BPSPD: getting good practices into everyday practice

Kim Burns, Ranmalie Jayasingha, Belinda Goodenough and Henry Brodaty report the experiences of dementia care staff in putting into practice knowledge of evidence-based interventions for better managing BPSPD.

Using medications to manage behavioural and psychological symptoms of dementia (BPSPD)* for residents in aged care can be risky, with antipsychotics especially problematic (Banerjee 2009; Hollis et al 2007). Despite evidence of increased risk of stroke, cognitive decline and death, and minimal evidence supporting their effectiveness to manage symptoms (see article p40), these medications continue to be prescribed inappropriately.

There are alternatives, with research highlighting a range of psychosocial and environmental interventions that direct care staff can use (Spector et al 2013). However, in our team’s experience a working knowledge of these strategies among care staff varies, and it can sometimes be a challenge for teams or organisations to change their approach to BPSPD management.

BPSPD education program
Knowledge translation (KT) is about bridging the gap in any field between what we know and what we do. It is more than just giving out information; from a research perspective we are also trying to improve our understanding of how organisations change – and the challenges for staff to deliver care that is the right mix of clinical experience, intuition, and science (CIHR 2010; Phillipson et al 2016). Direct care staff have an integral role to play in moving the KT field forward, yet they frequently lack a voice and the power to implement change.

Since 2015 Kim Burns has led a team of DCRC-based experts in delivering KT BPSPD workshops around Australia for direct care staff and health professionals, based on the evidence-based document Behaviour Management – a Guide to Good Practice: Managing Behavioural And Psychological Symptoms of Dementia (BPSPD Guide) (Burns et al 2012) and associated resources (see box p62). The workshop content reflected a review of research-based knowledge about managing BPSPD to improve the quality of care for people with dementia (Spector et al 2013).

The BPSPD education program partnered with the NSW / ACT Dementia Training Study Centre’s (DTSCs) Knowledge Translation Program to undertake a pilot study to evaluate the effectiveness of the workshops in remote and regional areas of NSW and Tasmania and gather feedback from staff about their experiences in putting new learnings into practice. The free two-hour workshops were funded by the NSW / ACT DTSC with the aim of increasing participants’ understanding of:
- Evidence-based resources available to assist in the management of BPSPD.
- Potential challenges to changing practice in response to evidence and learnings.
- Evidence-informed recommendations for more effective management of BPSPD.

This article summarises the feedback from 258 workshop participants, in particular their experiences in transferring knowledge of evidence-based interventions into practice to better manage BPSPD.

Care staff experiences
The workshops were attended by participants from a range of professional roles including, nursing (27.1%; registered, enrolled), assistant in nursing / personal care worker (57.9%), recreational officer / diversional therapist (4.6%), general services (4.6%) and other, eg allied health, management (5.8%).

Small group activities conducted during the workshops asked attendees to identify and discuss barriers and enablers to translating evidence-based knowledge of BPSPD management into everyday practice, and potential ways to overcome these challenges. Small groups of four to five were chosen for the activities to encourage participants to report their experiences openly and honestly. Anonymous demographic and evaluation data were collected after each of the workshops.

Feedback on workplace changes
Factors discussed below and summarised in Figure 1 (next page) outline feedback from participants indicating that they frequently found it difficult to suggest and implement changes in their workplace in relation to BPSPD management. While some participants reported that they did have opportunities to suggest changes, they still found implementation difficult for similar reasons.
Barriers and enablers to implementing evidence-based interventions for BPSD management

Difficulties with suggesting or implementing change

Organisational management, structure and culture
Consistent with the work of others (Cooke et al. 2014; Phillipson et al. 2016), participants reported that a lack of support from management and/or senior staff was a key barrier to their ability to suggest and trial changes. Management were often viewed as not interested in, or not in agreement with, suggestions from direct care staff. A lack of effective consultation, follow up and feedback where suggestions were made was also reported. One participant noted: “... I wrote a letter recommending changes in a secure unit and I knew there was funding available. There was no reply from management and nothing happened.”

