

Research Space Journal article

> Implementing the PIE (Person, Interaction and Environment) programme to improve person-centred care for people with dementia admitted to hospital wards: a qualitative evaluation Skingley, A., Godfrey, M., Henderson, R., Manley, K., Shannon, R. and Young, J.

- 1 Implementing the PIE (Person, Interaction and Environment) programme
- 2 to improve person-centred care for people with dementia admitted to
- 3 hospital wards: a qualitative evaluation
- 4

5 ABSTRACT

6 Background

- 7 Improving person-centred care for people with dementia in hospitals is a UK policy
- 8 priority. The PIE (Person, Interaction, Environment) programme comprises cycles of
- 9 observations of care by staff, identification of areas for improvement and plans for
- 10 practice change and evaluation. The aim of the research reported here was to
- 11 describe and evaluate PIE implementation in three UK NHS regions.

12 Methods

- 13 A qualitative design was adopted in ten case study sites (wards). Site selection was
- based on readiness for change criteria. Following a training workshop, PIE cycles
- 15 were introduced into each ward. Data collection comprised observation, interviews,
- 16 documentary analysis and an events log. Normalisation Process Theory provided a
- 17 guiding framework for analysis.
- 18 Results
- 19 PIE was fully adopted in two study wards over 18 months, which resulted in
- 20 sustained practice change and increased awareness of person-centredness. Partial
- 21 implementation of PIE took place in a further two wards but progress stalled before
- 22 significant action. The remaining six wards failed to implement PIE. Factors
- 23 influencing implementation were: salience of PIE, collective team involvement, fit
- 24 with strategic priorities, adequate resources, effective clinical leadership, good
- 25 facilitation and organisational stability.

26 Conclusions

- PIE has the potential to help staff improve person-centred care for people with
 dementia admitted to hospital wards. However, the evidence is limited to ten wards
 of which only two fully implemented the programme.
- 30 Implications for practice
- A programme for improving person-centred care for people with dementia in
 acute hospital wards- requires sustained commitment from both the
 organisation and the ward.
- Successful practice change depends on multiple key factors, including
 effective clinical leadership and good facilitation.
- Contextual factors at various levels of an organisation need to be considered.
- Use of the PIE tool has the potential to enable staff's attention to focus on
 person centred care for older people with dementia in acute settings.
- 39
- 40 KEYWORDS
- 41 Dementia; person-centred care; hospital wards; service improvement; Normalisation
- 42 Process Theory
- 43

44 BACKGROUND

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The ageing population has brought challenges for care services internationally 46 (Amalberti et al, 2016; Hung et al, 2018). In the UK up to two thirds of hospital beds 47 are occupied by older people (Royal College of Psychiatrists, 2005) and some 50% 48 of admissions of people over 70 have some degree of cognitive impairment 49 (Goldberg et al, 2012). Successive research reports have found that, despite pockets 50 51 of excellent practice, there exists unacceptable variation in the quality of care 52 experienced by people with dementia in acute settings (Alzheimer's Society, 2009; 53 Digby et al, 2016). This often results in a worsening of health, long hospital stays, and high numbers of patients being admitted to long term care. The Alzheimer's 54 55 Society report concluded that improving the experience of people with dementia in 56 general hospitals is a key to improving the NHS overall. 57

In the light of these trends, improving care for people with dementia in general 58 hospitals has become a policy priority in the UK. The National Dementia Strategy, 59 60 (Department of Health, 2009) covered 17 key objectives, including a need to improve the quality of care in general hospitals (in terms of person-centredness, addressing 61 coordination of dementia care, training and leadership), the provision of an informed 62 63 and effective workforce and the availability of research evidence to guide change. Since then, the Prime Minister's Dementia Challenge, (Department of Health, 2012; 64 2015) while highlighting progress, also identified what still needs to be done in terms 65 of driving up standards of care, better research and awareness of dementia and its 66 impact in society in general. 67

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Although there is a lack of consensus around the concept of person-centred care 69 70 (Kogan et al, 2016), particularly with regard to people with dementia, the work of Kitwood (1997) has been influential in addressing this. Kitwood proposed that 71 72 wellbeing for people with dementia can be realized if psychological and relational 73 needs and 'personhood' can be maintained. One initiative, developed and based on this concept, with a potential to improve the quality of person-centred care for people 74 admitted to hospital with co-incidental dementia, is the 'PIE' (Person, Interactions 75 76 and Environment) observation method.

