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A dementia communication training intervention based on the VERA framework for pre-registration nurses: Part I developing and testing an implementation strategy

Abstract

Background

People living with dementia experience progressive difficulty in expressing physical and emotional needs. Health care staff including student nurses require training to develop compensatory communication strategies. However, there is no standardised foundation level dementia communication training within pre-registration curricula.

Aim

This article describes the theoretical underpinnings and development of a foundation level dementia communication skills training based on the VERA (Validation, Emotion, Reassurance, Activity) framework.

Method

The training strategies drew on behavioural change theory using the COM-B model and Gagné's 9 Events of Instruction. The VERA framework was operationalised using a multicomponent teaching strategy. The intervention was refined based on quality improvement Plan-Do-Study-Act cycles with feedback from people living with dementia, facilitators and student nurses. Data collection used semi-structured questionnaires (n=51) and four focus group (n=19) interviews with students. Data analysis involved descriptive statistics and thematic analysis.

Results

The intervention was a 2.5-hour face-to-face training session delivered at the start of students' older adult unit placement with follow-up reflection sessions during placement. Training was delivered to 51 students, all students described the training as useful and would recommend it to their peers. Elements of the training that were highly valued were: opportunities to express concerns in caring for people with dementia, applying the VERA framework using role play and outlining realistic expectations of VERA. Students recognised the need for on-going training especially for more complex patients.

Conclusion

Combining behaviour change and education theory with stakeholder feedback strengthened the development of VERA as a foundation level dementia communication training for pre-registration nurses.

Key words: Dementia communication, skills, training, intervention design, student nurse, VERA framework

Introduction

Dementia is one of the leading health and social care challenges in the 21st Century. Globally, an estimated 46.8 million people live with the condition which is predicted to increase to 74.7 million by 2030 (Alzheimer's International 2017). Reflecting this population prevalence, between 25% to 42% of patients admitted to acute care settings have dementia (Timmons et al. 2015). There is substantial evidence of inadequate care received by older people and people with dementia in acute care (CQC 2014). The reasons are multifaceted, but are partly attributed to staff failures to recognise and respond to unmet physical and emotional needs (Clissett et al. 2013, CQC 2014, Dewing and Dijk 2014). Health care staff, especially students, readily admit to deficits in knowledge and skills to effectively engage with people with dementia (Scerri and Scerri 2013, Clissett et al. 2013, Dewing and Dijk 2014) with calls for specific dementia communication training.

This is the first of two articles reporting on the development and feasibility testing of a dementia communication intervention based on the VERA framework (Blackhall et al. 2011) for student nurses. The article outlines the theoretical principles and iterative development of the intervention based on stakeholder feedback from people living with dementia, facilitators, and students.

Background

National and international policy has highlighted inadequate preparation of the current and future health and social care workforce to meet the growing dementia challenge (Elliott et al. 2012, NICE 2017, WHO 2016). In the UK, the Dementia Core Skills Training Framework (Health Education England 2015) outlines three tiers of dementia knowledge and skill. Tier 1 applies to all health and social care staff with potential contact with people with dementia and implicitly includes student nurses. Across each of the three tiers, effective communication skills are a core competency with an expectation that all health and social care staff are 'able to communicate effectively and compassionately with people living with dementia' (HEE 2015, pg 13).

Within a dementia context ‘effective communication’ is a superficially simple concept. An effective communicator needs to take account of a person’s altered reality and sense of time and place; fluctuation in cognitive ability; prior life experiences and perhaps emotional trauma; sensory deficits; altered sense of risk or behavioural boundaries; reduced ability to retrieve, process, rationalise and retain information and articulate needs; with occasional episodes of distressed behaviour (Allan and Killick 2014). On top of which may be other acute illness, including delirium or depression and the unfamiliar, often frightening environment of acute care. There is a tendency to reduce this complexity to a simple list of ‘Do’s and Don’ts’. While core communication principles are valuable, effective communication, that takes account of the person’s individuality, optimises capacity to interact and facilitates meaningful involvement, requires lifelong learning and refinement. However, there needs to be a starting point, with foundation level training that enables all health care staff, including students to develop the same core communication building blocks and understanding of dementia specific needs. Yet despite over 30 years of research, there is no national or international consensus on what constitutes foundation or post-foundation dementia communication training.

