

“FITS into Practice” Developing Dementia Specialist Care Homes

Summary Report

**Report on the programme to translate research into practice
in reducing the use of anti-psychotic medication in care homes**

June 2014

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“FITS into Practice” has involved hard work, determination and a drive for excellence from many people over the past two years and during the original intervention and research. This work is based on original research conducted at King’s College London, in association with Oxford University, University of Newcastle and Oxford Health NHS Trust. Copyright of the original FITS manual is held by Dr Jane Fossey (Oxford Health NHS Trust) and Dr Ian James (University of Newcastle). As well as the Association for Dementia Studies’ authors of this report (Brooker, Latham, Jacobson, Perry & Evans) there are other members of the ADS team who have made a significant contribution including Jenny La Fontaine, David Moore, Michael Watts and Jennifer Bray.

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Key Findings and Recommendations of FITS into Practice

There is an emerging body of research evidence for the effectiveness of person-centred care practice in having a positive impact on the lives of people living with dementia in care homes. The original Focussed Intervention Training and Support (FITS) intervention (Fossey et al, 2006), evaluated by a cluster randomised control trial, is often quoted as part of this evidence base. This original intervention used an in-house “FITS therapist” to train and support care home staff and reduce the inappropriate prescription and use of anti-psychotic medications, by providing a person-centred framework for understanding and caring for people with behavioural symptoms. Results showed that, compared with usual care, the FITS programme reduced the prescribing of antipsychotics for people with dementia by over 40% (Fossey *et al*, 2006). Crucially, this was achieved without any increase in behavioural or psychological symptoms (Ballard *et al*, 2009).

However, translating this research study into every-day practice, is the real challenge. The original FITS intervention was high-cost and intensive and although it provided practical solutions (Fossey & James, 2008) there has not been an evaluation of how the intervention could be scaled up across a large number of care homes. Between April 2012 and April 2014, the Association for Dementia Studies, (ADS) worked with the Alzheimer’s Society (AS) to design, implement and evaluate an intervention that would remain true to the original FITS programme but that could be delivered across a large number of care homes. The FITS into Practice programme was characterised by the following features:

- Two university-based educators, designated as Dementia Practice Development Coaches (DPDCs) delivered an intensive nine-month education and supervision programme to care home staff designated as Dementia Care Coaches (DCCs).
- 106 care homes were recruited across England, Scotland and Wales. Each care home nominated a DCC to participate, with some DCCs allocated to work across two care homes.
- Ten courses for an average of 10 DCCs per course were delivered across the intervention period. Each course followed a 9-month structured programme facilitated by a DPDC, consisting of a 3-month training period (10 days training delivered fortnightly in 2 day training blocks) following by a 6-month supervision

phase (monthly half day support sessions) during which DCCs implemented changes in their care homes.

- Training and supervision focussed on: reviewing anti-psychotic prescriptions for residents; psychosocial alternatives to managing behavioural and psychological symptoms in dementia; modelling person-centred care; training and support of staff teams to achieve person-centred care.
- The training was delivered free of charge at a location convenient to the care homes taking part
- Care homes were recruited that were able to engage with the evaluation. A large care-home provider nominated approximately half of the care homes taking part, with the remainder drawn from a range of small and medium providers.

To evaluate the impact and process of the FITS into Practice programme a separate evaluation team drawn from ADS and AS staff gathered qualitative and quantitative data from multiple stakeholders with a view to ascertain not only the impact of the intervention on residents, staff and care homes but also the barriers and facilitators of implementing the FITS into Practice programme overall. Data gathered throughout the intervention included:

- Resident anti-psychotic prescriptions and goal attainment
- DCC knowledge, attitudes and confidence questionnaires
- DCC training evaluations
- DPDC reflective diaries and interviews
- Case studies of 9 participating care homes including interviews with DCCs, home managers and care home staff.

Key Findings: Residents

- There was a 30.5% reduction in antipsychotic prescriptions for residents from baseline to the end of the intervention, (Chi Sq 20.4 $p < 0.0001$).
- Residents achievement of personal goals and behavioural and psychological symptom goals showed a statistically significant improvement from baseline to the end of the intervention, although from a small data set (76/85 residents respectively).

- Qualitative data showed residents whose medication was reviewed were more alert, communicative and active, with improvements in mobility, eating and sleeping.
- Qualitative impacts were also reported across the whole resident group, not only those who were the subject of medication review, suggesting a cascading effect of DCC and staff practice.

Key Findings: Staff (Dementia Care Coaches)

- DCCs were drawn from a range of roles, with the majority coming from senior care assistant or deputy manager roles. There was a significant number of managers who participated as DCCs, despite initial guidance that the role was better suited to alternative roles.
- Questionnaires completed at 3 time points showed a statistically significant improvement in attitudes and knowledge about dementia from participating DCCs.
- DCCs evaluated all training and supervision very positively, with many citing the content and delivery as inspiring and confidence-building, resulting in an ability to role-model person-centred practice.
- DCCs cited peer support and the depth of supportive challenge provided by DPDCs through training and supervision as highly valued and influential.
- Both training and supervision were valued, although there was evidence that the maximum benefit could be seen from 4 supervision sessions rather than 6.

