King's Research Portal

DOI:
10.1177/1049732316632194

Document Version
Peer reviewed version

Link to publication record in King's Research Portal

Citation for published version (APA):
Hunter, A., Keady, J., Casey, D., Grealish, A., & Murphy, K. (2016). Psychosocial Intervention Use in Long-Stay Dementia Care: A Classic Grounded Theory. Qualitative Health Research, 1-11. DOI: 10.1177/1049732316632194

Citing this paper
Please note that where the full-text provided on King's Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

General rights
Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

•Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
•You may not further distribute the material or use it for any profit-making activity or commercial gain
•You may freely distribute the URL identifying the publication in the Research Portal

Take down policy
If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 16. Apr. 2018

Title Page

Full title
Psychosocial intervention use in long-stay dementia care: a classic grounded theory

Short Title
Psychosocial intervention use in long-stay dementia care

Abstract
This study explores psychosocial intervention use by staff with residents with dementia in long-stay care. 'Becoming a person again' emerged as the core category accounting staffs' psychosocial intervention use within long-stay care. Interview data was collected from participants in nine Irish long-stay settings: 14 residents with dementia, 19 staff nurses, 1 clinical facilitator, 7 nurse managers, 21 nursing assistants and 5 relatives. Constant comparative method guided the data collection and analysis. The researchers theoretical memos based on unstructured observation and applicable extant literature were also included as data. By identifying the mutuality of the participants' experience, this classic grounded theory explains staff motivation towards psychosocial intervention use within long-stay care. It also explains how institutional factors interact with those personal factors that incline individuals towards psychosocial intervention use.

Keywords: dementia, psychology-psychological Issues, quality of life, Ireland, grounded theory

Author details

Dr Andrew Hunter- Lecturer in Mental Health Nursing, School of Nursing and Midwifery, National University of Ireland Galway, PhD, RMN

Prof John Keady - Professor of Mental Health Nursing and Older People/ Dementia And Ageing Research Team School of Nursing, Midwifery and Social Work/Greater Manchester West Mental Health NHS Foundation Trust and Co-editor: *Dementia: the international journal of social research and practice*, PhD, RMN

Prof Dympna Casey- Senior Lecturer in Nursing, School of Nursing and Midwifery, National University of Ireland Galway, PhD, RGN

Dr Annmarie Grealish- Lecturer in Mental Health, Florence Nightingale Faculty of Nursing and Midwifery, King's College London, Salford, PhD, RMN, RGN

Prof Kathy Murphy- Professor School of Nursing and Midwifery National University of Ireland Galway, PhD, RGN

Abstract

The objective of this study was to develop a substantive grounded theory of staff psychosocial intervention use with residents with dementia in long-stay care. 'Becoming a person again' emerged as the core category accounting for staffs' psychosocial intervention use within long-stay care. Interview data was collected from participants in nine Irish long-stay settings: 14 residents with dementia, 19 staff nurses, 1 clinical facilitator, 7 nurse managers, 21 nursing assistants and 5 relatives. Constant comparative method guided the data collection and analysis. The researcher's theoretical memos, based on unstructured observation, and applicable extant literature were also included as data. By identifying the mutuality of the participants' experiences, this classic grounded theory explains staff motivation towards psychosocial intervention use within long-stay care. It also explains how institutional factors interact with those personal factors that incline individuals towards psychosocial intervention use.

Keywords: dementia, psychology-psychological Issues, quality of life, Ireland, grounded theory

Introduction

Global estimates suggest that there are currently 35.6 million people with dementia, with this number due to increase to over 63 million by 2030 and over 114 million by 2050 (Ferri et al., 2005; Prince et al., 2013a; Prince et al., 2013b). This increase equates to 7.7 million new cases of dementia each year (WHO, 2012).

In Ireland, current estimates suggest that there are 41,470 people with dementia (Cahill, O'Shea, & Pierce 2012). The increasing longevity of the general population indicates that this number will grow to 140,580 by 2041(Cahill, O'Shea, & Pierce 2012). Connolly, Gillespie, O'Shea, Cahill and Pierce (2014) describe current Irish community dementia care provision as nationally fragmented, poorly co-ordinated and inflexible. They suggest that the current lack of capacity and skills in the dementia care workforce in the community has a significant economic and social impact. Many people with dementia who could remain at home, are admitted to long-stay care earlier than necessary. The most up to date figures show that in Ireland 14,266 people with dementia are resident in long-stay settings, requiring 24 hour nursing care (Cahill et al., 2012). This figure is set to rise to rise to 47,797 by 2041 (Cahill et al., 2012).

As with community care providers, the long-stay care workforce in Ireland has been found to lack dementia care education and skills (De Siún & Manning, 2010; O'Shea,

2007). The care for people with dementia in Irish long-stay care settings is often not person-centred; as a consequence of this staff are unable to deliver psychosocial interventions in response to the needs of residents (Cahill & Diaz-Ponce, 2011; Cahill et al, 2012). Internationally, there is a growing consensus that psychosocial intervention use can improve the quality of life for residents with dementia. Unfortunately there is limited understanding of how to develop and embed psychosocial interventions in practice (Innes, 2009 & O'Conner et al. 2009; Vernooij-Dassen, Vasse, Zuidema, Cohen-mansfield, J & Moyle 2010).

