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Research into practice: challenges of implementing and embedding a programme to improve care for people with dementia in hospital wards.

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Abstract

We recently took part in a national research project which evaluated an intervention to enhance person-centred care for people with dementia in hospital. The PIE (Person, Interactions, Environment) programme involves staff observing care on a ward, focusing on these three areas. Findings from observations form the basis for introducing changes to ward practices. Implementing PIE led to improvements in practice, but proved challenging in the current context of the NHS. Sustaining the programme following the research required key features to be in place, in particular the presence of a 'driver' to maintain momentum, the support of the ward manager to encourage ward staff to take part, and a degree of flexibility and persistence in the implementation of the programme. Staff expressed satisfaction from taking part in PIE, which continues to be a tool which is used to improve care in this area of practice.

Key words: change programme, dementia care, hospital wards, implementation theory, observations of practice

Background: researching dementia care in hospitals

Improving the care of people with dementia has been identified as a policy priority in the UK and internationally over the last decade. Among the proposals put forward to achieve this, the Prime Minister's UK Dementia Challenge (Department of Health, 2015) highlighted a number of commitments, including a focus on research and on improved care in hospitals.

Between 2013 and 2015 we were fortunate to be involved in a national research study evaluating a change programme aimed at enhancing person-centred care for people admitted to hospital with co-incidental dementia (Godfrey et al, 2018). The programme was based on an observation tool, created for use in the first National Audit of Dementia Care in NHS wards (Royal College of Psychiatrists [RCP], 2011) and subsequently developed into a programme of improvement.

The RCP audit, covering 55 hospitals and 145 wards, found that care of people with dementia was generally reactive and task-driven, rather than being person-centred and proactive. Although there were pockets of individualised care, only a handful of the wards taking part reported practices which were consistently focused on the person. Evidence-based guidelines state that the principles of person-centred care underpin good practice in dementia care (National Institute for Health and Care Excellence [NICE], 2018) and suggest interventions to promote this, such as ensuring staff understand the person as an individual with their own life story.

The PIE (Person; Interactions; Environment) programme, which developed from the audit tool, is a whole ward intervention and service improvement process for staff to implement and embed change in routine care on acute hospital wards. Staff of all grades (managers, nurses, doctors, care assistants, housekeepers, students, volunteers) are encouraged to be part of a PIE implementation team. Implementation is seen as a cyclical process starting with

observation, by staff pairs, of current practice, focusing on a small group of patients. Staff concentrate on three areas: the Person (patient) and what is known about the individual and whether this knowledge is used in personalising care; the quality of Interactions with staff; and the impact of the immediate physical Environment or organisation of care. Structured reflection on observations is the basis for celebrating good practice and identifying goals and action plans to improve practice where necessary. Review of progress against planned action, including appraisal of barriers and facilitators of change, enables adjustment of action plans and/or review of goals (Fig 1).

We evaluated the programme and its implementation through multiple methods including researcher-led observation of practice, interviews with staff, records of 'PIE' action planning meetings and collecting documented PIE observations by staff. The PIE programme had been implemented on two wards in our trust (one orthopaedic, one care of older people) by the end of the research and there was evidence that it had changed care practices (see Boxes 1 and 2 and pictures 1 and 2 for examples of innovations). However, the process was not without problems, especially in embedding the programme and the new practices following the end of the research. In this article we aim to draw on this experience and offer our thoughts on what may help or hinder implementation of research findings in this area of practice.

Implementing change in theory and practice

Much has been written about implementation theory, the translation of research findings into practice and the enablers and challenges involved in the process. In the research, we used Normalisation Process Theory (May and Finch, 2009) as a framework to see if it helped explain what went well and what not so well. This theory proposes that new practices become 'normalised' when: they are seen as meaningful to individuals; they are felt to be worth

committing time to; practices are modified by the whole team; and the effects of the practice are monitored.

