told an HIV positive service user was arriving at the home; how aware of lesbian, gay, bisexual and transgender issues staff are in the home: and, what, if any, home policies relating to HIV exist. A copy of the interview schedule is included in the appendix. Notes were taken during the interviews and written up immediately. Some direct quotes were recorded but mainly general notes were written. A summary of the three interviews is given in section 3.1.

2.1.2. Knowledge, attitude and practice questionnaire

To measure HIV-related knowledge, attitude and practice (KAP) of course attendees before the course commences, a short questionnaire was completed at the very start of the training session (included in the apprendix). Participants were asked some simple demographic questions (e.g. gender and age), to rate their confidence and knowledge around HIV, and some KAP questions:

- Knowledge of simple HIV facts: true/false/don't know questions (e.g. *"'HIV' and 'AIDS' are just different names for the same thing." "You can become infected with HIV from kissing".)*
- Attitudes towards people living with HIV (PLWHIV): true/false/don't know questions (e.g. "*If you only have sex with people who look fit and healthy, you won't become infected with HIV." "Married people do not become infected with HIV."*
- Practice (some measure of behaviour): true/false/don't know questions *(e.g. "I would wear disposable gloves when feeding someone with HIV otherwise I may catch it." "If I heard someone make a joke about people with HIV I would tell them to stop it.")*

Scores were calculated for each section based on the factually correct or desired answer; for example, answering they would not be scared to touch someone with HIV or that they know you cannot catch HIV from a toilet seat would get a mark for being correct.

Each attendee was asked to complete the questionnaire independently and participants were reminded that their responses were anonymous. All attendees consented to complete the questionnaire.

2.2. Immediately after the Training

The same KAP questionnaire was distributed to the attendees at the end of the training day to measure any changes or improvements. Completing this questionnaire immediately after the training shows the impact on the participants in the short term. The aggregated results from the before and after KAP questionnaires are presented in section 3.2.

The training organisation (Sahir House) also distributed their standard evaluation form which asked questions about use of the course, how interesting it was and suggestions for improvements. The aggregated results of the Sahir House evaluation form are included in the appendix

It was the intention that semi-structured telephone interviews would be conducted with a selection of attendees within the three days after the course to assess immediate impact in more detail. However, due to shift patterns and the nature of a busy nursing home it proved difficult to contact the participants, so this element of the data collection had to be abandoned.

2.3. Longer Term Follow-up.

2.3.1. Interviews with managers

A second semi-structured telephone interview was conducted with the manager or deputy manager of each home 10 weeks after the training. This built on the original set of questions; participants were asked how the course was perceived by the attendees, if attitudes and knowledge had changed or improved, if any policies had been developed or amended as a result of attending the course and what impact it had had on the rest of the staff. The interview schedule is included in the appendix. Only two interviews were conducted as the manager and deputy manager at one home left employment between the training and follow-up. A replacement manager or deputy manager was not yet in post.

2.3.2. Questionnaire for Attendees.

A questionnaire of mainly open ended questions was sent to all homes to be distributed to each attendee. The follow up questionnaire tried to determine how the course had impacted on the way they interacted with service users, how confident they feel, if they had talked about HIV in and out of work and if they had used anything they learnt on the course.

The distribution was coordinated by the home manager or administrator. Five questionnaires were returned from Home A (71% response rate) and six from Home B (33% response rate). Home C, without a manager or deputy manager, was unable to return any questionnaires. The overall response rate was 32%.

2.3.3. Interview with Training Provider

At the end of the project a semi-structured interview was conducted with, the Development Manager at Sahir House. She had organised the training days and delivered the training in collaboration with another colleague. A face-to-face interview was conducted and covered topics such as how trainers perceived the organisation and reception of the training, what worked well with the training, how important it was to train this group and any changes or improvements that could be made. The interview was recorded and the main points typed up and reported in section 3.5. The interview schedule is included in the appendix.

2.4. Changes to the Methodology

The original methodology included telephone interviews with staff who had attended the training. These were to collect initial views in the week following the training. However, despite repeated attempts no staff could be reached, either because they were not on shift or were too busy to come to the phone and did not return the calls. This method is therefore thought to be inappropriate for this participant group.