Psychosocial interventions include a range of non-pharmacological interventions used when working with people with dementia, specifically when attempting to address the behavioural and psychological symptoms of dementia (Douglas, James, & Ballard 2004). Kitwood (1997) identified such interventions as being crucial to maintaining the personhood of the person with dementia. These interventions encompass psychosocial intervention use as part of positive relationship building between residents with dementia and staff. Kitwood and Bredin (1992) and Kitwood (1997) emphasise the mutual psychosocial benefits that arise from person-centred dementia care. The understanding that residents with dementia can benefit from psychosocial intervention use by staff is prevalent in the literature (Gibson, Carter, Helmes & Edberg 2010; Keady

Page & Hope 2009; Murphy, O'Shea & Cooney 2007; Nolan, Davies, Brown, Keady & Nolan 2004). Bates, Boote and Beverley (2004) define a psychosocial intervention as: 'a therapeutic endeavour involving human interactive behaviour' (p. e2). Similarly, Vernooij-Dassen et al. (2010) provide a definition that indicates psychosocial interventions should be used as part of *'every day'* care between staff and residents with dementia.

These conceptualisations offer the understanding that psychosocial interventions are central to all aspects of person-centred dementia care, and should include individualised communication that is part of overall care. This paper describes a classical grounded theory study which utilises these understandings of what psychosocial interventions are, and defines psychosocial interventions as: *everyday therapeutic endeavours involving purposeful human interactive behaviour between staff and residents with dementia*.

Background

The understanding that psychosocial intervention use by staff can benefit residents with dementia is reflected in the international and Irish dementia policy literature (DoH, 2014; WHO, 2012). Cahill (2010) argues that Ireland has been slow to develop and implement policy and structures that can drive the development of service

provision for people with dementia. Cahill (2010) also argues that Ireland must learn from the experience of other countries when attempting to develop policy along with the political will required to improve dementia care. In keeping with this view the recently published Irish National Dementia Strategy (DoH, 2014) emphasises the need to develop evidence based approaches that will improve the attitudes, understanding and communication skills of staff working in long-stay care.

While policy consistently advocates person-centred care which utilises psychosocial interventions, research continues to identify a lack of psychosocial intervention use in practice (Bird, Jones, Korten & Smithers, 2007; Cahill et al., 2012; Edberg, Bird, Richards, Woods, Keeley & Davis-Quarrell, 2008; Ward, Vass, Aggarwal, Garfield, & Cybyk, 2008). Ward et al. (2008) argue that the dominance of the bio-medical understanding of dementia provides staff limited opportunity to deliver psychosocial interventions. They argue that fundamental change in staff preparation for dementia care is required if they are to challenge existing ways of communicating with residents with dementia. WHO (2012) suggest that if care providers are to improve the quality of life for people with dementia there is a pressing need to address limited staff knowledge of dementia and the lack of training in psychosocial interventions. However, the mechanism by which individual and institutional factors influence psychosocial

intervention use in practice in not fully understood. This paper describes research that provides understanding of those factors that positively impact on psychosocial intervention use in practice, illustrating how these factors can be embedded in the everyday care of people with dementia in long-stay care.

Objective

The objective of this study was to develop a substantive grounded theory of staff psychosocial intervention use with residents with dementia in long-stay care.

Design

This study utilised classic grounded theory methodology as outlined by Glaser and Strauss (1967) and Glaser (1978, 1992 & 1998). This approach produces a parsimonious explanation of what is going on around the main concern of the participants (Glaser, 1978). Classic grounded theory research is best suited to areas of interest where there is little understanding of the social processes at work. The core category 'becoming a person again' emerged through the rigorous application of the constant comparative method, namely open coding, selective coding, theoretical coding, memoing and theoretical sampling. This rigorous application of the tenants of classic grounded theory provided data saturation, ongoing analysis and theoretical

saturation around the core category of ‘becoming a person again’. This allowed explanation of the overall social process. The research was conducted in four phases of data analysis and collection.

In each phase the data was subject to constant comparison, producing codes and categories. These provided direction for the subsequent data collection with new participants. As the data collection and analysis process proceeded the emergent categories became increasingly saturated. The development of clearer conceptual categories, specifically the core category, allowed the sampling and data collection to become more focused on the emergent theory, though there was always scope for the participants to add data that could be identified with new codes.

Phase 1 comprised two cycles of theoretical sampling, constant comparison, theoretical modelling and subsequent theoretical sampling. This is followed by constant comparison, theoretical modelling and subsequent theoretical sampling of all Phase 1 data. Data collection for Phases 2 to 4 follows on from these initial participants using the same process of theoretical sampling, constant comparison, theoretical modelling and subsequent theoretical sampling.