The research was set up to maximise these four conditions. For example, we ran workshops to encourage staff to be actively involved in the research, rather than just act as research subjects. We enlisted the support of senior managers within the organisation and we provided a manual to guide the cycles of observation, documentation, action planning and evaluation.

This did not guarantee success. Over the course of the two year research, a number of local factors, largely typical of the current NHS climate, challenged the PIE teams: lack of time and increasing workload; staff turnover, with new members unfamiliar with PIE; a CQC inspection which occupied managers' attentions; 'winter pressures' which lasted well into spring; a ward refurbishment which necessitated a physical move temporarily. Additionally, pairs of observers initially felt uneasy sitting in bays without contributing to ward work when the workload was high. They were also concerned that colleagues might think them unhelpful or even critical of their care. Implementation therefore progressed in fits and starts, depending on whether the prevailing conditions were conducive or not.

It became apparent that while Normalisation Process Theory could help explain the success or not of implementation at an individual and team level, it failed to take into account the context into which the new practices were being introduced. Other researchers (Hunter, 2013; Kristensen et al, 2016; Wye and McClenahan, 2000) have noted not only the importance of context to the embedding of new and evidence-based practices, but also that findings diffuse very slowly into practice over years rather than months.

Implementation of PIE did, however, continue on the two wards over the timescale of the research. We identified a number of factors which accounted for this:

- Leadership. The dementia specialist lead nurse acted as a 'driver' throughout this time and was a passionate advocate for person-centred care for people with dementia, as well as inspiring staff. In this she was supported by a second dementia specialist nurse and a practice development nurse. The presence of a driver ensured momentum was not lost following periods where conditions were challenging.

- Facilitation. Ward managers on both wards took an active interest in the programme. Although neither was directly involved in the PIE teams, they enabled staff to take time for meetings and actively encouraged staff to engage in PIE observations. Giving 'permission' to observe and attend meetings helped to resolve the feelings of unease for observers, and helped them to feel empowered. The ward manager also needed to agree to any actions resulting from PIE observations.

- Salience of PIE. A number of staff had specifically chosen to work on the wards because of an interest in caring for people with dementia, so the programme appealed to their interests. Individuals with dementia accounted for some 50% of patients on both wards.

- Collective team involvement. Working together within teams was an important part of the programme and the staff from both wards organised a successful cross-site meeting to compare activities, clarify aims and learn from each other.

- Fit with strategic priorities. The dementia specialist lead nurse was respected at all levels and was able to influence trust-level initiatives, incorporating PIE into the trust's dementia strategy.

- Relative organisational stability. Despite the general turbulence in the NHS in general, the trust included, the PIE wards maintained their designations over the research period, and care of people with dementia was praised by the CQC.

Reflecting on the research

We encouraged staff to reflect on their experience of both being involved in the research and on any difference which they felt new initiatives resulting from observations had made to practice. A number chose to write these down, indicating positive sentiments:

'My participation in PIE has been a positive experience…. The use of observation most certainly has helped staff understand how life on an acute medical ward appears to the person and as a result of this has led to change in practice…. [there is] evidence of the positive changes PIE has made to staff caring for those people living with dementia.' (Dementia specialist nurse)

'I was pleased to be asked to be part of this research and found it interesting making positive changes to the patients within the elderly care ward setting. I felt the outcome of the research was very positive and we made significant changes on the ward [examples given]…. people's attitudes have changed towards patients with dementia and behavioural problems, and people are more understanding if a patient likes to wander…. As therapists I have felt very proud how much time and effort my team have contributed and continued to do so.' (Occupational therapist)

'It was a huge privilege and honour to have participated in this project and I feel that it has positively impacted on my nursing practice … The project has helped me to gain in confidence within my career and I know that my career path still lies within dementia care in the acute hospital setting and I shall continue to pursue this with great enthusiasm, compassion and empathy.' (Staff nurse)

'The overall experience for me being involved in the PIE project has made me feel satisfied that improvement has been made to person-centred care within our environment … the person is now looked on as an individual and information is gathered to assist this. We have

improved our setting and believe there is still room to plan and implement change.' (Therapy support worker).