A paper survey of the attendees at 10-12 week follow up was developed to overcome the problems with telephone interviews. However, this methodology was not ideal either; one home did not return any questionnaires and another home was extremely delayed in returning them and only managed to return a third.

Nursing homes are very busy and often hectic environments where the staff, especially managers, have to work in a reactive way to rapid changes in situations. This means staff are often unavailable when they have said they would be. Despite early enthusiasm and agreement from one of the managers, we struggled to contact them on the telephone to request they return the questionnaires. Future evaluations in this setting would need to carefully consider the methods used.

3. Findings

3.1. Interviews with Managers Before the Training

Three interviews were conducted, all in the three days preceding the training at each home.

None of the homes had ever cared for someone who they knew to be HIV positive. All homes reported their staff knew very little about HIV, as they had not come into contact with anyone living with HIV they have never had to learn about the condition or how to care for people living with it. Managers had never heard staff talking about HIV but this was felt to be mainly because staff had never needed to.

"No one has ever spoken about it really".

They felt that their staff were especially unaware of the social aspects of HIV such as stigma, discrimination and the emotional impacts of these.

Managers were asked why they volunteered to be part of the pilot. Managers said that they have not had to look after someone with HIV but it could happen soon and they would want their staff to be prepared. They thought that staff needed to be ready, confident and able to care for someone with HIV and that they need to be more aware if they are going to provide good care. One manager reported wanting an insight into what people with HIV go through. Managers also wanted the training to dispel any myths, provide facts and figures and general education to enable their staff to feel empowered so that they can care for someone and maintain their dignity.

The interviewees reported that their staff probably don't realise the importance of HIV awareness and it was more their (the manager's) decision that it was worth attending.

When asked how their staff would react if they were told someone with HIV was coming into the home next week, all managers said they thought their staff would not be confident to care for them and staff would be scared. One manager thought their staff would react with "*I'm not going near them*". Another manager said her staff would "*panic – they wouldn't know how to deal with it or the person."* This manager was concerned that this fear and reaction would be noticed by the service user and make them uncomfortable and unhappy.

One manager was worried their staff would struggle to keep the information confidential, not because of malice, but because they are scared they would want to talk to colleagues about it. Another manager said their staff were aware of confidentiality issues because of current service users who have sensitive issues, but they thought the policies and exact way they would deal with it would need to be looked at.

Managers were asked how aware they thought their staff were of lesbian, gay, bisexual and transgender (LGBT) issues. Two managers thought their staff would presume everyone is heterosexual but that they would be accepting if they found out otherwise, especially the younger staff as they know gay people outside of work. Both of these managers discussed monitoring for sexuality, one in relation to Care Quality Commission (CQC) standards and the other in relation to a new assessment process their home has brought in. Both said their staff struggled to know how to broach the topic with older people. One of these managers thought that it was the other service users, rather than the staff, who may react negatively to a LGB or T service user. The third home manager thought their staff were generally aware and accepting as *"it's like that nowadays isn't it?"* They thought that people are more open and accepting than they used to be and that their staff did not presume all service users were heterosexual.

Participants were asked what policies or procedures were in place that relate to caring for people with HIV. All managers responded that HIV was not mentioned specifically in any policies. However, they all thought that HIV was implicit in their infection control, human resource (HR) and confidentiality policies. One manager said when they compiled a care plan for the new resident it would be included. Another home has a mutual respect and equal opportunities policy but HIV is not stated explicitly in these.

3.2. Questionnaire –Distributed Immediately Before and After the Training

3.2.1. Participants

Thirty four individuals took part in the training, seven from Home A, 18 for Home B and nine from Home C. Those taking part in the training were from a wide range of ages (table 1), and the majority were female (25 females, 4 males and 5 did not indicate gender). There was a wide range of staff on the training, half of whom were care assistants and care staff (table 2). There was also some non-care staff including office and administration staff and domestic staff. One individual indicated a different job category and stated 'Health Project Advisor'. Only eight of the 34 respondents had attended any HIV training events in the past.

