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## **Introduction**

Dementia is a major public health issue for the 21st Century for which there is presently no cure. This is recognised by growing demands for the improved delivery of care for people with dementia (Department of Health, 2009; 2012) with person centred care including the provision of meaningful activity and occupation becoming synonymous with quality provision in this area (Brooker, 2007). In accordance with these developments, the benefits of incorporating arts interventions in dementia care provision are becoming increasingly recognised (Zeilig et al, 2014). Moreover, in spite of the significant methodological problems in attempting to measure the impact of art involvement on well-being (Argyle and Bolton, 2005; Vink et al, 2006) there have been several convincing and methodologically stringent investigations into this impact (Zeilig et al, 2014). While much of this research has adopted a broad focus on the type of art involved, some studies have shown a positive relationship between music and well-being for people with dementia. For example, a study by Ziv et al (2007) found that music made people with dementia 'calmer'. Similarly, Wall and Duffy (2010) reviewed thirteen studies relating to the influence of music therapy on the behaviour of older people with dementia. The majority of these studies reported that it influenced their behaviour in a positive way by reducing levels of agitation and improving mood and social skills.

In spite of the advocacy of these types of person centred interventions, task centred approaches to care and a corresponding neglect of the social and activity needs of people with dementia is still widespread (Care Quality Commission, 2014). This apparent gap between research evidence on one hand and its practical implementation on the other has been a well recognised issue in health and social care provision (Grol and Grimshaw, 2003). With specific regard to dementia care provision, a number of reasons have been given for this 'implementation gap' including inadequate training and leadership (All Party Parliamentary Group on Dementia, 2009; 2014), contextual issues such as inadequate resources (Argyle, 2012), a lack of clarity on how good practice should be implemented (Brooker, 2004) and organisational cultures (Ravasi and Schultz, 2006). It has therefore been the aim of this research to identify the factors that can impede the implementation of a person centred intervention in dementia care provision, in order that they can be recognised and addressed in future practice. The research has focused specifically on the roles and perspectives of the team leading the intervention. This is because the leadership role has been found to be particularly important in the implementation of person centred care (Department of Health, 2009), helping to reduce resistance and providing clarity in organisational concepts and values within the context of limited resources, conflicting priorities and increasing demand. The proposed intervention was a pilot project called

'Music'. It adopted a person centred approach in that it was designed to build an individualised compilation of meaningful music, representing key aspects of each client's life. As the intervention was to be compiled and delivered by home care workers during their visits to clients with dementia, it also aimed to enhance care workers' person centred care skills.

## **Methods**

It was originally intended that research methods would involve an evaluation of the impact of the musical intervention on the well-being of around thirty clients of a dementia specialist home care service with the use of baseline and follow-up measures. However, it soon became clear that the intervention would not be fully implemented as originally intended and it therefore became the goal of the research to establish the reasons for this. This was achieved by conducting semi-structured interviews the five key staff involved in the management of the project. The first was a training provider who was responsible for preparing care staff and front line managers for delivering the intervention and compiling relevant documentation for this. The second was a senior manager who was central to initiating the project, identifying and recruiting care teams and front line managers to be involved in its implementation and providing them with ongoing support through the supervision process. Thirdly, was a front line leadership team including two front line managers and a supporting professional who were responsible for recruiting care staff and clients to take part in the project and helping to oversee its progress. Interviews were designed to elucidate the enablers, barriers and success factors that might usefully inform future projects, with emergent themes being identified and pursued (Bryman, 2012). These, interviews were tape recorded and transcribed, names have been anonymised in order to protect confidentiality and transcriptions were returned to respondents in order to elicit their clarification and consent.

## **Results**

### *The musical intervention*

All respondents were in agreement on the potential benefits of using music as part of the care regime:

*We have a lady who was very closed to meeting new carers and the only way we could get through to her was through music. (front line manager)*

*Using music in care should be part of the generic care offering and I still think that that's the vision right now. (training provider)*

Thus the training provider thought that interventions were essential in order to make the dementia home care service a truly specialist one:

*I'd be interested to find out from the team what it is that makes them specialist. Is it because they have additional skills and deliver a different type of service or is it just that they have a specialist clientele. So there's a difference between offering a specialist service and dealing with a specialist group, I think those are two different things. (training provider)*

Similarly, the senior manager regarded Music as fundamental to the delivery of person centred care, and as an important adjunct to specialist service provision:

*Music is fundamental to how we deliver person centred care because its what we are doing that's special and if we just keep people warm, fed, clean and safe then that's not specialist dementia care...its giving that quality of life to somebody with dementia. It shouldn't just be about coming in and doing. (senior manager)*

Such an approach, she felt, could have a positive impact on staff as well as clients:

*Anything that you can do that's fun, it makes your life better so there's a payoff for staff isn't there. (senior manager)*

In view of the potential benefits of the intervention, she thought that it should be introduced to clients early in the dementia trajectory although the question remained as to when that journey started for each individual client who were usually "somewhere down the line" by the time they were diagnosed. In this respect she thought that a flexible approach to clients was crucial to the implementation of a person centred approach:

*I think its about having staff who are chameleons and can adapt themselves to every setting because what would be right for you wouldn't be right for someone else and its about having the staff that can act on that. (senior manager)*

In spite of the general consensus on the perceived value of the intervention, a number of barriers to its implementation were identified by respondents including training, leadership and contextual issues and a range of equally eclectic approach were suggested in order to overcome them.