Ethics and Consent

Ethical approval for this study was granted by the research ethics committee of the National University of Ireland, Galway and five hospital-based research ethics committees responsible for the participating public long-stay units (University Ethics Reference Number: 08/Sep/05). The purpose of the research was explained to all prospective participants and they were asked if they wished to take part. All those who gave consent were given a study information sheet outlining the purpose of study, how taking part would affect them, possible benefits and harms.

Informed written consent was provided from all participants. Although all participating residents with dementia initially gave informed consent, ongoing participation was not assumed owing to the potential for fluctuating cognitive status. Process consent was therefore re-assessed at each follow-up visit (Dewing, 2007; Slaughter, Cole, Jennings & Reimer, 2007). Anonymity was preserved by allocating all participants and research sites a code, no names of participants or sites were used on transcriptions of interviews or demographic information forms. The names of participating long-stay care settings, residents with dementia, staff and relatives were securely stored in locked offices separately from their study codes.

Participants

Participants were recruited from ten long-stay care settings. Purposeful sampling was used to identify experienced nurses for the initial two interviews. Analysis of data directed the theoretical sampling and interviews for the subsequent phases. Phase 1 included four long-stay settings, from which three residents with dementia and eight staff were interviewed. Staff were included in the study if they had worked in the long-stay care setting for three months and would care for residents with dementia, for the duration of the study. Residents were included if they had lived in the long-stay care setting for at least one month and were likely to remain there for the duration of the study. Subsequent participants were indicated by the ongoing analysis and theoretically sampled accordingly. Phase 2 included three long-stay settings, from which eighteen staff were interviewed. Phase 3 included three long-stay settings, from which 11 residents with dementia, 22 staff and five relatives were interviewed. See Table 1.

Table 1

Data Collection

Data collection and analysis took place over four phases between March 2009 and December 2013. Table 2 provides an overview of the four phases.

Table 2

Memos

Memos were recorded throughout data collection and analysis. These captured the first author's questions regarding the data and data analysis adding to the emergent conceptual understanding as constant comparison continued (Glaser, 1998). Memoing also relates to reflexivity as the researcher analyses and constantly compares their own pre-conceptions and knowledge, scrutinising them for inclusion in or exclusion from the emergent theory (Glaser, 2003).

Interviews

One to one semi-structured interviews were used to collect data with residents with dementia, staff and relatives. The initial interviews took place with experienced staff. The question schedule included questions such as:

- Tell me about your experience of working with residents with dementia?
- Can you tell me what issues arise around emotional, psychological, social and behavioural needs when you are working with people with dementia?
- Can you describe an example of one of your current resident's psycho-social needs?

The interview approach and guide developed as the phases of the research progressed in response to the emergent theory. Interviews varied in length across the study between 20 and 60 minutes. The interviews became more focused and shorter as the categories became saturated and the core category emerged. It is worth noting that the resident with dementia interviews varied in length, some were very short while others were longer to meet the needs of individuals.

Unstructured Observation

Unstructured observation explored the manner in which psychosocial interventions were used within the long-stay setting by viewing staff-resident with dementia interactions. The amount of time spent in each site varied between 4 and 12 hours. The researcher placed himself in resident sitting rooms, dining rooms, staff offices and reception areas. As the researcher became more familiar with how psychosocial interventions were used by participants in the long-stay settings and the emergent theory, the observation and resultant memoing became more focused on the emergent codes and categories. Unstructured observation supported the interview process by developing understanding and generating questions.

Data Management

NVivo 10 was used to organise and order data and provide an audit trail illustrating the structured approach to the management of data and data analysis.

Data Analysis

Constant comparative data analysis as described by Glaser (1992) is the process of comparing incidents in the data or codes with each other as the data is collected to produce more abstract concepts. Four iterative phases of constant comparison were utilised. Constant comparison commenced with comparing the incidents applicable to each category and fracturing the data to allow as much comparison of the categories and properties that relate to the incidents as possible (Glaser, 1978; Holton, 2007).

This was followed by integration of categories and their properties, where new data is compared with extant categories and properties that have been developed (see table 3). The theory was then delimited as irrelevant categories and properties are discarded producing a clear number of high level theories. This process produced theoretical saturation which focused the research supporting the development of a core category (Holton, 2007). Finally writing the theory is the point at which the coded data is assembled with the categories, properties and theoretical memos explaining the link

between the categories. This produces a theoretical rendering that does justice to the data and the researcher's theoretical sensitivity (Glaser, 2002).

Table 3

The core category 'becoming a person again' emerged from this process, explaining how participants resolve their main concern, 'striving to make the most of time'. Open codes (initial comments/labels on the data) are grouped into categories (conceptual groupings of codes) and these are then related to the core category (the central, delimiting concept). Tables 3 and 4 show the progression of constant comparison as the open codes generated from the analysis of the data (interviews, observational data

and memos) are grouped under conceptual headings into categories. Table 3 outlines the constant comparative process while Table 4 shows how actual data progresses from coding and constant comparison to conceptualisation and theory development. The means by which memos arise from constant comparison and are incorporated into the process of theory development is also illustrated in these tables.