Table 1: Age of staff participating in training course

Age Group	Frequency	Percent
16 - 24	3	8.8
25 - 34	7	20.6
35 - 44	6	17.6
45 - 54	12	35.3
55 - 64	6	17.6
Total	34	100.0

Table 2: Staff category of staff participating in training course

Staff Category	Frequency	Percent
Care Assistant/care staff	17	50.0
Nurse/nursing staff	4	11.8
Domestic/kitchen/maintenance staff	2	5.9
Administration/office staff	3	8.8
Management	3	8.8
Health Project Advisor	1	2.9
No answer provided	4	11.8
Total	34	88.2

3.2.2. Self perceived knowledge and confidence

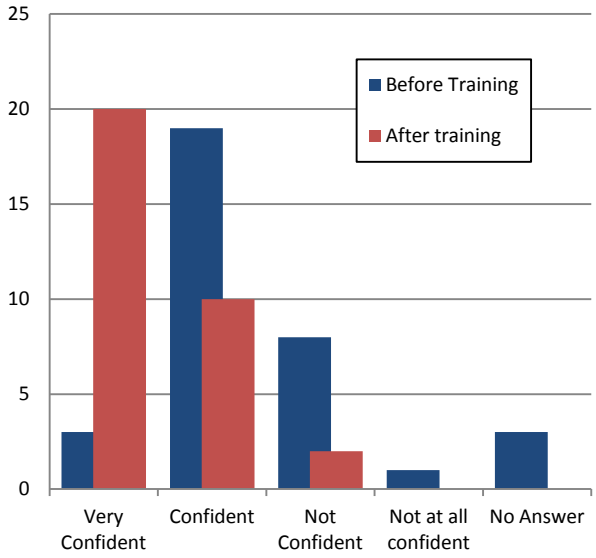
Attendees were asked to self-rate their knowledge prior to training. Seventeen (50%) rated their knowledge as good, 15 rated their knowledge as poor, and two individuals did not answer the question. No respondents rated their knowledge as very good or very poor (figure 1). After the training, all participants rated their knowledge about HIV/AIDS as either very good (18; 56%) or good (14). This shows a great improvement in how knowledgeable the attendees felt.

All attendees were asked how confident they would feel caring for a resident/service user who was HIV positive. Prior to the training the more than half (19; 56%) felt confident (figure 2). Three people gave no answer to the question. This shows that although people believed their knowledge before the training to be quite poor, they still felt quite confident they would be able to care for someone with HIV. After the training, feelings of confidence amongst the attendees increased with 20 people saying they now felt very confident and 10 confident. However, two still did not feel confident despite the training (figure 2).

*Figure 1: Self-rated knowledge before and after training**

* 34 responses before, 32 responses after training

*Figure 2: Self-rated confidence before and after training**



* 34 responses before, 32 responses after training

3.2.3. Improvements in Knowledge, Attitudes and Practice Post Training

Scores for knowledge, attitude and practice questions (both before and after training) were calculated with correct answers for those which were factually accurate or the desired, non-discriminatory attitude or practice. The HIV knowledge of the attendees was quite high even before the training. The knowledge questions that the most people got wrong and therefore the facts that most people were ignorant about were *'HIV' and 'AIDS' are just different names for the same* thing' (13 individuals answered incorrectly or did not know), '*all HIV positive people die from the infection before they get old' (12* answered incorrectly or did not know*)* and '*you can only get an HIV test at specialist HIV clinics'* (12 answered incorrectly or did not know). The attitude question that most people answered with the undesired option was '*I would <u>not</u> worry if someone with HIV was holding a baby I knew' (9* answered that they would worry or that they did not know*).*

The majority of respondents (28) thought that all staff had the right to know if someone living in the care home was HIV positive, however, very few (6) people thought that other residents or the families of other residents had the right to know. Ten respondents said they would wear disposable gloves at <u>all</u> times when with an HIV positive resident/service user.

