

What influences the sustainability of an effective psychosocial intervention for people with dementia living in care homes? A 9 to 12-month follow-up of the perceptions of staff in care homes involved in the WHELD randomised controlled trial

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Objectives

The study aims to understand the factors that care home staff felt enabled or hindered them in continuing to use the well-being and health for people with dementia (WHELD) psychosocial approach in their care home and investigate whether there was sustained activity 9 to 12 months after the study ended.

Methods: This qualitative study is part of a wider clinical trial, which demonstrated effectiveness of a psychosocial intervention on quality of life outcomes and neuropsychiatric symptoms for residents. Forty-seven care home staff within nine care homes in the United Kingdom participated in focus groups, between 9 and 12 months after the intervention had finished. Inductive thematic analysis was used to identify themes and interpret the data.

Results: The findings highlighted that staff continued to use a range of activities and processes acquired through the research intervention, after the study had ended. Three overarching themes were identified as influential: "recognising the value" of the approach for residents and staff, "being well practiced" with sufficient support and opportunity to consolidate skills prior to the withdrawal of the researchers, and "taking ownership of the approach" to incorporate it as usual care.

Conclusions: The WHELD approach can be sustained where the value of the approach is recognised, and sufficient support is provided during initial implementation for staff to build skills and confidence for it to become routine care. Further follow-up is required to understand longer term use and the impact for residents.

KEYWORDS

care homes, dementia, interventions, qualitative, staff, sustainability

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1 | INTRODUCTION

People living with dementia in care homes have high levels of needs arising from a range of factors including moderate to severe levels of cognitive impairment; high frequencies of concurrent neuropsychiatric symptoms such as agitation, aggression, and apathy; and medical and other mental health comorbidities,¹⁻³ which often contributes to a poor quality of life.⁴ In the United Kingdom, the National Dementia Strategy for England⁵ has emphasised the importance of training and a skilled workforce in the care home sector. Internationally, the World Health Organisation report *Global Action on Dementia*⁶ highlights the importance of effective staff training in improving the quality of care for people in care home settings. However, there is a paucity of high-quality studies on the outcomes and sustainability of staff training. In recent reviews of training materials and programmes,^{7,8} ongoing supervision and encouragement were found to be a critical element in the training provision that achieved identifiable resident benefits. Additionally, the need to understand systemic and organisational factors, which facilitate the maintenance of knowledge implementation, is also highlighted in a review of the effective components of psychosocial interventions.⁹

The difficulties in sustaining interventions beyond the period of training have been discussed in the literature.^{10,11} The degree to which staff can be enabled to continue to practice in a person-centred way, once they have developed effective approaches to improving residents' quality of life, needs further investigation⁹ to identify barriers and facilitators that may impact on the adoption and embedding of new practice.¹² A number of implementation frameworks are available to evaluate the implementation and dissemination process of research findings.¹³ Studies using models such as Promoting Action on Research Implementation (PARIHS),¹⁴ Reach, Effectiveness, Adoption, Implementation, Maintenance (REAIM),¹⁵ and the Consolidated Framework¹⁶ have investigated factors that are important in the adoption of best practice and with notable exceptions few have taken a longitudinal perspective beyond the implementation period.¹⁷

Our study followed a cluster randomised controlled trial (RCT)—well-being and health for people with dementia (WHELD)¹⁸—involving 69 care homes in London and Buckinghamshire to evaluate the effectiveness of psychosocial interventions, which had been developed from learning from earlier work.¹⁹⁻²¹ The RCT evaluated a complex training and psychosocial intervention for people with dementia in care homes. The intervention was delivered through a Dementia Champion model. Dementia Champions were existing members of care home staff who were selected by their managers for the role. They received 4 days of training and two and a quarter hours' weekly support from a research therapist to cascade learning to colleagues and implement a person-centred and social activities care approach in their home, over a period of 9 months. This approach sought to empower and support care staff in changing care behaviour in their roles through the weekly coaching opportunity to plan activities jointly with the research therapist, reflect on their practice and engage in a structured approach to problem-solving difficulties that arose. Over the course of the period, the intervention support was structured to change the balance of leadership (eg, initiating the goal setting) from the research therapist to the Dementia Champions.