Table 4

The example of a memo below illustrates how the researcher recorded his questions about the data. Hundreds of these memos were recorded, transcribed and analysed across the study. This memo relates to the developing conceptual understanding of staff attitude. It illustrates how the memoing process is central to the conceptual development and credibility of classic grounded theory:

> *Participants want to react positively to behaviours that challenge, but lack the time and knowledge to react in a timely and flexible manner. This indicates a link between education, knowledge, attitude to people with dementia and staff action. The link between time and flexibility is clear and also clearly relates to the prioritising physical care over psychosocial care. Staff say I just have time to do a bath, not to think psychosocially and I'm not minded to think psychosocially because I don't believe/know it will work.* Memo 11/02/09

Table 4 shows the actual contribution of data to theoretical development. This health care assistant data is open-coded under 'patience', considered in memos, then compared with other data. Doing this shows differences and similarities in the data with the open code patience grouped under 'caring attributes' and this category contributing to the higher level concept of 'balancing the influences', then in turn

relating to the core category 'becoming a person again'. This illustrates that the theory is developed directly from the data through constant comparison of numerous incidents in the data.

Sampled literature was also subject to constant comparison along with the other data once the emergent theory was well developed. This approach reduced the influence of existing theories and concepts on the emergent theory. Literature was accessed incrementally using the approach outlined by Urquhart and Fernandez (2013). This comprises a noncommittal phase, in which literature is at first broadly accessed, providing initial understanding of the research area. Followed by an integrative phase, Phase 4 of the data analysis in this study, during which a thematic and theoretical comparison of literature with the emergent theory takes place.

Quality Criteria

Glaser (1978, 1992) defines quality or rigor in classic grounded theory in four domains: '*fit', 'work', 'relevance'* and *'modifiability'*. Other qualitative approaches seek to produce verifiable factual results or full descriptions whereas classic grounded theory aims to deliver a systematically derived theoretical framework that explicates the behaviours noted in the data (Glaser & Strauss 1967). The resultant grounded theory is intended to be a conceptually abstract explanation that arises from, and is meaningful to the substantive area of enquiry. It

must also be conceptually abstract enough to be relevant beyond its substantive area and be open to the addition of further data. Unlike other forms of research these criteria are not applied at the outset of the research, they are applied to the emergent theory after its development. Glaser (2003) notes that a credible grounded theory will have 'product proof' meaning the research itself attests to credibility. The quality criteria were applied in two ways. The first is the detailed presentation of the use of the full complement of classic grounded theory components: constant comparison, memoing, the use of extant literature, theoretical sampling, theoretical saturation, substantive coding, theoretical coding, and application of theoretical sensitivity. Additionally the iterative presentation of subsequent analysis and theoretical sampling across the 4 phases provides evidence of fit, work, relevance, and modifiability illustrating the credibility and logical progression of the theoretical development.

Findings

The theory of becoming a person again explains a social process that changes over time subject to institutional and individual influences. 'Becoming a person again' emerged from the data as the core category. This core category explains the behaviours by which participants resolve their main concern: 'striving to make the most of time'. The overall social process is made up of four conceptual stages that cycle over time (see Figure 1). These are:

1. ‘Balancing the influences’; 2. ‘Individualising status’; 3. ‘Striving to make the most of time’ and 4. ‘Interpreting care’.

Figure 1

1. **Balancing the Influences**

‘Balancing the influences’ conceptualises the impact of personal and institutional factors on ’becoming a person again’. This staff nurse quote illustrates the *balancing* present in her direction to health care assistants regarding making time for psychosocial interventions:

When you're getting them up in the morning, it's not a perfect time to speak to them, but you've got ten, fifteen minutes of valued time and you can reminisce and you know it sets them up the right way for the day…Using the time well.(Staff Nurse)

Three institutional categories; 'weighing up what works', 'psychosocial intervention availability' and 'institutional directing' are balanced against the personal categories; 'caring attributes', 'experiencing care' and 'using education'. Balancing the influences explains how the categories constantly impact on individual capacity and inclination, influencing the balance towards or away from psychosocial intervention use.

2. Individualising Status

The 'balancing the influences' stage determines 'individualising status' which explains individual capacity and inclination towards psychosocial intervention utilisation. Constant comparison shows that individuals will react very differently to the same institutional influences producing staff with very different capacity and inclination as this relative quote illustrates:

I'm afraid I'm thinking in terms of a particular nurse, you know, it's a job and she does it and that's kind of it and I'm sure that she can walk out the door and

not worry about it. Having said that there are other long-term members of staff who are just super and they know the family so well they will tell us all these lovely little bits of information one person who interacts with our mother is an exceptional young girl, gosh, she could only be sort of twenty five or twenty six and she gets on famously with our mum and it's just lovely to see. (Relative)

Another example of 'individualising status' altering is provided in this next quote. Importantly the health care assistant's inclination towards delivering a PSI is altered by her context:

She (Health Care Assistant) was off-duty and she was waiting for her lift and she sat with this man in the conservatory, there with a book or magazine in her hands and the two heads together and this man was really interested. She was giving him her total and full attention. Because she was off duty and she was just waiting for her lift to come and she had a few minutes, she just utilised it and I thought it was lovely. (Staff Nurse)

Constant comparison of this and other data indicates that the innate qualities that allow 'positive caring' are contingent upon the influence of other influences. In this instance the staff nurse concluded that the quality of interaction observed occurred

because the health care assistant was off duty therefore she was free from the pressures of time and context.