In some cases an organisational culture which lacked flexibility in practice and approach to dementia care, existing policies and procedures and the hierarchical structure within organisations were seen as discouraging of suggestions regarding different ways of approaching BPSD management.

The shifting nature of the dementia care workforce was raised as being inconsistent with implementing changes systematically. Specifically, variable shift structure, high staff turnover, rigid care routines, staff fatigue/burnout and frequent rotation of staff from one area of the workplace to another (daily in some cases) reportedly limited motivation to suggest and implement changes. As a result care staff may not be invested in changing practice.

Direct care staff factors
Staff attitude was often seen as resistant toward change. Change in practice was sometimes perceived as too difficult to implement or not worth the effort. Fear of change and wanting to “stay in their comfort zone” was reported. Staff members who had been working in an organisation for an extended period were thought to be “set in their ways”. The potential for “long-term staff to instil ‘old ways’ in new staff” was seen as problematic in that resistance to trialling new approaches to BPSD management persisted. Participants also indicated that bullying of newer staff sometimes occurred where they were set up to fail when attending to the most “difficult” residents.

Difficulties around communication within the workplace and relevant information not being passed on were repeatedly raised as barriers. Specifically, communication breakdown was linked to:

- not reading resident/client notes and/or care plans
- information not recorded
- insufficient information provided at staff handover
- communication limitations due to language and cultural differences between staff members as well as between staff and people with dementia

Participants noted issues with identifying BPSD management strategies as such, and thus not passing the information on to others (e.g. providing a light breakfast at 6am calmed a resident who was otherwise call out

Barriers and enablers to KT in health care

In our review of the academic literature* we identified the following barriers and enablers to knowledge translation (KT) in health care.

Barriers
The four main categories of barriers to successful KT in health care are:

- accessibility of research findings
- anticipated outcomes of using research
- organisational support to use research
- support from others to use research (Retsas 2000).

A lack of authority and limited time to implement change as well as a lack of organisational support are often reported by health professionals as the greatest barriers to KT (Phillipson et al. 2016; Retsas 2000; Carlson et al. 2008; Malik et al. 2015; Chau et al. 2008; Atkinson et al. 2008).

Evidence-based practice is not always seen as a core component of clinical care (Harding et al. 2014). A lack of awareness of the current research and a lack of confidence to evaluate the quality of research outcomes are also ranked high on the list of barriers (Retsas 2000; Atkinson et al. 2008; McKenna et al. 2005; Draper et al. 2009; Grant et al. 2012).

The BPSD Guide provides access to synthesised evidence with all research outcomes rated for quality of the evidence.

Enablers
The literature also outlines enablers for evidence-based practice. These include:

- Providing integrated, multimodal education that meets the goals of the organisation (Nayton et al. 2014; Chesney et al. 2011).
- Initiating discussion among colleagues to reach consensus around changes to practice (Berland et al. 2012).
- Providing ready access to research outcomes (Atkinson et al. 2008) and KT strategies tailored to specific barriers in a specific participant group and setting (Grimshaw et al. 2012; Nayton et al. 2014; Baker et al. 2010).
- KT strategies are more likely to be successful where the approach is informed by an understanding of the probable barriers and enablers specific to the context (Grimshaw et al. 2012; Rosen et al. 2002; Low et al. 2015; Baker et al. 2015; Grol & Grimshaw 2003).

* Details of the literature review are available on request by emailing Kim Burns at k.burns@unsw.edu.au.
Promoting the BPSD Guide principles

The BPSD Guide (Burns et al 2012) was developed by Dementia Collaborative Research Centre: Assessment and Better Care (DCRC: ABC) with funding from the Australian Government.

