Strategies for changing staff care practices

Successfully changing staff practice in aged care homes to improve outcomes for residents is not easy, but a recent study has identified strategies that can be used. Lee-Fay Low, Jennifer Fletcher, Belinda Goodenough, Yun-Hee Jeon, Christopher Etherton-Beer, Margaret MacAndrew and Elizabeth Beattie report.

There are no ‘magic bullets’ when it comes to changing staff practices to improve care and outcomes for people in residential aged care. After an extensive review of published studies from around the world that evaluated interventions designed to change how staff care for residents, we can report that staff behaviour change is difficult and complex. There were many unsuccessful interventions. However, change is possible and we were able to identify elements that contributed to the success of those interventions that changed practice.

This article summarises our findings, including the things that residential aged care service providers should consider when contemplating programs requiring staff to change their behaviour and practices.

Reviewing the evidence

We conducted a systematic review in 2015. Two members of our research team went slightly cross-eyed reading the 7572 articles that came up in our search, before these were culled to 79 eligible papers reporting on 63 studies.

We excluded articles which focused only on staff well-being or turnover, or increasing staff knowledge without measuring changes in behaviour. We included only those studies which measured quantitative outcomes before and after the intervention. We did not include studies where researchers intervened directly with residents.

We grouped studies into clinical domains. These were: oral health (three studies); hygiene and infection control (three studies); nutrition (two studies); nursing home acquired pneumonia (two studies); depression (two studies); appropriate prescribing (seven studies); reduction of physical restraints (three studies); management of behavioural and psychological symptoms of dementia (six studies); falls reduction and prevention (11 studies); quality improvement (nine studies); philosophy of care (10 studies); and other (five studies).

For each study we recorded which intervention strategies were used to try to change staff behaviour. These ranged from education material for individual staff, to larger scale organisational structures (see box above).

What we learnt

A key finding was that no single strategy resulted in a greater likelihood of staff practice change. In particular, providing training alone (without support from other strategies) was not effective. We found that most studies reported using more than one type of strategy. Even so, there was no evidence that practice change outcomes improved as the number of strategies increased – there was no ideal number of components (eg two versus four).

Rather the important considerations reflected the features of the targeted staff behaviours or the work context. It appears to be easier to change staff behaviours in specific care tasks (eg oral care, physical restraints) than to change global practice (eg introducing person-centred care philosophy). Many studies reported barriers relating to staff (eg turnover, high workload, absenteeism, attitudes) or organisational factors (eg lack of funding, resources and logistics).

We also observed an interesting outcomes asymmetry. Studies showing change in staff behaviour did not always result in improved outcomes for residents (eg improved staff assessment of depression did not reduce levels of resident depression). However, studies that showed improved resident outcomes also reported changes in staff behaviour. The explanation for this finding is not clear and warrants follow up. It could be related to the way that interventions targeting staff were developed and evaluated. For example, studies show there were better outcomes if they used an intervention theory, such as Rogers’ diffusion of innovations theory (which seeks to explain how, why and at what rate new ideas and technology spread). Barriers around organisational and system issues seemed to relate specifically to implementing the new practices (eg insufficient funding, logistical issues and infrastructure difficulties). Several studies mentioned barriers and enablers related to residents’ high-care needs or attitudes of residents and/or families – these were rarely targeted as part of the intervention.

Implications for practice change

Aged care service providers contemplating programs requiring residential care staff to change behaviour should consider the following:

Introduce a multifactorial program rather than training alone – consider changing policy and procedures, using reminders, appointing staff champions, and using quality indicator data in audit and feedback.

Investigate and address barriers and enablers for the program – find out from staff, residents and family what problems they anticipate with their program (eg lack of time) and address these.

Use a theory of behaviour change or implementation – the choice of theory...
Checking the evidence for Appreciative Inquiry

Even the smallest changes in dementia care delivery can be challenging to implement. Appreciative Inquiry is one practice-change approach that’s gaining popularity in Australian organisations. Belinda Goodenough, Ruby Tsang and Michael Young investigate how it’s been used in dementia care settings and with what outcomes.

“We support progress – it’s the change we don’t like” (anonymous)

Do you struggle with breaking a habit? Feel stuck in a thought pattern? Can’t make a new routine ‘stick’? People can find change hard – even when the case for change is based on proven facts.

Organisations can also find change difficult. Whether it be implementing new processes, procedures, positions, or policies, many change initiatives do not deliver adequately on their change objectives and goals. This so-called ‘failure rate’ has been estimated to be as high as 70%, with research suggesting it is due partly to the ways that organisations address people management issues and individual differences (Probst & Raisch 2005; Caldwell & Liu 2011).

An essential factor in effective change management is the ability of managers and change agents to create an appropriate mindset of ‘change readiness’.

We can think of this mindset as the degree to which people involved in or affected by a change are individually and collectively primed, motivated, and capable of executing the change (Holt et al 2010).

Team leaders and managers know that even the smallest changes in dementia care delivery can be challenging to implement. Yet, because research-derived knowledge is continually being tested and updated, change is a constant expectation of good practice.

According to the Dementia Training Study Centres’ (DTSCs’) Knowledge Translation (KT) framework, the practice change journey involves at least four steps for new knowledge to make a difference to care (see Figure 1): people need to become aware of new methods, to adopt these new methods, and then find ways to adhere to (sustain) implementation. This sequence can take a long time, and also not be as linear as it sounds!

The DTSCs’ KT program worked with the DTSCs to identify the best ways to support the KT journey, and the methods for creating and leading a ‘change’ mindset. One approach gaining popularity in Australian organisations is ‘Appreciative Inquiry’. This article checks the evidence for the application of this method in dementia care.

What is Appreciative Inquiry?

With roots in positive psychology and business management, Appreciative Inquiry (AI) is a strengths-based philosophy of change management. AI aims to guide practice change efforts around what is working, rather than trying to fix what isn’t (the problem solving approach, see box p51).

A basic tenet of AI is that organisational culture (‘the way we do things around here’) reflects the direction that employees orient their attention. An appreciative approach is a deliberate choice to focus inquiry (attention) on success, rather than organisational failures.

This inquiry method is collaborative. It involves people sharing their views to reach a common understanding about the best of ‘what is’, and develop a vision for future featuring more of that best. The AI process has been described as a continuous cycles of the ‘4Ds’: discovery, dreaming, designing and destiny (Cooperrider & Whitney 1999).

Why is it popular?

AI has a positive lens. It can feel good! AI methods encourage interactive teamwork, are achievement oriented, with...