Key points

- Contrary to literature for other interventions, implementation of the WHELD approach was sustained by staff over a 9 to 12-month period beyond the end of a research trial.
- Embedding WHELD into routine practice developed staff confidence to continue beyond the formal period of trial support.
- Opportunities for staff to reflect on their practice and good leadership support underpinned staff success to continue using their learning.
- Further work is needed to identify the optimal approach to sustain benefits for residents.

This intervention demonstrated benefits for residents' quality of life, levels of agitation, and overall neuropsychiatric symptoms and was cost-effective.¹⁸ In order to inform ongoing care practice and training, there is a need to understand the sustainability of the approach beyond the involvement of the research therapist.

2 | METHODS

2.1 | Design

This qualitative substudy aimed to gather information on the experiences of the care staff working in homes that were involved in the study. Focus group discussions (FGDs) were held to understand the factors that staff felt enabled or hindered them in continuing to use the WHELD approach in their care home and investigate sustained activity 9 to 12 months after the WHELD study ended.

2.2 | Inclusion

Care homes were identified in the preceding RCT¹⁸ randomly from all care homes rated as "adequate" or "better" on the UK Care Quality Commission (CQC) register. The 36 care homes that had received the active intervention of training and support to implement person-centred psychosocial care, described above, were sent a letter of invitation to take part in the FGDs between 9 to 12 months after the intervention support had concluded in their home.

2.3 | Data collection

Nine care homes consented to take part, ranging from small (less than 30 residents) to large in size (more than 65 residents), with six being medium in size (30-64 residents). There was variation in size of governing organisation with four being from large organisations owning 10 or more care homes. Four were from not-for-profit organisations and five were from profit-making organisations. Four of the homes were registered to provide care only and the remainder to provide care with nursing.

Purposive sampling of staff took place in discussion with the care home manager. Staff eligible to attend included those who were involved directly with the intervention and also staff who were not directly involved or were new to the home since the completion of the RCT, so that the perspectives of staff in a variety of roles and with a range of experience could be obtained. The aim of the discussions was to understand the factors that staff felt enabled or hindered them in continuing to use the WHELD approach in their care home. The topic guide was developed iteratively so that the main issues that participants identified could be explored in depth. Open questions were used, for example, what was your experience of the WHELD study? How is any learning from WHELD being used now? What have you stopped doing? Further prompts were used to explore what has enabled practice and what has made it difficult. Participants were encouraged to express both positive and negative views, and any differences in opinions were explored. The FGDs were facilitated by research team members who had not previously been directly involved in the intervention delivery in the home. The discussions were recorded and transcribed verbatim and anonymised; observations and impressions were noted at the end of each group.

2.4 | Participants

In total, 47 care home staff participated in the nine focus groups, which varied in size and was pragmatic based upon staff availability on the day. Participants held a range of roles. Almost half of participants were either carers or senior carers: 16 carers (34%), seven senior carers (15%), three nurses (6%), six activity coordinators (13%), three managers (6%), six assistant managers (13%), and six traditionally nondirect care roles, such as gardeners and administrators (13%). The amount of time participants had worked in the home ranged from 2 months to 19 years, with 40.5% of participants having been in their home between 1 and 3 years. A total of 85% of the participants had been working in the care homes during the WHELD intervention, and 32% had been Dementia Champions during the RCT. The remaining 15% of participants had started work in the home after the research had finished in the care homes. The roles of attendees in each home are shown in Table 1.

2.5 | Data analysis

Thematic analysis was undertaken to identify themes and interpret the data.²² Four of the authors (J.F., L.G., C.F., and I.T.) read the transcripts

in order to familiarise themselves with the data and made notes about possible themes, which were then discussed and agreed. Multiple coding was conducted on two transcripts initially to enable the team to identify and discuss any alternative interpretations. The four authors then coded between one and three transcripts independently, using the agreed coding framework. The constant comparison method²³ was used to identify similarities and differences between the codes. Further discussion between the researchers led to the development of categories and subcategories. The illustrative quotations provided in the results Table 2 are anonymised and labelled with a focus group code number.