Student Nurses and dementia

In acute care settings, student nurses, during their clinical placements, are part of the front-line workforce with the most sustained contact with people with dementia and their families. They provide direct nursing care and often have greater opportunity to interact with patients through daily activities and social communication compared to qualified staff. Evidence suggests that student nurses hold largely positive attitudes toward older people and have a reasonable knowledge of dementia as a clinical condition (Liu et al. 2013, Scerri and Scerri et al. 2013). However, students report feeling ill-prepared, under confident and even fear engaging with people with dementia, especially in the presence of distressed behaviour (Liu et al. 2013, Garbrah et al. 2017, Hammar et al. 2017). Central to students’ negative experiences is an inability to relate or communicate due to patient disability, which can be compounded by observing and modelling task-focused communication used by qualified staff (Nilsson et al. 2012, CQC 2014). There are repeated calls for innovation in preregistration curricula for all health care professionals to better equip

students to work with older people and people with dementia (Collier et al. 2015, Elliott et al. 2012, Garbrah et al. 2017, Hammar et al. 2017).

Dementia communication interventions

Systematic reviews by Eggenberger et al. (2013) and Machiels et al. (2017) focused on communication skills training for normative or “daily care” interactions in dementia. They identified between 6-12 trials, but none were conducted in acute care settings or involved students. In general, dementia training improved staff’s knowledge and self-reported competence in communication skills, but the impact on staff behaviour change was less consistent. The training interventions tended to be multicomponent with a small number using follow-up strategies to maintain staff motivation (Eggenberger et al. 2013, Machiels et al. 2017). The trial papers focused on reporting statistical results and often contained a superficial description of the intervention development process. There is an even weaker evidence base for dementia training in preregistration curricula for healthcare professionals. Alushi et al. (2015) identified nine studies, none used a randomised control trial design and the intervention theoretical frameworks tended to be poorly articulated. This weak evidence base, has resulted in a failure to operationalise ‘daily activities’ dementia communication in standardised foundation level training (Jackson et al. 2016). In preregistration health care programmes, such training should be theory and evidence based; easily applied and replicated; practical in busy clinical environments; and deliverable at scale.

Theoretical underpinnings

The dementia training intervention described herein incorporated the VERA framework described by Blackhall et al. (2011) and adds to the emerging evidence for VERA as a foundation level dementia communication training (Hawkes et al.2015). The theoretical perspective underpinning the intervention design was behaviourist and combined Gagné’s 9 Events of Instruction with Michie et al. (2014) Behavioural Change model for intervention design.

The goal of the intervention was to enable behavioural change whereby students could operationalise more consistent approaches to person-centred interactions with people living with dementia through increased knowledge and confidence in their skills. The Michie et al. (2014) COM-B model was used to inform the selection of behavioural change strategies to influence the capacity (c), opportunity (o) and motivation (m) of students to adopt and apply the communication techniques in practice (Table 1). While the actual content and flow of the training session aligned with Gagné's 9 Events of Instruction. (Table 1 supplemental file).

VERA Framework

The core of the training introduced students to the VERA framework (Blackhall et al. 2011), which consists of four concepts: Validation, Emotion, Reassurance, Activity. The framework is influenced by a person-centred care model (PCC) and Validation Therapy. The ethos of VERA is to accept and enter the inner emotional and personal world of the individual. It explicitly values the individual; accepts the individual's perspective has meaning; and aims to create a social environment based on respect and positive interaction between the person with dementia and carers.

The VERA framework was developed at Anglia Ruskin University to support student nurses to operationalise PCC within the context of a clinical environment and their position as 'novice' learners. It sought to address students' uncertainties regarding 'the correct approach' to communicating when a person has dementia. For example, a key question asked by many students is 'Do you go with what the person is saying or do you try to bring them back to reality?'

This reflects an underlying tension between Reality Reorientation as a therapeutic approach to optimise and retain cognitive function (Spector et al. 2000) and Validation therapy as an approach to accepting the person's reality and emotional response as legitimate and responding with empathetic listening and searching for meaning (Neal and Barton Wright et al. 2003). The evidence base for either approach is weak and care staff should determine the most appropriate approach based on knowledge of the individual (NICE 2017).

VERA focuses on the person's emotional state rather than on actions or what is siad. The carer explores the unmet physical and/or emotional needs of the individual and avoids imposing a single reality or priorities for medical treatment. It supports staff to develop therapeutic relations with patients and move beyond task focused and superficial communication (Example of VERA http://bit.ly/2tuPCDP).