Mean total score for knowledge, for attitude and for practice before and after the training were calculated. Thirty four individuals completed the pre-training questionnaire and 32 completed the post training questionnaire. Mean knowledge scores increased from 7.8 to 9.3 out of ten showing an improvement in knowledge (table 3). Mean attitude scores were high even before the training at seven out of eight. This increased slightly to 7.7 out of eight after the training. Mean practice scores increased most dramatically from 5.9 out of nine to 8.6 out of nine showing an improvement in the intended and expected practice of individuals.

Table 3: Minimum, maximum and mean KAP scores before and after training

	Before training		**After training**		
	Range	Mean	Range	Mean	No. of questions
Knowledge Score	2 – 10	7.79	8-10	9.28	10
Attitude Score	4 – 8	7.03	6-8	7.72	8
Practice Score	1 - 9	5.88	5-9	8.59	9

The questions that saw the biggest improvement related to confidentiality, with those who attended the course indicating increased understanding and intentions to uphold patient and staff confidentiality.

3.3. Longer Term Follow up - Questionnaires to Course Attendees

People who had attended the course were asked how they would react if they were told they were getting a new service user or resident who was HIV positive. Respondents said they would feel confident, they would react in the same way as they would to any new admission and that they would feel able to treat them with dignity and respect.

> *"I would feel more confident, welcome the person and start getting to know them as I would any other resident"*

All respondents said that they felt confident that they could look after someone with HIV. Reasons for this included: knowing the facts, especially about transition; the information had put their mind at ease and corrected any misconceptions; they know more about how to care for someone with HIV now; and they understand that if they just take normal precautions there is no reason that someone with HIV would need to be treated any differently.

They were asked how they would feel working or socialising with someone with HIV. Respondents said they would be "*fine"*, "*not scared*" and that the training had changed their views. One respondent said they no longer saw HIV as a '*dirty disease'* like they used to. One respondent said the HIV information would probably remain at the back of their mind but that they would not treat the person any differently. Another respondent said they thought they themselves would still need to educate other people due to their prejudices.

> *"I would feel a lot more at ease working or socialising with someone with HIV since the awareness training. Now understanding the facts and not the myths."*

Most people had discussed the training and their new knowledge about HIV a few times with people who were on the course, other colleagues who were not on the course and with people outside of work. They had talked about the number of people with HIV, transmission, myths and about stigma. The four quotes below illustrate some of the discussions that respondents have had outside of work.

> *[I talked to] "a relative from a 'high risk group' about keeping safe and reducing exposure"*

> *"To my son, the importance of protected sex and the effect the virus can have on others (friends, family, partners). To my mother dispelling rumours and myths attached to the illness"*

> *"I spoke to my husband who had the same <u>wrong</u> information as myself. He also feels more confident."*

> *"Being able to say that it is actually quite a difficult virus to catch and figures show how many people have a 'normal' life, living with it"*

When asked to reflect on their experience of the training, overall the respondents said they had found it informative, enjoyable and interesting. Two respondents said they would like further training on the topic, especially about any new advances in care for HIV positive people, and one believed it should be offered to their colleagues who missed it. Another participant remarked that they had previously nursed a patient with HIV but that the training day was brilliant. One respondent highlighted it made them realise how judgemental they could be. Three respondents remarked how useful it had been meeting the guest speakers, it was emotional and had helped put a real life dimension on the training. Two respondents said they thought the friendly relaxed manner of the trainers was very helpful. One respondent said it was the best training they had had for a few years. The quotes below illustrate some of the opinions about the course

> *"Cath from Sahir House – a brilliant trainer and knows her subject. Thanks to the guest speaker – he made the training come to life ☺"*

> *"I found the course really good. I think it provided a lot of detail, stated facts and told us of any myths".*

> *"I found it very good. [It is a] serious of the subject but it was put across in a light, sometimes funny way which made it more understandable ☺"*

The training seems to have had a positive impact on the relationships between colleagues as well.

> *"[I] can now talk more openly about other intimate topics with colleagues who attended with me"*

The only suggestions for improvement were more training for the attendees and for those within the home who had missed it.

3.4. Longer Term Follow up – Interviews with Managers

Interviews were conducted with the managers at Home A and Home B. Both the manager and the deputy manager at Home C left employment before the follow up interviews and there was no one else appropriate to talk to at Home C. Two interviews are reported here.

