University of Lethbridge
'The Stakeholder Inclusion for Practice Change'

Final Report

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EXECUTIVE SUMMARY

It has been demonstrated that, due to over-adherence to rules and procedures, which ensure mealtimes run smoothly in residential care homes, residents living with dementia can lose, at least to some extent, their influence over what they eat, when they eat, how much, for how long, with whom, and in what surroundings. In addition, the ability of residents to participate in previous roles associated with the mealtime experience (e.g., meal prep and clean-up) is often lost. A shift in focus away from an institutional model of care, which impedes individuality and choice, toward a more person-centred model of care is needed. Person-centred care recognizes persons living with dementia as individuals who have different histories, preferences, customs, expectations, and needs at mealtimes.

The purpose of this project was to improve residential care homes' capacity to consistently provide relational and person-centred care, while also improving their overall adherence to provincial standards and regulations. The goal of this project was to co-develop and implement feasible and sustainable person-centred mealtime activities (e.g., involvement of residents in food preparation and mealtime set up and clean up, flexible eating times, etc.) in a residential care home. The objectives of this project were to use the Model for Improvement, developed by Associates in Process Improvement, to co-develop clearly defined aims, measures, and changes associated to person-centred mealtime activities and then to implement these through a plan-do-study-act (PDSA) cycle.

The project was unique and innovative because it aimed to improve collaboration, mutual understanding, and knowledge sharing among licensing inspectors, persons living with dementia, family members, and formal care team members in ways that enabled and promoted improved social and purposeful engagement of persons living with dementia in residential care homes. The setting for this project was St. Michael's Health Centre—Covenant Health in Lethbridge Alberta. Our target population was persons living with mid to late stage dementia who required supportive living environments. The timeline was a 12-month period beginning with participant recruitment and the development of the Process Improvement Team and concluded with planning for sustainability and spreadablility.

Using principals consistent with Critical Participatory Action Research (CPAR), we applied both qualitative and quantitative research methods to examine the processes and outcomes associated with our project. CPAR provides a framework for creating knowledge that is embedded in the belief that the individuals most impacted by the research should determine what actions might be the most useful in affecting change. Due to the nature of this project, the impacts were measured using two approaches: 1) Outcome measures to determine whether or not the project achieved its goals (these included: The Mealtime Scan (MTS) and The Dining Environment Audit Protocol (DEAP)), and 2) Process assessments to understand how the project is being implemented (these included in-depth interviews with all project participants).

The intervention resulted in statistically significant improvements to the mealtime environment overall and in the three domains of physical environment, social environment and relationship and person-centred care practices. Qualitative findings further supported the success we achieved in engaging care staff members, family, and residents in the implementation of person-centred mealtime practices. Finally, as a result of this project, we developed an innovation entitled the FASCCI (Feasible and Sustainable Culture Change Initiatives) model for change. The FASCCI model adds two key features that are not included in the Model for Improvement, which we found to be essential to successful practice change in residential

care settings.

OBJECTIVE & IMPLEMENTATION

As a result of this project, Dr. Sienna Caspar developed the FASCCI (Feasible and Sustainable Culture Change Initiatives) model for change. This model was developed to support the successful implementation of person-centred mealtime practices into everyday mealtime care practices in the continuing care context. The FASCCI model, which draws significantly from the Model for Improvement, provides an effective framework for stakeholder engagement and the means to evaluate, advance, and continually learn from changes that are made. Similar to the Model for Improvement, FASCCI uses a "Process Improvement Team" approach to actively engage key stakeholders to co-develop clearly defined aims (What are we trying to accomplish?), measures (How will we know that a change is an improvement?), and changes (What changes can we make that will result in improvement?) and then implements these changes through plan-do-study-act cycles. The FASCCI model adds two key features that are not included in the Model for Improvement. The first is the provision of leadership training to team leaders on the PIT teams. The second feature is the active exploration and application of three key intervention factors that are necessary in ensuring the feasibility and sustainability of the change initiative. These include: 1) predisposing factors (e.g., effective communication and dissemination of information), enabling factors (e.g., conditions and resources required to enable staff members to implement new skills or practices) and reinforcing factors (e.g., mechanisms that reinforce the implementation of new skills).