Insert Box 1Illustration of a reality reorientations versus VERA type response

Although the VERA framework has been in the public domain since 2011, there has been limited testing in other clinical settings or with different student or staff cohorts. This project focused on developing a pragmatic strategy to operationalise the VERA based dementia training and to refine it through student feedback and experience.

Insert Table 1 Application of COM-B behavioural change model

Developing the intervention

Ethical approval for the study was provided by the University Ethics Committee (HR15/162270). There were five overlapping phases in the intervention development over a 12 month period.

Phase 1: The initial selection of components in the training was based on a review of the literature on dementia communication interventions and in discussion with the DH from Anglia Ruskin University, where VERA is already part of the pre-registration nursing curriculum.

Phase 2: We held a co-design workshop with 7 first year adult nursing students who had completed placements in an older adult unit (OAU). The students recounted their experiences from placement, communication challenges and how they dealt with them. Based on these experiences CN and CB scripted 4 case vignettes for student role play, scripts were shared with students to verify authenticity (supplemental file). Students asked for specific communication strategies as they already knew many of the broad principles (use short sentences, avoid too many questions, etc.) of dementia communication. They were unsure of 'how far to go along' with someone's reality and what to do if a person became aggressive. Finally,

while they understood the concept of distraction activities, there were few ideas of how to achieve this in an acute care environment, they were also worried about staff's reaction to them 'trying out' new approaches with patients.

Phase 3: The first trial of a 2 hour training session was held with 18 second year students from both the mental health and adult programme as part of a scheduled older adult module. Students' reactions were positive, they liked the VERA framework and described it as 'making sense' and intuitive. They valued the opportunity to practice VERA using role play. Based on facilitator experience and student feedback, there was inadequate time for student rehearsal of VERA and discussion of its application in more complex cases.

Phase 4: In collaboration with the Alzheimer's Society, we visited a Service User Review panel to present the project ideas. CN and VT meet with 3 people living with dementia and 3 members of staff in an Alzheimer Society Day Centre. During the meeting we presented an overview of the training and an illustration of VERA. We discussed VERA as a concept and sought their views on teaching this approach and reviewed one of the case vignettes.

Among the panel there was agreement that student nurses should receive specific preparation for communicating with people with dementia, in particular, the concept of accepting the person's reality resonated strongly with the group. The panel liked the simplicity of VERA, and they felt the role play case vignette was authentic, reflecting some of their experiences of hospitalisation.

A male panel member with Alzheimer's disease commented:

'Become confused when in the hospital; might upset the person; VERA might have a great effect; it is a waste of time to drag into reality. No trust; only comfortable when talking about the old days; do it (use the framework) very enthusiastic about it; fundamental [students get training]'.

Phase 5:The subsequent development used quality improvement plan-do-study-act (PDSA) cycles to modify the training (Health Foundation 2013). The training was delivered at the start of students' routine older adult unit placements (OAU). These placements were selected due to the high prevalence of patients with dementia,

which afforded students the opportunity to apply the training in practice. OAU managers were provided with information and details of the dementia training. Over 5 PDSA cycles training was modified based on feedback from students at the end of each session and from focus group interviews at the end of clinical placements (Table 1 supplemental file).

The final intervention was 2.5 hours in length and consisted of a combination of information giving (PowerPoint presentation), video story of a PWD, active learning techniques, practice using distraction activities, demonstration, student roleplay applying the VERA framework to case vignettes, discussion of application in practice and difficult communication situations, goal setting, a student dementia manual and letter for the student's clinical mentor indicating they had completed the dementia training. In addition, there were follow-up one-to-one or small group reflections with students during clinical placement. The purpose was to reinforce the learning and explore students' experiences of implementing the techniques in practice. These visits were part of the scheduled contact between students and the OAU link lecturer (a member of the university faculty who visits the students during their clinical placement to support both students and mentors).

Delivering the Intervention

Students from the adult nurse programmes allocated to OAU in two acute hospitals over an 8 month period (April to December 2016) were eligible to receive the training. There were five separate placements ranging from four to twelve weeks in duration.

