Author’s response to reviews

Title: Process evaluation of the response of nursing homes to the implementation of the dementiaspecific case conference concept WELCOME-IdA: A qualitative study

Authors:

Daniela Holle (daniela.holle@hs-gesundheit.de)
Sonja Teupen (sonja.teupen@dzne.de)
Rabea Graf (rabea.graf@uni-bielefeld.de)
Rene Müller-Widmer (rene.mueller-widmer@dzne.de)
Sven Reuther (sven.reuther@dzne.de)
Margareta Halek (margareta.halek@dzne.de)
Martina Roes (martina.roes@dzne.de)

Version: 1 Date: 14 Aug 2019

Author’s response to reviews:

Dear Editor and Reviewers,

Thank you very much for your valuable feedback and comments regarding our manuscript, which have helped us improve the paper. Below you will find the point-by-point responses to your feedback and recommendations. For clarity, the revisions in the manuscript have been marked in red, and we have made changes in the font.

It was noted that the manuscript needs to be edited for language before being published. Prior to the submission of the paper, we sent the manuscript to American Journal Experts (AJE) to provide English language editing. Before re-submitting, we sent the article to AJE again with the request that they re-examine the English language. We hope that the manuscript now meets the journal’s requirements. As proof of both processes, we have attached the certificates of language editing from AJE.

Kind regards,

Daniela Holle, on behalf of all authors
BMC Nursing

Editor Comments:

1. In the Declarations, please clarify whether the consent obtained from the participants was written or verbal

Verbal informed consent was obtained from each participant in the telephone interviews, and written informed consent was obtained from each participant in the focus groups in advance of the interviews.

This information was added to the declarations.

2. Please remove the funding and ethics approval from the supplementary files.

Funding and ethics approval information was removed from the supplementary files.

Kristine Nordlie Williams (Reviewer 1)

Areas to clarify include the rationale for completing some phone interviews (with individuals) and some focus groups - how may the different formats have affected the findings and how these were integrated.

Thank you for the comment.

The telephone interviews aimed to obtain the individual interviewees’ perspectives on the ongoing implementation of the intervention, while the focus groups were conducted to learn how the different groups experienced the implementation process. Within both formats, the interviewees were addressed both as a group as representatives of their organization and as individuals. However, the dynamics of the group interviews resulted in data that can be understood as representing the group’s opinion, while the statements in the phone interviews are mainly understood as representing the participants’ individual perspectives on the organization. The reporting of the results reflects these different perspectives.

The missing information was added to the manuscript

Completing only 7 DSCCs in 1.5 years across 4 nursing homes is a very limited experience in implementing this program.

The nursing homes completed 47 DSCCs in total over a period of 1.5 years. Each nursing team (n = 7) conducted an average of 7 DSCCs during the 7-month intervention phase. The time span of 1.5 years resulted from the stepped wedge design of the cluster RCT. The intervention was
rolled out sequentially to one nursing home every 3 months over a period of 19 months. The missing information was added to the manuscript.

It should be addressed why some interviews were conducted very early in the implementation process (after first supervised DSCC).

The interviews were conducted promptly after the DSCC had been carried out, when the carers' memories of the past DSCC and their preparation for it were still very fresh and information could simultaneously be gathered regarding the preparation for the upcoming DSCC. This information was added to the manuscript. In addition, a table was added to provide information about the sequence of the intervention phase and data collection.

Future feasibility/scalability is also an issue due to the intensive 2-day training plus on-site supervision and should be addressed.

Thank you for the comment.

The WELCOME-IdA intervention already requires a considerable amount of time for training and facilitated practice; however, the results show that the intensive training of key people is not only necessary but also beneficial in the long run.

The missing information was added to the manuscript.

Table 1 includes description of the nursing staff who participated in the interviews and focus groups - it would be informative to know how many staff of different roles participated in the DCCS and what their roles were. It appears that nursing assistants (who are the largest group of direct care staff) were only minimally included.

We added information regarding who attended the in-service trainings for WELCOME-IdA, the DSCC and the coaching sessions for the steering group.

A direct comparison between the interview participants and the participants in the DSCC was not possible due to missing data. However, you are right that the majority of the people who attended the DSCC were registered nurses.

Was there any assessment of leadership style for administration and culture of the nursing homes?

We did not assess the leadership style of the administration or the culture of the nursing homes.

Descriptive information about the nursing homes would be helpful.

Descriptive information about the nursing homes was added to the manuscript.

Information is needed about how interview and focus group participants were recruited and if they provided an informed consent and were paid or otherwise compensated for participation.
Each nursing home had a study coordinator who was responsible for the recruitment of interview participants. All interview participants were provided with written material in advance of the interviews. For the telephone interviews, the participants gave verbal informed consent prior to each interview, which was then audiotaped. Written informed consent was obtained for all focus group interviews. None of the participants received financial incentives or gifts.

The missing information was added to the manuscript.

The discussion should also include plans for future research that might include a menu of strategies for nursing homes to select from to implement the program and also how success can be measured in terms of resident behavior management and other relevant outcomes.

Thank you for the comment.