The FASCCI model has nine phases:

1. Forming the Teams: Including the right people on a Process Improvement Team (PIT), which is composed of those who work in the system, is critical to a successful improvement effort. A PIT team composed of key stakeholders (i.e., care staff members, family members, administrators, managers, and interdisciplinary care team members) was formed.
2. Setting Aims: The PIT members actively engaged in setting the project aims specific to enhancing person-centred mealtimes.
3. Establishing Measures: Measurement is a critical part of testing and implementing changes. We used outcome measures, process measures, and balancing measures (see below for further explanation) to determine if specific changes actually lead to improvements.
4. Selecting Changes in Care Practices: Changes in this project was specific to the implementation of CHOICE principles. CHOICE is an education training and evaluation program created by Dr. Heather Keller at the University of Waterloo. This program aims to improve person-centred mealtime practices in long-term care. The goal of CHOICE is to make mealtimes more homelike, respect resident's dignity, increase socialization, and honour resident's choice and preferences. Ideas for changes will come directly from the PIT members.
5. Developing Strategies Associated to Three Key Intervention Factors: The PIT members selected and enacted the requisite predisposing, enabling and reinforcing factors determined by them to be essential to the success of the project.
6. Testing Changes: The Plan-Do-Study-Act (PDSA) cycle, which is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned, was implemented. As anticipated, several PDSA cycles were conducted during the project.
7. Implementing Changes: After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the teams implemented the change on a broader scale — for example, they spread the change to multiple units.
8. Receiving Responsive Leadership Training: Team leaders on the PIT team received a day-long training session on responsive and supportive leadership.
9. Spreading Changes: After successful implementation of a change or package of changes on an entire unit, the teams have now begun to spread the changes to other parts of the organization.

The purpose of this project was to improve residential care homes' capacity to consistently provide relational and person-centred care, while also improving their overall adherence to provincial standards and regulations. The objectives of this project were to co-develop and implement feasible and sustainable person-centred mealtime activities (e.g., involvement of residents in food preparation and mealtime set up and clean up, flexible eating times, etc.) in a residential care home.

Process and approaches undertaken

Using principals consistent with Critical Participatory Action Research (CPAR), we applied both qualitative and quantitative research methods to examine the processes and outcomes associated with our project. CPAR provides a framework for creating knowledge that is embedded in the belief that the individuals most impacted by the research should determine what actions might be the most useful in affecting change.
Due to the nature of this project, the impacts were measured using multiple approaches:

1. Outcome measures to determine whether or not the project is achieving its goals (e.g., How often where person-centred mealtime activities offered to residents?) and to measure how the project impacts persons living with dementia (e.g., How did the residents respond to the person-centred mealtime activities?). These included: The Mealtime Scan 2.0 (See Appendix A) and The Dining Environment Audit Protocol (See Appendix B). In total, thirty-eight mealtime scans were completed.

2. Process assessments to assess how the project is being implemented (e.g., What kinds of problems were encountered in delivering person-centred mealtime activities? To what extent were the person-centred mealtime activities implemented as planned?) and to determine whether or not it is sustainable (e.g., Are the person-centred mealtime activities continuing to be delivered? If not, why not?).

3. Balancing assessments to determine whether or not changes designed to improve one part of the system are causing new problems in other parts of the system (e.g., How did the project impact nutritional services, care staff routines, or housekeeping? What were the unintended consequences of the project?).

Outcome measures were analyzed using non-parametric Kruskal-wallis test with follow-up Mann-whitney U tests and application of Bonferroni Correction. Process and balancing assessments were conducted using 1:1 interviews with all PIT members. In total, nineteen interviews were conducted.