The nature of individual psychosocial intervention use subsequent to 'individualising status' is explained by four sub-categories; can't and willing, can and will, can and won't and can't and won't. These sub-categories explain the nature of psychosocial interventions delivered in phase 3 'striving to make the most of time' as participants main concern is resolved and actual care delivered.

3. Striving to Make the Most of Time

'Striving to make the most of time' serves two functions within the theory of 'becoming a person again'. It is both the main concern of the participants and the stage of 'becoming a person again' where actual psychosocial interventions are provided following 'balancing the influences' and 'individualising status'. In the quote below a relative outlines how she would like staff to strive to make the most of time with her relative:

> *How wonderful would it be for you know the head of that organisation to be able to say well actually, you know the staff sat down with your relative the other day and started singing old Vera Lynn songs and your relative was*

absolutely enamoured with it. He started singing the words himself. For the person at the top of the organisation to actually realise that they can tell families that we've got something special going on here that is different to purely physical caring. It's actually looking at the whole person. (Relative)

'Striving to make the most of time' is the main concern of residents with dementia as well as staff and relatives, with the conceptualisation arising from the understanding that residents *'strive'* to be known and have social interaction. This resident with dementia quote illustrates the lack of communication experienced and the time pressure on staff. There was irony in the laugh when responding to the question, what do staff talk to you about when helping you dress?:

Well, not a lot, only tell me to put my arms out here (laughs) (Resident with Dementia).

This next resident identifies time as the reason staff do not talk about his likes and dislikes and then notes how staff use their time:

Ah well, they are busy now like… They haven't that much time… Working and cleaning and cooking and all that. (Resident with Dementia)

The two participant quotes below illustrate different approaches to 'striving to make the most of time' in response to dementia specific education. Both were asked how they utilise psychosocial interventions:

> *You're here every day like and you're definitely using it. You know, I use what I do every day because I'm going through them every day and get them up out of bed. We take them for showers and you have the one-to-one time with them.* (Health Care Assistant)

> *Well, to be honest now, we don't really have time because it's very hard here, like you know.* (Health Care Assistant)

The risk that staff will not view delivering psychosocial interventions as a positive use of time can in part be countered by mutuality of understanding. Positive instances of 'striving to make the most of time' emerged as a function of staff having positive attitudes that enable them to care for residents with dementia as individual people, rather than as sets of symptoms and tasks. This relative data is important as it illustrates the value placed upon staff time being used delivering a routine PSI. This data contributes to the understanding of mutual benefits for all participants and provides a clear example of positive 'striving to make the most of time':

> *I mean that can light up your world when you hear that your mother was awake in the middle of the night so they* (the staff) *gave her a cup of tea and sat with her and looked through old photographs. You think, well that's lovely and it makes you feel good. Things like that are important, that someone has that personal touch*. (Relative)

The constant comparison of resident with dementia data and relative data with staff data results in the understanding that regardless of how the main concern is resolved 'striving to make the most of time' relates to the mutual understanding of the core category 'becoming a person again', as individuals and organisations deliver and interpret care.

4. Interpreting Care

The conceptual stage 'interpreting care' explains how participants view their personal resolution of the main concern. As with the overall theory of 'becoming a person again' 'interpreting care' is influenced by the interaction of institutional and personal categories. This balancing defines the individuals' awareness of the overall process and its impact on outcomes for the resident with dementia. Individual responses to

‘interpreting care’ have the potential to impact on the ongoing process, feeding back into ‘balancing the influences’ (see Figure 1). ‘Interpreting care’ results either in no change where individuals are satisfied with their actions; no change with the individual not satisfied with their actions, but unable to alter practice; or in re-balancing with resultant change as the process continues. The example below has a manager ‘interpreting care’ following dementia specific education. This data shows education along with managerial support resulting in cultural change (rebalancing) in the setting which helps staff meet the conditions of ‘becoming a person again’:

> *It’s making them* (staff) *a better person, a better carer because they’re taking more pride in their work. They are more conscientious and when somebody new comes in they are initiating conversations with residents to know their likes and dislikes. One resident will pick at the flowers that are out the back, that’s what she loved to do. I think people before were concerned about the fact she was going out and she might be going out and getting wet in the rain or she might hurt herself* (Nurse Manager)

‘Interpreting care’ feeds individual responses to the care they have delivered back into the ongoing process of ‘becoming a person again’ with a potential effect on ‘balancing the influences’. By identifying that something has changed making staff, ‘*a better*

person, a better carer', the manager in the quote above is illustrating positive 'interpreting care'. The conceptualisation of 'becoming a person again' indicates that this understanding can impact upon 'balancing the influences' in a manner that maintains or instigates positive rebalancing as part of the overall process. While there is an ongoing process over time there is no certainty that 'interpreting care' will effect 'balancing the influences' in a manner that will change how the main concern is resolved. This nurse manager quote on the impact of training illustrates that homeostasis is often maintained as change proves difficult to achieve:

> *I found it* (training) *very good, but as a nurse in charge I wouldn't do it again because I haven't enough of time to do it and I haven't enough of time to give to do it. I know the other girls found it hard as well to find the time to do it.* (Nurse Manager)

While building 'psychosocial intervention availability', in this case reminiscence training, has the potential to impact upon 'balancing the influences' it is clear that substantive positive re-balancing in favour of 'becoming a person again' requires a number of institutional and personal categories to change. Even when trained this manager did not feel able to alter her care or that delivered by her team. Training

alone had not altered this individuals 'interpreting care' sufficiently to bring about positive re-balancing.

Discussion

Given the global prevalence of dementia and evidence that that current care provision is sub-optimal WHO (2012), there is a clear need to better understand how change can be achieved in the way care is delivered. The theory of 'becoming a person again' provides understanding of the mechanism by which person-centred care, underpinned by psychosocial interventions is provided. The central understanding of the theory of 'becoming a person again' is that the mechanism of psychosocial intervention use for residents with dementia and staff is mutually experienced. This mutuality also defines how psychosocial interventions can be incorporated into care. This understanding shows similarities to that developed by Dewing (2008) and McCormack, Dewing & McCance (2011) who discuss the challenge of providing person-centred care while addressing the physical and temporal reality of the care context. The theory of 'becoming a person again' provides the understanding that mutually maintaining personhood for residents with dementia and staff is interpersonal and psychosocial in nature. When residents with dementia and staff 'strive' mutually to meet the conditions of person-centred care identified in the 'theory of becoming a person again',

positive change in care provision and experience can be achieved. This understanding gives service providers a theoretical framework upon which they can base efforts to implement change.

The concept of 'balancing the influences' explains how the interaction of institutional and personal factors defines the nature of mutuality and subsequent psychosocial intervention delivery. Research by Edberg et al. (2008) and Ward et al. (2008) finds that staff use of psychosocial interventions is influenced by a complex interaction of institutional and personal factors. By explaining and modelling mechanism at work this study adds to this understanding and provides service providers with a means of positively influencing psychosocial intervention use.

The concept of 'individualising status' explains how providing staff with educational opportunity and managerial/colleague support can result in improved staff capacity and inclination towards psychosocial intervention delivery. Campbell (2003) and Figueiredo, Barbosa, Cruz, Marques and Sousa (2013) provide two research examples that also consider staff empowerment and the impact of psycho-educational sessions. These examples conclude that where staff experience empowerment they feel greater commitment to their workplace and provide better quality care for residents with

dementia. ‘Individualising status’ provides understanding of the relationship between those factors that shape staff capacity and inclination towards psychosocial intervention use and what they actually do in practice. ‘Individualising status’ explains how improving staff capacity and inclination empowers them and through the mechanism of mutuality empowers residents with dementia.

The concept of ‘striving to make the most of time’ represents actual psychosocial intervention use, the main concern of the participants. This conceptualisation explains that that while there is a role for education in bringing about change in care delivery, the main concern is resolved through a complex interaction of factors. Vasse et al. (2010) in their systematic review of educational intervention literature, identify a number of factors which facilitate the incorporation of psychosocial interventions in practice. These include personal feedback on education, interactive learning, ongoing support after training, linking the psychosocial interventions utilisation with daily care, and making set times to deliver the interventions. Kuske, Hanns, Luck, Angermeyer, Behrens and Riedel-Heller (2007) in their systematic review of educational intervention literature, recommend organisational change, ongoing support, and post intervention evaluation of change in both staff and residents with dementia. The theory of

‘becoming a person again’ offers clear understanding of a four stage social process that accounts for the use or failure to use psychosocial interventions.

The concept of ‘interpreting care’ provides understanding of how individuals can become aware of their own negative beliefs and practice; and the potential to positively address these. Awareness alone is not enough to modify ‘balancing the influences’, but the action it can stimulate is an important component of change. ‘Interpreting care’ can perpetuate current ‘balancing the influences’ where there is no change. Alternatively it can illuminate failings resulting in positive balancing or it may illuminate failings resulting in strain with no positive effect. Sumner (2010) explores the concepts of self-reflection and moral maturity, noting the potential for positive change in staff self-worth and empowerment. When writing on nurses’ capacity to critically reflect Sumner (2010) notes that while desirable such empowerment and emancipation is rare amongst nursing staff. Sumner (2010) argues that individuals who have not attained the required level of self-reflection avoid critical self-reflection and as such are unable to challenge poor care. Vernooij-Dassen, Moniz-Cook, Woods, de Lepeleire, Leuschner & Zanetti (2005) identified similar understandings from analysis of focus group data around staff stigma beliefs towards people with dementia. Unchallenged stigma beliefs can limit inclination towards caring; reduce residents with

dementia to collections of problems, impair the ability of staff to identify need and diminished psychosocial intervention use. The conceptualisation of 'interpreting care' links staff attitude to dementia and awareness of positive psychosocial intervention use to positive re-balancing, see Figure 1. This conceptualisation offers researchers, educators and service developers the understanding that change in practice arises from the relationship between staff self-awareness, self-reflection and their empowerment.