External feedback was also received from visitors to the ward. For example, a care home assessor visiting to see a patient commented on the positive change on the ward since her previous visit. In particular she pointed to the staff's attitude change and greater knowledge around dementia care.

Embedding and sustaining change

At the end of the research we felt the PIE programme offered sufficient potential to be continued and, possibly, rolled out to other wards in the trust, with process evaluation. We received confirmation from the trust's research and innovation department that formal ethical committee approval was not required, as this was regarded as a 'grey area' project. We identified areas where there was a high proportion of patients with dementia or cognitive impairment and obtained agreement from senior management. However a number of the other contextual factors which had facilitated the research were no longer in place. One ward manager felt there were too many other initiatives being introduced to do PIE justice; the staff on other wards were unfamiliar with PIE; volunteer workers had reduced in number; after a period of stability, there was uncertainty over ward designations and other changes; and we no longer had all the resources of the research team to run further workshops and provide documentation. Further, the momentum which had been maintained by being the centre of attention in a national research project, (the 'Hawthorne Effect') was lost.

Crucially, however, the dementia specialist lead nurse, as 'driver' remained in place and experience suggested that, with adaptations, the PIE programme might be maintained, since it was always designed to be used flexibly. This has meant a need for persistence and perseverance when conditions were not favourable. A new band 4 associate practitioner had

recently joined the dementia team and acted as a second 'driver', maintaining, and introducing where necessary, the PIE observations. On one of the original wards, staff who had left were replaced with others who expressed an interest, while on a new ward, where a manager was keen to introduce the programme, action planning meetings were held jointly with the existing ward. This device of using what is already in place is recommended in the literature (Wye and McClenahan, 2000). With these changes, the PIE programme has continued, albeit in a changed format and at a much slower pace than at first envisaged. Meetings continue on a two monthly basis where observations are discussed and feedback provided to the ward teams. Where good care has been observed this has been fed back and found to be good for staff morale.

Other implementation activities were also supported in existing evidence. Arranging information workshops on a new ward was proving ever more challenging amid the pressures of work, but was achieved through a more pragmatic but intensive one-to-one or two relationship, as recommended by Wye and McClenahan (2000) and Hunter (2013). Feedback from PIE teams that the paperwork was proving overly time-consuming led to a re-design of both that and the guidance manual which aimed to retain the essential elements of the programme in a usable form. The need to adapt to local context in such a way is highlighted in further literature (Kristensen et al 2016).

As in the original research, there is evidence of positive and sustained change: the practice of walking patients to a lunch table continues and has spread to non-PIE wards, and music has become a standard alternative intervention considered for managing distressed individuals by staff who had previously not thought of this.

Discussion

A recent review of the literature has shown that there are generally negative consequences for people with dementia of being in hospital (Dewing and Dijk 2016). In order to improve this situation, there is clearly a need for new practices to be implemented and sustained. The PIE programme was shown to have the potential to enhance person-centred care (Godfrey et al, 2018), but its implementation, and particularly its continuation post-research, showed that success is very much context-dependent and subject to changing NHS circumstances.

Factors which enhanced or hindered sustainability were not, however, unique to this programme. For example the need for commitment from senior staff and the deleterious effects of insufficient time and resources were also features of the Royal College of Nursing's SPACE project (Evans et al 2015). That project, also aimed at improving dementia care, similarly noted the importance of specialist dementia posts and organisational stability.

Staff, as well as patients, appeared to benefit from being involved in the PIE programme. Sentiments such as pride, honour and privilege were expressed in addition to noting learning. This incidental benefit was also noted in the implementation of the SPACE programme (Bray et al 2015) and is probably attributable to feelings of having a sense of ownership of the programme.