### *Training*

Traditional explanations for the 'implementation gap' have focused on the availability and presentation of evidence (Grol and Grimshaw, 2003). For example, cognitive theories suggest that staff need better information about the evidence base and that this may promote better compliance. In addition, adult learning approaches state that people need to experience the problem and reflect of solutions themselves rather than being subjected to a more didactic approach to knowledge acquisition. These perceptions were echoed by the Music training provider who felt that education and training was central to improving the quality of dementia care and in bridging the gap between evidence and practice:

*How people learn and how people then put that into practice is something I'm particularly interested in – so Music is great, what is delivered to the service users is great, it's the stuff in between that I'm interested in. This is how do people learn and grasp a concept and how do they implement it and how you get people to actually develop their practice or change their way of thinking, so the learning process is what I'm interested in. (training provider)*

In her view, this process of knowledge translation was often hindered not only by tokenistic training provision but also by the lack of clarity in the meaning of person centred care and how to put it into practice:

*I think the challenge of delivering good quality home care services is probably the same across the board. Care is still approached as a time and task operation. The idea of person centred care, although people probably understand what that means, they don't necessarily understand how to implement it. (training provider)*

In accordance with this, she observed that explanations from front line leaders on the failure to implement the musical intervention suggested their implicit adoption of this “time and task” approach to caring:

*What struck was what was said by one of the line managers, that they didn't have time to use Music with the service users because they were too busy delivering care...how is that activity separate from getting to know a person and engaging with a person. Those things should be happening all at the same time. (training provider)*

However, for the front line leaders themselves, barriers to implementation were compounded by the inadequacies of relevant training provided. Thus while all felt that parts of the theoretical aspects of this training were good and resonated with them, it wasn't made clear how the intervention should be practically implemented especially with regard to their own expected role in this implementation. They therefore believed that training for the intervention needed to be improved upon. This view was reflected by the training provider herself who accepted that this training should become more wide reaching and, in accordance with adult learning approaches, less didactic, being preceded by awareness raising and followed by reinforcement.

### *Leadership*

Behavioural theories (Grol and Grimshaw, 2003) suggest that barriers to person centred care arise from leadership issues such as lack of feedback, incentives, role modelling and reinforcement. In accordance with this, both the senior manager and the training provider thought that the front line leaders should have played a key role in supporting the implementation of the Music initiative and in the promotion of good quality care more generally:

*In any organisational structure there have to be people who facilitate Music and take the leadership role for making sure that it happens....It's the role of the manager, middle and junior, to set the tone and the culture of what the service will be. (training provider)*

However, it was felt by the trainer and senior manager that front line leaders had not fully performed this role and had not implemented adequate systems for collecting the Music data, supervising their staff and keeping track of their work. Care workers were therefore left in limbo, baseline assessments did not happen, nobody appeared to know which clients were taking part in the study and there was no apparent implementation plan or strategy:

*Music was a way to improve the quality of care of service users. They agreed that Music was a means to meet that aim. Because they had that very noble and worthwhile aim we assumed that they had the motivation to drive the project forward....they had the vision and the aim but no strategy. (training provider)*

Nevertheless, the training provider did go on to recognise that perceived deficiencies in the performance of front line leaders were partially attributable to similar deficiencies in the guidance and leadership which they had received:

*I think the (front line) managers were very interested and engaged in Music during the training and they definitely understood what it was about but. I think it was less clear what their role would be in facilitating Music for service users. That is partly because it wasn't made clear enough. There wasn't a formal action plan set by ourselves as the people delivering Music training but also there was an assumption that if you bought into the approach you would make sure that things were happening. I think that that was a bad assumption to make. (training provider)*

The lack of adequate guidance given to front line leaders was echoed by the leaders themselves who thought that the paperwork was "cumbersome" and "complicated" and the process of transition from theory to implementation "on a practical level" was not made clear:

*It was never made clear to me what my role was, especially regarding the paperwork, we were a bit confused on how to implement it....it started off quite positive but ended up with a bit of a struggle. (front line manager)*

In addition, front line leaders felt that the intervention had been imposed on them, a perception that was confirmed by the senior manager who conceded that they may have not been consulted adequately in the implementation process and could have felt "done to" as a consequence of this. This may have been compounded by the restructuring of the homecare service and changes in personnel with the senior manager moving jobs shortly after the intervention was to be introduced. While the redesigning of the home care

providers care plans meant that they were no longer compatible with the Music interventions own documentation.