Limitations

Systematic application of constant comparative analysis and consequent theoretical sampling as described by Glaser (1978) resulted in the majority of data in this study being collected from staff participants. The ratio of 19 residents with dementia and relatives interviewed to 48 staff could be taken as illustrative of the nature of long-stay settings, where institutional considerations take precedence over those of residents with dementia. With this in mind it should be acknowledged that obtaining more data from residents with dementia may have allowed further comparison of incidents and may have altered the overall conceptualisation. That said the resident with dementia and relative data collected did earn its place into the analysis by showing fit, work, and relevance. Constant comparison of this data allowed for 'mutuality' of understanding.

Without the resident with dementia and relative interviews, data saturation of the emergent concepts and the resultant theoretical modelling could not have been achieved.

In addition Glaser (2003) argues that the use of computer assisted qualitative data analysis software (CAQDAS) interferes with the researchers' ability to conceptualise, producing descriptive accounts rather than conceptualisation. In 2009 the researcher attended NVivo training, satisfying himself that while there were potential problems with the use of CAQDAS these were by far outweighed by the benefits. The researcher remained conscious of the warnings of Glaser (2003) and did not use the software as a means of analysis or conceptualisation.

Conclusion

The theory of 'becoming a person again' relates to previous efforts to theoretically explain person-centred care and psychosocial intervention use with residents with dementia in long-stay care. However this theory offers new knowledge of how psychosocial intervention use arises from balancing in various forms around the mutual needs and experiences of residents with dementia and staff. By explication of how incidents of balancing effect the process of 'becoming a person again' this classic

grounded theory offers understanding of how staffs' aspiration towards psychosocial intervention use can be met by achieving the conditions of 'becoming a person again'. 'Becoming a person again' offers service providers, educators, service developers and policy makers a model for enhancing the uptake of psychosocial intervention training and embedding that training in practice to the mutual benefit of staff and residents with dementia.

Funding

The research was undertaken in parallel to and contributed towards the Dementia Education Programme Incorporating Reminiscence for Staff (DARES) study which was supported by a grant from the Health Research Board, Ireland.

References

Bates, J., Boote, J., Beverley, C. (2004). Psychosocial interventions for people with a milder dementing illness: A systematic review. *Journal of Advanced Nursing,* 45 (6), 644-658.

Bird, M., Jones, R.H., Korten, A., Smithers, H. (2007). A controlled trial of a predominantly psychosocial approach to BPSD: treating causality. *International Psychogeriatrics,* 19 (5), 874-891

Cahill, S. (2010). Developing a National Dementia Strategy for Ireland. *International Journal of Geriatric Psychiatry, 25*, 912-916.

Cahill, S., and Diaz-Ponce, A. (2011). "I hate having nobody here, I'd like to know where they all are": Can qualitative research detect differences in Quality of Life among Nursing Home Residents with different levels of Cognitive Impairment? *Ageing and Mental Health*, 15 (5), 562-572.

Cahill, S., O'Shea, E., Pierce, P. (2012). *Creating Excellence in Dementia Care*. Dublin: Department of Health.

Campbell, S.L. (2003). Empowering Nursing Staff and Residents in Long-Term Care. *Geriatric Nursing*, 24 (3), 170-175.

Connolly, S., Gillespie, P., O'Shea, E., Cahill, S. & Pierce, M. (2014). Estimating the economic and social costs of dementia in Ireland. *Dementia: The International Journal of Social Research and Practice,* 13 (1), 5-22.

Department of Health (2014) The Irish National Dementia Strategy Department of Health, Dublin

De Siún, A. and Manning, M. (2010). *National Dementia Project: Dementia Education Needs Analysis Report.* Dublin, HSE.

Dewing, J. (2007) Participatory research: A method for process consent with persons who have dementia. *Dementia*, 6, 11-25.

Dewing, J. (2008). Personhood and dementia: revisiting Tom Kitwood's ideas. *International Journal of Older People Nursing*, 3, 3–13.

Douglas, S., James, I., Ballard, C. (2004). Non-pharmacological interventions in dementia. *Advances in Psychiatric Treatment*, 10, 3, 171-179

Edberg, A.K., Bird, M., Richards, D.A., Woods, R., Keeley, P., Davis-Quarrell, V. (2008). Strain in nursing care of people with dementia: Nurses' experience in Australia, Sweden and United Kingdom. *Aging and Mental Health*, 12 (2), 236–243.

Ferri, C.P., Prince, M., Brayne, C., Brodaty, H., Fratiglioni, L., Ganguli, M., … Scazufca, M. (2005). Global prevalence of dementia: A Delphi consensus study. *The Lancet*, 366, 2112-17.