Key Findings: Care Homes

- 67 of 106 care homes completed the necessary training and supervision and implemented the FITS into Practice programme. The original intention to have DCCs working across 2 homes was not practicable and this accounted for a large proportion of this reduction. DCCs who withdrew from the programme cited pressure of work or resignation as their reason for not completing the course. Although withdrawals appear high, this is not unusual when compared with other studies in the care home sector in which staff turnover tends to be high.
- Qualitative findings demonstrated very positive changes in care practice in care homes whose DCC completed the programme. These included: improved physical environment, improved staff team engagement, increased activity and engagement between staff and residents, improved relationships with family and enhanced reputation with regulators and local commissioners.

Key findings: Barriers and Facilitators of Implementation

- To achieve maximum benefit care home organisations and management needed to provide role clarity and protected time for the DCCs to implement FITS in their care home. Where this did not occur, DCCs struggled and implementation was significantly reduced. What implementation did occur within these circumstances was usually due to the personal commitment, time and resources of the DCC.
- The level of practical support from management within the care home made a significant difference to implementation by DCCs. This required an understanding of the requirements of the FITS programme from the outset. Where managers attended a mandatory managers meeting prior to the programme, management support was more likely.
- The existing role of the DCC was less important to implementation than protected time and management support. Both senior and junior roles created different affordances or challenges to implementation, but with protected time and support DCCs were able to respond to them.
- Where owning organisations facilitated protected time and management support for DCCs, implementation was more successful. Owning organisations that required multiple changes in their care homes at the same time as FITS, whose communication across management levels was unclear, or where values and ethos contradicted the FITS approach presented particularly challenging barriers to implementation
- FITS implementation was more successful when external factors, such as the approach of GPs and local community mental health teams was consistent with the FITS approach. Where these external factors did not take a similar approach to reducing prescriptions, or where new residents were admitted from acute setting with prescriptions, then implementation was more challenging.
- The second home model of implementation did not work as DCCs needed to be present in the care home with protected time for implementation. Barriers to implementation were exacerbated for DCCs in the second home, to the point of being insurmountable.

Conclusions & Recommendations

- 1) The **Dementia Practice Development Coach** is able to provide sufficient teaching and supervision for successful implementation of the programme. Revisions have been made to the job description and person specification of the DPDC to ensure

sufficient knowledge, skills and support for this role in practice whether the post is positioned within or external to the care home provider.

- 2) The **Dementia Care Coach** role is able to initiate and model behaviours within the staff team to successfully decrease the need for anti-psychotic prescribing and improve person-centred care, when their management and organisations are supportive of this role in practice. Revisions have been made to the job description and person specification of the DCC to help clarify this for care providers.
- 3) In order to pre-empt barriers to implementation, the **care home manager** should undertake a 1-day workshop prior to commencement of the programme and engage with 2 key sessions of the training and supervision programme.
- 4) A structured recruitment process to the programme, including mandatory management meetings and pre-course contact between the DPDC and organisational representatives is necessary to ensure that **organisational understanding and support** is adequate and the training is recognised as effective only in the context of an holistic organisational approach.
- 5) The new **course outline** suggests the programme takes place across a 30 week period, with longer time between training sessions and an interim supervision session to encourage implementation throughout the whole programme.
- 6) The main **supervision period** remains at the end of the programme, although this is shortened to 4 sessions and renamed as **support sessions** to better reflect its purpose.
- 7) The **Dementia Care Coach manual** has been revised to include additional content essential for the adequate knowledge base of coaches and to adapt to the train-the-trainer format.
- 8) The **peer support** gained by DCC's participating in face to face training and supervision was highly significant to the positive experience and implementation of FITS and it is recommended that a face-to-face model be retained to create a community of practice for staff.
- 9) The name "FITS" should be changed to better describe the work a DCC carries out. Thus the Dementia Care Coach undergoes the dementia care coaching course delivered and supervised by a suitably qualified Dementia Practice Development Coach. This enables the care home to deliver **dementia specialist care practice**.

Overview of the FITS into Practice Evaluation

Context

It has been estimated that 180,000 people with dementia in the UK are prescribed antipsychotic medication for the treatment of behavioural and psychological symptoms such as aggression, agitation and psychosis (Banerjee, 2009). However, while these medications can offer short-term benefits in the treatment of aggression and psychosis, there is no evidence that they are effective in the treatment of other behavioural symptoms or that they work when prescribed over longer periods (Ballard *et al*, 2009). In addition, any potential benefits of antipsychotics need to be balanced against a range of substantial side effects and adverse outcomes with which they are associated. These include reduced mobility and Parkinsonism as well as increased risk of stroke, cognitive decline, pulmonary embolism and death (Ballard *et al*, 2009).

It is in this context that serious concerns have been raised about the appropriateness of some prescribing of antipsychotic medication for people with dementia. A report for the Department of Health (Banerjee, 2009) suggested that as few as 36,000 of the 180,000 people with dementia being prescribed antipsychotics were receiving any benefit from them, while inappropriate prescribing was leading to up to 1,800 extra deaths in the UK each year. The report concluded that antipsychotic prescribing to people with dementia should be reduced by two thirds. Given that much of this prescribing is for people living in care homes, this change can only be achieved by ensuring that the workforce has the necessary skills and knowledge to deliver person-centred care.