3 | RESULTS

Three key themes were identified in relation to the sustainability of the approach: "recognising the value," "being well practiced," and "taking ownership of the approach." Illustrative quotations, identified by care home number for all the themes, are provided in Table 2.

3.1 | Recognising the value

Recognising the value that the WHELD programme had for those involved was key to its ongoing use. Particular elements of the WHELD approach were sustained where staff felt there was a tangible benefit for their work. This incorporated two subthemes "value for people" and "value of adapting organisational practice."

3.1.1 | Value for people

There was consensus amongst the FGDs that a strong driver for continuing to use the approach was when methods had a clear benefit for residents. The recognition of individual needs and the positive effect that tailored care could have on people's well-being engendered a sense of pride in staff as they felt able to improve resident's lives. The value they noticed was both immediately in residents' responses to their changed approach and ongoing over a longer period. This was evident for those with direct care and wider support services roles.

Some staff reported that participating in the WHELD programme had transformed their perspective on their work, and this had an

TABLE 1 Summary of the number of participants by role and care home

Focus Group Discussions	Manager	Assistant Manager	Nurse	Activity Coordinator	Senior Carer	Carer	Nondirect Care Roles	Total Number of Staff Attending per Home
FG1	0	1	0	1	1	6	0	9
FG2	1	0	0	0	0	3	0	4
FG3	0	0	0	2	0	1	2	5
FG4	0	3	0	0	2	1	0	6
FG5	0	0	0	1	2	0	3	6
FG6	0	1	0	1	1	1	1	5
FG7	0	1	0	0	0	1	0	2
FG8	1	0	1	0	0	2	0	4
FG9	1	0	2	1	1	1	0	6

TABLE 2 Quotations illustrating main themes

Themes	Examples of the issues identified within the theme	Quotations to illustrate examples	
Recognising the Value			
a) Value for people	i) Staff getting to know residents	<i>i) Made me more aware of more, you know they're still a person, they still have needs, they still want to be- a purposeful life and their well-being and have happiness (FG7)</i>	
	ii) Tailoring care for individuals	<i>ii) Our chef would go along to resident of the day, which would be on both units, talk to them about all their likes and dislikes of foodand make sure that you know they're engaging with the resident - the resident feels they're really interested in my likes and dislikes, you know and actually they feel valued you're asking me what I do and don't like. (FG8)</i>	
	iii) Change in perspective	<i>iii) when I came back to work [following the training] I was like a different person" (FG2)</i>	
	iv) Relationships with families : positive : difficulties engaging : supporting care	<i>iv) you know families and friends were really impressed and have got on board with a lot of things (FG9)</i>	
		<i>some not so much, we did invite but then how many families really get involved in care homes anyway? (FG6)</i>	
		<i>all this [family involvement] has totally helped the home progress, I am sure the staff here would agree with me that we have made progress in dementia care (FG4)</i>	
	b) Value of adapting organisational practice	i) Organisation of care	<i>i) We become more confident to do things ... my team before they didn't know where to go. Now it is written in the guidance and we know what to do (FG2)</i>
		ii) Sharing amongst the team	<i>ii) I think our communication skills as a team has got a lot better as well like a lot more information is passed on from different shifts" (FG7)</i>
		iii) Recognition by others	<i>iii) the social workers can see how we approach and they are the ones referring to us (FG2)</i>
		<i>a friend who visited in dementia care and they were impressed and they gave us a donation of £200, so I've given the money to the carers to decide what they want to do with it [for resident benefit] (FG5)</i>	
<i>It's almost like the project is almost going to be like the [care home] family heirloom our claim to fame (FG8)</i>			
Being well practiced			
a) Understanding the philosophy	i) Importance of developing empathy	<i>i) WHELD made me put myself in their shoes more and you understand them a lot more going for this. And you understand them a lot more definitely, coming back and honestly interact with them a lot more (FG2)</i>	
	ii) Impact of experiential learning	<i>ii) the part I loved more was when I put my care in to the practical - to be the patient (FG1)</i>	
	iii) Changed understanding of meaningful activity	<i>iii) But even letting the individual chose what they were going to wear that day and chatting away while they're doing it is an activityas a carer you're doing it anyway but making it an activity not a task. I think staff were probably impacted quite a lot by that (FG8)</i>	
b) Acquiring personal growth, new confidence and knowledge	i) New confidence	<i>i) We have confidence, but that gave you more .. some professional has taught us. We are doing the right thing. We are able to see a new way (FG1)</i>	
	ii) Time to develop	<i>ii) Sometimes they come into an environment and they might spend ten years in caring where it was more task orientated so we try and change the culture (FG9)</i>	
c) Recognising sustained change	i) Altered approach	<i>imagine for nine month we have had [WHELD therapist] and to remove that is a little bit of a deflating feeling (FG2)</i>	
		<i>i) I have heard a lot more explanations going on rather than two carers talking over them, trying to wash somebody (FG7)</i>	
	ii) Approaches that become routine	<i>Our crockery,.. cutlery has all been changed - it's more dementia friendly, so the residents can see it (FG4).</i>	
		<i>ii) We do the life story (FG3)</i>	
<i>The pen pictures, you know their past and what they used to do, family things like that (FG7)</i>			
<i>Activities that worked well- five or ten minutes for each resident (FG9)</i>			