The Guide incorporates a comprehensive evidence- and practice-based overview of BPSD management principles with practical strategies, interventions and example scenarios. It was developed to provide guidance for clinicians, particularly those working in the Dementia Behaviour Management Advisory Services (DBMAS), in their role of assisting residential aged care facility staff, community care staff and family members caring for people with dementia with BPSD. Demand for the BPSD Guide led to the development of a suite of hard copy and electronic resources to support clinicians, family carers and frontline care staff.

But just distributing guidelines or providing evidence-based information does not lead to changes in practice (Vollmar et al 2010; Phillipson et al 2016; Freeman & Sweeney 2001). The successful implementation of evidence-based information requires a range of KT activities (Vollmar et al 2010; Fruhauf et al 2004) including providing ready access to tailored information based on systematic reviews (Conroy & Shannon 1995; Grimshaw et al 2012).

The DCRC: ABC team undertook the following KT strategies (CIHR 2010) to support uptake of the evidence-based principles of the BPSD Guide into everyday practice:

- Hard copy and PDF versions of the resources, and links to electronic resources, disseminated to target audiences throughout Australia, directly and via expert clinicians.
- PDF versions and links to electronic resources available via the DCRC website.
- Oral and poster presentations at relevant dementia forums.
- Tailored in-service training and evaluation packages developed for skilled clinicians to deliver evidence-based training in their workplace.
- Plain English versions of the hard copy and electronic resources developed for family carers and frontline care staff.
- In collaboration with the Dementia Training Study Centres (DTSC), BPSD workshops were delivered to health professionals and frontline staff in urban, regional and remote centres throughout Australia.


Repeatedly until breakfast was served at 8am, disrupting all around her).

Often, staff members were not encouraged to see and/or value their approach or simple strategies as legitimate interventions where these avoided or reduced BPSD.

A lack of confidence to suggest changes was linked to “feeling inferior” and “never staff feeling intimidated”. This prevented them from raising suggestions based on their observations and individual successes for discussion with other staff and/or management.

Previous unsuccessful attempts at implementing strategies for a particular resident/client with BPSD leaving staff feeling defeated, and inconsistent implementation of strategies by different staff members and across shifts were reported as problematic. Participants also described the lack of a forum to discuss practice change and reach a team consensus as well as encourage teamwork and collaboration in the implementation process.

Interpersonal and professional issues related to group processes reportedly hindered teamwork that could affect practice change. These include lack of co-worker support, interpersonal conflict, differing personalities and viewpoints and resistance to taking direction based on others’ suggestions.

Resource constraints Consistent with the literature (Phillipson et al 2016; Retsas 2000; Draper et al 2009; Low et al 2015), time constraints were repeatedly raised as a barrier to implementing new approaches to managing BPSD. Participants reported a “lack of time to try new things” and that they found it “difficult to get people to listen because they are busy”. Implementing evidence-based practice was often viewed as a separate activity to everyday care, to be trialled if and when time and resources permit.

Budget constraints seen as barriers as “staff may require training but [it] may not be in the budget”. Limited access to training and education reduced opportunities to identify relevant evidence-based information, leading some to the perception that they did not have the necessary knowledge or skills to do their job.

At times, a lack of education meant BPSD was viewed as a ‘normal’ part of dementia and not something that could be successfully managed.

Attending education was also hindered by lack of time due to “work commitments” and workload, a lack of awareness regarding opportunities and the practicalities of “getting all staff to attend at [the] same time”.

Participants reported that where some staff members were sent/invited to attend external training, opportunities to follow up or support to consider new information did not occur afterwards. New strategies and information may then be lost to others in the organisation with little or no attempt at implementation.

In some cases where the physical structure of a care environment was inappropriate for those with dementia, this was seen as a restriction to implementing changes. Lack of access to technology such as computers and hand-held devices in the workplace was seen as a barrier to accessing evidence-based information on the job.

External factors Participants indicated that the person with dementia’s family and/or doctor may resist changes to care strategies. Those participants providing care in the community reported finding it difficult when family or clients resisted suggestions to trial doing things differently in their home: “Many behaviours are difficult to manage and families do not always understand [the] care process”.