The managers reported that their staff had found the training very useful, interesting and engaging; both thought the training gave a good amount of information and it allayed attendee's fears by "*putting things into perspective".* One manager said even the nursing staff had found the information new and refreshing and that all staff had been shocked that older people could have HIV.

The managers themselves found the training to be '*well rounded'* and *'interactive and informative'.* One manager thought it had been very '*intense'* but interesting and enjoyable. Both mentioned that they particularly valued the guest speakers and felt they added a very real perspective to what they had been told during the training. One manager said that before the guest speakers arrived there was a feeling of anticipation as none of the staff had knowingly met anyone who was living with HIV. However, once they arrived they were so down to earth and friendly that they "*completed the day*". They showed how anyone could be affected by HIV, that *"any of us could be walking round with HIV and we wouldn't know it".*

The staff now realise that it is not easy to acquire HIV, especially in a controlled healthcare setting such as a nursing home and that people with HIV are *"just like anyone else and you can shake hands, kiss etc and you will be fine".* The other manager particularly appreciated that they could ask the guest speaker lots of questions about any topic. They viewed the guest speaker attending as an opportunity to gain feedback on the homes' processes regarding HIV positive residents, such as how to make them more appealing and acceptable to people living with HIV. The managers also praised the facilitators saying they were very interesting, knowledgeable and friendly.

Managers were asked if there had been much discussion about the training amongst the staff. One manager mentioned a member of domestic staff who had been particularly affected by the training. Because of the fears and prejudices about HIV, which had come from the media in the 1980s, the attendee had viewed it as a *'dirty infection'* but after the training her views had completely changed. The staff were very humbled by the positive speakers and more accepting and understanding. The other manager said there had been a lot of discussion amongst management and senior nurses, especially in relation to policies. The training had also been formally discussed at the committee meeting of the parent organisation.

The training was seen as having a positive impact on the staff. Both managers thought that their staff now felt confident, prepared and would be happy to care for someone with HIV. They also now understand the importance of confidentiality. One manager thought the training had a particular impact on staff who's knowledge about HIV was based on the "*doom and gloom of the tombstone"* adverts and the high profile deaths as this training had educated them about the real impacts of HIV, how long people now live with HIV and the discrimination they face.

One manager said that they now would not necessarily tell all the staff if they accepted a service user with HIV because it would not be such a *"big deal".* This would now be treated on a 'need to know' basis as the care they provide and the infection control procedures would be the same. If they are using the same precautions, not all staff would need to know. The other manager was pleased the training had covered confidentially thoroughly and reminded staff how important it is; for example, they had never considered that family and friends of an HIV positive resident may not know that they have the condition.

One manager stated "*I've changed. It has given me confidence to know I would be able to say 'it is not a problem' [if a new resident in the home was living with HIV]. They are just like any other patient and I know the great needs they have for understanding".* She had also found it *"quite empowering"*. The other manager said they found it particularly interesting to think about how people are 'labelled' and how people respond to these labels.

When asked if the information and changes from the training had filtered through to the other staff in the home the one manager said they didn't really think it had, the impact had mainly been on those who attended the training. The other manager said she thought it had a bit but would have had the biggest impact on those who attended the training.

Both homes had made changes since the training. One home produced an information booklet about HIV that all staff are encouraged to read. The other manager discussed the changes they had made to their policies since the training. They had developed a new HIV policy. They had wanted to do this for a while but had not had the confidence to do this as it was such a *"grey area".* As a result of the training they had also updated their sexuality policy and reviewed their confidentiality and Equality and Diversity policies

The other home had not developed or changed any policies or procedures as a result of the training; however they had discussed and considered the issue. The interviewee felt that it did not need an explicit, separate policy because a separate policy may stigmatise the condition. They believed that confidentiality and standard infection control policies were fully appropriate for HIV so new ones were not needed. It had made the interviewee realise how many other policies HIV comes under and made her more aware of it.

Both managers were very eager for other staff to attend the training and thought it would be very beneficial for all staff to attend. One manager said the training made you question your ideas, interpretations and fears and that this would not have such an impact if it was passed on by other staff. To gain the most from the training the other staff need to attend in person.