There appear, therefore, to be certain principles which may apply more generally to the embedding of new practices in hospital-based dementia care and beyond. Caffrey et al (2016) have noted that systems in which health research is generated and used are complex, making the implementation of new initiatives unpredictable and challenging. This is certainly what we found. But Caffrey et al also pointed out that the adaptive nature of 'actors' (in our case the PIE and ward teams, together with specialist nurses and senior managers) can be a source of innovation. Characteristics required for this are perhaps illustrative of the Chief Nursing Officer's '6 Cs' in practice (NHS Commissioning Board 2012) (Table 1).

There are, however, limitations to our evaluation of PIE implementation. Neither the original research not the current practice have been able to demonstrate yet any clinical outcomes resulting from the initiative. Although statistics such as rates of delirium and length of hospital stay might serve as useful indicators, lack of resources to collect such data means that, at present, less objective outcomes must be used in our work of improving care for people with dementia on our wards. This is a challenge for future practice and research.

Conclusion

The PIE change programme encountered challenges in implementing and embedding the new practices post-research. Key features for successful implementation were the presence of a 'driver' to retain momentum, the support of the ward manager to encourage and involve staff and a degree of flexibility and adaptation to changing circumstances. These features, also mentioned in related literature, may be generalizable to other areas of practice. PIE has continued to be used as a tool through which to improve care for people with dementia in our hospital wards.

Acknowledgements

Our thanks to all the staff at East Kent Hospitals who have been involved in the research and implementation of the project.
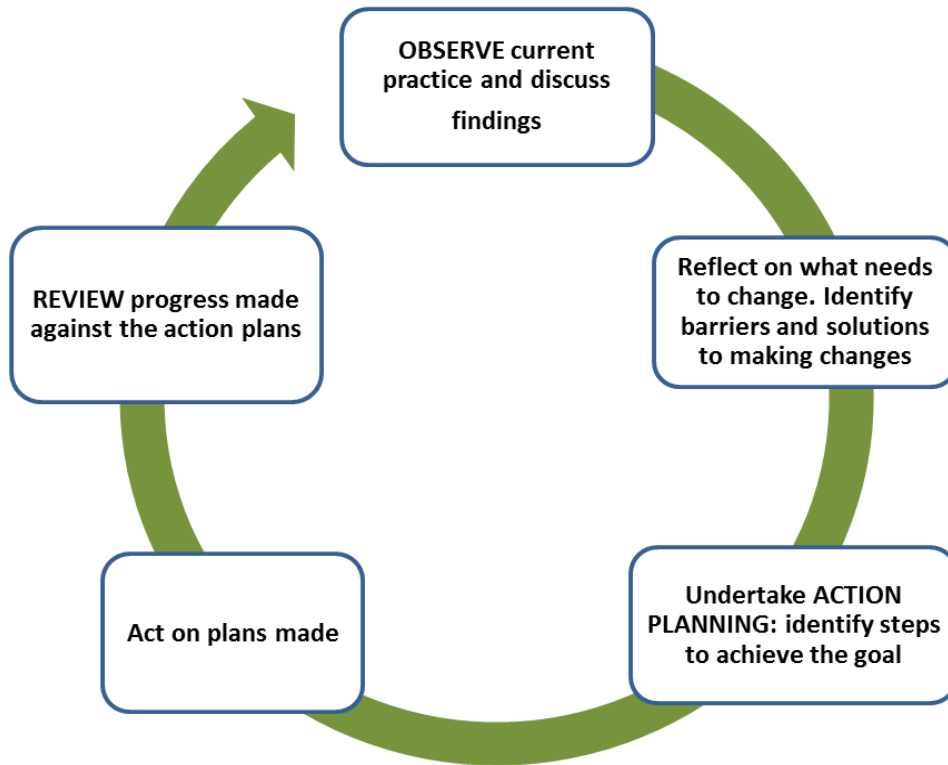
Conflicts of Interest

The authors have no conflicts of interest to declare.