In recognition of these issues, the training provider felt that there should be more consultation with managers and care staff in the future implementation of Music with clearer implementation guidelines and with the intervention itself being driven by those in receipt of the service:

*People who are receiving the service, if you are looking at it from a person centred perspective, are the people who drive what that service looks like. (training provider)*

A similarly bottom up approach was suggested by the senior manager through the advocacy of greater involvement of front line leaders in the implementation process and by empowering them to challenge poor practice. One way in which this could be achieved would be through the shift in the supervision process to a more clinical focus:

*Supervision with care team leaders is business based but you also need that clinical supervision.....We're going to have to have a lot more conversations with the care team leaders and they've got to really buy into it, its got to be part of their supervision. (senior manager)*

Similarly, the front line leaders thought that simpler paperwork should be adopted which would be compatible with the home care services care plans. They also felt that there should be more managerial support and consultation with the front line staff involved in implementing the intervention.

### *Contextual issues*

Organisational and structural theories attribute barriers to implementation to the wider context in which the practitioner operates (Grol and Grimshaw, 2003). This can be due to such things as inadequately organised care processes and a culture that is not orientated to the improvement of this care. For structural approaches, barriers can also arise from low levels of public awareness and poor resourcing (Argyle, 2012). All respondents referred to these contextual issues and their role in undermining the provision of a person centred approach. Thus the senior manager referred to an organisational culture within the home care service that could discourage particular initiatives or innovations:

*People are in that maintenance set where they're doing the job and that's it and barely doing their job and I don't think people are very good at self reflection. I don't think that's something that they've ever done at provider services...and I don't think people see themselves as role models either. (senior manager)*

For the training provider, inflexible and unresponsive commissioning practices had an important role to play in this culture:

*I think commissioners have a very large part to play in the culture within care services and from my experience it is the idea of commissioning based on time-slots and pre-assessing people for what they need...at the point of commissioning, it is already defined and decided what you're going in to do with that person...everyone needs personal care but being alive is not the same as living. (training provider)*

All other respondents referred to commissioning as forming a barrier to person centred approaches. Thus, the senior manager felt that social care budgets were underfunded:

*As providers it's difficult to provide what we haven't been commissioned to do. (senior manager)*

Similarly, the front line leaders referred to the detrimental impact of commissioning and resourcing more generally on their work:

*I think it is possible to integrate (Music) into daily care but it didn't always work that easily...our carers are under such time pressure anyway... it comes from commissioning, we're told what to provide. (front line manager)*

Front line leaders said that they were also experiencing time pressure due to staff shortages amongst their team meaning that they had not "pushed" the Music intervention:

*It's just like an extra thing on top which doesn't seem essential. (front line manager)*

In recognition of the significance of adequate staffing levels and resourcing, all respondents recognised the need for more appropriate commissioning in order to facilitate the prompt and prolonged implementation of the intervention and of person centred care more generally.

Furthermore, the senior manager cited the need to address broader issues of resources in order to promote communities that are truly 'dementia friendly':

*We've got to be political about it...poverty dimensions such as people's living environment preventing people from participating in their communities...libraries are going to be closing and museums and things like that. It's your social fabric isn't it. Its not just statutory services, it's all that that's going to impact on how you experience your daily life. (senior manager)*

Table 1 here

## **Discussion**

Research provides a great deal of evidence to suggest that the use of musical interventions can yield significant benefits to people with dementia. However, while respondents in this research supported this basic premise, a number of interrelated factors appear to have impeded the implementation of the musical intervention featured in this research. As it has been seen, these factors broadly correspond to those identified in existing literature (Grol



and Grimshaw, 2003) and are summarised in table 1. Firstly were perceived inadequacies in the knowledge and training of front line leaders and care staff giving rise to a lack of understanding on how both the musical intervention and person centred approaches more generally should be implemented. Secondly were deficiencies in leadership which compounded the lack of clarity surrounding the implementation with all believing that greater levels of staff consultation, communication and support should have taken place. A third identified barrier to implementation arose from contextual issues with restructuring and staff turnover serving to undermine communication and continuity of care. More broadly, the constraints of “time and task” based commissioning, was a commonly expressed theme, while the senior manager suggested the desirability of addressing the wider “social fabric”. She thus felt that such measures would facilitate the community development of ‘Dementia Friendliness’ which Crampton and Eley (2013) recognise, is not simply the domain of health and social care provision but is also facilitated or constrained by the wider social context. Similar constraints can arise from the high levels of dependency amongst those who are diagnosed and in receipt of specialist dementia services, leading to a focus on maintaining their safety and a corresponding marginalisation of activities which are not seen to be part of basic care (Taylor and Donnelly, 2006).