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78 PIE was developed as an audit tool for use in the first national audit of dementia in

79 NHS hospital wards (Royal College of Psychiatrists, 2011) during a three-year

research study (2008-2010). Now in its fourth iteration (Royal College of

81 Psychiatrists, 2019), the national audit has consistently found that aspects of

82 dementia care, although improving, fail to reach acceptable standards.

83

PIE takes the form of a programme which guides staff to undertake real-time observations of small numbers of patients with an emphasis on three main areas: the extent to which staff are considering what is known about the individual patient as a **P**erson to personalise their care; the quality of patient Interactions with staff; and the impact of the immediate modifiable physical <u>E</u>nvironment or organisation of care. Observation notes are then discussed within the staff team and areas of both good practice and areas where care could be improved are identified collaboratively.

The PIE audit tool has subsequently been developed into an improvement 92 programme which further extends its remit to enable the formulation of goals and 93 94 achievable action plans which are then implemented and reviewed. Further guidance was produced by the research team in collaboration with key hospital staff to 95 96 describe the steps to be taken for action plans to be operationalised. Steps identified include the formation of a PIE implementation team for each ward, agreeing which 97 98 actions will be taken forward and communicated to staff, use of a revised workbook 99 and a preparatory workshop and guidelines for reviewing progress and identifying 100 barriers to success. The PIE tool has therefore been developed into a practice 101 improvement process (authors, 2018) comprising cycles of observation, reflection, 102 planning, action and review (Figure 1).

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Since the use of PIE in the National Dementia Audit was limited to one-off use for
audit, the extent to which it can be implemented as a programme in general hospital
wards, and its effect on care delivery is unclear. We therefore developed a research
study to address these issues.

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109 METHODS

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111 Design

112 A longitudinal, mixed method design was adopted, incorporating multiple case

113 studies. A case study investigates contemporary phenomena in depth and within a

real-life context which is taken into consideration. It also deals with a multitude of

variables, relies on multiple sources of evidence and often benefits from a theoretical

underpinning (Yin, 2009). Each case, or unit of analysis, consisted of a ward within

an acute NHS hospital trust. The qualitative component of the mixed methods isreported here.

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120 Sample and setting

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122 Ten wards which had a substantial proportion of older people with dementia among 123 their patient intake were purposely selected in five NHS hospital trusts, located in

their patient intake were purposely selected in five NHS hospital trusts, located ithree English regions. Trusts varied in size and populations served. Criteria of

125 'readiness' to engage in a change process were identified prior to recruitment,

informed by previous research on delirium prevention_(authors, 2013):

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Expressed interest among senior acute hospital staff in participating in the
 research to improve person-centred care for people with dementia.

- Agreement of senior ward staff to engage in a practice improvement
 programme over a prolonged period.
- Commitment from a clinical lead external to the ward with responsibility for
 practice development to assume a leadership role in initiating and facilitating
 PIE.
- 135
- 136 Data collection

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138 The process of PIE implementation, following a workshop delivery by the research 139 team, was documented through the methods outlined in Box 1.

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141 Data analysis

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Qualitative data drawn from interviews, notes of workshops, observation of action 143 planning and review meetings, and examination of completed documentation, were 144 drawn together to provide a descriptive account of the engagement of staff with each 145 step in the PIE cycle for each ward. Individual wards (cases) were then compared in 146 a cross-case analysis (Yin, 2009) using Normalisation Process Theory (NPT) (May 147 and Finch, 2009) as a sensitising framework. NPT proposes that complex 148 149 interventions become routinely embedded (implemented and integrated) in their organization and professional contexts as the result of people working, individually 150 151 and collectively, to implement them. Four generative mechanisms are put forward to explain how this is operationalised within routine care: coherence, cognitive 152 153 participation, collective action and reflexive monitoring. New practices, the theory 154 contends, become embedded when:

The work that defines and organises a practice/intervention is understood as
 meaningful and invested in, in respect of the knowledge, skills, behaviours
 and actions required to implement it at an individual and collective level
 (coherence);

- The work is perceived as something worthwhile and appropriate to commit individual time and effort to -bring about the intended outcome (cognitive participation);
- Work practices and the division of labour through which these are carried out
 are modified or adapted to incorporate the change/intervention into the social
 system of the host organisation (collective action);
- Those engaged appraise the effects as attributable to the intervention and
 congruent with valued goals (reflexive monitoring).
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Analysis drew on May et al's (2015) suggestion that the theory can be used as a
sensitizing device, to direct thinking in a structured way. It also drew on the review by
Fixsen et al. (2005) of implementation research which identifies distinct
implementation stages: exploration and adoption; programme installation; initial
implementation; full adoption; innovation; sustainability (Box 2).