One manager discussed the possibility of employing an HIV positive staff member in the future and, because of the availability of effective modern drugs, they did not think other staff members would be at risk. The interviewee did not think they would ask if someone was HIV positive but, if they did, they felt equipped to support them if necessary.

One manager discussed dealing sensitively with LGBT service users. They thought their staff were already dealing with these issues sensitively, but the training helped to reinforce this. This manager remarked "*a human being is a human being and it is important to nurture everyone."*

One manager ended the interview saying that the training needs to be delivered in other homes and to other healthcare professionals. The interviewee thought that there is a tendency to panic about infection control, but was aware that this can cause stigma. Now, they would be happy to say *"yes we can deal with this - not a big deal".*

3.5. Interview with Training Provider

The Development Manager at Sahir House was interviewed to determine her experience of the training, what worked, how things could be improved and how successful it was from the point of view of the training provider. The key points of the discussion are summarised below.

- Very few organisations, if any, are providing HIV awareness training in nursing homes. Feedback from networking at conferences and with other service providers is that they believe it to be quite a progressive piece of work. She has been in contact with an organisation that is producing resources regarding issues facing older people with HIV. They were really interested and she used her experiences from the pilot to comment on a draft of some resources this organisation is developing.
- It is important that care staff are confident and able to care for people without ignorance or prejudice. It is beneficial that NHS Wirral has implemented the findings of the needs assessment and organised this training proactively, and not at crisis point when someone living with HIV has a negative experience in a nursing/care home. Sahir House has been able to be quite flexible and have easily managed to adapt and implement the training.
- Many people who work in care homes are not highly trained health professionals, therefore know very little about HIV. She is sometimes concerned that people attend training because they had been told to by their manager and not necessarily because they had volunteered. However, the reactions of the attendees and the way in which they embraced the training reassured her that this was not the case in this pilot.
- In most homes some non-health/care staff also attended the training. For example, in Home B, the gardener attended, which was a pleasant surprise. This could be viewed as unnecessary, but the managers of Home A adopt a very healthy team approach and recognise that all personnel need to take responsibility where a service user is concerned. They had a strong agenda of treating service users with respect and understand confidentiality and appreciated that every member of the team has a role to play
- Thanks to the enthusiasm of the nursing homes, people genuinely wanted to know more about HIV and were keen and eager to learn. People were very reflective and friendly during the day.
- The three Homes were very different and had different cultures but they all responded well. There were some practical issues that meant some sessions worked better than others. Home B was very organised and had a very high turnout, not just care staff. In Home C the training was delivered as two morning sessions on consecutive days. The practicalities of shift work had an impact in this home as some staff had just come off a night then gone straight into the second part of the training. This meant that some of the staff seemed exhausted and struggled to concentrate. This may have had an impact on the Guest Speakers, as they came in at the end of the session, and if half the group look bored or exhausted it can be difficult or upsetting for them.
- It was important that the managers attend as well as the general staff. One manager from Home A, and two managers from Home B attended and fully engaged with the training. Unfortunately, in Home C the two senior managers were unable to attend. The day felt different and better when the managers were there. At Home A the manager was very enthusiastic and open and her learning curve was very obvious. This helped the development of the other staff in attendance as it was obvious to them that their manager was rethinking things, she was self critical and open. This encouraged other staff to do the same and she felt confident the manager would make changes as she took everything on board.
- Half way through their session a manager from Home B asked the trainer to make sure she covered confidentiality and some other specific issues and was really grateful when she did. She thought it was more interactive to have a manager present as they got to have some input into the day. Managers are aware of things going on in the home and by being there could respond to the needs of their staff and make sure it covered what they want their staff to know. Home B managers were really enthusiastic and keen for Sahir House to help them to develop wider equality policies.
- Having the managers present meant that the session could look at HR issues as well as caring for HIV positive service users.