Change in resident’s behaviour might not be the most suitable primary outcome for the chosen study design, the time frame, and the complexity of the situations in which challenging behaviour occurs. We think that another effective study with more time is needed so that success can be evaluated in terms of resident-related outcomes. Furthermore, we recommend a higher degree of staff and team outcomes. A hybrid III Design (Curran 2012) might also be a possibility.

This information was added to the manuscript.

Jacomine de Lange, Ph.D (Reviewer 2):

The manuscript describes the evaluation of the implementation of a mono-disciplinary approach for challenging behaviour in dementia. Why did the authors choose for a mono-disciplinary approach and not for a multidisciplinary approach, which is the standard approach for challenging behaviour in dementia (Zwijsen et al, 2014; Pieper et al, 2018)?

The intra-professional approach was chosen due to the results of prior feasibility testing of WELCOME-IdA (source Holle et al. 2015) that indicated that nursing staff did not feel competent in interdisciplinary involvement or the involvement of residents’ family members. At the time of our study, the participating nursing staff did not feel ready (e.g., accomplished/competent enough) to discuss the problems they experienced with people who were not NH/unit staff (e.g., general practitioners or relatives). To our knowledge, interdisciplinary consultation and the involvement of relatives took place before or after the DSCC. In Germany, neither physicians nor psychologists are part of the organization (nursing home).

The missing information was added to the manuscript.
The authors describe five triggers for analysing challenging behaviour. On the basis of which model or theory were these triggers chosen and why not for instance physical discomfort (pain), or unmet needs?

How did the analysis work and what kind of hypotheses were drawn up? A short example could help.

For the analysis of challenging behaviours, the IdA provides five different domains. Each domain includes several triggers of challenging behaviour. Unmet needs, physical discomfort and pain are included within the five domains of the IdA.

The need-driven compromised behaviour model (NDB model) provided the framework of the IdA. We decided not to describe the IdA in detail in this manuscript. Instead, we outlined in the manuscript that the development and evaluation of IdA have already been described elsewhere and added the reference to this manuscript (see reference Halek et al. 2017).

3 I miss the involvement of the client and his/her family in the decision making process. Please comment on that topic.

Please see our response to point 1.

This information was added to the manuscript.

4 R87

The study is part of a larger study with an RCT into the effectiveness of the intervention. For this manuscript and for the implications for practice it could be interesting to know something about the effectiveness of the intervention.

The results of the effectiveness study have been submitted to a journal and are still in the review process. That is why we decided not to report the results of the effectiveness of the intervention.

5 Method R116/117:

The authors state that this report follows COREQ? I do not recognize the COREQ criteria in the manuscript. Is it possible to add a table with the criteria and how they have been met in an appendix?

The manuscript is based on the recommendation of the COREQ guideline, but we did not follow the COREQ guideline in detail. This information is made explicit in the manuscript.
How were the participants of the RCT selected? Were there any refusals?

As the recruitment process was organized by a study coordinator at each nursing home, we have no knowledge of who refused to participate.

This missing information was added to the manuscript.

Is it possible to conduct telephonic semi-structured interviews in 15 minutes? How do you ensure sufficient depth? Give an overview of the themes of the semi-structured interviews and the focus groups.

The themes of the different semi-structured interview guidelines have been outlined in table 4.

The reasons for adoption or adaptation are not always described. This can be important for adjusting the intervention in the future.

Thank you for the comment. We carefully checked the manuscript and added the reasons for adoption and adaptation when possible. In cases in which the data did not reveal an explanation for the adoption or adaptation, we deleted the information from the manuscript.

Is it possible to add a description of the coding tree?

Due to the primarily deductive approach, we decided not to include a coding tree in the article. The structure and the headings of the result section provide the logic of the categories that were analysed.

the dominating person of the other nursing team: is this a disadvantage of the composition of the case conference or a task of the moderator?

Thank you for the comment.

This example shows the challenges of mixed teams and the different understandings about being a moderator.

We added complementary information in the manuscript to make this point of view clearer.
Are there also advantages reported of participation of staff from other teams by nursing staff? Did they reflect on their own role as nurse from another team in the case conference?

The nursing staff reported occasionally on the advantages of working with colleagues from another residential area. Nevertheless, among the nursing staff, the estimation that the DSCCs contributed to better communication within their own teams predominated since otherwise, nursing teams rarely have the opportunity in their everyday work to exchange information and to reflect on their different points of view, which were often described as heterogeneous.

12 Discussion:

The discussion is quite long with a lot of repetition. I would like to have a reflection on whether there are limits to the adaptation of the intervention or not.

Add clear implications for practice (adaptation of the intervention), for education and for research

We tried to shorten the discussion and reduce repetition. In the discussion, we outlined possible adaptations and limitations.

Added implication for practice:

Education of nursing staff, particularly in the field of dementia care, needs to cover hermeneutic methods of understanding behaviour like those lying beneath the IdA. One part of the intensive training within WELCOME-IdA aims at building this specific competency. Thus, intensifying hermeneutic methods in the basic nursing education (e.g., RN’s but also for CNA’s) would have an impact on the educational requirements of interventions focusing on complex reflecting and understanding such as WELCOME-IdA.

The missing information was added to the manuscript.

13 Conclusion:

is very general. Give a more detailed answer on the research question.

The conclusion was modified.