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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

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 2006). Crucially, this was achieved without any increase in behavioural or psychological symptoms (Ballard 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

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.

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 theredenmpntthae(t)5 (h)-4 (ere)50p -16.92 Tc

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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

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

The 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.

In order to pre-empt barriers to implementation, the should undertake a 1-day workshop prior to commencement of the programme and engage with 2 key sessions of the training and supervision programme.

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 is adequate and the training is recognised as effective only in the context of an holistic organisational approach.

The new suggests the programme takes place across a 30 week

Overview of the FITS into Practice Evaluation

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 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 , 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.

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 2006). Crucially, the FITS programme achieved this without any increase in behavioural or psychological symptoms (Ballard 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 stake-holders 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 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-

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.

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 difficultly 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

Number of primary homes	61
Number of 2nd homes	6
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

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.

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

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.

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.

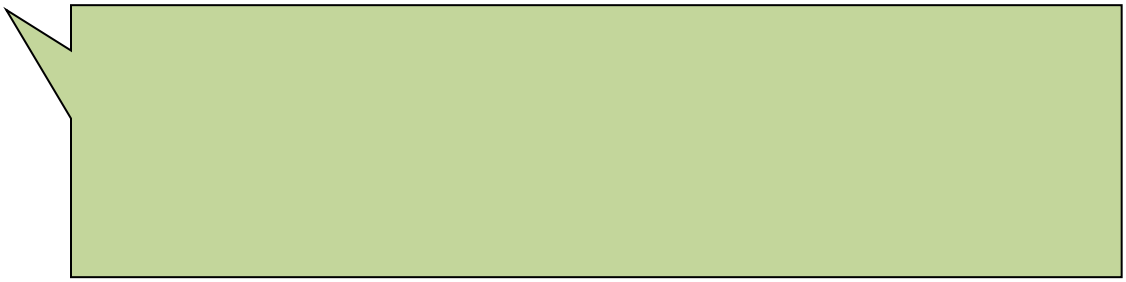
DCCs were also asked to provide information on their experience of implementation in their care homes. Overall, the majority of DCCs felt confident about being a coach in their own care home. The majority of DCCs who commented positively explained that the FITS programme was instrumental in their confidence, 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.

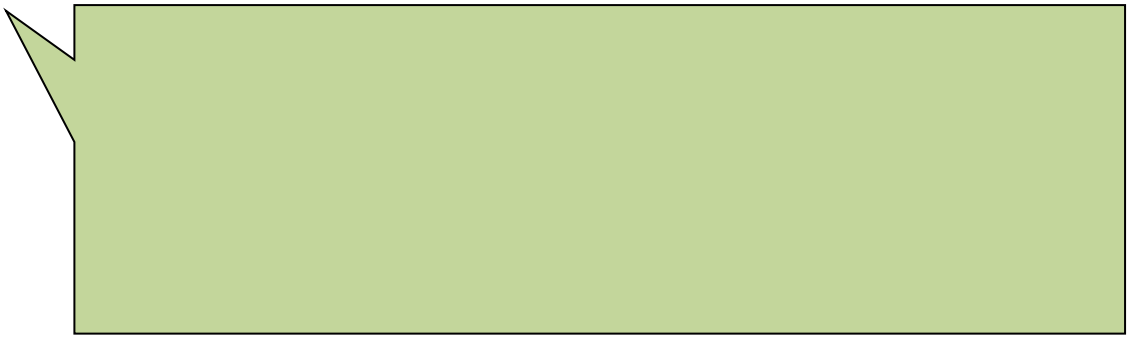
Qualitative data demonstrated that FITS participation had a positive effect on the staff teams of homes that took part. Staff were seen to have improved skills and confidence leading to a more empowered approach, and to show an increased willingness to

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



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.



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.

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-

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.

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.

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.

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-M4 (g)-2 (f-18 -28.n)]TJ1 0 0 1 403.39 30 (h

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

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

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.

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-

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

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