- She compared a training session without a manager (Home C) to delivering sessions in a school without the teacher present. As the teacher may not fully understand HIV, she worries that at a later date they may undermine or contradict her teaching. With a manager who isn't as knowledgeable as the staff, there may be power issues and staff may not feel able to challenge any management ignorance. It is also the managers who can influence policies, such as HR and infection control, so they need the knowledge as much as their staff. Obviously there are practical issues that make it difficult for people to attend but it is important that the managers attend.
- It is therefore very important that managers are encouraged to attend and this should be part of the information provided when offering the training to other nursing homes.
- Due to the shift nature of nursing homes, only providing one training session in each home means that many staff will miss the session. She suggested holding a variety of sessions in neutral training venues in Wirral that people can voluntarily attend at a time suitable to them. This means they can fit the training around their shift patterns and all staff at a home have the opportunity to attend.
- Holding sessions in neutral venues would also limit staff being pulled back into work activities (e.g. taking phone calls and seeing service users). It is good to get into a different environment and out of the normal work environment.
- Group training would also be good for networking; by their nature care homes can be quite isolated. Group sessions might facilitate networking and sharing of best practice.
- Training should remain as a whole day activity, instead of being split between two half days. She believed one whole day encouraged continuity and more practical when arranging to attend in between shifts. The half days were a bit disjointed and risk people not turning up to the second session.
- It might be good to roll out the training into broader social care settings such as older people's day centres. In day centres there is more opportunity for group activities and interaction and they might be able to take away information and activities that they can use with their clients. Day centres are currently unlikely to be seen as HIV- or gay- friendly. This would target training to other disability/older people services that maybe are not as far down the line as nursing homes or palliative care. This might also occasionally identify an undiagnosed HIV case.
- Home A had a World AIDS Day cake sale and brought some money to Sahir House – this was a very generous and thoughtful thing for them to do.
- Comments made to her during the training and on their evaluation forms showed that people felt empowered and realised how common and 'normal' HIV can be – it makes it seem achievable to confidently care for an HIV positive service user. People realised that the information is not necessarily "rocket science", but it is useful to challenge prejudice and ignorance. Once people have had some training it demystifies and reduces the worry of the possibility of caring for someone with HIV.
- Before the sessions there was general concern amongst the attendees about whether it is safe to touch someone with HIV and if their laundry can be washed with clothes belonging to other residents. These may seem very basic to us but there is such fear and myths around HIV and people are never told anything else. After the training she believed the attendees felt empowered to be able to deal with such situations.
- It is important how we inform the local HIV population about HIV friendly homes and services. We don't necessarily want to imply some services are 'unfriendly' but we need to let people know that some services are very knowledgeable about the issues. She suggested there being a nominated link person at each home, prospective residents could be put in contact with this link person so that that older people with HIV feel more confident that the home and staff are HIV aware.
- The Guest Speakers (who are HIV positive themselves) found it reassuring and interesting that homes were so receptive to training. We have a responsibility to care for people with HIV when they are older. She felt the guest speakers should be praised as they are dealing with issues about their future vulnerability which is probably distressing for them. They are open and helpful which makes a big difference. Their input provides another dimension to the training package – on the Sahir House evaluation forms the attendees highlighted that the guest speaker's input was incredibly useful and enlightening.

- It would be good to publicise the pilot in trade publications and magazines aimed at people living with HIV. We should also inform the National AIDS Trust and within the social care sector in the local authority.
- She intends to inform the Aging and HIV network of the results of the pilot and to ensure other organisations are involved in the future to aid joint working. She is also going to investigate if the Care Quality Commission has any relevant existing standards.
- The whole process of organising and delivering the training has been very smooth, the commissioning was very simple and the evaluation was easily integrated. She thought that the need was 'well spotted' by the PCT who acted quickly and simply to try to address it.