Frontline staff indicated that they did not have the confidence to make suggestions to GPs and felt they may not be taken seriously if they did: “Some GPs are resistant to suggestions, even when certain strategies are successful”.

Where suggesting or implementing change was possible Supportive management and evidence-based strategies Participants who indicated less difficulty suggesting or trialling
changes in their workplace typically reflected a supportive management. Where suggestions were viewed as being in line with current policies, managers were more likely to take them on board and try to implement change. Management were reportedly more accepting of strategies if suggestions were evidence-based.

Where management was perceived as open to suggestions and actively encouraged new strategies, participants felt more confident to approach them with their ideas.

**Effective communication between staff and with family**

Unsurprisingly, participants reported that it was relatively easy to suggest and implement new strategies where communication between staff was effective via clear documentation of successful strategies, considering others’ suggestions, education sessions and shift handovers. Gaining family members’ support to trial and implement interventions by communicating with them beforehand was also reported as helpful.

**Suggested strategies to overcome barriers to implementing change**

**Organisational approach to implementing changes**

Modifying organisational approaches to implementing change was proposed as a way to help overcome KT barriers. Suggestions included:

- Increased management support and time to trial strategies.
- Greater consistency of staff across shifts as well as referral to services, such as Specialist Mental Health Services for Older People (SMHSP) and DBMAS for additional support and new evidence-based ideas to assist with BPSD management.
- Building staff members’ confidence and capacity to suggest and implement change, and allowing them to take leadership of new strategies. For example, a catalyst or champion to provide positive mentoring and motivate others to work through the difficulties around implementing changes.

Some participants indicated that a shift in organisational and management support, as well as the broader workplace culture and hierarchy was needed to encourage staff to suggest and implement changes.

At an organisational level, suggestions included changes to policies and procedures as well as modifying current communication and feedback channels to reduce barriers caused by hierarchical structures.

At a management level, suggestions included increased guidance and mentoring as well as recognition and acknowledgment that the contributions of direct care staff are valuable.

**Communication**

Participants suggested that improved methods of communication via staff alerts, meetings, behaviour charts, memos and documentation would support implementing changes. Multidisciplinary case management meetings were also suggested as a method of encouraging staff to develop and decide strategies and to trial them as a team. Increased opportunities for feedback between staff and management using formal feedback channels and anonymous surveys were also suggested.

**Resources**

Suggestions related to resources included more realistic time frames to trial and evaluate new interventions, the use of quality improvement tools and interagency forums to support practice. Participants noted that increased opportunities for education and training to upskill staff, such as in-services and more workshop-based learning, were needed to “present fresh ideas and evidence-based practice, inspire culture change, and challenge old ideas”.

Training for staff to develop new or reinforce previously learned but unused skills to cope with the challenges of BPSD management and carer burnout were suggested. Participants also requested access to evidence-based information that validated their existing practices. Some participants felt that in instances where they were intervening successfully to avoid or manage BPSD, having access to research that showed the intervention/s were validated by evidence would reinforce to others that their approach was worthwhile adopting.

**Engage others in the process**

Case/family conferences and medication reviews to involve family members and GPs in the process of implementing new interventions with their support and understanding were proposed.

**Feedback on the workshops**

Participants also identified aspects of the workshops that they found most useful. Many reported their increased awareness of the resources available in hard copy and electronic formats to assist with BPSD management.

Others indicated the benefits of an increased awareness of services available to support those caring for a person presenting with BPSD, such as a national after-hours helpline, Dementia Behaviour Management Advisory Services (DBMAS), DCRC and DTSC as well as the benefits of networking with other services and health professionals. The workshops also provided opportunities to hear and share others’ experiences of BPSD management and the challenges of implementing change in the workplace, for example “no matter what area you work in the majority of the staff felt the same way and [were] asking the same questions”.

Some participants reported that the workshops reinforced their current knowledge enabling them to “feel more confident that in a work situation I can be more proactive in supporting people with dementia” and another to “trust my own knowledge base and position in remote/rural setting with resistance to change”.