Permissions

We confirm that we have permission to use the photographs submitted form the people featured.

Fig 1. PIE service improvement process (Godfrey et al 2018)

A circular process diagram showing five stages connected in a clockwise cycle:

- OBSERVE current practice and discuss findings
- Reflect on what needs to change. Identify barriers and solutions to making changes
- Undertake ACTION PLANNING: identify steps to achieve the goal
- Act on plans made
- REVIEW progress made against the action plans

Box 1. Mealtime as a social event

PIE observations: Noted some patients were not eating well and some have to await assistance while staff attend to others.

Plan: Help patients to the table in the bay to have lunch with others. Use tablecloth, jug of juice and decorate with flowers. Staff to sit at table and encourage/assist all while observing intake unobtrusively. Occasional teatime events also to be held.

Evaluation: Patients eating better, engaging more with others and mobilising more (to get to table).

Box 2. Music as therapeutic activity

PIE observation: Noted continuous noise from radio, thought to be mainly for benefit of staff. Potential adverse effect on patients with dementia (over-stimulation and increased stress).

Plan: Following discussion about therapeutic effect of music, and eliciting patient preferences, introduction of calming music after lunch. Later extended to include a volunteer musician and singing sessions at Christmas.

Evaluation: Patients appeared calmer and less stressed.

Table 1. PIE implementation and the CNO's '6 Cs'

The 6 Cs	Illustrated in PIE implementation.
Care	Enhances person-centred care for people with dementia.
Compassion	Empathy, respect and dignity for people with dementia. Relationship-based.
Competence	Staff have the right skills and knowledge around dementia care.
Communication	Implementation depends on teamwork and also communicating with people with dementia 'in their own world'.
Courage	Introducing changes to practice in dementia care despite obstacles and difficulties encountered.
Commitment	Having the persistence to keep going in implementing improvements for people with dementia.

References

Bray J, Evans S, Bruce M et al (2015). Improving activity and engagement for patients with dementia. Nursing Older People 27, 8, 22-26.

Caffrey L, Wolfe C and McKevitt C (2016). Embedding research in health systems: lessons from complexity theory. Health Research Policy and Systems 14:54: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4957897/

Department of Health (2015). Prime Minister's Challenge on Dementia 2020. Department of Health: London: www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

Dewing J, and Dijk S, (2016). What is the current state of care for older people with dementia in general hospitals? A literature review. Dementia 15, 1, 106-124.

Evans S, Brooker D, Thompson R et al (2015). Introduction to the transforming dementia care in hospitals series. Nursing Older People 27, 6, 18-24.

Godfrey M, Young J, Shannon R, et al (2018). The Person, Interactions & Environment Programme (PIE) to improve care for people with dementia admitted to hospital: a multi-site study. Health Services and Delivery Research 6, 23, issn 2050-4349: https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr06230/#/abstract

Hunter B (2013). Implementing research evidence into practice: some reflections and challenges. Evidence Based Midwifery 11, 3, 76-81.

Kristensen N, Nymann C and Konradsen H (2016). Implementing research results in clinical practice: the experiences of healthcare professionals. BMC Health Services Research 16: 48. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-016-1292-y

May C and Finch T (2009). Implementing, embedding and integrating practices: an outline of normalization process theory. Sociology, 43, 3, 535–554.

NHS Commissioning Board (2012). Compassion in Practice. Department of Health: Leeds: https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

NICE (2018). Dementia: assessment, management and support for people living with dementia and their carers. NICE Guideline 97: https://www.nice.org.uk/guidance/ng97

Royal College of Psychiatrists (201. Report of the national audit of dementia care in general hospitals. Royal College of Psychiatrists: London.

Wye L and McClenahan J (2000). Getting better with evidence: experiences of putting evidence into practice. King's Fund: London.