From Research to Practice

The original FITS programme was specifically designed as a research intervention to enable care home staff to deliver effective person-centred care for people with dementia, and reduce the inappropriate prescription and use of anti-psychotic medications, by providing a person-centred framework for understanding and caring for people with behavioural symptoms. A randomised controlled trial demonstrated that, compared with usual care, the FITS programme reduced the prescribing of antipsychotics for people with dementia by over 40% (Fossey *et al*, 2006). Crucially, the FITS programme achieved this without any increase in behavioural or psychological symptoms (Ballard *et al*, 2009).

However, this original intervention was high cost and experimental. Therefore work was needed to translate that intervention into an approach that remained true to the intention and outcomes of the original programme but that could be delivered across a large number of care homes. The Association for Dementia Studies (ADS) won a tendering process to work with the Alzheimer's Society to draw up this intervention, to administer it and to learn from it for future practice.

Over a 2-year period two University-based educators (Dementia Practice Development Coaches) were employed to deliver an intensive nine month education and supervision programme to in-house "Dementia Care Coaches" (existing care home staff) to enable them to safely reduce antipsychotic medication and to put in place best evidence-based practice interventions to improve well-being and reduce BPSD in residents with dementia. The original aim was to deliver this intervention across 150 care homes in different locations over the UK. Data was gathered from the viewpoint of multiple stakeholders into the process of undertaking this intervention to improve its practical application. In addition, the impact on anti-psychotic prescribing and goal attainment was monitored to compare with the impact of the original FITS research intervention.

This report summarises how this worked in practice and offers an analysis of the data collected from a variety of sources over the 2-year period.

The FITS into Practice Training and Supervision Programme

The training and supervision programme was delivered between October 2012 and January 2014. 10 Cohorts of on average 10 DCCs attended a 10 day structured training programme held in two day blocks across a 3 month period. This was facilitated by a DPDC and DCCs were expected to put into practice new skills from the course between training days. Training was followed by a 6-month supervision period in which DCCs implemented fully in their homes and received a half day group supervision once a month. Teaching and supervision sessions took place face-to-face, with locations chosen to reflect the location of participating care homes. However, some DCCs still had substantial distances to travel due to the spread of homes, particularly those in the North of England and Scotland.

A broad outline of the training and supervision content is as follows:

Days 1 & 2 learning outcomes

- Explain why dementia has become a national priority;
- Describe the background to and purpose of the FITS programme;
- Demonstrate a basic understanding of the functioning of the brain and how it is impacted by dementia;
- Discuss the importance of person-centred care;
- Demonstrate an understanding of how to use the best practice guide for behavioural and psychological symptoms of dementia.

Days 3 & 4 learning outcomes

- Describe your role as a Dementia Care Coach
- Understand the importance of life history in person-centred care
- Measure quality of care in a care home

Days 5 & 6 learning outcomes

- Identify the importance of person-centred care planning;
- Use person-centred tools to identify an individual's social and emotional needs and to plan activities;
- Explain how to use different resources to implement person-centred care;
- Explain how to use resources that examine the individuals' experience, behaviour and well-being.

Days 7 & 8 learning outcomes

- Evaluate a range of teaching / training methods;
- Undertake a training audit to identify your services' education needs;
- Design and evaluate an appropriate teaching / training session to meet these needs;
- Inform your teaching based on good communication techniques;
- Identify the importance of supervision.

Days 9 & 10 learning outcomes

- Identify the purpose of evaluation;
- Know how to use Goal Attainment Scaling;
- Using other tools in the evaluation of the FITS program;
- Demonstrate an understanding of the next steps that need to be undertaken in the FITS programme.

Supervision sessions 1-6

Supervision was tailored to the needs of the DCCs and the skills of each DPDC. Sessions were held as a group, usually at the venue where training had previously taken place. Each group met for half a day on a monthly basis to discuss issues arising. DCCs were reminded by email a week before supervision to come prepared with an update on the implementation of FITS, successes, concerns and issues arising. If there was a theme or

topic for the supervision session, this would also be communicated in advance. During supervision, the DPDC would facilitate discussion to ensure DCCs had equal opportunity to share concerns and ideas.

DCCs were encouraged to take an active role in providing reflection, ideas, advice and support to each other. At the end of each supervision session Dementia Care Coaches would be asked to think about what they would like to implement in the coming month. This would be recorded and referred back to in the following supervision to encourage a focus on continued implementation and improvement.

Some cohorts attempted a teleconference approach for some supervision sessions, particularly when DCCs had substantial distances to travel. However, these did not prove popular or as effective. Some groups rotated the location of supervision to include some participating homes and this proved popular and effective. The DPDCs also facilitated maximum attendance and completion by offering one-to-one telephone supervision for DCCs who were struggling to maintain minimum attendance during the supervision phase.

Programme participants

Care Homes

The initial plan was to recruit 150 care homes to the programme, from whom 100 DCCs would participate. Recruitment took place between May 2012 and January 2013. Recruitment occurred in two phases with a large care home provider undertaking to recruit 50 DCCs who would work across 100 care homes in their organisation. The remaining 50 homes were recruited from small to medium care providers via ADS and AS communication networks. In both phases, interested parties were provided with detailed information outlining requirements of the programme (including time expectations for the DCCs) and the implications of taking part. The large care home provider shared this information electronically, with later recruitment requiring care home managers to attend a mandatory meeting prior to recruitment to the programme.