(Continues)

TABLE 2 (Continued)

Themes	Examples of the issues identified within the theme	Quotations to illustrate examples
Taking Ownership of the approach		
a) Leadership stability	i) Company policies	<i>i) We have just been told that the new company has got another pack for us so it means we will be changing this again. So it depends on what they expect us to do, because everyone has their own policy (FG3)</i>
	ii) Focus of care	<i>ii) the rota is now around the residents rather than the residents around the rota (FG7)</i>
	iii) Leadership support	<i>iii) I think there is such a difference between [past manager] who was 100% behind this ... we went and said to her look we need to spend an hour a week with this resident and the WHELD project but we would like to do it for the whole home. She says alright and it was 100% support (FG8)</i> <i>when you have a few team leaders that you know are passionate about the residents and person centred care then they will filter that down to the care team (FG6)</i>
	iv) Peer support	<i>iv) When I do the activities you know some of them are shy. So now they are confident. I tell "you can do this" and I show them what to do (FG1)</i> <i>I feel guilty, because your colleagues probably think oh she is sitting there chatting to them (FG4)</i>
b) Working as a team	i) Working together	<i>i) we all work as a team, we don't say "oh lets go to [participant 3] and [participant 4] because this is happening" it's just ... cos we work as a team (FG5)</i> <i>it really has promoted a good team spirit and that's where job satisfaction comes in (FG2)</i>
	ii) Ethos was supported	<i>ii) It did fit quite nicely with what we were already doing because we were already quite person centred care (FG9)</i>
	iii) Need for ongoing training	<i>iii) There are some staff that you think ohh, we need to get you in and we need to talk about WHELD and then there are others that we are thinking actually you're hitting it all (FG6)</i>
c) Moving Forwards	i) Induction of new staff	<i>i)...because it has been such an achievement to being following the WHELD study we used the first floor [that was involved in the study] as an induction program for all the new staff coming in.... we are now enrolling more of the new staff and the likes of the dementia leads they would be put aside time to spend with the new team looking at what you call about the person centred approach (FG2)</i>
	ii) Opportunities to be creative	<i>ii) The emoticons one's as well, you know it's just something quick for them to look at really that we devised as well. Likes and dislikes once someone's moved in (FG9)</i>
	iii) Adapting to meet new needs	<i>iii) We are hungry to do what is best way. Because we are moving in a change of sectors - you know they never stop in the care industry (FG2)</i>

enduring quality to their ongoing practice, which also extended to the families of the residents. Most groups acknowledged that during and after the study there had been a notable change to the way they tried to involve families in care planning and activities as a means to better embed person-centred care. Although this had been difficult in some homes, as there was sometimes a lack of clarity about how best to work with relatives and not all family members wanted to be involved with care. However, the experience of having relatives actively involved had encouraged them to consider different ways in which this could be achieved and for most staff across the focus groups this relationship building had continued.