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- 174 To minimise bias, analysis of qualitative data was conducted manually, separately
- and collectively by members of the research team (XXXXXX). This was done at
- 176 regular time intervals to compare emerging findings across cases (wards).
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- 178 Ethics
- 179 Ethical approval for the study was obtained from National Research Ethics
- 180 Committee Yorkshire & The Humber Bradford (reference 12/YH/0442). Written,
- informed consent was sought from health care staff who were interviewed, or who
- took part in the observed PIE meetings. Data were pseudonymised and personal
- 183 data deleted from trust and ward documentation where appropriate.
- 184
- 185 FINDINGS
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All sites participated in exploration (Fixsen et al's first stage) and met the 'readiness' 187 criteria, achieved through meetings, a willingness to invest resources, and providing 188 signed agreement. However, not all wards subsequently proceeded to full PIE 189 190 adoption. A distinction was made between 'full implementers'; 'partial implementers' 191 and 'non-implementers'. 'Full implementer' wards pursued implementation over 18 months broadly as intended (two wards within a single trust). 'Partial implementers' 192 193 made some progress but did not persist to full adoption (two wards in two different trusts). 'Non-implementers' were either lost early on following programme installation 194 195 (three wards in one trust) or did not begin installation (three wards in two trusts). 196 Trusts and wards were given pseudonyms to maintain confidentiality (Table 1). 197 198 On most wards the prevalence of dementia was between one third and a half. For

the dementia-orientated wards (Netherton and Denton) this figure was close to100%.

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This paper firstly describes the progress of each site in the light of the stages of implementation (Box 2). It then compares implementation processes across settings to discern generalisable features that may account for variation and identify factors conducive to full implementation (cross-case analysis).

207 Full implementers

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209 Exploration to Programme Installation

The last trust to be recruited into the research, Seaford Trust engaged encouragingly 210 with the idea of PIE with good attendance at each of the two sites' workshops. The 211 212 PIE implementation team on Poplar ward comprised nursing and care staff (practice 213 development facilitator, dementia nurse specialist, ward sister (senior ward nurse), 214 staff nurses, health care assistants (HCAs) and therapy assistant). Joint leadership 215 was assumed by the practice development facilitator and dementia nurse. Both were external to the routine ward work and had a developmental role in relation to staff on 216 217 it. Although the ward manager was not a formal team member, she provided active 218 support, facilitation and encouragement.

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220 On Crane Ward, membership of the PIE team included the lead dementia nurse

221 specialist, senior occupational therapist (Senior OT), occupational therapist (OT) (all

external to the ward team), two therapy assistants, ward manager (on assuming the

post and for part of the project) and ward sister. At the outset, direct involvement of

front-line nursing and care staff was absent, although senior staff actively

- encouraged their participation.
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227 Programme Installation to initial implementation

The first PIE cycle on Poplar began after the introductory workshop. Five team members, working in pairs conducted a total of five hours observation over different

times of the day, including a weekend, in time spans of around an hour.

231 Researcher's notes from staff feedback showed that for both observers and

observed it was perceived as 'out of their comfort zone' at the beginning. 'Observers'

found it difficult to look without acting, and the objects of observation, the staff

234 'observed', were wary. PIE observation notes showed both positive and suboptimal

235 care practices:

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237 10.50am: GT has a visitor. Interacting, smiling and looking at pictures.

11.20am: Student nurse tidies room, places drink within reach. However, nointeraction with patient.

241

Initial implementation on Crane followed behind Poplar by two months. PIE was 242 243 slower in getting off the ground on this ward. Partly this reflected situational factors 244 at ward level. A new ward manager with a practice development background had 245 recently been appointed. A well-attended second workshop was held which generated renewed enthusiasm. Leadership and responsibility were assumed by the 246 247 lead specialist dementia nurse. Other team members included a senior OT and her staff (OT and therapy assistant). For the first cycle, there were four sets of 248 observations, typically conducted in pairs, each an hour long, undertaken at different 249 times and in different spaces. As in Poplar, observations revealed variation in care 250 251 quality:

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253 2.35pm: Student returns: 'Martha [not real name] would you like more tea?' Assists
254 patient to drink. 'You're doing really well' (encouraging). Wipes mouth. 'You're
255 struggling, aren't you?' Then 'fantastic, well done'.

256

09.25: Patient asleep in bed, radio on loudly next to him..... a lot of noise coming
from resource room. Ward as a whole is noisy – feeling quite stressful.