In total, 106 care homes were initially recruited and signed up to the programme. The primary reason for this shortfall in recruitment was the difficulty the large care home provider experienced in allocating second homes to their DCCs. Overall, only 67 of the original 106 care homes completed the required training and supervision to implement FITS. This reduction is explained by the withdrawal of DCCs from the programme during training and supervision and the substantial challenges faced by DCCs allocated to work across more than one home.

The table below shows the geographical location of participating homes

Total number of participating homes	67
Number of primary homes	61
Number of 2 nd homes	6
Region of the UK	Number of care homes
East Anglia	0
East Midlands	3
London	3
North East	5
North West	18
South East	2
South West	7
Yorkshire & Humberside	5
West Midlands	11
Wales	5
Scotland	8

Participating care homes represented the full range of home size, registration and owner size. 50 participating homes were from for-profit owning organisation, with the remaining 17 representing not for profit, registered charity and local authority-owned homes.

Dementia Care Coaches

66 DCCs, from an original registration of 100, successfully completed the programme. The vast majority implemented FITS in one home only, with a few working across two homes. Initially, recommendations suggested that the role of DCC was ideally suited to someone in a senior care assistant/team leader position in the home, due to the requirement for role-modelling frontline practice and the time commitments required for implementation. In eventuality and in response to care home requests, DCCs were drawn from a wide range of roles including registered managers, nurses and care home trainers.

In order to have successfully completed the FITS into practice training programme, DCCs needed to attend at least 8 out of 10 training session and 4 out of 6 supervision days. 14% of registered participants failed to complete the training phase of the programme, and thus did not progress to the supervision phase. A further 20% of participants withdrew during the supervision phase. In total, a third of participants failed to complete the programme. While a significant number, this is not unusual for interventions of this type in the care home sector. Reasons for participant withdrawal were recorded throughout the programme, with the majority accounted for by work pressures or resignation.

Evaluation measures

The evaluation was intended to explore not only the impact of the FITS programme on residents and DCCs but also the experience of implementing such a programme across a wide range of care homes. As such quantitative and qualitative evaluation measures were used and directed at a wide range of stakeholders involved with the programme.

Quantitative data was analysed to identify the impact of participating in FITS for DCCs and Residents. Qualitative interview, diary and case study data was analysed to identify themes arising in relation to: positive and negative impacts of FITS participation, useful features of FITS training and supervision; barriers and facilitators of FITS implementation

Assessing the impact on DCCs

The following measures were used to capture the impact and experience on DCCs.

- Training evaluations after each training block
- Role Confidence questionnaire: pre-training, post-training and post-supervision.
- Approaches to dementia questionnaire (Lintern et al, 2000): Pre-training, post-training and post-supervision.
- Dementia knowledge questionnaire (Macdonald & Woods, 2005) : pre-training, post-training and post-supervision
- Adherence to implementation questionnaire at the end of supervision to measure level of implementation.

Assessing the impact on residents

The following measures were used to capture the impact on residents

- Anti-psychotic prescriptions: pre-training and post-supervision.
- Goal Attainment Scaling (residents' progress towards personal goals); throughout programme

Capturing the experience of DPDCs

The following measures were used to capture the experience of DPDCs throughout the programme.

- In depth interviews at the start and end of the programme
- Monthly reflective diaries, reporting on their own experiences and gathering qualitative experiences of the groups and DCCs.

Case Studies

9 care home were recruited as case studies to explore in-depth the impact and experience of FITS participation. Case studies utilised

- DCC Job satisfaction (Russell et al, 2004) and stress (Stanton et al, 2001) questionnaires ; pre-training, post-training and post-supervision
- DCC interviews post training and post-supervision
- Manager and staff interviews post supervision.

Impact of FITS Participation and Implementation

As the FITS programme encourages an individualised approach to planning and implementing change in each care home, the ways in which DCCs undertook implementation varied depending on their own skills and the needs of their care home. The most defining characteristic of FITS implementation therefore is its variable and individual nature. However, case studies showed a number of similar features relating to both the substance and style of implementation used by DCCs

- 1) Medication review; making contact and negotiating with prescribers regarding residents prescribed antipsychotics
- 2) Generalised care planning review; for all residents with a particular focus on behavioural analysis.
- 3) Education for fellow staff; analysing training needs and supporting development of staff skills.
- 4) Consideration of activities and meaningful interaction with residents; introduction of 'toolboxes', personalised music and changes in routines
- 5) Review of use of language; role-modelling and challenging of negative language use

Impact on DCCs

Training evaluations demonstrated an overwhelmingly positive response to the training phase of the programme with content, pace, learning methods and presentation being rated highly by the vast majority of participants for every set of training days. When asked what changes they felt should be made, the vast majority stated that nothing should be changed. Participants regularly gave comments relating to the benefits of the training and the impact of the training on their attitudes, confidence and skills in dementia care.

In relation to job role, questionnaires showed that participation in the programme had a strong positive impact on DCCs confidence in their role, their ability to explain their skills

to others and their ability to teach others about dementia, with most impact occurring during the training phase of the programme. A positive impact was also found in DCCs perceptions of themselves as a role model, and their perceptions of the status of working with people with dementia.