Students were initially offered training during their university study days, but there was insufficient space in the curriculum and student up-take was low. Instead, the research team negotiated with ward managers from the intervention OAU to release students for training during the first week of their clinical placement. Training was delivered in on-site education facilities attached to the hospitals, but separate from the OAU. In total, 14 training sessions were delivered across two sites with between 2 to 10 students per session. This approach maximised student recruitment in the intervention sites.

Evaluation from facilitators' perspective

The training was delivered mainly by three facilitators CN, RV and RE, this ensured consistency in the training, but added significantly to teaching workload. From facilitators' perspectives, the training was interactive and students were motivated and enthusiastic about participating. In the small group setting, students felt more comfortable expressing concerns and fears in caring for people with dementia and there was greater opportunity to tailor the session to individual group needs. The disadvantages were the time commitment from facilitators, difficulty securing teaching space, and additional work for OAU student coordinator in roistering students for training and possible interruption of ward activity. Finally, some students may have felt pressurised to participate in the training.

In addition to the 2.5 hour teaching session, there were student follow-up reflection sessions facilitated by the ward link lecturers (CN, RV). Due to time pressures and the busyness of the units, only 5 such sessions took place and lasted between 10-15 minutes with 1-4 students per session.

Evaluation methods

At the end of each training session, students provided anonymous feedback using a paper semi-structured questionnaire. Students were asked to comment on a) what did you like about the training? b) What did you not like? c) what would you change to improve the training? Students were also asked to rate on a five point Likert scale their perception of the training with responses ranging from 'very likely' to 'very unlikely': a) how likely are you to use the communication techniques in practice? b) how likely are you to recommend the training to other students? c) how likely are you to use on-line resources if available?

Focus group interviews

At the end of clinical placement 4 focus group interviews were carried out with 19 students. Interviews were staggered from May to December 2016 to gauge students' reactions to intervention modifications. In this article responses to the specific questions on the 2.5 hour dementia training are presented.

Student's responses from both the questionnaires and focus group interviews were uploaded to NVIVO 11 software. Descriptive statistics and thematic analysis as outlined by Braun and Clarke (2006) was used to identify common and divergent

themes from the perspective of the intervention strengths and areas for improvement (table 3).

Results

In total 51 students participated in the training and provided questionnaire feedback (intervention group). Students were mainly from the larger BSc. programme and were in the first or second year of their course (Table 2). Over 60% had experience of people with dementia, but nearly one third had no prior training on dementia. The profile of students (n=19) who participated in the focus group interviews was similar to that outlined in Table 2 (supplemental file).

Table 2 Profile of students undertaking training

All students (100%) who participated in training indicated they found the training useful, they were likely or very likely to use the skills in practice and would recommend the training to other students. Over 83% indicated they would use on-line resources if available.

In the synthesis of the open-ended questions in the survey with the focus group interviews four main themes were identified related to the training: increased knowledge but more required, role play love it or hate it, session format, and additional resources. Table 3 illustrates students' perspective on the strengths and areas for intervention improvement.

Increased knowledge but more required

There was a consensus among students that they had increased their knowledge and understanding of dementia communication approaches. This positively impacted on their confidence at the start of placement and relieved some of their stress.

> It was reassuring to know others had the same struggles, I worry about communicating with people with dementia, now I feel much more confident about how to alter my approach to suit someone with dementia [Focus group (FG) 1, Participant (P) 5].

Students in the mid and final stages of their programmes commented that they would value the training earlier in their first year, as they had cared for people living with dementia in other medical and surgical units.

> Really useful! Makes you look back at past experiences wishing you knew what you learnt today then [FG 4, P12]

Students valued the training, but many recognised they required additional skills and strategies to manage patients with distressed behaviour.

> Could be longer so we can discuss more difficult cases - i.e. people who are uncommunicative, crying, or aggressive [questionnaire anonymous]

Role play 'love it or hate it'

Role playing the application of the VERA framework attracted the most comments. The vast majority perceived it as beneficial and even enjoyable, it made the session interactive and helped students visualise how they could apply the framework in practice.

> It gave me some practical experience through role-play with feedback so I feel comfortable to try and implement this in practice" [FG 2, P 8].

During the early phases of testing the intervention, students indicated they wanted the opportunity to play the part of both the nurse and the patient with dementia. Students commented that playing the part of the patient gave them an insight into what it felt like to experience difficulty communicating their needs; this change was subsequently introduced to the role play. Some students requested more opportunities for role play, especially with more challenging situations.