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260 Initial implementation to full adoption

261 Moving forward from conducting observations on Poplar was not without challenges, 262 since the team found it difficult to identify convenient meeting times. Further 263 hindrances came with a temporary ward move due to refurbishment, which occurred soon after moving to what was intended to be its permanent home. In addition, an 264 imminent Care Quality Commission (CQC) site visit absorbed staff energy. 265 266 The first action plan on Poplar established several areas to work on: communication, 267 268 nutrition and activities. In response to observations indicating inconsistency in nurse-patient interaction and little interaction between patients, an initial action plan 269 270 focused around mealtimes as a social event. Starting in a single bay, patients were 271 encouraged to sit around a table for lunch. This set in train work addressing several

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- goals, beginning with small steps, subsequently expanded to all bays through the
 process of appraisal and review (including new observations). This initiative also
 contributed to the goal of -patient mobilisation, getting people up and moving
 between bed and tables. Interview data revealed staff viewed this positively:
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We found that sitting them up at the table, a patient that maybe didn't talk, didn't eat, all of a sudden, with other patients that maybe haven't got delirium or dementia, they've actually sat there, they've spoke, and they've actually eaten. We have found that's really a big, big thing. Interview with HCA

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282 Implementation on Crane began in earnest following the workshop. Observation about noise from the radio resulted in a plan to elicit patient preferences about music 283 284 on the ward. This moved on to establishing music as a collective and purposeful 285 activity at lunchtime and then extended to plans for a regular monthly singing 286 session, as patients appeared to derive pleasure from joining in. Like Poplar, a small 287 step at one level, led to a significant change in how things were usually done, with space and momentum created through the action planning and review process. 288 289 Again, impressions were positive:

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291 ... the environment is better I think, they certainly have looked at the radios because
292 they did used to put the radios on and it was just going, but that's not happening as
293 much now. Interview with OT

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295 Full Adoption toward Sustainability

PIE observations on Poplar continued periodically throughout the research. The
experience of doing observation reinforced its value to 'see' action and interaction in
a different way:

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It's allowed us to step back and look at what we're doing. 'Cos when we're right in
the middle of it, it's all quite difficult, seeing what's going on and what you should be
doing. Interview with Staff nurse.

New issues identified resulted in new action plans, including ensuring that patients did not feel isolated or ignored (e.g., leaving curtains closed around patients postcare delivery, not excluding patients within earshot from discussions, and regular checking that clocks in the bays were accurate).

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A focus of action planning was providing stimulating activities for patients who were
well enough to take part, including newspapers, games_⊥ and reminiscence resources
(RemPodsTM). By the end of the third improvement cycle, observations indicated
positive change: staff sitting with, and encouraging patients to read and using
pictures as conversation prompts. These action plans were evaluated as 'partially
met'. Engagement was constrained by staff availability which waxed and waned
depending on demand, patient flow and unpredictable levels of patient acuity.

Over time, the composition of the PIE ward team changed. Although never a formal team member, the ward manager played a crucial enabling role in supporting staff to get involved in PIE and in facilitating communication of action plans to the wider staff group.

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322 On Crane, alongside 'music as stimulating activity' which expanded over time, new 323 action plans were -pursued. These included encouraging patients who were well 324 enough and near to discharge to dress in their own clothes during the day, not usual 325 on this ward. This was viewed as supporting the transition from hospital to home. It 326 was also aimed at nursing, care and therapy staff to increase person-focused 327 interaction while they helped the person choose their clothes and get dressed. Making 328 this happen involved negotiating with relatives to bring in clothing and ensuring staff 329 did the work.

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Four PIE cycles were completed on Crane, though in practice (as with Poplar), the interplay of observation-planning-action-review represented a spiral more than a cycle, since learning and practice were continually being built on. Subsequent observations were shorter (30 minutes) – to make the process manageable. As on Poplar, Investment of staff time was an ongoing issue, particularly during 'winter pressures' when the team covered an additional six beds. The cramped nature of

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the environment and lack of patient space, outside of the bays, was a constraint.
Engagement in activities was assessed as being 'partially' implemented. Again, as
on Poplar ward the composition of the PIE team changed as therapist posts rotated
and there was less engagement than Poplar by frontline staff.

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A significant collaborative event, a cross-site workshop for Poplar and Crane, was held a year after PIE introduction, instigated by Poplar. Ten staff across both wards took part, including the Trust's dementia specialist nurse and the researcher. The meeting allowed both teams to clarify how person-centred care was conceived. A statement of purpose was agreed:

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both staff and patients feeling valued and treated as individuals, while promoting
independence, holistic and effective care, choice and high-quality experience.