DCCs questionnaire scores related to their attitude to residents with dementia showed an improvement across the programme. Both hopeful attitudes and person-centred attitudes improved. A statistically significant effect on person-centred attitudes was seen from the training phase of the programme, with a statistically significant effect on hopefulness seen from the combined effect of training and supervision.

DCCs knowledge of dementia improved following the training programme, although knowledge was already very high at the start of their participation. DCCs came from a variety of existing roles and it may be expected that those in more senior positions would have better knowledge and therefore show less improvement. However, this was not the case. DCCs from care assistant or senior care assistant roles did not have lower levels of knowledge at baseline and, in fact, the range of scores for more senior positions at baseline was wider (4-10) than for carers/senior carers (6-10). This suggests that it is not safe to assume that those in senior positions will have the basic knowledge required to support a more junior level of staff undertaking a DCC role and this has implications for future delivery of the programme.

Qualitative data emphasised the positive impact of participation on DCC's confidence and willingness to challenge and change practice.

"I think it was liberating. I don't care anymore, I'll go and tell the queen!"

(DC7, manager, interview 2)

"I'm a lot more confident, I think. I understand a bit more...like when people are struggling to eat, I go into it a bit more whereas before I'd be like 'Here you are, there's your knife and fork.' Now I show them and talk them through it, so I think without even realising I go more in depth with it,"

(DC5, carer, interview 2)

Overall, the vast majority of DCCs experienced FITS positively and showed improvements personally and in their care homes. However, it is important to note that qualitative data suggests that the small minority who encountered substantial, often insurmountable, organisational barriers to implementation experienced FITS to have a negative impact on themselves. Increased stress and frustration were reported by DCCs where they were not given time to implement FITS, particularly where they were overloaded by other

organisational requirements and did not receive management support. DCCs often had to use substantial personal resources to participate and implement FITS. In a few cases, participation in FITS in these circumstances contributed to the DCC decisions to resign their posts. This negative impact is significant because it demonstrates that provision of training and development opportunities to staff, without adequate consideration of implementation requirements, is not only ineffectual but potentially detrimental for those staff who take part. This has implications for future FITS delivery, as it will need to ensure that appropriate organisational planning is in place.

Impact on Care Homes

DCCs were also asked to provide information on their experience of implementation in their care homes. Overall, the majority of DCCs felt confident about being a coach in their own care home. The majority of DCCs who commented positively explained that the FITS programme was instrumental in their confidence, with a few also acknowledging the impact of their own skills, additional training and organisational support on their confidence. Those participants who did not feel confident often cited that this was due to barriers within their care homes, rather than the FITS programme itself. These barriers focussed on lack of time to implement FITS, lack of management/organisational support and having a role that was not suited to being a Dementia Care Coach (e.g. one which did not sit primarily within a single care home).

The majority of DCCs estimated they had implemented 50% or more of the FITS programme in their care home by the end of their participation. However, given that this measure was taken following a six-month supervision phase dedicated to implementation, the low proportion (27 respondents) of respondents who had been able to implement 75% or more is important to note. Those with positive responses cited facilitators within their homes, such as team work and staff support, as helpful to implementation. Those with a negative experience of implementation cited lack of time, staff and organisational resistance as the rationale for low implementation.

DCCs working in second homes were also asked to rate how confident they felt in that role. Two thirds of those who responded did not feel confident in this role. Explanatory comments cited lack of time as the primary reason for this. More than half of those responded had not implemented anything from FITS in their second home, with only one DCC having implemented more than 50%. Lack of time and lack of support were again the reasons given for lack of implementation in second homes.

Qualitative data demonstrated that FITS participation had a positive effect on the staff teams of homes that took part. Staff were seen to have improved skills and confidence leading to a more empowered approach, and to show an increased willingness to

interact with residents and reduce negative language. Staff also showed more positivity and enthusiasm for their work following involvement with FITS through their DCC.

"We used to be stressed to death, it's slowed, the pace has slowed a little because we're giving a little more one to one and that's fabulous as well, we spend a lot more time with our residents...since the introduction of FITS we are finding things have slowed down a bit...I've worked here a long time, so I know the changes that have taken place...we have a lot more laughs now. Positive, positive, positive"

(CS1, interview with carer)

The care home environment also improved as a result of FITS participation and this was a consistent theme in the qualitative data. Primarily this was due to push to create more opportunities for meaningful activity with residents, with all case studies introducing sensory equipment, rearranging rooms to allow more interaction and ensuring items to encourage interaction were always available. In addition, case studies showed that FITS participation resulted in a more individualised use of the existing environment, such as flexibly using space to encourage mealtimes or maximising freedom of movement for residents.

Qualitative data also demonstrated a positive reputational impact as a result of FITS participation. Half of the participating case studies cited positive impacts on their relationships with social work teams, mental health teams, commissioners and regulators.