However, a small group of students felt too self-conscious and found it very difficult to act out the part of the patient, which in turn impacted on their partner's ability to apply the VERA framework. To help overcome this problem we wrote more detailed patient scripts and facilitators were prepared to step in with suggested phrases.

Session format

There were mixed views on the duration of training. For many students, 2.5 hours was adequate to meet their learning needs. For others, especially those with less experience, they found the session contained a lot of new information and they would like separate sessions. A group size of 8-10 student worked well as it allowed students to get to know other students on placement with them. While practicing the role play together reinforced their commitment to use the training once back on the OAU.

Additional resources

At first, the Dementia Communication Manual was given to students at the end of the session, however, feedback in the focus groups suggested that many students never used it. The manual was then incorporated into the session with students using it to practice distraction activities such as reminiscence or word games during the training. There were some reports of increased use, but students suggested that revisiting the manual during the follow-up reflections with link lecturers and making a copy available on the OAU may increase use.

Other suggestions from students were to provide more examples of student and patient experiences and videos of nurse and patient interactions. Developing an on-line e-learning resource was considered in response to feedback in the questionnaires. However, when explored in greater depth in the focus group interviews, there was a less positive response, with many students feeling they were unlikely to use e-learning activities as an optional extra. Students' preference was for face-to-face training and follow-up during their placement.

Table 3 Feedback on intervention and areas for improvement

Discussion

The dementia training based on the VERA framework was co-produced with educators, students and people living with dementia. The training was enthusiastically received by students with many feeling more confident and less anxious about starting placement. The training drew on theories of adult learning and behaviour change. The specific training components were selected to optimise students, capacity, opportunity and motivation to apply VERA during interactions with patients with dementia.

The design process was iterative and evolved to reflect students' immediate reactions to training and their feedback from their experiences in practice. Low fidelity simulation using role play was a core component of the training intervention. Students acted the part of the patient and nurse with briefings before and after to stimulate reflective learning. The Standards of Best Practice: Simulation (INACSL 2016) were not available at the time of this work, however, the majority of the 11 INACSL criteria were implicitly met. Further refinement of the intervention can be strengthened by application of these standards.

The primary purpose of this study was to design a foundation level dementia communication training that was meaningful and acceptable to students and that was potentially scalable across large student cohorts. The VERA framework has an implicit simplicity that helps students to begin to manage the sometimes very complex communication challenges of people living with dementia. It does not claim to meet the demands of every patient scenario or overcome complex organisational cultures (Dewing and Dijk et al. 2014). However, it instils and operationalises principles of person-centred care that can be built upon in future training. In essence, it is the equivalent of teaching students basic handwashing skills, but throughout their professional life they will build on their wider infection control practice.

Wood et al. (2016) described a more intensive, 7 hour intervention for a multidisciplinary studentship with follow-up visits to a care homes. In terms of resources, such an intervention may be difficult to deliver at scale, but it is likely to contain greater education content compared to the 2.5 hour intervention described herein. Barboasa et al. (2016), tested the impact of education combined with clinical coaching in a care home setting; however, even in trial conditions, it was difficult to

sustain the intervention and the early improvement in staff behaviour deteriorated over time. There are resource implications in delivering dementia training, the implementation format described here was a combination of theory and pragmatic decisions, but in terms of scalability, it may not be practical to deliver training aligned to older adult placements, especially as some students miss OAU placements altogether. Alushi et al. (2015) highlight the lack of funding for rigorous research to establish an evidence-based intervention to address students' request for dementia communication training. A failure to provide specific dementia communication training in preregistration programmes for all health care professionals is a missed opportunity to influence the future workforce (Elliott et al. 2012, Jackson et al. 2016).

Limitations

The design and delivery of the intervention were constrained by resources and time. In particular, more structured follow-up during clinical placement and adjunct e-learning materials may have helped re-enforce student learning. The same researchers were involved in both the delivery of the intervention and data collection; this potentially could have resulted in socially desirable responses from participants.

Conclusion

There is an urgent need to develop a standardised foundation level dementia communication intervention to better prepare future health and social care staff to meet the dementia challenge unfolding around the world. Nursing curricula can lead the way through testing and refining pragmatic, fit-for-purpose frameworks such as VERA. This paper outlines the theoretical assumptions, learning materials and pragmatic decisions taken in designing this training intervention. The second paper reports on data from the feasibility evaluation.

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