While there was much consensus on the nature of the barriers to implementation identified, opinions differed on the level of leadership at fault, with a certain degree of mutual recrimination being expressed by respondents. These conflicts have been found to be common between the health and social care workforce hierarchy and can be seen to arise from opposing priorities (Ravasi and Schultz, 2006). Nevertheless all the respondents in this research were in agreement on the potential value of the musical intervention which could, in itself, be seen as a major facilitator to its future use. This general consensus was reflected in respondent’s identification further potential facilitators, with issues of commissioning and leadership being prominent themes. As such, the involvement and commitment of managers at a number of different levels is likely to be integral to the success of person centred interventions in order to ensure that adequate time and other resources are made available for their implementation (All Party Parliamentary Group, 2014). Managers therefore need to create environments where both workers and their clients (All Party Parliamentary Group, 2014) are consulted and encouraged to explore and expand the options and possibilities. In addition, to be truly person-centred, services for people with dementia need to be flexible, responsive and individually tailored and in order for this to be achieved commissioning practices need to be similarly flexible and adequately resourced. Diagnosis should also be prompt in order that appropriate service can be introduced at an early stage in the dementia trajectory (Patmore and McNulty, 2005). While policy recommendations

have consistently supported this need for early diagnosis (All Party Parliamentary Group, 2014), the lack of availability of appropriate post diagnosis support is likely to undermine the goal of prompt intervention that such measures aim to promote.

## **Conclusion**

The promotion of person centred approaches within health and social care provision for people with dementia is widely advocated. Musical interventions can be an important component of these approaches. However, the practical implementation of the musical intervention featured in this study was problematic with a number of barriers serving to impede this process. While key stakeholders tended to have conflicting views on the individual team members responsible for these problems, there was a high degree of congruence on the nature of these barriers, with issues of training, leadership and contextual issues such as commissioning all being commonly alluded to. In view of the multi-levelled nature of these obstacles, a similarly eclectic approach should be adopted in order to facilitate the implementation process. This could include such things as greater support, consultation and clarity around this process as well as the availability of more flexible commissioning practices. Moreover, the impact of contextual barriers on the introduction of person centred approaches suggest that measures aiming to overcome them should transcend their focus on the promotion of individual well-being and address the factors that can impede or facilitate this goal both within organisations and in the wider community.

## **Implications for practice**

- The use of music and of arts interventions more generally are important components of person centred approaches to dementia care.
- In spite of the benefits that can be gained by people with dementia from engagement in music, the process of implementing such interventions can be subject to a number of barriers.
- These barriers are multi-levelled and include aspects of training, leadership and the wider organisational and social context.
- Due to the diverse nature of these barriers, measures to overcome them should adopt a similarly eclectic approach.

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Table 1: Barriers and facilitators to implementation

Barriers	Facilitators
Training	
<p>Lack of understanding of person centred care and how to implement it leading to a prevailing task centred focus. (training provider and senior manager)</p> <p>Lack of clarity in training on how the intervention should be implemented. (training provider and front line leaders)</p>	<p>The recognition of the intrinsic benefits of the intervention. (all)</p> <p>Training which is preceded by awareness raising and followed by reinforcement. (training provider)</p> <p>More wide reaching and audience targeted training. (all)</p>
Leadership	
<p>Lack of leadership by the senior manager. (front line leaders)</p> <p>Lack of leadership by front line managers. (senior manager and training provider)</p> <p>Business focused rather than client focused supervision. (senior manager)</p> <p>Staff turnover leading to discontinuity in leadership. (senior manager and front line leaders)</p> <p>Lack of consultation, communication and support in the implementation process. (all)</p>	<p>The adoption of an approach which is driven clients and carer workers. (all)</p> <p>Better leadership with a greater focus on clinical issues in staff supervision. (all)</p> <p>Clearer rationale for selecting staff to be involved and the provision of more staff support and consultation. (all)</p>
Context	
<p>Time and task focused commissioning practices. (all)</p> <p>A culture of inertia amongst front line staff. (senior manager)</p> <p>Organisational restructuring and cumbersome paper work which was incompatible with new client care plans. (front line leaders)</p> <p>Time pressure and conflicting demands on this time. (front line leaders)</p> <p>Cut backs and resource limitations in the wider community. (senior manager)</p>	<p>More flexible and responsive commissioning practices. (all)</p> <p>The promotion of 'dementia friendly communities' through improved community resources. (senior manager)</p> <p>The provision of a person centred and responsive service. (senior manager and training provider)</p> <p>Simpler paperwork which is compatible with the services new care plans. (all)</p>