Participants also indicated that they gained additional information on approaches to BPSD management including “identifying pain”, “understanding physical conditions of dementia”, “addressing little things (UTI, environment etc)” and that “medication is not always an effective treatment”.

Additionally, team work, “the importance of multidisciplinary team meetings”, improved communication and information sharing were identified as key strategies that would help participants implement evidence-based interventions to manage BPSD more effectively in their workplace.

**Conclusions**

The KT experiences of the frontline dementia care staff reported in this article are consistent with the four categories of barriers to successful KT identified in the literature (see ‘barriers and enablers’ p61). Of these, ‘accessibility of research findings’, ‘organisational support to use research’ and ‘support from others to use research’ were mentioned the most by participants.

Aged care staff differed from the health care professionals reported in the literature in that the ‘anticipated outcomes of using research’ category was underrepresented.

This may reflect a lack of awareness around the relevance of evidence-based information to direct care staff. This suggests the need to raise awareness of the potential benefits of evidence-based care practices for frontline staff in aged care.

It is not our intention to criticise those working in aged care management and we acknowledge the challenges of the system. The organisations
and facilities involved in this study had previously introduced the BPSD Guide resources into their workplace and they embraced the opportunity for the training workshops. Clearly these providers have a commitment to improving staff knowledge and skills in BPSD management. In spite of this, evidence-based practice was rarely seen as central to everyday care but rather something to be implemented where time permits. The BPSD Guide and associated resources can assist in overcoming KT barriers by providing access to synthesised evidence and practice-based information, including quality ratings for the evidence outcomes.

However, unsupported dissemination of the information does not change practice. An awareness of the potential barriers, and strategies to assist in overcoming these, is essential to the effective implementation of evidence-based interventions for better managing BPSD in residential and community settings. Participants’ feedback may inform other direct care staff and managers, highlighting some of the factors that make change possible, those that make change difficult and strategies to help overcome these challenges. The combined efforts of management and researchers can provide access to a rich knowledge base to support the use of evidence-based strategies which will improve the quality of dementia care.

More information

• The Behaviour Management – A Guide to Good Practice: Managing Behavioural and Psychological Symptoms of Dementia (BPSD Guide) and associated resources, including a ‘travel size’ version of the guide, for clinicians, are freely available on the DCRCs’ new DementiaKT Hub website at http://dementiakt.com.au/.

• A set of 11 posters, based on the principles in the BPSD Guide, are also available for use by health professionals supporting people with dementia in Aboriginal communities in remote areas of Australia. Details p67.

• Staff training workshops

Is your dementia care team interested in a BPSD Guide management staff training workshop? Email Kim Burns for more details at k.burns@unsw.edu.au.

* Editor’s note: While AJDC acknowledges there is ongoing debate over the use of terms such as ‘behavioural and psychological symptoms of dementia (BPSD)’ and ‘managing BPSD’ in relation to people with dementia, our current editorial policy is to continue publishing articles that include these terms when it is clear they are used in the context of the research or practice described and the author’s intent is to promote person-centred care. However, AJDC encourages the use of terms such as or ‘responsive behaviour’ or ‘distressed behaviour’ to underline the importance of seeing agitation, calling out, aggression, wandering and disinhibition primarily as expressions of need requiring an individual response in each case.

References


Canadian Institutes of Health Research (CIHR) (2010) Knowledge to action an end-of-grant knowledge translation casebook. Ottawa: Canada: Canadian Institutes of Health Research.


The following authors are part of the BPSD team (DCRC: ABC, UNSW Australia), responsible for developing and implementing the BPSD Guide: Kim Burns, Research Officer; Dr Raminiale Jayaasinha, Senior Data Analyst; and Professor Henry Brodaty, Director, DCRC; ABC and Co-director, Centre for Health Brain Ageing (CHiBA). Associate Professor Belinda Goodenough was the DCRC Knowledge Translation Program Manager at the time of writing.