3.1.2 | Value of adapting organisational practice

During the intervention period, some homes had adapted their organisational practices and reported that using the written documentation and guidance provided during the study had been helpful in providing direction and clarity in continuing the WHELD approach in

practice. Some of the practice routines, which participants felt had been established during the research intervention, for example, in the way they shared information about residents' needs within the home through meetings and structured review, had also continued. These were felt to be helpful in being able to share person-centred care principles with the wider staff group. A significant motivator for staff in sustaining their practice was also when other people recognised the quality of their care that arose from embedding this approach. Positive feedback from professionals and visitors was a highly valued source of affirmation of their achievements.

3.2 | Being well practised

Repeated opportunities for staff to develop their practice emerged as important for them in being able to use WHELD approaches. This was described by staff as "being well practised" and included the duration of time that they received training and coaching from the research

therapist during the study and also the ongoing frequent use of techniques with different residents, which consolidated their learning and skills. These were demonstrated in three subthemes: “understanding the person-centred philosophy”; “acquiring personal growth, new confidence, and knowledge”; and “recognising sustained change.”

3.2.1 | Understanding the person-centred philosophy

A notable skill which staff reported had become embedded was their understanding of the person-centred philosophy that underpinned the WHELD programme. The FGDs indicated that key to this was staff developing empathy and being able to identify more closely with residents. Many FGD participants reported this was achieved most effectively through experiential learning exercises, run by Dementia Champions with their colleagues. These experiential activities had additional impacts in terms of developing new communication skills and staff feeling better able to prioritise ways to tailor their approach to individuals. The FGD discussions identified a perception of a sustained change in staff's understanding that activities could be done “any time” and incorporated into physical care tasks through the use of conversations and short individual activities. Ongoing use of this approach was regarded as a particular benefit.

3.2.2 | Acquiring personal growth, new confidence, and knowledge

Staff felt that they had developed skills through practicing WHELD and that the amount of time they had had been coached by the research therapist—over the 9-month intervention period of the study had been important in building confidence to use new approaches. Staff who had been Dementia Champions during the intervention phase of the study reported that the WHELD programme had also given them opportunities for personal growth. A number of staff noted that the expectation that they train their colleagues had caused considerable anxiety at the start of the study but that the support and coaching that they received had enabled them to build confidence to do this and created a real sense of achievement. All FGDs talked about the ongoing nature of trying to change their practice and recognised that they had to bring new ideas to colleagues with long established practices. This was felt to be difficult at times, particularly due to pressures of time and the external support from the project was seen to be helpful in initiating this and experienced as a loss when it was withdrawn.

3.2.3 | Recognising sustained change

The majority of FGDs could identify positive changes that had occurred as a result of their participation in the research. Seeing the evolution of practice over time for themselves acted as encouragement to continue. These noticeable changes in staff behaviour included the way staff had altered their interactions with residents and also the adoption of some specific activities which had been incorporated as part of “routine”

approaches in the home. Practical strategies such as collecting life stories of residents and focusing on setting clear goals for periods of social engagement as part of the care planning process were most readily identified as changes to staff practice. In addition, physical changes to care resources that had been established during the project, as a result of staff gaining a better understanding of how to support residents' independence through environmental changes, had endured beyond the time of the active research intervention.

3.3 | Taking ownership of the approach

The degree to which staff could take ownership of the WHELD approach was a salient theme in all the FGDs. Their ability to do this was influenced by factors discussed in three subthemes, namely, “leadership stability,” “working as a team,” and “moving forward.”