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351 The meeting provided opportunity for reflection on what was needed. There was 352 considerable enthusiasm about being part of a process that actively involved staff on 353 the front line to effect change, and which encouraged them to use their initiative to 354 try out ideas. They perceived a change in practice: increased use of the patient biographical tool, This is me® booklet (Alzheimer's Society, 2017); greater 355 356 involvement with patients' families; and heightened awareness of patient experience 357 as the centre of what they did. Concerns centred on time constraints; how to sustain 358 PIE after the research ended and how to embed changes in routine practice. Issues 359 to pursue included incorporating PIE information into routine staff induction and 360 involving all new ward staff in undertaking a short PIE observation with a link PIE 361 team member.

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Explicit links were made between the PIE objective of enhancing person centred
care and the trust's Shared Purpose Framework (authors, 2014). The role played by
the dementia specialist team in championing PIE, which was critical, was also
perceived as a vehicle through which aspects of the dementia strategy could be
pursued. Both operated in synergy with -one another.

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369 Partial implementers

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1 Exploration to Programme Installation

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On Netherton ward, the introductory meeting revealed a passionate commitment to 373 374 improvement in care delivery for their patients, directorate level support to the 375 research, and interest among the training and practice development team to assist 376 with PIE. The PIE workshop was attended by seven staff, at different levels of 377 seniority and roles (manager and charge nurse, staff nurses, HCAs and an 378 occupational therapist attached to the ward) who formed the PIE team. Training and practice development staff also took part, to support the ward in implementing PIE. 379 380 Feedback on the workshop was very positive and ward staff indicated willingness 381 and enthusiasm to get going.

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383 Rivermead was also a long established and cohesive team. The ward manager was 384 very supportive of improving care of people with dementia on her ward and had worked closely with the practice development lead; both had a particular interest in 385 386 dementia care. A total of nine staff attended the PIE workshop (two sisters, two staff 387 nurses, three HCAs, a housekeeper and therapy assistant). Their composition reflected engagement and interest across the staff group working in a diversity of 388 389 roles. At the conclusion of the workshops, both wards had plans underway for PIE 390 installation, PIE teams and identified support out with the wards.

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392 Initial implementation

Following the initiating workshop on Netherton, the first PIE cycle began with observations by PIE ward team. Observations were conducted over a two-hour period in pairs on two occasions, at different times of the day (mid- morning and afternoon). The observers initially felt inhibited and anxious, concerned that staff might act differently knowing that they were being observed.

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Observations indicated positive features of practice (responsive and reassuring with anxious patients; encouraging interaction between patients; offering food and drink choices and getting it straight away; ward clean and warm; patients in bed appearing content; others up and about in the day room and corridor). Immediate feedback was provided to staff on shift and welcomed by them as acknowledging the strength
of team working. The value of observation in 'seeing' things in a different way was
emphasised by observers. Further observations were planned for different times of
the day and night to see whether care was consistent across different shifts.

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Immediate action was initiated from these observations. One of these was introduction of staggered staff breaks in the morning (no more than two at a time) to ensure responsiveness during a period when staff were relatively invisible in the bays (observed as buzzers going unanswered, and patients being left longer than usual for assistance). Another action point was addressing temperature of the ward for patients who were inactive by offering blankets (staff constantly in motion did not experience this).

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Over the following three months, further sets of observations occurred involving all
seven PIE team members and the practice development co-ordinator. Additional
support anticipated from staff at directorate level did not transpire. Apart from
individual examples (e.g. a dozing patient not being offered a drink), observation
elicited a picture of responsive practice.

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A meeting was held to discuss action plans. However, a number of factors resulted in lack of follow-through. Senior staff were preoccupied with changes at ward level in response to a trust directive to speed patient flow at a time when patient acuity was rising, and the staff complement deemed inadequate. Four months on progress had stalled. The researcher observed that staff appeared stressed simply trying to maintain responsive care, amid 'winter pressures' and staffing shortages, leaving little headroom for initiating practice change.

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On Rivermead three months elapsed between the introductory workshop and the
first set of observations. Three pairs of staff (three HCAs, a housekeeper, nurse and
ward manager) carried these out at different times of the day. Reflections on
observations occurred informally afterwards. Despite the number, range and length
of observations, documentation revealed a relatively superficial portrayal of practice
and goals for improvement, largely related to professional 'visitors' to the ward

436 (pharmacists, phlebotomists, porters and medical staff). Feedback with the

researcher revealed that observers had 'seen' and noted little interaction between

438 staff and patients for long periods in the evening, but this was interpreted as

439 requiring additional staff to resolve and therefore it did not feature as a goal for

440 change. 'Knowledge' of the problem was uncontested; their judgement that they

441 were powerless to act on it impacted its utility as a focus of action planning.