PIT members also participated in surveys as part of the CHOICE education tools. These included:

a. Organizational Readiness for Implementation of Change Questionnaire (See Appendix C)
b. Staff Mealtime Satisfaction Survey (See Appendix D)

Environment and Resources

This project involved collaboration among multiple organizations. The project was implemented in St. Michael's Health Centre-Covenant Health, located in Lethbridge Alberta. Covenant Health was established on October 7, 2008. St. Michael's Health Centre is one of 16 facilities owned and operated by Covenant Health. St. Michael's Health Centre has extensive experience working with and caring for persons living with dementia. St. Michael's Health Centre provides care and services to 48 long-term care residents, 24 rehab patients, individuals in 24 community support beds, 84 supportive living residents, 12 mental health residents and 10 palliative care residents.

By creating and supporting a Process Improvement Team (PIT), meaningful engagement and participation of persons impacted by dementia was supported throughout this project. Feelings of social inclusion was increased since these individuals have rarely been included "at the table" or on the team when significant change to care practices have been developed and implemented in residential care

settings.

Three of the nine phases of the FASCCI model are part of the implementation phase. Persons affected by dementia were active participants in all of them.

1. Testing Changes: All PIT members were active participants in the each of the three Plan-Do-Study-Act (PDSA) cycles.

2. Implementing Changes: The PIT members were actively involved in implementing the changes on a broader scale.

Spreading Changes: The PIT members initiated the successful implementation of changes to mealtime practices to other parts of the organization.

IMPACT FOR PEOPLE LIVING WITH DEMENTIA

Initial analysis of qualitative data shows that care staff were grateful for the opportunity to collaborate with other members of the care team to solve problems.

"We are learning more about each other's scopes, so we can work together to get a common goal. I think [its] awesome"

"I really felt I was part of the group, and I was really impressed with management coming and talking with us directly instead of just treating us as a visitor, I really was impressed"

Care staff working directly with residents noticed changes in resident routines around mealtimes and the joy they get from being able to make choice about their mealtime routines.

"I had no idea that one of the residents lived on a farm and once I found that out, we had so much to talk about".

"We have had trouble getting one of the residents to sit and eat at meal times, now that we are sitting with the residents, he comes to meals, sits and even feeds himself".

"The residents love choosing what they are going to drink for dinner and conversations increase as we give them choice".

Relationships between family and staff has changed. Before the project started family was "not allowed" to be in the kitchen and help with residents (other than their own family member). Enabling family and staff to work together in creating and implementing person-centred mealtime practices has changed the dynamic of this relationship. Family now feel like they are more part of the team.

Family members:

"During mealtimes, I felt, well, I wasn't allowed to do much accept with my [own] family, [but] they are all my family, this is their house, this is my family. After I became a member of the [process improvement team] I was able to help everyone, it was really good"

"I look forward to coming in at lunch now, and I look forward to seeing another member of the PIT team in the house"

Like any project, the Stakeholder Engagement for Practice Change also came with its challenges. Challenges that PIT members felt were most difficult to manage were trying to teach care staff members who were not PIT members about the project and being met with resistance.

"It's hard, I find a lot of [people] still don't understand what we are doing, it's frustrating sometimes"

"We need more management support, some people need more step-by-step guidance about what we are doing"

Although staff found it difficult with some individuals they did also find a lot of people who were not on the PIT team who were willing to try and really wanted to provide more person-centred care.

"You get to see the excitement from others when you are explaining it to them, you say, 'this is what we are doing and this is how it helps'"

The staff and family were also able to describe their experiences in the short video created at the end of study celebration. The video is a great qualitative data piece highlighting the positive outcomes of the study in the words of the people who made it happen. "Stakeholder Engagement for Person-centred Mealtime Practices video" located at https://youtu.be/6D7xyLlIc88.

Return to Stakeholder Inclusion to Practice Change and click on "Evaluation" for evaluation results.

Contact seniorshealth.scn@ahs.ca for a copy of the Stakeholder Inclusion to Practice Change Final Report.