"(County Council) have clearly been pleased with the progress of FITS as they have made plans to roll out the programme across all of their homes and have been meeting with FITS coaches to talk about ways of doing this, with those Coaches already in place leading the implementation," (DPDCb, reflective diary)

"On a recent inspection, even though the home had been without a manager for a month, CQC commended them for their work on the programme and has asked the participant if she would consider going to a couple of neighbouring homes to do some training," (DPDCa reflective diary)

Relationships with family members improved through FITS participation as demonstrated through the qualitative data. Families often provided positive feedback to homes following implementation, or evidenced improved engagement with the home and interaction with their family member. Families were often contacted by DCCs to provide information for life histories or items for memory boxes and toolkits and this provided a way for them to get more involved. In addition, a number of DCCs ran

training and support sessions for families which again resulted in better relationships and engagement.

Impact on residents

Overall, the percentage of residents prescribed antipsychotics decreased from 20.1% at baseline (301 out of 1500 residents with dementia) to 13.9% (216 out of 1558 residents) following the FITS intervention. This represents a 30.5% reduction in antipsychotic use (Chi Sq 20.4 $p < 0.0001$). These results also need to be considered in the context of a considerable public and professional awareness campaign regarding the inappropriate prescribing of anti-psychotics (MHRA, 2012). From the case study data and the DPDC diaries the decrease in AP prescribing was initiated by the Dementia Care Coaches. The majority were supported by the GPs they worked with but the change would not have occurred without being initiated by the FITS into Practice programme.

Goal Attainment Scaling (GAS) was used to help staff set and track progress towards personal goals for residents participating in the project. Only goals that were rated at baseline and at least one further follow up were included in our analysis. Completed data on personal goals was available for 76 participants. On average, people improved by a mean of 1.27 (SD 1.36) on personal GAS goals ($p < 0.0001$). Completed data for BPSD goals was available for 85 participants. On the behaviour goals, people improved by a mean of 1.42 (SD 1.52) ($p < 0.0001$). Analysis was undertaken using a binary outcome of improvement (2,3,4) or no-change/ worsening (0/1) in performance to avoid bias introduced by having more data points reflecting improvement.

A significant benefit was seen in personal GAS goals (Pearson Chi Squared 0.03), but not in behaviour goals (Pearson Chi Squared 0.823). These results should be taken as preliminary only due to the small number of participants who completed the GAS tool as a proportion of the total number of people with dementia in the study (an average of 1 per coach and ~5% of the total sample). This may have introduced bias into the sample selection.

Qualitative data showed a number of positive impacts on residents when antipsychotic prescriptions were reduced or removed. The range of improvements was wide, including improved communication abilities, improved sleeping, eating and mobility, increased independence, improved interactions between residents and staff or family and decrease in behaviours that staff found challenging .

“one lady...in the last few days the carers ran to me and asked me to go and see her because she had a smiley face, very happy, and she was responding...she is responding with questions ...she always had slurred speech and never had communication, always like grabbing to staff and residents,”

(DC1 nurse interview 2)

Qualitative data also showed positive impacts for all residents in the home, regardless of whether they were the focus of medication review. This was usually due to an increase in meaningful activity, improved life history knowledge or changes to care planning as a result of FITS. This suggests that FITS implementation has impacts beyond individual residents.

“We had someone who had never been out on a single outing or a trip, and when we analysed why that was, it was because he would say ‘oh, I’m not sure’...and they’d go back and he’d probably dropped off to sleep or just didn’t answer, so they’d think he didn’t want to go. Well, he’s been out several times now... (and) they said to him one day ‘would you like a coffee?’ and he said ‘I think I’d like a beer’. So he’s had a beer!” (DC7, manager, interview 2)

The DPDC Role

The work and experiences of the DPDC themselves was tracked throughout the programme, in recognition that this role had changed significantly from the initial FITS trial, in which a DPDC was placed within the care home itself whilst implementing change. The DPDC’s role and influence was highly rated by all DCCs as significant in their learning and confidence to implement. Key features of the DPDC role, crucial to its success are as follows and should be considered in any future delivery of the FITS programme:

Training design and delivery

Both DPDCs brought substantial training skills and experience into the role and used them to develop training resources, manage diverse groups of DCCs and respond to changing group needs.

Supervision Delivery

The role of providing support and motivation for implementation required different skills and approach to that of a trainer and the DPDC needed to manage this dual role throughout the programme.

Relationship building with DCCs

DPDCs reflected that the role required special consideration of the relationships they formed with each group and individual DCCs, as it was essential that these were emotionally and practically supportive. This required self-reflection and awareness, as well as considerable time and effort on behalf of the DPDCs.

Organisational Negotiation

Due to the arms-length cascade training approach, DPDCs had limited impact on implementation within care homes. This created challenges for DPDCs to the extent of advice and influence over organisational barriers they could provide.

DPDC support needs

Both DPDCs reflected that the role was a challenging one due to the lone-working and travel required. Both formal supervision and informal support between the two DPDCs was crucial to their ability to successfully complete the role.

Useful Features of FITS Training and Delivery

There were a few components of the FITS programme that stood out in Dementia Care Coaches and DPDCs reflections as being particularly useful. In particular, the Cohen-Mansfield tool box approach appears to have been particularly striking, and was implemented by almost all coaches, even those who struggled with other aspects of implementation. In addition, improved knowledge of person-centred care, guidance on reducing antipsychotic medications and resources to help train other staff were highlighted as significant. Peer support was highlighted as very important by a number of Dementia Care Coaches, regardless of their existing role, as an opportunity to network and share experiences for others. This occurred across the whole programme but was particularly felt during supervision and included problem-solving, practice-sharing and emotional support. This is an oft-neglected benefit and impact of face-to-face programmes.