4. Key Findings

- Prior to training, none of the participant homes had ever knowingly cared for someone who was HIV positive. Managers felt staff had little knowledge about HIV and would be worried if they had to look after someone. They thought it was important that their staff were confident and able to care for someone living with HIV in a sensitive and dignified way. Awareness of LGBT issues was limited but managers believed that their staff would be generally accepting and understanding as societal attitudes have changed in recent years. Keeping a service user's HIV status confidential was expected to be a difficult issue for some staff. None of the homes had any policies that specifically mentioned HIV, although managers believed it was implied in infection control, Human Resource and confidentiality policies.
- Thirty four individuals took part in the training on three separate occasions. The three homes were very different in terms of size, type of organisation, types of service users/residents and management.
- Whilst self-rated knowledge of HIV was rated low before the training, confidence in caring for a service user/resident with HIV was quite high. After training all participants rated their knowledge as good or very good and all but two felt confident or very confident to care for someone with HIV
- A selection of questions explored knowledge of HIV before and after the training. Knowledge improved after the training; mean scores increased from 7.8 to 9.3 out of ten. A second set of questions assessed attitudes and stereotypical views towards HIV and people with HIV; scores were high at the start of the training (mean 7.0 out of 8.0) and increased slightly to 7.7 after the training. The last set of questions assessed views of how they would care for an HIV positive resident. Scores in this section increased the most, from 5.9 out of 9 before the training to 8.6 after the training. The most dramatic improvements in KAP related to confidentiality and confidence.
- Ten weeks after the training a follow-up survey was distributed amongst the attendees. On this survey, staff reported that they felt confident and able to care for a service user with HIV, the majority also reported they would feel confident and happy socialising or working with someone with HIV. Most people had discussed the training and their new knowledge with colleagues (both who had and had not attended the training) and/or people outside of work. Overall, they had found the training enjoyable, informative, and interesting.
- Ten weeks after the training an interview was conducted with the managers of two participant homes. The managers reported having been very pleased with the training. They had found it to be an interesting and useful day and felt it was empowering and engaging. Both managers reported they would feel confident and competent to welcome a service user or resident with HIV to the home, they would also be confident their staff would be able to care for the service user.
- The training coordinator at Sahir House reported that the attendees had been very welcoming, enthusiastic and eager to learn. She felt the training had dispelled common myths about HIV and given the attendees the confidence to care for someone with HIV. She was pleased and thought it was progressive that non-care staff, such as admin and domestic staff, were also invited to the training. The training worked best when delivered in one whole day and not divided over two days. The training coordinator also felt that the training was more successful when the managers attended with care and non-care staff. The training coordinator believed that this was important because the managers are responsible for making changes within the homes with respect to what was learned in the training.
- There was a lot of interest from managers and attendees to have some more training, or to roll out the training to their colleagues.
- The guest speakers were particularly positively received by all the attendees and managers and were also praised by the training coordinator. The participants believed the guest speakers brought a personal, powerful and real-life element to the training that was particularly valued by the attendees.
- Staff and managers said they had talked about the training to some degree but many, especially the managers, said that the full impact of the training that challenged prejudices could not be communicated by attendees and needs a skilled trainer. One manager reported writing and updating policies to include HIV. However, although the training had an impact on those who attended the training, it does not really seem to have filtered through the home to other staff.

5. Recommendations

- Further training should be commissioned in other nursing and residential homes in Wirral.
- Managers and senior nurses should be strongly encouraged to attend the training. The managers gained a lot from the training and have the ability to make the biggest changes to ways of working, policies and influence culture within the homes. To do this they would need the same level of knowledge as their staff.
- The commissioners and training coordinator should consider ways to encourage attendance and ensure the most staff from each home attend. The content of the training is in depth and attempts to dispel myths and challenge prejudiced attitudes. It is not realistic to expect it to 'filter through' the home and cause a culture shift without the majority of staff attending the training.
- The commissioners could consider rolling out the training into broader social care setting such as older people's day centre and groups.
- Feedback from the training provider showed that attending the training around shift patterns seemed to have been difficult. The commissioners and training coordinator could consider providing sessions at a neutral and centrally located venue where staff from different homes can attend at a suitable time that fits around their shifts. This was, however not mentioned by the staff or managers at homes. This will need to be discussed with staff and the managers as some potential attendees may not want attend training away from their regular workplace or may not have the ability to travel to other areas of Wirral.
- Training could be offered to the other staff at the three pilot homes who could not attend the initial training.
- The findings of this evaluation should be disseminated to local HIV organisations and service providers. These services should also be informed of which homes have taken part in the training to allow them to signpost potential services users to homes that are more knowledgeable about HIV.

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