Figueiredo. D., Barbosa, A., Cruz, J., Marques, A., & Sousa, L. (2013). Empowering Staff in Dementia Long-Term Care: Towards a More Supportive Approach to Interventions. *Educational Gerontology*, 39 (6), 413-427.

Gibson, M.C., Carter, M.W., and Helmes, E., Edberg, A. (2010). Principles of good care for long-term care facilities. *International Psychogeriatrics*, 22 (7), 1072–83.

Glaser, B.G. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.

Glaser, B.G. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: The Sociology Press.

Glaser, B.G. (1998). *Doing Grounded Theory: Issues and Discussions* Mill Valley, California, Sociology Press.

Glaser, B.G. (2002). Constructivist grounded theory? Forum Qualitative Sozialforschung / Forum: *Qualitative Social Research*, 3(3), Art. 12.

Glaser, B.G. (2003). *The Grounded Theory Perspective II: Description's Remodelling of Grounded Theory Methodology.* Mill Valley, California: Sociology Press.

Glaser, B.G., and Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine.

Holton, J.A. (2007). The Coding Process and its Challenges. In Bryant, A., and Charmaz, K. (Eds.), *The Sage handbook of grounded theory.* Thousand Oaks, CA: Sage.

Innes, A. (2009). *Dementia Studies: a social science perspective*. London: Sage Publication.

Keady, J., Page, S., Hope, K. (2009). The person with dementia. In Norman, L., and Ryrie, L. (Eds.), *The Art and Science of Mental Health Nursing.* Maidenhead: Open University Press.

Kitwood, T., and Bredin, K. (1992). Towards a theory of dementia care: personhood and well-being. *Ageing and Society,* 12, 269–287.

Kitwood, T. (1997). *Dementia Reconsidered: The Person Comes First*. Buckingham: Open University Press.

Kuske, B., Hanns, S., Luck, T., Angermeyer, M. C., Behrens, J., Riedel-Heller, S.G. (2007). Nursing home staff training in dementia care: A systematic review of evaluated programs. *International Psychogeriatrics*, 19 (5), 818–841.

McCormack, B., Dewing. J., McCance, T., (2011). Developing Person-Centred Care: Addressing Contextual Challenges Through Practice Development. *The Online Journal of Issues in Nursing,* 16 (2), Manuscript 3.

Murphy, K., O'Shea, E., Cooney, A. (2007). Quality of life for older people living in long-stay settings in Ireland. *Journal of Clinical Nursing*, 16, 2167-2177.

Nolan, M., Davies, S., Brown, J., Keady, J., Nolan, J. (2004). Beyond 'person-centred' care: a new vision for gerontological nursing. *International Journal of Older People Nursing,* 13, 45–53.

O'Connor, D.W., Ames, D., Gardner, B., King, M. (2009). Psychosocial treatments of behavior symptoms in dementia: A systematic review of reports meeting quality standards. *International Psychogeriatrics,* 21 (2), 225-240.

O'Shea, E. (2007). *Implementing Policy for Dementia Care in Ireland: the time for action is now.* Dublin: Alzheimer's Society of Ireland.

Prince, M., Guerchet, M., and Prina, M. (2013a). The Global Impact of Dementia 2013-2050. London: Alzheimer's Disease International.

Prince, M., Bryce, R., Albanese, E., Wimo, A., Ribeiro, W., Ferri, C.P. (2013b). The global prevalence of dementia: A systematic review and meta-analysis. Alzheimer's and Dementia: *The Journal of the Alzheimer's Association*, 9, 63–75.

Slaughter, S., Cole, D., Jennings, E., Reimer, M.A. (2007). Consent and assent to participate in research by people with dementia. *Nursing Ethics*, 14 (1), 27-40.

Sumner, J. (2010). Original article Reflection and moral maturity in a nurse's caring practice: a critical perspective. *Nursing Philosophy*, 159–169.

Urquhart, C., and Fernández, W. (2013). Using grounded theory method in information systems: the researcher as blank slate and other myths. *Journal of Information Technology*, 28 (3), 224–236.

Vasse, E., Vernooij-Dassen, M., Spijker, A., Olde-Rikkert,M., Koopmans, R. (2010). A systematic review of communication strategies for people with dementia in residential and nursing homes. *International psychogeriatrics*, 22 (2), 189–200.

Vernooij-Dassen, M.J., Moniz-Cook, E.M., Woods, B., de Lepeleire, J., Leuschner, A., Zanetti, O. (2005). Factors affecting timely recognition and diagnosis of dementia across Europe: from awareness to stigma. *International Journal of Geriatric Psychiatry*, 20, 377–386.

Vernooij-Dassen, M., Vasse, E., Zuidema, S., Cohen-mansfield, J., Moyle, W. (2010). Psychosocial interventions for dementia patients in long-term care. *International Psychogeriatrics*, 22 (7), 1121–1128.

Ward, R., Vass, A., Aggarwal, N., Garfield, C., and Cybyk, B. (2008). A different story: exploring patterns of communication in residential dementia care. *Ageing & Society*, 28 (05), 629-651.

World Health Organisation. (2012). *Dementia: a public health priority*. Geneva: WHO.