Barriers and facilitators of FITS implementation

Whilst the majority of DCCs managed to implement some aspects of the FITS programme, it was to different degrees. Qualitative data provided evidence of a number of factors that operated as either barriers or facilitators to implementation of the FITS programme by DCCs

1) Time available for the DCC

The allocation and protection of time for the DCC to complete FITS work was the dominant theme occurring and it primarily exhibited itself as a barrier to implementation. At entry to the project, all care home organisations were informed that the DCC role should be considered to be equivalent to a half time post and as such sufficient time should be protected from other duties of their existing role. However, the vast majority of DCCs did not receive sufficient protected time, with many receiving none at all.

"I haven't been allocated any shifts to do it. I've known I've needed it, but we've been short staffed and holidays and sickness and stuff and people leaving...I've just not had the chance. And then I get given my days off and I can't come in on my days off, I can't, so that's been one of the main hurdles really,"

(DC5, Care Assistant, interview 1)

Lack of allocated time did not affect DCCs in management roles more or less than those in less senior positions. However, a senior role did sometimes mean they were more able to manage their other work to create time for FITS. However, this required other organisational factors to be flexible. Lack of time affected DCCs from across all types of roles, care home and organisations, and this would suggest that it is an endemic barrier to achieving the impact from a programme such as FITS. Therefore, any future delivery of FITS must consider ways to ensure protection of sufficient time for DCCs if full effect is to be achieved without taking advantage of DCCs personal commitment and conscientiousness. When asked, DCCs suggested that time allocated to FITS should be between a day and two days a week in order to be effective, providing those hours were actively protected from other tasks in the home and cover for existing duties provided.

2) Characteristics of the DCC

In addition to time, there were other characteristics of the DCC which appeared to affect the implementation that took place. Primarily, the DCC's existing role created affordances or challenges for implementation. For example, DCCs from more senior positions reported that their authority and status helped with implementation and often influenced the way in which they undertook it. However, these same DCCs often reported that it was harder to role-model as they were not participating in direct care. In addition, those DCCs in management roles that took them away from a single home (e.g. to cover sickness or conduct investigations) struggled significantly with implementation. DCCs from more junior roles did not explicitly identify lack of authority as a barrier for implementation. Instead they identified that being present 'on the floor'

helped with implementation, and acknowledged that this was the best route due to their particular position

Successful DCCs, regardless of their position, tended to exhibit the following characteristics: they were enthusiastic, willing and had a person-centred ethos; they were able to listen to others and be reflective on their own practice; they were able to command the respect of others; and they were persistent, strong and confident.

“They’ve got to be able to watch and listen...you’ve got to be able to hear everything that is going on all around you...being able to talk to people and...put a different point across to see if they take it on board...Listen to everybody and everything because it’s not your opinion, it’s everyone’s. Everyone’s input needs to be put into it,” (DC3, senior carer, interview 2)

3) Care home staff factors

DCCs experienced barriers and facilitators that related to the staff team within which they were attempting to implement the FITS programme. Whilst these factors relate to peer groups and front line staff it is important to note that many of them were highly influenced by the way in which the care home was internally managed and influenced by the wider management organisation. Other dementia training that staff received during the FITS programme was highlighted by some to significantly aid implementation. In several cases it was explicitly used by DCCs as a vehicle to distribute the messages of FITS.

Staff teams that were cohesive, open and receptive and knew their residents well helped with implementation. Where the opposite occurred, particularly when staffing was insufficient or unstable, there was little time for DCCs to engage in implementation, let alone involve others.

“We’re well off here, compared to a couple of them in my group who... were really just fire-fighting. I actually go home thinking, how are these folks actually going to do anything. And if they do, hats off to them... They were people who were obviously very keen...but they were up against it really,” (DC2, trainee manager, interview 2)

4) Care home management factors

The level of practical and emotional support provided to DCCs by their manager was crucial to successful implementation, not least because this primarily manifested itself through the allocation of time and resources to undertake the work. This support required managers to understand the requirements of the FITS programme from the

outset. It is notable that management barriers were less frequent when managers were required to attend a mandatory meeting before recruitment to the programme.

"I think obviously you've got to be there sometimes just to listen to the coach moan....it's just for them to let off steam...they've got to know that you are there for them," (CS3, interview with interim manager)

"Our focus has been on...more practical issues...Where we've missed the point and missed opportunities is the fact that {DCC} and I have not taken the opportunity to sit down and say 'okay how can we best use what you're learning and put it into practice in the home?'" (CS5, interview with manager)

Barriers DCCs experienced related to management, were often closely allied to those relating to the wider organisation.

5) Organisational factors

Owning organisations, whether large or small, were often ultimately responsible for the allocation of time and resources for DCCs to implement FITS. Therefore, where DCCs received this support it facilitated their plans for implementation. This practical support was evident when the overall ethos of an organisation was focussed on improving person-centred care and valuing staff, and this helped DCCs to implement change, particularly long term.

