‘Lost without Translation’

Practice Leaders as Code Breakers

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Context:

More than ever, people are living with dementia:

- It is estimated that there are 850,000 people living with Dementia in the UK, rising to over one million by 2025

(Alzheimer's Society, 2017)

Restrictive intervention practice – the practice challenge:

- Mental health practitioners manage restrictive interventions when working with people with dementia in a broad context of evidence based literature, legislation, policy guidance and evolving case law – it is highly complex.

Research Question

‘What factors impact on restrictive intervention management by mental health workers in acute settings for people with dementia?’

Literature Review

A review and thematic synthesis (quantitative /qualitative /mixed methods studies):

<u>Themes:</u>

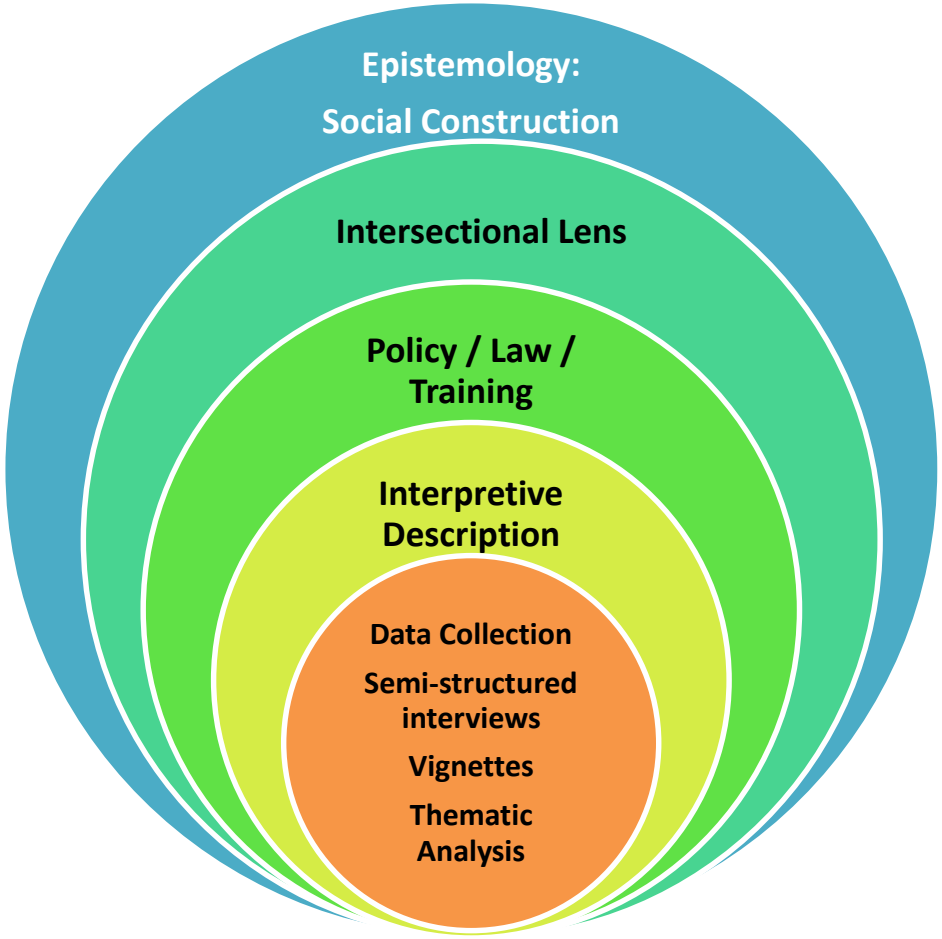
1. The impact of staff education on restraint levels.
2. The impact of supervision (consultancy, guidance, coaching) on restraint levels.
3. Dementia as a predictor of restraint.
4. Gender, dementia and restraint.

Research Setting:

- 2 acute NHS mental health in-patient facilities for older people provided by 1 mental health NHS Trust.