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443 Initial implementation coincided with a period of organisational turbulence including a 444 negative CQC report which led to major trust reorganisation. This absorbed the energy of the key facilitator (now matron) at a time when the ward manager was off 445 sick. Ward staff were working day to day, still coping with extra patients as 'winter 446 pressure' beds remained open. The offer of an extra workshop was not taken up, 447 since staff could not be spared to attend. It was several months later that the key 448 facilitator was able to hold an action planning meeting, but the time lapse since 449 450 observations, together with work pressures, staff sickness and vacancies meant that further PIE work was unrealistic. 451

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453 Non-implementers

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In contrast with 'partial implementers', these six wards did not proceed far with PIE installation and fell at the hurdle of initial implementation. Rose, Beech and Denton wards in Central Trust are more accurately characterised as betwixt 'partial' and 'non' implementers and are considered together as the same factors operate for all three. Ambridge and Oak wards (in Valley Trust) and Cedar ward (City Trust) were unambiguous non-implementers and did not engage with PIE at any meaningful level.

- 462
- 463 Exploration

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The three wards in Central Trust worked closely together, with the Denton ward
manager strongly supportive of PIE, organising and facilitating joint workshops and
encouraging Rose and Beech wards. At the time of the research the trust was,
however, undergoing organisational turbulence as services were reconfigured, which

proved inimical to practice change and development. While practice observations
took place on Beech and Rose wards, there was no further activity as staff coped
with changes which finally resulted in the transition of Beech from an acute to a stepdown ward, and the eventual closures of both Rose and Denton wards.

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In the two Valley Trust wards, the departure of the practice development lead in the
course of baseline fieldwork who was to act as 'external' facilitator coupled with
staffing pressures on both, evident during fieldwork, meant that on neither ward was
engagement in PIE viewed as feasible. Of several workshops planned to introduce
PIE only one took place; two others were cancelled when it became clear that staff
would be unable to attend. Attempts to re-ignite interest in engaging with PIE over
several months were unsuccessful.

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Cedar ward similarly did not take part in PIE. Demand pressures and organisational change at City Trust (which impacted on Rivermead) affected Cedar ward directly; additionally, the ward manager was focused on creating a team ethos in context of a new ward model and staff group. Reflecting back, she considered that the decision to take part in the research had underestimated the level of work involved in forging a new team, coupled with demand pressures; the 'timing' was not right.

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489 CROSS-CASE ANALYSIS AND DISCUSSION

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491 The PIE programme was fully adopted in only two of ten study wards (both based in 492 the same trust) and proceeded to innovation and sustainability. A cross-case 493 analysis, undertaken to explore why some wards adopted PIE and others only 494 partially or not at all, highlighted a number of factors which appeared to influence the process of implementation to varying degrees: salience of PIE, collective team 495 involvement, fit with strategic priorities, resources, leadership, facilitation and 496 497 organisational stability. These factors are here discussed in turn using Normalisation Process Theory (NPT) to assist analysis. 498

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500 Salience of PIE

It is accepted that in order to effect practice change, education and awarenessraising alone is not enough (Handley et al., 2017). Rather a change has to be seen
as meaningful and engendering *coherence* in terms of NPT. In both wards in
Seaford, the process of PIE implementation engendered confidence, collaboration, a
sense of empowerment and agency among the staff group, including among HCAs
in trying out new ways of working. Positive change was visible and in turn acted as a
spur to keep going.

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510 Among 'partial' implementers PIE was embraced enthusiastically at the outset. On Netherton, observation reinforced pride among the staff team of the general quality 511 512 of care provided. But translating observations into action plans that addressed valued goals proved more difficult. Although not articulated in the beginning, 513 observations reinforced and solidified the primary goal of senior staff to improve 514 515 patient care through reduction in the size of the ward and more staff time to provide stimulating activities. However, neither were seen as actions which could be pursued 516 through PIE, since they required significant resource commitment. This poses the 517 question as to whether there exists a quality 'ceiling' effect in terms of a 'person-518 519 focused' approach within the constraints of acute care delivery. Additionally, within 520 this ward, there existed a team culture and routine systems and mechanisms to 521 engage in deliberative practice reflection to secure quality improvement; apart from observation, the additional work of PIE seemed superfluous. 522