In addition to failing to protect time for FITS implementation, organisational barriers occurred when DCC's organisations had poor internal communication across management levels, required them to make a number of significant changes at the same time as FITS, or provided practical barriers such as corporate styles or bureaucratic processes that prevented changes being made easily. In addition, where staff felt devalued or disempowered by the organisation, they struggled to implement their learning from FITS.

"The hardest things will be getting inspectors, auditors and the company to understand...each person we care for is an individual...I do hope (they) don't come across and say they want set boxes for the toolkits. I think that will happen because I think it will look tidy, but then it will look institutionalised...If the individual wants to walk about with a shopping basket then that can be their toolkit," (DC9, manager, interview 1)

"Two homes owned by the same group are struggling to implement change because of rigid policies around the home looking like a hotel and apparent lack of understanding from owner and managers," (DPDCb, reflective diary)

6) External Factors

Two issues emerged as external to the care home or the care home organisation as potential facilitators or barriers to implementation of FITS: the attitude of healthcare professionals (in particular GPs) and the engagement of families in the care home. Where GPs were approachable and engaged with the aim of FITS, then implementation was significantly easier. A number of DCCs reported receptive and encouraging encounters with their prescribers and care home liaison teams. However, there were a number of occasions when prescribers were reluctant to engage. These situations took substantial time and effort on behalf of DCCs. DCCs expressed frustration where new residents were admitted to their homes from hospitals with anti-psychotic prescriptions.

Where families were engaged in the life of the care home and residents, DCCs reported them to be an important facilitator of FITS implementing, by supporting life story work and providing materials for memory boxes and activities.

All DCCs chose to engage with families as part of their FITS implementation and found it a huge facilitator. However, on a few occasions where family were not able to engage with life history work, either because of distance or lack of information, DCCs understandably found it harder to implement ideas for that particular resident.

Conclusions and Recommendations

- **FITS into Practice works but management sign-up is crucial**

The FITS into Practice Programme provides a robust way to bring about positive change for care home residents, their families, staff teams and the care home environment more generally. However, these changes only occurred where Dementia Care Coaches were able to implement the changes they learnt about. To achieve maximum benefit care home providers have to provide role clarity and protected time for the Dementia Care Coach role to be undertaken, as well as a management support structure and organisational value base that facilitates this. The persistence of organisational barriers to implementation within this project suggests that future delivery must raise awareness of and actively combat such barriers to ensure results are achieved from training investment.

- **Maximising management support**

In order to maximise management commitment and understanding of the programme the care home manager should undertake a 1-day workshop prior to the start of the

programme and attend 2 training and supervision sessions alongside the Dementia Care Coach. This is aimed at combatting barriers to implementation and ensuring appropriate selection and support of the Dementia Care Coach.

- **Developing a shared community of practice**

The peer support gained by participating in face to face training and supervision was highly significant to the positive experience and implementation of FITS. It is therefore recommended that a face-to-face model be retained, including facilitation of visits to participating care homes where possible. Whilst financial pressures often lean towards virtual alternatives of delivering training, this evaluation suggests these pressures should be resisted as to do so would lose one of the most significant facilitators of success.

- **What's in a name?**

The name "FITS" should be changed to better describe the work a Dementia Care Coach carries out. This will simplify the task of the Dementia Care Coach in communicating the purpose of their work in the care home and with external partners. Consideration should be given to developing Dementia Specialist Care Practice. Thus the Dementia Care Coach undergoes the Dementia Care Coaching Course delivered and supervised by a suitably qualified Dementia Practice Development Coach. This enables the care home to deliver Dementia Specialist Care Practice.

- **The Dementia Practice Development Coach role**

The role and skills of the DPDC are crucial to the success of the delivery. Their knowledge and experience of working with care home organisations and undertaking organisational negotiation are of particular importance, in addition to knowledge and skills in dementia care practice and education.

- **Training and supervision course structure and content**

A revised course structure has been developed to incorporate learning from the evaluation. Training and support sessions are interspersed and take place across a 30 week period; the optimum timeframe for implementation. A revised Dementia Care Coach manual, designed to support their learning and implementation will be available, including new content designed specifically for FITS into Practice and valued highly by participants.

- **Models of future delivery for large and small providers**

A major change of the FITS into Practice delivery compared to the original FITS pilot model was the repositioning of the DPDC role from one internal to specified care homes to one supporting Dementia Care Coaches at arms' length from the care home. This

distancing did cause some difficulties when organisational or managerial barriers to implementation existed. However, this repositioning was necessary in attempting to widen the access to such a resource (and thus the impact of a 'FITS approach') across the care home sector. Therefore, in future delivery, two future models could be considered as outlined below.

- a) Dementia Care Coaching Courses delivered by DPDC employed directly by the care home provider organisation
- b) Dementia Care Coaching Courses delivered by an external DPDC, employed externally to provider organisations.

- **An holistic approach**

It should be noted that this in-depth, mixed methods evaluation was able to explore many of the contextual barriers and facilitators of implementation within care homes. These are essential to consider, regardless of the training intervention that is being pursued. Successful implementation from training only occurs when it addresses internal and external contextual barriers to appropriate implementation. Training delivery and attendance is only one aspect of achieving change. Thus it is essential that any future FITS delivery recognises and responds to this in order to prevent FITS becoming simply 'another training programme'.

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