Site 1	Site 2
Restrictive intervention training specific to people with dementia	Restrictive intervention training for mental health
Modern environment – single en-suite bedrooms	'Traditional' – 4 bedded single sex bedrooms

The Methodological Framework:



Bryman, A. (2012) Social Research Methods. Oxford. Oxford university press; Carter, S. & Henderson, L. (2005) Approaches to qualitative data collection in social science. In: Bowling A. & Ebrahim, S (eds) Handbook of Health Research Methods: Investigation, Measurement and Analysis. Buckingham. OU Press; Denzin, n. & Lincoln, Y. (2011) (4th Ed) The Sage Handbook of Qualitative Research. London. Sage; Thorne, S., Kirkham, S. & O'Flynn-Magee, K. (2004). The Analytic Challenge in Interpretive Description. International Journal of Qualitative Methods. *3*(1), 1–20.

Group	Sampling	Recruitment	Data Collection
Group 1 **Practitioners (n=18)**	Purposive (sampling frame – all MH staff linked to dementia wards)	Via matrons – letters sent to all practitioners within the accessible population	Semi-structured using vignettes, digitally recorded and transcribed
Group 2 **Practice Leaders (n=5)**	Purposive (participants sought as specific sources of clinical experience / leadership)	Via matrons	Semi-structured using vignettes, digitally recorded and transcribed

Ritchie, J. and Lewis, J. (2003) Qualitative Research Practice. London. Sage.

Data Analysis:

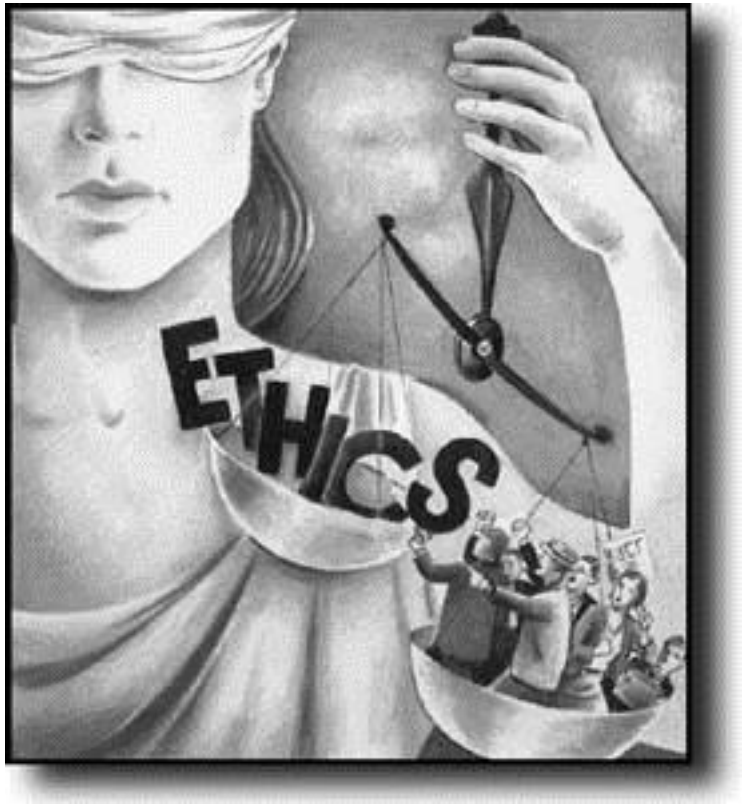
Six Phase Model - Braun & Clarke (2006)

- Familiarisation with the data
- Coding
- Searching for themes
- Reviewing themes
- Defining and naming themes
- Writing up

Braun, C & Clarke, V. (2006) Using thematic analysis in psychology. Qualitative Research in Psychology. 3.77-101

Ethical Issues:

- Formal approval from Lancaster University & the host NHS Trust
- Anonymity / confidentiality (due to the small sample of participants)
- Practitioner concern / distress when discussing sensitive issues
- The power differential between the researcher and participants



British Psychological Society (2010) Code of Human Research Ethics. Leicester. British Psychological Society; Gibbs G (1988) Learning by Doing: *A guide to teaching and learning methods*. Further Education Unit .Oxford; Nuffield Council on Bioethics (2009) Dementia: ethical issues. Cambridge. Cambridge Publishers.