3.3.1 | Leadership stability

The importance of leadership at all levels of the organisation was evident in all the FGDs. Changes in ownership of some of the homes caused uncertainty and frustration for staff about the extent to which they could maintain the approach they had established since the end of the study. New corporate policies and processes could quickly create challenges for staff in adapting their practice and a sense that in some organisations there was no forum to discuss this. However, strong local leadership around the way care was organised and support by the home manager was seen to greatly facilitate care staffs' ability to continue putting training into practice. Additionally, where staff had a strong sense of their own agency and of peer support then participants felt that it was easier to sustain the practices acquired through research participation. Delegation of responsibility for continuing specific WHELD elements appeared to be particularly successful, although at times individuals expressed a tension between continuing with the practice they had learned and an awareness of the pressures and perceived occasional negative attitudes of colleagues engaged in other care activities.

3.3.2 | Working as a team

One of the factors that mitigated the sense of divided loyalties between taking time for conversation and activity with individuals and supporting busy colleagues in practical tasks was evident in the FGDs when staff described their team approach to implementing person-centred care. Working together to ensure people's needs were addressed, enabled homes to sustain their practice. Unsurprisingly, this was more evident in FGDs in homes in which they felt that the project had been closely aligned to their existing ethos and supported a way of working, which they had already been trying to achieve. In these instances, the project had enabled them to use it as a springboard to implement new ideas, and the research protocols provided structure to achieve this. All FGDs identified a need for regular training and review of their practice to enable them to both support new members of staff and refresh the skills of established staff to reflect together on how best to develop the care they provide.

3.3.3 | Moving forward

Most of the homes had embraced the use of the project methods and materials, and many had identified ways to incorporate methods to achieve regular training and review since the end of the project. One home had devised an induction process for new staff and the development of dementia lead roles. Others had supported staff to be creative in devising new ways to seek residents' views about their care or offer a wider range of activities, which had created a sense of ownership of the activity rather than it being a "one-off" project. In these instances, there was a clear recognition of the importance of evolving practice through further training or involvement in more research, in the context of a changing environment.

4 | DISCUSSION

This study demonstrates that following sustained support during a research intervention, staff can continue to use the new approaches they have developed 9 to 12 months after the research ends. This is a key finding as the benefits of many previous training interventions have been lost shortly after the training ends. Three clear themes emerged as important in enabling staff to continue to use their learning through recognising the value of their work, being practiced in the activities, and taking ownership of the approach. This has important implications for developing ways to sustain changes in care practice in the future.

Our findings suggest that where staff could see value both for residents and for themselves this acted as a strong motivator to continue to engage with the WHELD approach. This desire to continue was further enhanced by recognition and feedback from others of the positive effects of their ways of working. Lehr and Rice²⁴ suggest that a lack of a clear rationale for a particular way of working can quickly lead to its lack of use and indications that the rationale needs to be refreshed frequently to decrease likelihood of people reverting to previous practices.²⁵ The repeated evidence of resident benefit was perhaps one mechanism in this study, which enabled staff to be repeatedly reminded of this. Developing relationships with relatives was also important, and our findings were similar to those of Chenoweth et al²⁶ that family appreciation and involvement could be a strong source of support and where they have clear expectations of care, it can act as a prompt to remind staff of particular approaches. Developing guidance about ways to build on the involvement of families may be a useful addition in sustaining practice.

The importance of considering the full range of factors associated with creating an organisational memory of new practices in order to sustain practice has been highlighted in an organisation learning framework, which can be applied to a range of health care settings.¹² The key factors in this framework are the needs of people, practice routines, procedures and policies, the relationships between individuals, organisational information, culture and structure. A care home specific model developed by Cammer et al¹⁷ elucidates a framework of factors that interact to support the adoption of knowledge and best practice in which care is underpinned by a clear philosophy, the nature of

relationships within and outside the home, an ability to address ambiguity, acknowledge changes to the context described as "flux" and recognise the opportunities and limitations of resources and the physical environment in staffs' ability to deliver care. Two elements influential in all these areas are, firstly, leadership and mentoring and, secondly, experience and confidence. Our finding strongly supports this model.