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Enthusiasm and interest in improving practice also required supportive environments
to sustain belief in staff agency to effect change so that investment of time and
resources was seen as worthwhile. Demand pressures and organisational
uncertainty dampened both, evident not only in Rivermead but in all three Central

528 Trust wards.

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530 Collective team involvement

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532 The degree of success of any group initiative depends on teamwork (Dixon-Woods

et al. 2014), which for PIE very much depended on the implementation teams

534 created within the wards involved. Attending the workshop, then undertaking the

535 cycles of observation, planning, action and review required the teams in Seaford Trust to identify themselves with the project aims and commit time to them, which 536 necessitated agreed ways of communicating and working together (cognitive 537 participation). A good example of the outworking of this phase of NPT in Seaford 538 539 was the joint meeting between the two participating wards which allowed for time to 540 clarify values and aims. Netherton ward, too, demonstrated a collective enthusiasm 541 for PIE, moving in a timely manner, like Seaford wards, to planning soon after the 542 workshop and devoting an away-day to reflecting on these. Conversely, Rivermead 543 ward experienced long delays between workshops and observations, suggesting 544 less cohesive participation.

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546 Fit with strategic priorities

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PIE was not the only initiative aimed at improving the care of people with dementia 548 549 underway in participating trusts. The challenge lay in introducing these at a time when numerous directives were simultaneously being handed down. In Seaford the 550 team of three dementia nurse specialists worked directly with ward staff to model 551 552 good practice in dementia care and provide support and education, but also engaged in high level organisational changes at trust level, for example developing dementia 553 554 pathways. From the outset the specialists embraced PIE as one vehicle through which to develop practice change and drive the collective action that NPT identifies. 555 556 In this way PIE and the trust's dementia strategy worked synergistically and were a 557 good fit with the trust's new Shared Purpose Framework.

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559 In other trusts (City and Ironbridge) the creation of Dementia Champions aimed to 560 raise awareness and set up training for staff at all levels around dementia. However, how the recruitment of 'champions' would translate into a means of changing 561 practice at ward level was not clear. In City, the matron who had championed PIE 562 envisioned that the initiative would feed into use of PIE at ward level; a vision that 563 564 was not necessarily shared among those involved in developing the dementia strategy. For staff on Netherton, the Champions initiative appeared diffuse and 565 566 lacking depth and impact. Further, as the initial focus of the initiative was in raising 567 general awareness of dementia, this was not seen to address staff perception of the

problem, namely how ward staff were to be provided with the skills necessary to
work with challenging patients and also with the participative approaches required to
enable sustained implementation of PIE.

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572 Resources

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574 Implementing quality improvement initiatives in the NHS requires adequate resources (Dixon-Woods et al., 2014; Handley et al., 2017) in terms of staffing, time 575 576 and space to reflect, plan and engage in *reflexive monitoring*, the final stage of NPT. Apart from Netherton and Denton (dementia wards), on most wards there was 577 578 limited or no collective space for activities or interaction and finding time and space for action-planning and review meetings was problematical. When this did occur, 579 580 notably with Seaford's cross-site meeting and Netherton's away days, this allowed 581 for discussions around person-centred care and what that means in their own 582 context. Similarly, for both these wards, staff expressed that time spent undertaking PIE observations allowed them to stand back and see things differently. A further 583 584 issue was staffing levels; three of ten wards did not attain the Royal College of 585 Nursing staff/patient ratio for safe working on older people's wards (Hayes and Ball, 2012), namely eight staff for 28 beds, a ratio of 1/3.5. Most did not meet the 586 587 recommended ratio of registered nurse to health care assistant of 65:35. Although 588 most wards were subject to staff being removed to cover other wards due to staff 589 absence, Seaford Trust wards' staffing levels were comparatively better able to cater 590 for the needs of patients with dementia than others were.

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592 Leadership

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Leadership had been identified as a 'readiness criterion' for practice change and this is also supported in existing literature (Ferlie and Shortell, 2001; Dixon-Woods et al., 2014). This applies to workplace culture as well as organisational culture (authors, 2019). In implementation wards this took the form of key individuals beyond the ward whose professional authority and vertical networks legitimated the priority attached to the work of improvement in face of competing priorities. In Seaford Trust this role was adopted by the dementia specialist nurses, (jointly with the practice

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601 development lead on Poplar). This did not happen in other wards; although external practice development leads were also originally involved in partial implementing 602 wards this did not continue. On Netherton, the ward manager assumed the PIE 603 604 leadership role but only partially enacted it, and participation of the 'external' 605 facilitator, who had helped with observations, was not called upon to assist in driving subsequent action-planning processes. On Rivermead the external facilitator 606 607 became involved in the trust turbulence secondary to major restructuring, with no time to devote to the PIE programme. There was a similar lack of an external driver 608 609 on non-implementing wards; in Valley Trust, for example, the senior nurse for older people, initially designated for this role, moved to another post early on in the 610 611 research and no replacement could be found.