Findings – Theme 1 Legislation:

- Legislative frameworks (eg Mental Capacity Act and Deprivation of Liberty Safeguards) not consistently understood by frontline practitioners.
- Practice approaches described were person centred and least restrictive but not framed by legislation

'I think the problem is that the guidance is so huge, detailed and shifting that it's actually not very helpful.....the sheer volume of guidance coming out and the subtlety and shifting nature...I think the ward staff do understand quite well, degrees of restrictiveness...and I think in practical terms, that's probably the most important thing' (Practice Leader)

*Legislation was then **TRANSLATED** into an organisational context.*

Findings – Theme 2 The Organisational Context:

Organisational policies and processes were utilised by participants to inform restrictive intervention practice: risk, medication, environment, time:

'I think we are in a much more sophisticated and…humane culture of care delivery now…than 15 years ago and part of that sophistication …has been the by-product of introducing …the MCA and DoLS' (Practice Leader)

*'I think you need to exhaust every other option, without exhausting her first and then going for that (*medication*) maybe'* (Practitioner)

*Policies / processes were then **TRANSLATED** by Practice Leaders to inform training.*

Findings – Theme 3 Training:

Findings which identified sources of knowledge which directly inform restrictive practice – training and supervision.

'I love mental health nursing. I think it's one of the most fascinating subjects you could get into....I was always learning something new, it never stays the same. When the Mental Capacity Act and Deprivation of Liberty Safeguards were being introduced, I was really interested in it because essentially.....it scared me because I thought 'I don't know if I really understand this'.....I constantly relate everything to a nurse being able to deliver the care in line with legislation and best practice at 3 o'clock in the morning after their fourth night shift in a row. Is this something that somebody can easily deliver and understand?' (Practice Leader)

*Practitioners then **TRANSLATED** training into practice.*

Findings – Theme 4 Person Centred Restrictive Intervention Practice:

'there is never a general rule….every single person is completely different'

'it's not gender related, it's not age related.....it's around their care needs....personalised care'

(Practitioners)

'I think that the staff on the wards have an inherent wish to make lives better and I think that 15 years ago that was expressed in terms of giving good personal care...and now I think there is more understanding about freedom'

'I think that one of the big responsibilities of the team...is to try to understand what's going through this guy's mind, what his concerns are….and that's not easy...but I think that's important'

(Practice Leaders)

Translation – A Summary:

An illustration of the story that the themes tell – how knowledge progresses from legislation to practice and how that journey is dependent on **TRANSLATION:**

So what does this mean:

Practice leaders come to know and use information in a different way to practitioners:

- leaders actively pursue knowledge via academic routes,
- practitioners actively participate in practice and learning

Reason, P. (2006) Choice and quality in action research practice. Journal of Management Enquiry. 15.2.187-203.

A Suggested Model of 'Translated' Ways of Knowing

Law / case Law / statute

1st translation by Practice Leaders : from law into the organisation - how to interpret complex , shifting guidance

Organisational Context:

Policies / Procedures / environment developed

2nd Translation by Practice Leaders : from policy to practice 'on the ground'- the development of training programmes

Mandatory participation in person centred restrictive intervention training

3rd Translation by Practitioners: Person centred restrictive intervention practice

Person with Dementia receiving care

To Conclude:

What are the implications for Practice:

- The model of translated knowing gives validity to the investment in practice leadership
- Knowledge expectations of frontline practitioners are unrealistic and unworkable – time to rethink?

What are the implications for Research:

What is the impact on environments which do not / cannot invest in practice leadership:

- Care homes?
- Domiciliary Care?

Do the most vulnerable people with dementia have the least access to practice informed by translation?

Thanks for listening……

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