Of note in our study having Dementia Champions who had passion and a clear role to support others enabled many homes to widen the pool of people who hold knowledge and created experience and confidence as staff developed their abilities. Our model promoted repeated opportunities to practice their learning through experiential in-house sessions that were supported by written guidelines and which could be used as an ongoing resource that the participants reported to be of benefit. Although the formal training sessions were only 4 days in total, the extended period of support for implementation over 9 months was of particular benefit as evidenced in the theme of "being well practiced." In the last month of intervention, the research therapists helped the Dementia Champions to prepare for their withdrawal by encouraging them to think about what they would continue and how. Setting realistic goals on an organisational level, that generalised the skills of goal setting that staff had undertaken with residents, was also a mechanism for supporting staff to sustain change. Our findings described in the subtheme, "working as a team," suggest that this was effective, particularly where this is congruent with the prevailing care home culture. For all homes, finding resources such as time to continue with ongoing training was an issue with some being more successful than others at embedding this into their routine. Positive examples of this included using induction or shadowing opportunities for new staff.

Our findings were similar to other studies in identifying a key role for leadership in the success of sustaining practice^{9,26} and also highlighted the importance of the interrelationships in team working and value of peer support at a local level. Care homes are diverse communities, and the ways in which our participants reported sustaining the WHELD approach were highlighted in the theme, "taking ownership." Homes found different solutions pertinent to their local context in continuing the approach. For example, the ways in which information is gathered and then communicated in practice are often founded in the ways individuals relate to each other. Creating protocols for communication can help to embed practice, and creative developments led by staff to personalise them for the home context can be effective in generating a sense of ownership and commitment to sustained practice.

To maximise the potential of sustained uptake, future care home training programmes need to ensure that materials and processes are developed that look beyond the immediate training sessions. Approaches that promote demonstrable value for residents and staff that are practiced and reinforced through peer and family feedback on a repeated basis in addition to initial "expert" coaching seem most likely to be successful.

One of the strengths of this study is the relatively large sample size for qualitative research, with a quarter of the eligible homes participating in the FGDs providing data on the sustainability of the approach across a range of settings. Participants included 15% of staff who had joined their homes since the main study ended, and their experiences provide an

indication of embeddedness within the settings. However, there may also be selection bias in our sample with only those homes who have continued to engage with elements of the project being motivated to participate in the follow-up FGDs. There is also the possibility that the descriptions of continued practice were either over or under reported by the homes. This could have arisen for different reasons such as social desirability with staff being more likely to report positive outcomes to research team members or due to the group size or membership of the group discussions, which required careful facilitation.²⁷ For example, there was a risk that mixing junior and senior staff could inhibit discussion. We tried to mitigate against this by using experienced qualitative researchers as group facilitators who had not been directly involved in the intervention delivery in homes where they conducted focus groups. They attended to potential issues related to group dynamics by encouraging participation from all members, being clear that there were “no right answers” and making every effort to elicit both positive and negative views and the breadth of opinions from individuals within the group.

This research demonstrates that a complex psychosocial intervention, which has been implemented with training/coaching support for staff over a period of 9 months can be sustained over a period of a further 9 to 12 months without ongoing coaching. However, it also highlights the need for further research to understand the degree to which there is fidelity to the model and if homes are adapting the approach in the light of changing organisational circumstances, whether this continues to confer benefit on residents' well-being and health.

5 | CONCLUSIONS

This work indicates that, unlike other training programmes in the literature, impact and desired activity continued beyond the period of the study intervention, and related to perceived positive impacts on care staff and residents. Longer term follow-up is required to understand the patterns of use and benefit to residents.

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ETHICS STATEMENT

Ethical approval was obtained from the University of Oxford Central Research Ethics Committee MS-IDREC-C1-2015-140, and written consent was obtained from all participants.

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