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613 Facilitation

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On implementation wards there was involvement of senior ward staff, in the person 615 616 of the ward managers, facilitating and encouraging direct involvement in the change process and in ensuring planned changes were communicated to the wider staff 617 618 team. However, the conception of 'facilitation' in this study differs from that projected in some frameworks for implementing change, for example PARiHS (Rycroft-Malone 619 620 et al., 2002) and practice development (McCance et al., 2013), both of which place 621 emphasis on skilled, holistic facilitation in effecting change. In this research the ward 622 manager, integrating leadership with facilitation, did not 'drive' implementation but played a critical role in enabling the ward team. The need for this integration of 623 624 facilitation and leadership for practice development is echoed in the Venus Model of workplace transformation (authors, 2020). 625

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On both Poplar and Crane wards, the ward manager was fully supportive of PIE, by encouraging observations and allowing time for reflection and action-planning and, where time permitted, joining the meetings themselves. On the partial-implementing wards this involvement did not happen; the Rivermead manager was off sick during the project period while the Netherton manager had attempted to be the facilitator but found this to be too much to take on. Denton ward (non-implementer) had a similar experience with a supportive ward manager who had no external facilitator to work with. On Cedar ward, a late entrant to the project, the ward manager was fullyabsorbed in creating a new team within a newly created model of care.

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637 Organisational stability

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Collective action is also dependent upon the larger system in which individuals and 639 640 teams function (Ferlie and Shortell, 2001). Although all participating wards 641 experienced change at multiple contextual levels, the degree of turbulence varied 642 over trusts. While Seaford Trust experienced changes as a result of a negative CQC inspection report (albeit praising dementia care), these did not appear to percolate 643 644 down to ward level or adversely impact on PIE. Other sites encountered greater turbulence; Central Trust was particularly affected by reorganizational changes such 645 that the two participating wards closed during the course of the research and a third 646 underwent remodelling. Rivermead ward, a partial implementer, also closed as part 647 648 of a major restructuring in City Trust over this time.

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650 CONCLUSIONS AND CRITIQUE OF THE METHOD

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Seven factors have been suggested as influential in the implementation of the PIE 652 653 programme, which can be partially aligned with the four stages of NPT. However, 654 NPT as a theory, while acknowledging contextual factors, is located within a 655 sociological context which assumes individual and collective agency in any given 656 situation. Three further factors (leadership, facilitation and organisational stability) 657 were also found to be crucial to success, suggesting NPT may be viewed as 658 providing necessary, but not sufficient conditions to explain outcomes. Further, the 659 notion that practices become 'routine' may be critiqued, as in the dominant nursing discourse of the 1970s and 1980s, when 'routine care' was thought to imply 660 ritualised and mechanical practices, anathema to individualised care (Hutchinson 661 662 and Jackson, 2015).

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Findings from this research suggest that the PIE programme has the potential to
help staff improve person-centred care for people with dementia admitted to hospital
wards. Though evidence is drawn from ten wards, only two fully implemented the

programme due largely to external organisational factors found to be necessary to
success. Conclusions must therefore remain tentative but the absence of these
factors in partial and non-implementing wards may add weight to the findings. A
further limiting factor is the time limit over which PIE was studied, and evidence
suggests that sustainability was challenging even for the full implementer wards
(authors, 2018). This and other dimensions of PIE, such as patient -related outcome
measures, may be the focus of future research.

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675 IMPLICATIONS FOR PRACTICE

- Developing person-centred care practices for people with dementia in acute
 hospital wards via a practice improvement process such as PIE requires
 meaningful commitment and participation from both the organisation and the
 ward.
- Successful practice change depends on several key factors, including
 effective clinical leadership and good facilitation inside and outside of the
 ward. External facilitation is necessary to help prioritise the programme and
 place it in allegiance with wider trust objectives.
- Readiness criteria for implementing a PIE programme should consider, in
 addition to these key factors, contextual factors, including institutional stability
 and no planned major change for wards.
- Observations of practice using the PIE tool has the potential to enable staff's
 attention to focus on person centred care for older people with dementia in
 acute settings.

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